15 – Resolution of Provider Disputes

Overview

Introduction

This section identifies the policies and procedures for dispute resolution that providers have a contractual obligation to follow. Some of the operational issues that may be identified as areas of concern for providers participating with BCBSNM are:

- Disputes regarding claims
- Determination of medical necessity
- Contract issues, including contractual language, reimbursement, termination, and credentialing/quality issues
- Quality-of-care issues
- Potential cases of fraud

The subsections below further define the five BCBSNM classifications of provider disputes:

- Claims reimbursement
- Claims bundling and medical disputes
- Contractual and operational disputes
- Provider terminations
- Medical appeals on behalf of the member

If after following the procedures set forth below, the issue is not resolved, or if you have a question regarding the procedure, contact the Network Services Department to speak with the Network Contract Representative or Lead Provider Representative for your geographic region. See the telephone directory at the beginning of this manual or go to Contact Us on the provider home page at bcbsnm.com.

Continued on next page
Overview, Continued

## Contents

This section contains the following topics:

<table>
<thead>
<tr>
<th>Section</th>
<th>See Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.1 Claims Reimbursement Disputes</td>
<td>15-3</td>
</tr>
<tr>
<td>15.1.1 Initial Submission of a Claim</td>
<td>15-3</td>
</tr>
<tr>
<td>15.1.2 Appeals</td>
<td>15-4</td>
</tr>
<tr>
<td>15.2 Claims Bundling, Complex Procedures, etc.</td>
<td>15-6</td>
</tr>
<tr>
<td>15.3 Contractual and Operational Disputes</td>
<td>15-7</td>
</tr>
<tr>
<td>15.4 Provider Terminations</td>
<td>15-8</td>
</tr>
<tr>
<td>15.4.1 Determination of Termination</td>
<td>15-8</td>
</tr>
<tr>
<td>15.4.2 Notification of Termination</td>
<td>15-8</td>
</tr>
<tr>
<td>15.4.3 Appeal Rights and Responsibilities</td>
<td>15-9</td>
</tr>
<tr>
<td>15.4.4 Fair Hearing</td>
<td>15-9</td>
</tr>
<tr>
<td>15.4.5 Notification of Final Determination</td>
<td>15-11</td>
</tr>
<tr>
<td>15.4.6 Expedited Terminations</td>
<td>15-11</td>
</tr>
<tr>
<td>15.5 Appeal on Behalf of the Member for Medically Related Issues</td>
<td>15-13</td>
</tr>
<tr>
<td>15.6 Other Provider Disputes, Complaints, and Appeals</td>
<td>15-14</td>
</tr>
<tr>
<td>15.7 Attachments:</td>
<td>15-14</td>
</tr>
<tr>
<td>Claim Review Form</td>
<td></td>
</tr>
<tr>
<td>Grievance Procedures</td>
<td></td>
</tr>
<tr>
<td>Provider Request for Appeal on Behalf of a Member</td>
<td></td>
</tr>
</tbody>
</table>
15.1 Claims Reimbursement Disputes

15.1.1 Initial Submission of a Claim

Claims will be returned at initial submission if they are missing vital provider identification or the member information cannot be identified. These claims are sent back via the “reject” report for electronically submitted claims or physically returned with the missing information noted. Your contract stipulates that claims returned for any additional information must be returned to BCBSNM within 30 days of receipt. If these claims are not resubmitted, you risk being denied for timely filing if discovered late (180 or more days). When these claims are returned, they are considered to be the initial submission of the claims. Refer to Section 8 for Timely Filing requirements.

The most common reasons for rejection of claims or a request for additional information are:

- Member’s group coding is incorrect or not present (if you file electronically, this is automatically researched and filled in)
- Provider tax ID, addresses, etc., do not match the provider NPI given
- No procedure or diagnosis codes

If within 30 days from the date of service, you have not received an accounting of the claim, please do not resubmit the claim. BCBSNM provides self-service options utilizing the internet to request claim status on previously submitted claims. For more information regarding the available on-line tools visit Availity. There is also an automated interactive voice response system (IVR) available to verify claim status.

Obtaining claim status prior to re-filing saves administrative costs by eliminating duplicate handling of previously submitted claims. If you wish to follow-up by phone, please call:

- Provider Service Unit: **1-888-349-3706**
- Federal Health Plan Unit: **1-800-245-1609**

Continued on next page
15.1 Claims Reimbursement Disputes, Continued

15.1.2 Appeals

Provider appeals include, but are not limited to:

- Payer allowance
- Medical policy or medical necessity
- Incorrect payment/coding rules applied

Provider appeals are not considered:

- Corrected claim (see Section 8.5)
- General inquiry/question
- Claim denials needing additional information

Should the provider dispute the payment of a claim for any reason (e.g., the claim was denied, paid at an incorrect benefit level, or reimbursed incorrectly), the provider has the following appeal procedure options:

Timely Filing of Claim

Section 8, Claims describes the process for claims submission. The timely filing section defines the requirements and the documents considered acceptable as proof of timely filing.

Claims

Initial telephone inquiry is generally made with a Customer Advocate (CA) in the Provider Service Unit (PSU) or Federal Health Plan Unit associated with the member’s benefit plan. Contact can be regarding the member’s benefits, eligibility, or the status of a claim. If it is a question regarding the claim reimbursement [as shown on the Provider Claims Summary (PCS)], the CA will research the claim to determine if the claim has been paid correctly. If a payment error was made, the claim is then processed as an adjustment.

If the provider office has examined the PCS and determined that the claim was processed in error, it may be appealed directly by using the Claim Review Form following this section. Please follow the directions on the form and identify the issue as clearly as possible.

Continued on next page
15.1 Claims Reimbursement Disputes, Continued

15.1.2 Appeals (continued)

Resolution of a Claim
Once a determination of payment is made, the appropriate unit is contacted with a recommendation as to the final disposition of the claim. Most claim disputes are handled at the customer service level by the supervisor in coordination with the unit manager. For complex or high-dollar claims, the issue may be escalated to a director of the claims unit.

Level of Reimbursement
If the provider’s concern is that the payment of the claim was insufficient for the level of service provided, for consideration of add-on codes, or other claims reimbursement issues, the provider should contact Customer Service. If the issue is not resolved to the provider’s satisfaction, the provider may contact the Network Contract Representative for the geographic region where the provider resides. The contract representative then consults with representatives of the Medical Review Unit (MRU), who may refer the question to the Medical Director to evaluate the provider’s claim for additional reimbursement. If the complexity of the procedure warrants increased payment as determined by the Medical Director, a request for adjustment is then submitted to the appropriate unit.

Change in Fee Schedule
If the situation requires a change in the fee schedule for all claims submitted by the provider, the request is reviewed by a Network Management committee consisting of:

- Network Services Contract Representative
- Network Services Manager
- Divisional Vice President, Network Management
- President
15.2 Claims Bundling, Complex Procedures, etc.

Disputes about bundling, complex procedures, medical policy, etc., are sent to the Medical Review Unit (MRU) of the Health Services Department for resolution. If the decision is reversed after the review is completed, additional benefits will be paid through an adjustment. If the original decision is upheld, the Health Services Department will inform you by letter within 20 working days after receipt of all requested information.

Note: For medical appeals on behalf of members, see Subsection 15.5.

