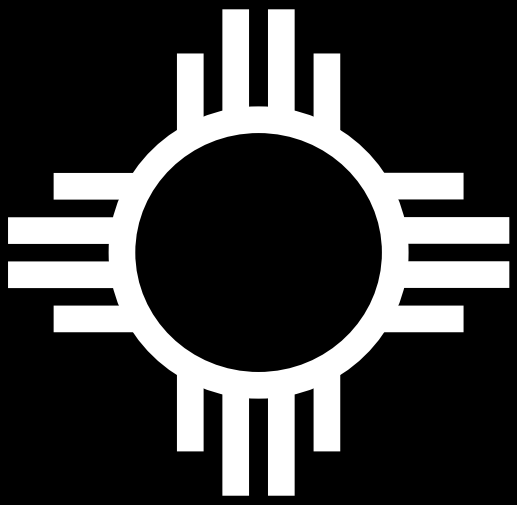
NEW MEXICO REGISTER



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Issue Number 9
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New Mexico Register

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The official publication for all notices of rulemaking and filings of adopted, proposed and emergency rules in New Mexico

The Commission of Public Records
Administrative Law Division
Santa Fe, New Mexico
2012

New Mexico Register

Volume XXIII, Number 9
May 15, 2012

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Effective Date and Validity of Rule Filings

Rules published in this issue of the New Mexico Register are effective on the publication date of this issue unless otherwise specified. "No rule shall be valid or enforceable until it is filed with the records center and published in the New Mexico register as provided by the State Rules Act. Unless a later date is otherwise provided by law, the effective date of a rule shall be the date of publication in the New Mexico register." Section 14-4-5 NMSA 1978.

A=***Amended***, E=***Emergency***, N=***New***, R=***Repealed***, Rn=***Renumbered***

The ***New Mexico Register*** is available free at http://www.nmcpr.state.nm.us/nmregister

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Notices of Rulemaking and Proposed Rules

NEW MEXICO GAMING CONTROL BOARD

NEW MEXICO GAMING CONTROL BOARD

NOTICE OF HEARING TO CONDISER THE REPEAL AND REPLACEMENT OF THE EXISTING RULES

The New Mexico Gaming Control Board ("Board") will hold a public hearing at 10:00 a.m. on June 28, 2012, at the New Mexico Gaming Control Board, 4900 Alameda Blvd., N.E., Albuquerque, New Mexico 87113 to consider the repeal and replacement of the existing rules for the following rules: **15.4.1 NMAC,** *General Provisions,* **15.4.2 NMAC,** *Application for Licensure,* **15.4.3 NMAC,** *License and Staff Permit Renewal,* **15.4.4 NMAC,** *Licensed Premises,* **15.4.5 NMAC,** *Operating procedure Standards,* **15.4.6 NMAC,** *Equipment, Bingo, Raffle, Pull-Tabs,* **15.4.7 NMAC,** *Conduct of Bingo,* **15.4.8 NMAC,** *Conduct of Raffle,* **15.4.9 NMAC,** *Conduct of Pull-Tabs,* **15.4.10 NMAC,** *Accounting Requirements,* **15.4.11 NMAC,** *Variance Procedures,* **15.4.12 NMAC,** *Enforcement Proceedings,* **15.4.13 NMAC,** *License or Staff Permit Revocation,* **15.4.14 NMAC,** *Administrative Appeal*

Copies of the proposed amendments are available upon request to the New Mexico Gaming Control Board, 4900 Alameda Blvd., N.E., Albuquerque, New Mexico 87113, or by calling (505) 274-4345. The proposed changes are also available on our website at www.nmgcb.org. The Board can provide public documents in various accessible formats.

The hearing will be held before a hearing officer appointed by the Board. All interested parties may attend the hearing and present their views orally or submit written comments prior to the hearing. Written comments should be directed to the Gaming Control Board, Office of the General Counsel, 4900 Alameda Blvd., N.E., Albuquerque, New Mexico 87113.