Effective November 21, 2008, Medical Doctors and Doctors of Osteopath (MDs/DOs) may file a post-service provider appeal to resolve disputes limited to the application of coding, payment rules, and methodology related to ClaimsXten, bundling and modifiers. BCBSNMs internal appeal process must be exhausted before an external appeal will be considered. The provider appeals are conducted by an independent review organization, MES Solutions. An appeal can be submitted online, by fax, or by mail. The guidelines for submitting an appeal and the applicable fees can be found at MES Solutions.
15.3 Contractual and Operational Disputes

The Customer Service Unit receives all provider correspondence regarding contractual language or reimbursement disputes. This correspondence is imaged and sent to the Network Services Department for review by the contract representative for each provider's geographic region. The contract representative will reply within 20 working days of receiving all information required for resolution. Depending on the nature of the complaint (i.e., contract language, fee schedule change, etc.), the request may be reviewed by a committee consisting of:

- Network Management Contract Representative
- Network Services Manager
- Divisional Vice President, Network Management
- President

The preceding information identifies the general categories of dispute presented by providers. It also lists individuals responsible for resolution of the various types of operational disputes. We encourage contracted providers to discuss any concerns they may have regarding BCBSNM operations. Correspondence received in Customer Service from providers regarding operational disputes is routed to the appropriate division for review.
15.4 Provider Terminations

Overview

BCBSNM affords any provider terminated from our network the right to appeal the termination decision in accordance with the New Mexico Managed Health Care Plan Rule and the New Mexico Patient Protection Act. Appeal rights do not apply to a provider-initiated resignation from the network, a mutually agreed upon dissolution of a contractual relationship, expirations, or non-renewals of fixed-term contracts, or contract default.

15.4.1 Determination of Termination

A provider may be terminated by BCBSNM as a result of business needs; contractual issues; failure to meet standards or performance expectations related to credentialing, re-credentialing, utilization management, quality assurance, quality improvement, or fraud and abuse issues; or any other internal review process. Each of these internal processes includes avenues for addressing issues prior to termination, when such avenues are appropriate.

15.4.2 Notification of Termination

When BCBSNM terminates a provider from the network, BCBSNM notifies the provider in writing at least 30 calendar days in advance of the effective date of the termination, unless BCBSNM determines there is imminent risk to the health and safety of its members, in accordance with the expedited termination process described below.

The notification correspondence describes the reason for termination and, if applicable, summarizes any previous corrective action that took place in an attempt to avoid the need for termination. This correspondence informs the provider of the effective date of the termination of each applicable contract the provider holds with BCBSNM. The correspondence also details the provider’s rights regarding an appeal of the termination.

Continued on next page
15.4 Provider Terminations, Continued

15.4.3 Appeal Rights and Responsibilities

Notification of termination includes an explicit explanation of the provider’s right to request, in writing, an appeal which includes the right to a fair hearing if the termination is on a for-cause basis. The provider is informed:

- how to submit the written request for appeal to BCBSNM;
- that he or she may submit a written appeal with any supporting documentation or may appear in person at a fair hearing if the termination is for cause;
- that he or she may provide additional written information before or during the fair hearing, regardless of whether or not the provider attends the hearing;
- that he or she may ask questions of any BCBSNM representative at the fair hearing;
- that he or she has the right to representation, including but not limited to legal representation; of reasonable responsibilities that he or she must accept, including compliance with time frames, written notification of confirmation of attendance or non-attendance, and compliance with the rules of procedure established for the fair hearing, if a fair hearing is requested.

If BCBSNM determines in good faith and with reasonable belief that further care by the provider will result in imminent and significant harm to members, and then terminates the provider without advance written notice, the provider is notified that he or she may have an expedited hearing.

15.4.4 Fair Hearing

Providers terminated on a for-cause basis are afforded the opportunity to request in writing a fair hearing as part of their appeal rights. Providers may choose to exercise their appeal rights by providing written material and/or by:

- attending the fair hearing
- attending a fair hearing at which the provider may be represented by an attorney or by any other person the provider chooses
- having a representative attend a fair hearing in their place

Continued on next page
15.4 Provider Terminations, Continued

15.4.4 Fair Hearing (continued)

In all cases, “attending” a fair hearing is interpreted to include attendance in person, by teleconference, by videoconference, or by whatever method or technology that may exist that allows for real-time communication by which the provider may exercise his or her rights as described in this document.

After a fair hearing is requested in writing, the provider is informed of the rules of conduct and procedure of the hearing. To promote maximum information exchange, the hearings are held as informal proceedings that are not subject to civil rules of evidence.

The fair hearing is held as expeditiously as possible within 30 calendar days of BCBSNM’s receipt of written notification of the provider’s intent to appeal.

The fair hearing is facilitated by a senior management staff member. Other staff members are assigned to the hearing as appropriate based upon the nature of the reason for termination. BCBSNM legal counsel may attend the hearing.

At the fair hearing, the provider is afforded the opportunity to:

- Be informed of all information used in making the determination to the extent such access is permitted under state and federal law, regulation and rules, and BCBSNM policy.
- Present, in oral or written format, any information to the fair hearing officer or committee that the provider feels would support a reversal of the determination.
- Ask any questions of BCBSNM representatives on the committee.
- Answer questions posed by BCBSNM representatives on the committee.

The appeals process and fair hearing (if requested by the provider) leads to a determination of whether or not to uphold the termination. This determination is reviewed and approved by a senior vice president or official designee prior to being sent to the provider.

Continued on next page
15.4 Provider Terminations, Continued

15.4.5 Notification of Final Determination

BCBSNM informs the provider in writing of the final determination within 15 days of the date of the fair hearing. If the termination is reversed, the provider is also notified of any limitations, stipulations, contingencies, or follow-up required. If the termination is upheld, the termination occurs as scheduled in the initial notification letter.

15.4.6 Expedited Terminations

If BCBSNM reasonably determines that a provider poses an imminent risk to the health or safety of members, BCBSNM may issue an expedited termination.

BCBSNM considers certain actions that are a matter of official record to be sufficient, on their face and a priori, for BCBSNM to conclude in good faith and with reasonable belief that there is an imminent and significant risk to the health and safety of members. Depending on the specific details, these actions may include but are not limited to:

- Loss, restriction, sanction, or stipulation of professional license
- Loss, restriction, sanction, or stipulation of clinical privileges
- Legal findings of gross negligence
- Inclusion on a Medicare or Medicaid sanction report
- Indictment or conviction of a felony
- Conviction of a misdemeanor that substantially endangers the public, such as driving while intoxicated

When BCBSNM determines it must institute an expedited termination, the effective date may be less than 30 days from the date of notification. In cases where BCBSNM has determined in good faith and with reasonable belief that further care by the provider would result in imminent and significant harm to members, the provider is notified in writing of the termination; however, written advance notice of the termination may be waived.

Continued on next page
15.4 Provider Terminations, Continued

15.4.6 Expedited Terminations (continued)

If BCBSNM terminates a provider from the network without written advance notice because BCBSNM has determined in good faith and with reasonable belief that further care by the provider would result in imminent and significant harm to members, the provider is informed that he or she may request in writing an expedited fair hearing. This written request must be made within 15 calendar days of the notification of termination or it will be deemed that the provider has waived appeal rights. The date for an expedited fair hearing will be set to occur as soon as practicable, within 30 days of the provider’s termination.

All other elements and conditions of the Provider Grievance of Terminations plan described above apply to expedited terminations, including written notification, explanation of the reason for termination, explanation of appeals and fair hearing rights and responsibilities, and notification of the final determination.
15.5 Appeal on Behalf of the Member for Medically Related Issues

This section applies to "member/patient" appeals, where they are requesting assistance from their health care provider to appeal an adverse determination of medically related issues. The member/patient must provide authorization, as indicated by their signature and a statement to this fact. See the attached Provider Request for Appeal on Behalf of Member form. For additional information regarding the grievance procedures available to members and providers acting on behalf of members, see the Grievance Procedures from Sections 13.10.17.1, et seq., NMAC reprinted at the end of this section. Appeal information may also be obtained by calling the BCBSNM Appeals Department at 1-800-205-9926 and/or the appropriate Customer Service area (use the phone number on the member's ID card).

Department of Labor (DOL)-ERISA
Members who received their appeal rights under DOL-ERISA receive one level of appeal called the DOL-ERISA committee appeal. The member or his or her representative can provide additional information to the committee, but the member does not participate in the actual committee meeting. The request for an appeal must be received at BCBSNM within 180 days of the initial denial.

Not covered under Managed Health Care or DOL-ERISA regulations
Members who are not covered under either of the above regulatory bodies are entitled to one level of appeal that is a chart review and not a panel or committee review process. The member may submit additional information and the request must be received within 180 days of the original denial.
15.6 Other Provider Disputes, Complaints, and Appeals

Other Provider Disputes, Complaints, and Appeals

Providers that are dissatisfied with the results of BCBSNM’s internal grievance procedure and that have exhausted BCBSNM’s internal grievance procedure may file a complaint with the superintendent regarding the subject of the provider’s grievance to BCBSNM.

Providers seeking the superintendent’s review of BCBSNM’s grievance decision shall file a written request with the superintendent within 30 days from receipt of a written decision of BCBSNM concerning the grievance. After appropriate investigation of a provider’s complaint, the superintendent may schedule and conduct a hearing pursuant to Article 4 of the Insurance Code.

For assistance with the resolution of any provider disputes, complaints or appeal processes not described above, please contact your NM Network Services Contract Representative.

15.7 Attachments

- Claim Review Form
- Grievance Procedures
- Provider Request for Appeal on Behalf of a Member
Endorsement: Grievance Procedures

This endorsement is made a part of your Blue Cross and Blue Shield of New Mexico (BCBSNM) health care plan benefit booklet effective June 1, 2012. This endorsement applies to all fully insured individual and group health plans. If you have a question about these changes, please call your Customer Service Advocate at the phone number printed on the back of your identification card.

BY:

Kurt Shipley
President, Blue Cross and Blue Shield of New Mexico

GRIEVANCE PROCEDURES

The following provision establishes procedures for filing and processing adverse determination grievances and administrative grievances regarding actions taken, or inaction taken, by BCBSNM and replaces the current “Appeals Process” under the Claims Payments and Appeals section of your benefit booklet:

DEFINITIONS: As used in this section:

administrative grievance means an oral or written complaint submitted by, or on behalf of, you regarding any aspect of a health benefits plan other than a request for health care services, including but not limited to:

(1) administrative practices of BCBSNM that affect the availability, delivery, or quality of health care services;
(2) claims payment, handling, or reimbursement for health care services; and
(3) terminations of coverage;

An Independent Licensee of the Blue Cross and Blue Shield Association
adverse determination means any of the following: any rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time), a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit including any such denial, reduction, termination, or failure to provide or make payments that is based on a determination of a participant’s or beneficiary’s eligibility to participate in a plan, and including with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational, or not medically necessary or appropriate;

adverse determination grievance means an oral or written complaint submitted by, or on your behalf, regarding an adverse determination;

certification means a decision by BCBSNM that a health care service requested by a provider or you has been reviewed and, based upon the information available, meets BCBSNM's requirements for coverage and medical necessity, and the requested health care service is therefore approved;

culturally and linguistically appropriate manner of notice means;

(1) notice that meets the following requirements:
   a. BCBSNM must provide oral language services (such as a telephone customer assistance hotline) that includes answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English language;
   b. BCBSNM must provide, upon request, a notice in any applicable non-English language;
   c. BCBSNM must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by BCBSNM; and

(2) for purposes of this definition, with respect to an address in any New Mexico county to which a notice is sent, a non-English language is an applicable non-English language if ten percent (10%) or more of the population residing in the county is literate only in the same non-English language, as determined by the department of health and human services (HHS); the counties that meet this ten percent (10%) standard, as determined by HHS, are found at http://ccio.cms.gov/resouces/factsheets/clas-data.html and any necessary changes to this list are posted by HHS annually;
grievant means any of the following:

1. a policyholder, subscriber, enrollee, or other individual, or that person’s authorized representative or provider, acting on behalf of that person with that person’s consent, entitled to receive health care benefits provided by BCBSNM;
2. an individual, or that person’s authorized representative, who may be entitled to receive health care benefits provided by BCBSNM;
3. Medicaid recipients enrolled in BCBSNM’s Medicaid plan;
4. individuals whose health insurance coverage is provided by an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act;

health benefits plan means a policy, contract, certificate or agreement offered or issued by BCBSNM or plan administrator to provide, deliver, arrange for, pay for, or reimburse the costs of health care services; this includes a health benefits plan as defined under NMSA 1978 Section 59A-22A-3(D) as “the health insurance policy or subscriber agreement between you or the policyholder and BCBSNM which defines the covered services and benefit levels available”;

health care insurer means a person that has a valid certificate of authority in good standing issued pursuant to the Insurance Code to act as an insurer, health maintenance organization, nonprofit health care plan, fraternal benefit society, vision plan, or pre-paid dental plan;

health care professional means a physician or other health care practitioner, including a pharmacist, who is licensed, certified or otherwise authorized by the state to provide health care services consistent with state law;

health care services means services, supplies, and procedures for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury, or disease, and includes, to the extent offered by the health benefits plan, physical and mental health services, including community-based mental health services, and services for developmental disability or developmental delay;

hearing officer, independent co-hearing officer or ICO means a health care or other professional licensed to practice medicine or another profession who is willing to assist the superintendent as a hearing officer in understanding and analyzing medical necessity and coverage issues that arise in external review hearings;

medical necessity or medically necessary means health care services determined by a provider, in consultation with BCBSNM, to be appropriate or necessary, according to any applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or any applicable clinical protocols or practice guidelines developed by BCBSNM consistent with such federal, national,
and professional practice guidelines, for the diagnosis or direct care and treatment of a physical, behavioral, or mental health condition, illness, injury, or disease;

*provider* means a duly licensed hospital or other licensed facility, physician, or other health care professional authorized to furnish health care services within the scope of their license;

*rescission of coverage* means a cancellation or discontinuance of coverage that has retroactive effect; a cancellation or discontinuance of coverage is not a rescission if:

1. the cancellation or discontinuance of coverage has only a prospective effect; or
2. the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage;

*summary of benefits* means the written materials required by NMSA 1978 Section 59A-57-4 to be given to you by BCBSNM or group contract holder;

*termination of coverage* means the cancellation or non-renewal of coverage provided by BCBSNM to you but does not include a voluntary termination by you or termination of a health benefits plan that does not contain a renewal provision;

*traditional fee-for-service indemnity benefit* means a fee-for-service indemnity benefit, not associated with any financial incentives that encourage you to utilize preferred providers, to follow preauthorization rules, to utilize prescription drug formularies or other cost-saving procedures to obtain prescription drugs, or to otherwise comply with a plan's incentive program to lower cost and improve quality, regardless of whether the benefit is based on an indemnity form of reimbursement for services;

*uniform standards* means all generally accepted practice guidelines, evidence-based practice guidelines or practice guidelines developed by the federal government or national and professional medical societies, boards and associations, and any applicable clinical review criteria, policies, practice guidelines, or protocols developed by BCBSNM consistent with the federal, national, and professional practice guidelines that are used by BCBSNM in determining whether to certify or deny a requested health care service.

**COMPUTATION OF TIME**

Whenever these procedures require that an action be taken within a certain period of time from receipt of a request or document, the request or document shall be deemed to have been received within three (3) working days of the date it was mailed.
GENERAL REQUIREMENTS REGARDING GRIEVANCE PROCEDURES

Written grievance procedures required. BCBSNM shall establish and maintain separate written procedures to provide for the presentation, review, and resolution of:

1. adverse determination grievances; BCBSNM shall establish procedures for both standard and expedited review of adverse determination grievances that comply with the requirements of 13.10.17.17 NMAC through 13.10.17.22 NMAC;
2. administrative grievances; BCBSNM shall establish procedures for reviewing administrative grievances that comply with the requirements of 13.10.17.33 NMAC through 13.10.17.36 NMAC; and
3. if a grievance contains clearly divisible administrative and adverse decision issues, then BCBSNM shall initiate separate complaints for each issue; with an explanation of the insurer's actions contained in one acknowledgement letter.

Assistance to grievants. In those instances where you make an oral grievance or request for internal review to BCBSNM, or expresses interest in pursuing a written grievance, BCBSNM shall assist you to complete all the forms required to pursue internal review and shall advise you that the managed health care bureau of the insurance division is available for assistance.