If you are an individual with a disability who is in need of an auxiliary aid or service to attend or participate in the hearing, please contact Denise Leyba, Gaming Control Board, at least one week prior to the hearing at (505) 274-4345.

NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION

NOTICE

The New Mexico Human Services Department (HSD) is scheduling two public hearings on Tuesday, June 19, 2012.

The subject of the first hearing is: Medicaid Managed Care to be held at 9:00 am in the South Park Conference Room, 2055 S. Pacheco, Ste. 500-590 in Santa Fe. The Human Services Department (the Department), Medical Assistance Division (MAD), is proposing amendments to 8.305.16 NMAC, *Medicaid Managed Care, Client*

The subject of the second hearing is: Coordinated Long-Term Services to be held at 1:00 pm in the ASD conference room, Plaza San Miguel, 729 St. Michael's Drive, Santa Fe. The Human Services Department (the Department), Medical Assistance Division (MAD), is proposing amendments to 8.307.16 NMAC, *Coordinated Long-Term Services, Client Transition of Care*.

Both hearings are on the same topic: The Department has added new requirements for mass transfer transitions that mandate that prior authorizations be honored for longer periods of time than those timeframes required for individual transfers. This will ensure continuity of care for members transitioning to a new managed care organization (MCO) during a mass transfer. It also allows time for the MCO to arrange for contracted providers and services if indicated. The new language also mandates participation by all MCOs and the Statewide Entity in a workgroup to define transition processes necessary to begin the transfer of encounter data and member data in mass transfer situations.

Interested persons may submit written comments no later than 5:00 p.m., June 19, 2012, to Sidonie Squier, Secretary, Human Services Department, P.O. Box 2348, Santa Fe, New Mexico 87504-2348. All written and oral testimony will be considered prior to issuance of the final regulation.

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in any HSD public hearing, program or services, please contact the NM Human Services Department toll-free at 1-888-997-2583, in Santa Fe at 827-3156, or through the department TDD system, 1-800-609-4833, in Santa Fe call 827-3184. The Department requests at least 10 days advance notice to provide requested alternative formats and special accommodations.

Copies of all comments will be made available by the Medical Assistance Division upon request by providing copies directly to a requestor or by making them available on the MAD website or at a location within the county of the requestor.

Copies of the Human Services Register and their proposed rules are available for review on our Website at http://www.hsd.state.nm.us/mad/registers/2012.html or by sending a self-addressed stamped envelope to Medical Assistance Division, Benefits Services Bureau, P.O. Box 2348, Santa Fe, NM. 87504-2348.

NEW MEXICO COMMISSION OF PUBLIC RECORDS

NOTICE OF REGULAR MEETING AND RULE HEARING

The New Mexico Commission of Public Records will hold a regular meeting on Tuesday, June 19, 2012, at 9:30 A.M. During the meeting the Commission will also hold a Rule Hearing to take public comment regarding the following proposed rulemaking actions:

Amendment

1.15.2 NMAC GRRDS, General Administrative Records
1.18.420 NMAC ERRDS, Regulation and Licensing Department
1.18.521 NMAC ERRDS, Energy, Minerals, and Natural Resources Department
1.18.665 NMAC ERRDS, Department of Health
1.18.667 NMAC ERRDS, New Mexico Environment Department

A copy of the agenda and proposed rules are available at the Office of the State Records Administrator, 1205 Camino Carlos Rey, Santa Fe, NM 87507 and on the Commission website at: www.nmcpr.state.nm.us/index.htm. The agenda is subject to change up to 24 hours prior to the meeting.

The meeting will be held at the NM State Records Center and Archives in the Commission Room, which is an accessible facility, at 1205 Camino Carlos Rey, Santa Fe, NM. If you are an individual with a disability who is in need of a

reader, amplifier, qualified sign language interpreter, or any form of auxiliary aid or service to attend or participate in the hearing, please contact Antoinette L. Solano at 476-7902. The Commission requests at least 5 business days advance notice to provide requested alternative formats and special accommodations. Public documents, including the agenda and minutes, can be provided in various accessible formats.