Retaliatory action prohibited. No person shall be subject to retaliatory action by BCBSNM for any reason related to a grievance.

INFORMATION ABOUT GRIEVANCE PROCEDURES

For grievants. BCBSNM shall:

1. include a clear and concise description of all grievance procedures in boldface type in the enrollment materials, including in member handbooks or evidences of coverage, issued to you;
2. for a person who has been denied coverage, provide him or her with a copy of the grievance procedures;
3. notify you that a representative of BCBSNM and the managed health care bureau of the insurance division are available upon request to assist you with grievance procedures by including such information, and a toll-free telephone number for obtaining such assistance, in the enrollment materials and summary of benefits issued to you;
4. provide a copy of its grievance procedures and all necessary grievance forms at each decision point in the grievance process and immediately upon request, at any time, to you, your provider or other interested person;
(5) provide a detailed written explanation of the appropriate grievance procedure and a copy of the grievance form to you or your provider when BCBSNM makes either an adverse determination or adverse administrative decision; the written explanation shall describe how BCBSNM reviews and resolves grievances and provide a toll-free telephone number, facsimile number, e-mail address, and mailing address of BCBSNM’s consumer assistance office;

(6) provide consumer education brochures and materials developed and approved by the superintendent, annually or as directed by the superintendent in consultation with the insurer for distribution;

(7) provide notice to enrollees in a culturally and linguistically appropriate manner;

(8) provide continued coverage for an ongoing course of treatment pending the outcome of an internal appeal;

(9) not reduce or terminate an ongoing course of treatment without first notifying you and sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of the proposed reduction or termination; and

(10) allow individuals in urgent care situations and receiving an ongoing course of treatment to proceed with an expedited external review at the same time as the internal review process.

For providers. BCBSNM shall inform all providers of the grievance procedures available to you and providers acting on your behalf, and shall make all necessary forms available to providers, including consumer education brochures and materials developed and approved by the superintendent, annually or as directed by the superintendent in consultation with the insurer for distribution.

Special needs. Information about grievance procedures must be provided in accordance with the Americans with Disabilities Act, 42 U.S.C. Sections 12101 et seq., and 13.10.13 NMAC, Managed Health Care, particularly 13.10.13.29 NMAC, Cultural and Linguistic Diversity.

CONFIDENTIALITY OF A GRIEVANT’S RECORDS AND MEDICAL INFORMATION

Confidentiality. BCBSNM, the superintendent, independent co-hearing officers, and all others who acquire access to identifiable medical records and information of yours when reviewing grievances shall treat and maintain such records and information as confidential except as otherwise provided by federal and New Mexico law.

Procedures required. The superintendent and BCBSNM shall establish procedures to ensure the confidential treatment and maintenance of identifiable medical records and information of yours submitted as part of any grievance.
RECORD OF GRIEVANCES

Record required.  BCBSNM shall maintain a grievance register to record all grievances received and handled during the calendar year. The register shall be maintained in a manner that is reasonably clear and accessible to the superintendent.

Contents.  For each grievance received, the grievance register shall:

1. assign a grievance number;
2. indicate whether the grievance is an adverse determination or administrative grievance, or a combination of both;
3. state the date, and for an expedited review the time, the grievance was received;
4. state the name and address of the grievant, if different from yours;
5. identify by name and member number the covered person making the grievance or for whom the grievance was made;
6. indicate whether your coverage is provided by an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act, the medicaid program, or a commercial health care insurer;
7. identify the health insurance policy number and the group if the policy is a group policy;
8. identify the individual employee of BCBSNM to whom the grievance was made;
9. describe the grievance;
10. for adverse determination grievances, indicate whether the grievance received expedited or standard review;
11. indicate at what level the grievance was resolved and what the actual outcome was; and
12. state the date the grievance was resolved and the date you were notified of the outcome.

Annual report.  Each year, the superintendent shall issue a data call for information based on the grievances received and handled by BCBSNM during the prior calendar year. The data call will be based on the information contained in the grievance register.

Retention.  BCBSNM shall maintain such records for at least six (6) years.

Submittal.  BCBSNM shall submit information regarding all grievances involving quality of care issues to BCBSNM's continuous quality improvement committee and to the superintendent and shall document the qualifications and background of the continuous quality improvement committee members.
Examination. BCBSNM shall make such record available for examination upon request and provide such documents free of charge to you, or state or federal agency officials, subject to any applicable federal or state law regarding disclosure of personally identifiable health information.

PRELIMINARY DETERMINATION

Upon receipt of a grievance, BCBSNM shall first determine the type of grievance at hand.

If the grievance seeks review of an adverse determination of a pre- or post-health care service, it is an adverse determination grievance and BCBSNM shall review the grievance in accordance with its procedures for adverse determination grievances and the requirements of 13.10.17.17 NMAC through 13.10.17.22 NMAC.

If the grievance is not based on an adverse determination of a pre- or post-health care service, it is an administrative grievance and BCBSNM shall review the grievance in accordance with its procedures for administrative grievances and the requirements of 13.10.17.33 NMAC through 13.10.17.36 NMAC.

TIMEFRAMES FOR INITIAL DETERMINATIONS

Expedited decision. BCBSNM shall make its initial certification or adverse determination decision in accordance with the medical exigencies of the case. BCBSNM shall make decisions within twenty-four (24) hours of the written or verbal receipt of the request for an expedited decision whenever:

1. your life or health would be jeopardized;
2. your ability to regain maximum function would be jeopardized;
3. the provider reasonably requests an expedited decision; or
4. in the opinion of the physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim;
5. the medical exigencies of the case require an expedited decision;
6. your claim involves urgent care.

Standard decision. BCBSNM shall make all other initial utilization management decisions within five (5) working days. BCBSNM may extend the review period for a maximum of ten (10) working days if it:

1. can demonstrate reasonable cause beyond its control for the delay;
2. can demonstrate that the delay will not result in increased medical risk to you; and
3. provides a written progress report and explanation for the delay to you and provider within the original five (5) working day review period.
INITIAL DETERMINATION

Coverage. When considering whether to certify a health care service requested by a provider or by you, BCBSNM shall determine whether the requested health care service is covered by the health benefits plan. Before denying a health care service requested by a provider or by you on grounds of a lack of coverage, BCBSNM shall determine that there is no provision of the health benefits plan under which the requested health care service could be covered. If BCBSNM finds that the requested health care service is not covered by the health benefits plan, BCBSNM need not address the issue of medical necessity.

Medical necessity.

(1) If BCBSNM finds that the requested health care service is covered by the health benefits plan, then when considering whether to certify a health care service requested by a provider or you, a physician, registered nurse, or other health care professional shall, within the timeframe required by the medical exigencies of the case, determine whether the requested health care service is medically necessary.

(2) Before BCBSNM denies a health care service requested by a provider or you on grounds of a lack of medical necessity, a physician shall render an opinion as to medical necessity, either after consultation with specialists who are experts in the area that is the subject of review, or after application of uniform standards used by BCBSNM. The physician shall be under the clinical authority of the medical director responsible for health care services provided to you.

NOTICE OF INITIAL DETERMINATION

Certification. BCBSNM shall notify you and provider of the certification by written or electronic communication within two (2) working days of the date the health care service was certified, unless earlier notice is required by the medical exigencies of the case.

24-hour notice of adverse determination. BCBSNM shall notify you and your provider of an adverse determination by telephone or as required by the medical exigencies of the case, but in no case later than twenty-four (24) hours after making the adverse determination, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan or have insurance coverage. If you fail to provide such information, you must be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. Additionally, BCBSNM shall notify you and provider of the adverse determination by written or electronic communication sent within one (1) working day of the telephone notice.
Contents of notice of adverse determination.

(1) if the adverse determination is based on a lack of medical necessity, clearly and completely explain why the requested health care service is not medically necessary. A statement that the health care service is not medically necessary will not be sufficient;
(2) if the adverse determination is based on a lack of coverage, identify all health benefits plan provisions relied on in making the adverse determination, and clearly and completely explain why the requested health care service is not covered by any provision of the health benefits plan. A statement that the requested health care service is not covered by the health benefits plan will not be sufficient;
(3) the date of service, the health care provider, the claim amount, the diagnosis code, the treatment code and corresponding meaning of these codes, the denial code and its corresponding meaning;
(4) include a description of the BCBSM standard that was used in denying the claim;
(5) provide a summary of the discussion which triggered the final determination;
(6) advise you that he or she may request internal review of BCBSNM's adverse determination; and
(7) describe the procedures and provide all necessary forms to you for requesting internal review.

RIGHTS REGARDING INTERNAL REVIEW OF ADVERSE DETERMINATIONS

Right to internal review. If you are dissatisfied with an adverse determination, you shall have the right to request internal review of the adverse determination by BCBSNM.

Acknowledgement of request. Upon receipt of a request for internal review of an adverse determination, BCBSNM shall date and time stamp the request and, within one (1) working day from receipt, send you an acknowledgment that the request has been received. The acknowledgment shall contain the name, address, and direct telephone number of an individual representative of BCBSNM who may be contacted regarding the grievance.

Full and fair hearing. To ensure that you receive a full and fair internal review, BCBSNM must, in addition to allowing you to review the claim file and to present evidence and testimony as part of the internal claims and appeals process, provide you, free of charge, with any new or additional evidence, and new or additional rationale, considered, relied upon, or generated by BCBSNM, as soon as possible and sufficiently in advance of the date of the notice of final internal adverse benefit
determination to allow you a reasonable opportunity to respond before the final internal adverse benefit determination is made.

Conflict of interest. BCBSNM must ensure that all internal claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions in a way that decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

TIMEFRAMES FOR INTERNAL REVIEW OF ADVERSE DETERMINATIONS

Upon receipt of a request for internal review of an adverse determination, BCBSNM shall conduct either a standard or expedited review, as appropriate.

Expedited review. BCBSNM shall complete its internal review as required by the medical exigencies of the case but in no case later than seventy-two (72) hours from the time the internal review request was received whenever:

1. your life or health would be jeopardized;
2. your ability to regain maximum function would be jeopardized;
3. the provider reasonably requests an expedited decision;
4. in the opinion of the physician, with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim; or
5. the medical exigencies of the case require an expedited decision.

Standard review. BCBSNM shall complete a standard review of both internal reviews as described in 13.10.17.19 NMAC and 13.10.17.20 NMAC within twenty (20) working days of receipt of the request for internal review in all cases in which the request for review is made prior to the service requested, and does not require expedited review, and within forty (40) working days of receipt of the request in all post-service requests for internal review. BCBSNM may extend the review period for a maximum of ten (10) working days in pre-service cases, and twenty (20) working days for post-service cases if it:

1. can demonstrate reasonable cause beyond its control for the delay;
2. can demonstrate that the delay will not result in increased medical risk to you; and
3. provides a written progress report and explanation for the delay to you and provider within the original thirty (30) day for pre-service or sixty (60) day for post-service review period;
4. if the grievance contains clearly divisible administrative and adverse decision issues, then BCBSNM shall initiate separate complaints for each decision.
Failure to comply with deadline. If BCBSNM fails to comply with the deadline for completion of an internal review, the requested health care service shall be deemed approved unless you, after being fully informed of your rights, have agreed in writing to extend the deadline.

FIRST AND SECOND INTERNAL REVIEW OF ADVERSE DETERMINATIONS FOR GROUP HEALTH PLANS

Scope of review. Health care insurers that offer group health care benefits plans and entities subject to the Health Care Purchasing Act shall complete the review of the adverse determination within the timeframes above.

(1) Coverage. If the initial adverse determination was based on a lack of coverage, BCBSNM shall review the health benefits plan and determine whether there is any provision in the plan under which the requested health care service could be certified.

(2) Medical necessity. If the initial adverse determination was based on a lack of medical necessity, BCBSNM shall render an opinion as to medical necessity, either after consultation with specialists who are experts in the area that is the subject of review, or after application of uniform standards used by BCBSNM.

Decision to reverse. If BCBSNM reverses the initial adverse determination and certifies the requested health care service, BCBSNM shall notify you and provider as discussed above.

Decision to uphold. If BCBSNM upholds the initial adverse determination to deny the requested health care service, BCBSNM shall notify you and your provider as discussed above and shall ascertain whether you wish to pursue the grievance.

(1) If you do not wish to pursue the grievance, BCBSNM shall mail written notification of the medical director's decision, and confirmation of your decision not to pursue the matter further, to you within three (3) working days of the medical director's decision.

(2) If BCBSNM is unable to contact you by telephone within seventy-two (72) hours of making the decision to uphold the determination, BCBSNM shall notify you by mail of the medical director's decision and shall include in the notification a self-addressed stamped response form which asks you whether you wish to pursue the grievance further and provides a box for checking “yes” and a box for checking “no.” If you do not return the response form within ten (10) working days, BCBSNM shall again contact you by telephone.
(3) If you respond affirmatively to the telephone inquiry or by response form, BCBSNM will select a medical panel to further review the adverse determination.

(4) If you do not respond to BCBSNM's telephone inquiries or return the response form, BCBSNM shall select a medical panel to further review the adverse determination when the review is an expedited review.

Extending the Timeframe for Standard Review. If you do not make an immediate decision to pursue the grievance, or you have requested additional time to supply supporting documents or information, or postponement, the timeframe for completing the review shall be extended to include the additional time required by you.

INTERNAL PANEL REVIEW OF ADVERSE DETERMINATIONS

Note: If you are insured under an individual health plan, you will have one level of internal review.

Selection of an internal review panel. In cases of appeal from an adverse determination or from a third party administrator's decision to uphold an adverse determination, BCBSNM shall select an internal review panel to review the adverse determination or the decision to uphold the adverse determination.

Notice of review. Unless you choose not to pursue the grievance, BCBSNM shall notify you of the date, time, and place of the internal panel review. The notice shall advise you of the rights specified in the “Information to grievant” section on the next page. If BCBSNM indicates that it will have an attorney represent its interests, the notice shall advise you that an attorney will represent BCBSNM and that you may wish to obtain legal representation of your own.

Panel membership. BCBSNM shall select one or more representatives of BCBSNM and one or more health care or other professionals who have not been previously involved in the adverse determination being reviewed to serve on the internal panel. At least one of the health care professionals selected shall practice in a specialty that would typically manage the case that is the subject of the grievance or be mutually agreed upon by you and BCBSNM.

Scope of review.

(1) Coverage. The internal review panel shall review the health benefits plan and determine whether there is any provision in the plan under which the requested health care service could be certified.

(2) Medical necessity. The internal review panel shall render an opinion as to medical necessity, either after consultation with specialists who are
experts in the area that is the subject of review, or after application of uniform standards used by BCBSNM.

**Information to grievant.** No fewer than three (3) working days prior to the internal panel review, BCBSNM shall provide to you copies of:

1. your pertinent medical records;
2. the treating provider's recommendation;
3. your health benefits plan;
4. BCBSNM's notice of adverse determination;
5. uniform standards relevant to your medical condition that is used by the internal panel in reviewing the adverse determination;
6. questions sent to or reports received from any medical consultants retained by BCBSNM; and
7. all other evidence or documentation relevant to reviewing the adverse determination.

**Request for postponement.** BCBSNM shall not unreasonably deny a request for postponement of the internal panel review made by you. The timeframes for internal panel review shall be extended during the period of any postponement.

**Rights of grievant.** You have the right to:

1. attend and participate in the internal panel review;
2. present your case to the internal panel;
3. submit supporting material both before and at the internal panel review;
4. ask questions of any representative of BCBSNM;
5. ask questions of any health care professionals on the internal panel;
6. be assisted or represented by a person of your choice, including legal representation;
7. hire a specialist to participate in the internal panel review at his or her own expense, but such specialist may not participate in making the decision.

**Timeframe for review; attendance.** The internal panel will complete its review of the adverse determination as required by the medical exigencies of the case and within the applicable timeframes above. Internal panel review members must be present physically or by video or telephone conferencing to hear the grievance. An internal review panel member who is not present to hear the grievance either physically or by video or telephone conferencing shall not participate in the decision.
ADDITIONAL REQUIREMENTS FOR EXPEDITED INTERNAL REVIEW OF ADVERSE DETERMINATIONS

In an expedited review, all information shall be transmitted between BCBSNM and you by the most expeditious method available.

If an expedited review is conducted during your hospital stay or course of treatment, health care services shall be continued without cost (except for applicable co-payments and deductibles) to you until BCBSNM makes a final decision and notifies you.

BCBSNM shall not conduct an expedited review of an adverse determination made after health care services have been provided to you.

NOTICE OF INTERNAL PANEL DECISION

Notice required. Within the time period allotted for completion of its internal review, BCBSNM shall notify you and your provider of the internal panel's decision by telephone within twenty-four (24) hours of the panel's decision and in writing or by electronic means within one (1) working day of the telephone notice.

Contents of notice. The written notice shall contain:

1. the names, titles, and qualifying credentials of the persons on the internal review panel;
2. a statement of the internal panel's understanding of the nature of the grievance and all pertinent facts;
3. a description of the evidence relied on by the internal review panel in reaching its decision;
4. a clear and complete explanation of the rationale for the internal review panel's decision;
   a. the notice shall identify every provision of your health benefits plan relevant to the issue of coverage in the case under review, and explain why each provision did or did not support the panel's decision regarding coverage of the requested health care service;
   b. the notice shall cite the uniform standards relevant to your medical condition and explain whether each supported or did not support the panel's decision regarding the medical necessity of the requested health care service;
5. notice of your right to request external review by the superintendent, including the address and telephone number of the managed health care bureau of the insurance division, a description of all procedures and time deadlines necessary to pursue external review, and copies of any forms required to initiate external review; this notice of your right
to request external review is in addition to the same notice provided to you in the summary of benefits and health benefits plan.

EXTERNAL REVIEW OF AdVERSE DETERMINATIONS

Right to external review. If you are dissatisfied with the results of a medical panel review of an adverse determination by BCBSNM and where applicable, with the results of a grievance review by an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act, you may request external review by the superintendent at no cost to you. There shall be no minimum dollar amount of a claim before you may exercise this right to external review.

Exhaustion of internal appeals process. The superintendent may require you to exhaust any grievance procedures adopted by BCBSNM or the entity that purchases health care benefits pursuant to the New Mexico Health Care Purchasing Act, as appropriate, before accepting a grievance for external review.

Deemed exhaustion. If exhaustion of internal appeals is required prior to external review, exhaustion must be unnecessary and the internal appeals process will be deemed exhausted if:

1. BCBSNM waives the exhaustion requirement;
2. BCBSNM is considered to have exhausted the internal appeals process by failing to comply with the requirements of the internal appeals process; or
3. you simultaneously request an expedited internal appeal and an expedited external review.

Exception to exhaustion requirement.

The internal claims and appeals process will not be deemed exhausted based on violations by BCBSNM that are de minimus and do not cause, and are not likely to cause, prejudice or harm to you, so long as BCBSNM demonstrates that the violation was for good cause or due to matters beyond the control of BCBSNM, and that the violation occurred in the context of an ongoing, good faith exchange of information between BCBSNM and you. This exception is not available if the violation is part of a pattern or practice of violations by BCBSNM.

You may request a written explanation of the violation from BCBSNM and BCBSNM must provide such explanation within ten (10) days, including a specific description of its basis, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects your request for immediate review on the basis that BCBSNM met the standards for the de minimus exception, you have the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the
external reviewer or court rejects the claim for immediate review (not to exceed 10 days), BCBSNM shall provide you with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon your receipt of the notice.

FILING REQUIREMENTS FOR EXTERNAL REVIEW OF ADVERSE DETERMINATIONS

Deadline for filing request.

(1) When required by the medical exigencies of the case. If required by the medical exigencies of the case, you or your provider may telephonically request an expedited review by calling the managed health care bureau at (505) 827-3928 or 1-877-673-1732.

(2) In all other cases. To initiate an external review, you must file a written request for external review with the superintendent within twenty (20) working days from receipt of the written notice of internal review decision unless extended by the superintendent for good cause shown. The request shall be:

(a) mailed to the Superintendent of Insurance, Attn: Managed Health Care Bureau - External Review Request, New Mexico Public Regulation Commission, Post Office Box 1269, 1120 Paseo de Peralta, Santa Fe, New Mexico 87504-1269; or

(b) e-mailed to mhcb.grievance@state.nm.us, subject External Review Request;

(c) faxed to the Superintendent of Insurance, Attn: Managed Health Care Bureau - External Review Request, at (505) 827-4734; or

(d) completed on-line with a NM PRC, Division of Insurance Complaint Form available at http://www.nmprc.state.nm.us.

Documents required to be filed by the grievant. You shall file the request for external review on the forms provided to you by BCBSNM or entity that purchases health care benefits and shall also file:

(1) a copy of the notice of internal review decision;

(2) a fully executed release form authorizing the superintendent to obtain any necessary medical records from BCBSNM or any other relevant provider; and

(3) if the grievance involves an experimental or investigational treatment adverse determination, the provider's certification and recommendation as described in the section for “Additional Criteria for Initial External Review of Experimental or Investigational Treatment
Adverse Determinations by Insurance Division Staff” later in this section.

Other filings. You may also file any other supporting documents or information you wish to submit to the superintendent for review.

Extending timeframes for external review. If you wish to supply supporting documents or information subsequent to the filing of the request for external review, the timeframes for external review shall be extended up to ninety (90) days from the receipt of the complaint form, or until you submit all supporting documents, whichever occurs first.

ACKNOWLEDGEMENT OF REQUEST FOR EXTERNAL REVIEW OF ADVERSE DETERMINATION AND COPY TO BCBSNM

Upon receipt of a request for external review, the superintendent shall immediately send:

(1) an acknowledgment to you that the request has been received;
(2) BCBSNM a copy of the request for external review.

Upon receipt of the copy of the request for external review, BCBSNM shall, within five (5) working days for standard review or the time limit set by the superintendent for expedited review, provide to the superintendent and you by any available expeditious method:

(1) the summary of benefits;
(2) the complete health benefits plan, which may be in the form of a member handbook/evidence of coverage;
(3) all pertinent medical records, internal review decisions and rationales, consulting physician reports, and documents and information submitted by you and BCBSNM;
(4) uniform standards relevant to your medical condition that were used by the internal panel in reviewing the adverse determination; and
(5) any other documents, records, and information relevant to the adverse determination and the internal review decision or intended to be relied on at the external review hearing.

If BCBSNM fails to comply with the requirements listed immediately above, the superintendent may reverse the adverse determination.

The superintendent may waive the requirements of this section if necessitated by the medical exigencies of the case.
TIMEFRAMES FOR EXTERNAL REVIEW OF ADVERSE DETERMINATIONS

The superintendent shall conduct either a standard or expedited external review of the adverse determination, as required by the medical exigencies of the case.

**Expedited review.** The superintendent shall complete an external review as required by the medical exigencies of the case but in no case later than seventy-two (72) hours of receipt of the external review request whenever:

1. your life or health would be jeopardized; or
2. your ability to regain maximum function would be jeopardized.

If the superintendent's initial decision is made orally, written notice of the decision must be provided within forty-eight (48) hours of the oral notification.

**Standard review.** The superintendent shall conduct a standard review in all cases not requiring expedited review. Insurance division staff shall complete the initial review within ten (10) working days from receipt of the request for external review and the information required of you and BCBSNM in Subsection B of 13.10.17.24 and Subsection B of 13.10.17.25 NMAC respectively. If a hearing is held in accordance with 13.10.17.30 NMAC, the superintendent shall complete the external review within forty-five (45) working days from receipt of the complete request for external review in compliance with 13.10.17.24 NMAC. The superintendent may extend the external review period for up to an additional ten (10) working days when the superintendent has been unable to schedule the hearing within the required timeframe and the delay will not result in increased medical risk to you.

CRITERIA FOR INITIAL EXTERNAL REVIEW OF ADVERSE DETERMINATION BY INSURANCE DIVISION STAFF

Upon receipt of the request for external review, insurance division staff shall review the request to determine whether:

- you have provided the documents required;
- you are or were a grievant of BCBSNM at the time the health care service was requested or provided;
- you have exhausted BCBSNM's internal review procedure and any applicable grievance review procedure of an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act; and
- the health care service that is the subject of the grievance reasonably appears to be a covered benefit under the health benefits plan.
ADDITIONAL CRITERIA FOR INITIAL EXTERNAL REVIEW OF EXPERIMENTAL OR INVESTIGATIONAL TREATMENT ADVERSE DETERMINATIONS BY INSURANCE DIVISION STAFF

If the request is for external review of an experimental or investigational treatment adverse determination, insurance division staff shall also consider whether:

coverage; the recommended or requested health care service:

(1) reasonably appears to be a covered benefit under your health benefit plan except for BCBSNM's determination that the health care service is experimental or investigational for a particular medical condition; and

(2) is not explicitly listed as an excluded benefit under your health benefit plan; and

medical necessity; your treating provider has certified that:

(1) standard health care services have not been effective in improving your condition; or

(2) standard health care services are not medically appropriate for you; or

(3) there is no standard health care service covered by BCBSNM that is as beneficial or more beneficial than the health care service:

(a) recommended by your treating provider that the treating provider certifies in writing is likely to be more beneficial to you, in the treating provider's opinion, than standard health care services; or

(b) requested by you regarding which your treating provider, who is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat your condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service requested by you is likely to be more beneficial to you than available standard health care services.

INITIAL EXTERNAL REVIEW OF ADVERSE DETERMINATION BY INSURANCE DIVISION STAFF

Request incomplete. If the request for external review is incomplete, insurance division staff shall immediately notify you and require you to submit the required information within a specified period of time.

Request does not meet criteria. If the request for external review does not meet the applicable criteria, insurance division staff shall so inform the superintendent. The superintendent shall notify you and BCBSNM that the request does not meet the
criteria for external review and is thereby denied, and that you have the right to request a hearing within thirty-three (33) days from the date the notice was mailed.

*Request meets criteria.* If the request for external review is complete and meets the applicable criteria, insurance division staff shall so inform the superintendent. The superintendent shall notify you and BCBSNM that the request meets the criteria for external review and that an informal hearing has been set to determine whether, as a result of BCBSNM's adverse determination, you were deprived of medically necessary covered services. Prior to the hearing, insurance division staff shall attempt to informally resolve the grievance.

*Notice of hearing.* The notice of hearing shall be mailed no later than eight (8) working days prior to the hearing date. The notice shall state the date, time, and place of the hearing and the matters to be considered and shall advise you and BCBSNM of the rights of the parties. The superintendent shall not unreasonably deny a request for postponement of the hearing made by you or BCBSNM.

**HEARING PROCEDURES FOR EXTERNAL REVIEW OF ADVERSE DETERMINATIONS**

*Conduct of hearing.* The superintendent may designate a hearing officer who shall be an attorney licensed to practice in New Mexico. The hearing may be conducted by telephone conference call, video conferencing, or other appropriate technology at the insurance division's expense.

*Co-hearing officers.* The superintendent may designate two (2) independent co-hearing officers who shall be licensed health care professionals. If the superintendent designates two (2) independent co-hearing officers, at least one of them shall practice in a specialty that would typically manage the case that is the subject of the grievance.

*Powers.* The superintendent or attorney hearing officer shall regulate the proceedings and perform all acts and take all measures necessary or proper for the efficient conduct of the hearing. The superintendent or attorney hearing officer may:

1. require the production of additional records, documents, and writings relevant to the subject of the grievance;
2. exclude any irrelevant, immaterial, or unduly repetitious evidence; and
3. if you or BCBSNM fails to appear, proceed with the hearing or adjourn the proceedings to a future date, giving notice of the adjournment to the absent party.

*Staff participation.* Staff may attend the hearing, ask questions, and otherwise solicit evidence from the parties, but shall not be present during deliberations among the superintendent or his designated hearing officer and any independent co-hearing officers.
Testimony. Testimony at the hearing shall be taken under oath. The superintendent or hearing officers may call and examine you, BCBSNM, and other witnesses.

Hearing recorded. The hearing shall be stenographically recorded at the insurance division's expense.

Rights of parties. Both you and BCBSNM have the right to:

1. attend the hearing; BCBSNM shall designate a person to attend on its behalf and you may designate a person to attend on your behalf if you choose not to attend personally;
2. be assisted or represented by an attorney or other person; and
3. call, examine and cross-examine witnesses; and
4. submit to the ICO, prior to the scheduled hearing, in writing, additional information that the ICO must consider when conducting the internal review hearing and require that the information be submitted to BCBSNM and the MHCBS staff.

Stipulation. You and BCBSNM shall each stipulate on the record that the hearing officers shall be released from civil liability for all communications, findings, opinions, and conclusions made in the course and scope of the external review.

INDEPENDENT CO-HEARING OFFICERS (ICOs)

Identification of ICOs. The superintendent shall consult with appropriate professional societies, organizations, or associations to identify licensed health care and other professionals who are willing to serve as independent co-hearing officers in external reviews who maintain independence and impartiality of the process.

Disclosure of interests. Prior to accepting designation as an ICO, each potential ICO shall provide to the superintendent a list identifying all health care insurers and providers with whom the potential ICO maintains any health care related or other professional business arrangements and briefly describe the nature of each arrangement. Each potential ICO shall disclose to the superintendent any other potential conflict of interest that may arise in hearing a particular case, including any personal or professional relationship to you or to BCBSNM or providers involved in a particular external review.

Compensation of Hearing Officers and ICOs.

1. Compensation schedule. The superintendent shall consult with appropriate professional societies, organizations, or associations in New Mexico to determine reasonable compensation for health care and other professionals who are appointed as ICOs for external grievance reviews and shall annually publish a schedule of ICO compensation in a bulletin.
(2) **Statement of ICO compensation.** Upon completion of an external review, the attorney and co-hearing officers shall each complete a **statement of ICO compensation form** prescribed by the superintendent detailing the amount of time spent participating in the external review and submit it to the superintendent for approval. The superintendent shall send the approved statement of ICO compensation to BCBSNM.

(3) **Direct payment to ICOs.** Within thirty (30) days of receipt of the statement of ICO compensation, BCBSNM shall remit the approved compensation directly to the ICO.

(4) **No compensation with early settlement.** If the parties provide written notice of a settlement up to three (3) working days prior to the date set for external review hearing, compensation will be unavailable to the hearing officers or ICOs.

The hearing officer and ICOs must maintain written records for a period of three (3) years and make them available upon request to the state.

**SUPERINTENDENT’S DECISION ON EXTERNAL REVIEW OF ADVERSE DETERMINATION**

*Deliberation.* At the close of the hearing, the hearing officers shall review and consider the entire record and prepare findings of fact, conclusions of law, and a recommended decision. Any hearing officer may submit a supplementary or dissenting opinion to the recommended decision.

*Order.* Within the time period allotted for external review, the superintendent shall issue an appropriate order. If the order requires action on the part of BCBSNM, the order shall specify the timeframe for compliance.

(1) The order shall be binding on you and BCBSNM and shall state that you and BCBSNM have the right to judicial review and that state and federal law may provide other remedies.

(2) Neither you nor BCBSNM may file a subsequent request for external review of the same adverse determination that was the subject of the superintendent’s order.

**INTERNAL REVIEW OF ADMINISTRATIVE GRIEVANCES**

*Request for internal review of grievance.* Any person dissatisfied with a decision, action or inaction of BCBSNM, including termination of coverage, has the right to request internal review of an administrative grievance orally or in writing.

*Acknowledgement of grievance.* Within three (3) working days after receipt of an administrative grievance, BCBSNM shall send you a written acknowledgment that it has received the administrative grievance. The acknowledgment shall contain the
name, address, and direct telephone number of an individual representative of
BCBSNM who may be contacted regarding the administrative grievance.

Initial review. BCBSNM shall promptly review the administrative grievance. The
initial review shall:

(1) be conducted by a BCBSNM representative authorized to take
corrective action on the administrative grievance; and
(2) allow you to present any information pertinent to the administrative
grievance.

INITIAL INTERNAL REVIEW DECISION ON ADMINISTRATIVE
GRIEVANCE

BCBSNM shall mail a written decision to you within fifteen (15) working days of
receipt of the administrative grievance. The fifteen (15) working day period may be
extended when there is a delay in obtaining documents or records necessary for the
review of the administrative grievance, provided that BCBSNM notifies you in
writing of the need and reasons for the extension and the expected date of resolution,
or by mutual written agreement of BCBSNM and you. The written decision shall
contain:

- the name, title, and qualifications of the person conducting the initial
  review;
- a statement of the reviewer's understanding of the nature of the
  administrative grievance and all pertinent facts;
- a clear and complete explanation of the rationale for the reviewer's
decision;
- identification of the health benefits plan provisions relied upon in
  reaching the decision;
- reference to evidence or documentation considered by the reviewer in
  making the decision;
- a statement that the initial decision will be binding unless you submit a
  request for reconsideration within twenty (20) working days of receipt
  of the initial decision; and
- a description of the procedures and deadlines for requesting
  reconsideration of the initial decision, including any necessary forms.

RECONSIDERATION OF INTERNAL REVIEW OF ADMINISTRATIVE
GRIEVANCE

Committee. Upon receipt of a request for reconsideration, BCBSNM shall appoint a
reconsideration committee consisting of one or more employees of BCBSNM who
have not participated in the initial decision. BCBSNM may include one or more covered persons other than you to participate on the reconsideration committee.

*Hearing.* The reconsideration committee shall schedule and hold a hearing within fifteen (15) working days after receipt of a request for reconsideration. The hearing shall be held during regular business hours at a location reasonably accessible to you, and BCBSNM shall offer you the opportunity to communicate with the committee, at BCBSNM's expense, by conference call, video conferencing, or other appropriate technology. BCBSNM shall not unreasonably deny a request for postponement of the hearing made by you.

*Notice.* BCBSNM shall notify you in writing of the hearing date, time and place at least ten (10) working days in advance. The notice shall advise you of the rights specified in the *Rights of grievant* section below. If BCBSNM will have an attorney represent its interests, the notice shall advise you that BCBSNM will be represented by an attorney and that you may wish to obtain legal representation of your own.

*Information to grievant.* No fewer than three (3) working days prior to the hearing, BCBSNM shall provide to you all documents and information that the committee will rely on in reviewing the case.

*Rights of grievant.* You have the right to:

1. attend the reconsideration committee hearing;
2. present your case to the reconsideration committee;
3. submit supporting material both before and at the reconsideration committee hearing;
4. ask questions of any representative of BCBSNM; and
5. be assisted or represented by a person of your choice.

**DECISION OF RECONSIDERATION COMMITTEE**

BCBSNM shall mail a written decision to you within seven (7) working days after the reconsideration committee hearing. The written decision shall include:

- the names, titles, and qualifications of the persons on the reconsideration committee;
- the reconsideration committee's statement of the issues involved in the administrative grievance;
- a clear and complete explanation of the rationale for the reconsideration committee's decision;
- the health benefits plan provision relied on in reaching the decision;
- references to the evidence or documentation relied on in reaching the decision;
• a statement that the initial decision will be binding unless you submit a request for external review by the superintendent within twenty (20) working days of receipt of the reconsideration decision; and
• a description of the procedures and deadlines for requesting external review by the superintendent, including any necessary forms. The notice shall contain the toll-free telephone number and address of the superintendent's office.

EXTERNAL REVIEW OF ADMINISTRATIVE GRIEVANCES

Right to external review. If you are dissatisfied with the results of the internal review of an administrative decision you shall have the right to request external review by the superintendent.

Exhaustion of remedies. The superintendent may require you to exhaust any grievance procedures adopted by an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act or BCBSNM, as appropriate, before accepting an administrative grievance for external review.

Deemed exhaustion. If exhaustion of internal appeals is required prior to external review, exhaustion must be unnecessary and the internal appeals process will be deemed exhausted if:

1. BCBSNM waives the exhaustion requirement;
2. BCBSNM is considered to have exhausted the internal appeals process by failing to comply with the requirements of the internal appeals process; or
3. you simultaneously request an expedited internal appeal and an expedited external review.

Exception to exhaustion requirement.

Notwithstanding the Exhaustion of remedies section above, the internal claims and appeals process will not be deemed exhausted based on violations by BCBSNM that are de minimus and do not cause, and are not likely to cause, prejudice or harm to you, so long as BCBSNM demonstrates that the violation was for good cause or due to matters beyond the control of BCBSNM, and that the violation occurred in the context of an ongoing, good faith exchange of information between BCBSNM and you. This exception is not available if the violation is part of a pattern or practice of violations by BCBSNM.

You may request a written explanation of the violation from BCBSNM and BCBSNM must provide such explanation within ten (10) days, including a specific description of its basis, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or a
court rejects your request for immediate review under the *Exhaustion of remedies* section on the previous page on the basis that BCBSNM met the standards for the exception under Paragraph (1) of the *Exception to exhaustion requirement* above, you have the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), BCBSNM shall provide you with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon your receipt of the notice.

**FILING REQUIREMENTS FOR EXTERNAL REVIEW OF ADMINISTRATIVE GRIEVANCE**

*Deadline for filing request.* To initiate an external review, you must file a written request for external review with the superintendent within twenty (20) working days from receipt of the written notice of reconsideration decision. The request shall either be:

1. mailed to the Superintendent of Insurance, Attn: Managed Health Care Bureau - External Review Request, New Mexico Public Regulation Commission, Post Office Box 1269, 1120 Paseo de Peralta, Santa Fe, New Mexico 87504-1269;
2. e-mailed to mhcb.grievance@state.nm.us, subject External Review Request;
3. faxed to the Superintendent of Insurance, Attn: Managed Health Care Bureau - External Review Request, (505) 827-4734; or
4. completed on-line using a NM PRC, Division of Insurance Complaint Form available at http://www.nmprc.state.nm.us.

*Documents required to be filed by the grievant.* You shall file the request for external review on the forms provided to you by BCBSNM pursuant to Subsection G of 13.10.17.36 NMAC.

*Other filings.* You may also file any other supporting documents or information you wish to submit to the superintendent for review.

*Extending timeframes for external review.* If you wish to supply supporting documents or information subsequent to the filing of the request for external review, the timeframes for external review shall be extended up to ninety (90) days from the receipt of the complaint form, or until you submit all supporting documents, whichever occurs first.
ACKNOWLEDGEMENT OF REQUEST FOR EXTERNAL REVIEW OF
ADMINISTRATIVE GRIEVANCE AND COPY TO BCBSNM

Upon receipt of a request for external review, the superintendent shall immediately send the:

(1) an acknowledgment to you that the request has been received;
(2) BCBSNM a copy of the request for external review.

Upon receipt of the copy of the request for external review, BCBSNM shall provide to the superintendent and you by any available expeditious method within five (5) working days all necessary documents and information considered in arriving at the administrative grievance decision.

REVIEW OF ADMINISTRATIVE GRIEVANCE BY SUPERINTENDENT

The superintendent shall review the documents submitted by BCBSNM and you, and may conduct an investigation or inquiry or consult with you, as appropriate. The superintendent shall issue a written decision on the administrative grievance within twenty (20) working days of receipt of the complete request for external review.