NEW MEXICO PUBLIC SCHOOL CAPITAL OUTLAY COUNCIL

PUBLIC SCHOOL CAPITAL OUTLAY COUNCIL

NOTICE OF PROPOSED RULEMAKING AND PUBLIC HEARING

The Public School Capital Outlay Council ("Council") is scheduled to consider the following rulemaking actions: 6.27.30 (STATEWIDE ADEQUACY STANDARDS) - Amend Rule.

There will be a public hearing regarding the proposed new rule on Tuesday, May 29, 2012 at 9:00am at the University of New Mexico, Science and Technology Park Auditorium, 800 Bradbury SE, Albuquerque, New Mexico. The proposed rules are posted on the Public School Facilities Authority's website at www.nmpsfa.org) and have been disseminated to public school districts, charter schools, and other interested parties. Copies may also be obtained by contacting Lena Archuleta, Public School Facilities Authority, 2019 Galisteo, Suite B-1, Santa Fe, NM, 87505 ((505) 988-5989); larchuleta@nmpsfa.org). Written comments regarding the proposed rulemaking should be submitted to Ms. Archuleta at the addresses shown above. Comments may also be telefaxed to Ms. Archuleta at (505) 988-5933. Written comments must be submitted no later than 5:00 p.m. on Friday, May 25, 2012; however, submission of written comments as soon as possible is encouraged.

The Council will act on the proposed rules at its June 21-22, 2012 meetings. Notice of any changes regarding the date, time, and location of the Public School Capital Outlay Council meeting will be provided in accordance with the Council's open meetings policy. The agenda will be electronically mailed to public school districts and charter schools.

If you are an individual with a disability who is in need of a reader, amplifier, qualified sign language interpreter, or any other form of auxiliary aid or service to attend or participate in the hearing, please contact Lena Archuleta at (505) 988-5989 by May 21, 2012. Public documents, including the agenda and minutes, can be provided in various accessible forms. Please contact Lena Archuleta if a summary or other type of accessible form is needed.

End of Notices and Proposed Rules Section

Adopted Rules

NEW MEXICO DEPARTMENT OF GAME AND FISH

This is an emergency amendment to 19.31.12 NMAC, Section 12, effective 4-19-2012.

19.31.12.12 ORYX HUNTING SEASONS:

A. Oryx premier hunts for any legal weapon shall be as indicated below, listing the open areas, eligibility requirements or restrictions, hunt dates, hunt code, number of licenses and bag limit. Two persons may apply on one application. These hunts are restricted; only those who have never held an oryx once-in-lifetime license may apply. Only New Mexico residents returning from military service in Iraq or Afghanistan are eligible to apply for oryx hunts designated as "Iraq/Afghanistan vets" or "I/A vets". Proof of military service in Iraq or Afghanistan must accompany application or, if applying online, forwarded to the department by the application deadline date, pursuant to 19.31.3.11 NMAC.

open GMUs or areas	2011-2012 hunt dates	2012-2013 hunt dates	2013-2014 hunt dates	2014-2015 hunt dates	hunt code	lic.	bag limit
Rhodes canyon **YO**	9/8-9/10	9/7-9/9	9/6-9/8	9/5-9/7	ORX-1-100	30	ES
Rhodes canyon **MI**	9/8-9/10	9/7-9/9	9/6-9/8	9/5-9/7	ORX-1-101	20	ES
Stallion range	9/23-9/25	9/21-9/23	9/20-9/22	9/19-9/21	ORX-1-102	70	ES
Stallion range **I/A vets**	9/23-9/25	9/21-9/23	9/20-9/22	9/19-9/21	ORX-1-103	5	ES
Rhodes canyon	10/7-10/9	10/5-10/7	10/4-10/6	10/3-10/5	ORX-1-104	70	ES
Rhodes canyon **I/A vets**	10/7-10/9	10/5-10/7	10/4-10/6	10/3-10/5	ORX-1-105	5	ES
Stallion range	11/18-11/20	11/16-11/18	11/15-11/17	11/14-11/16	ORX-1-106	70	ES
Stallion range **I/A vets**	11/18-11/20	11/16-11/18	11/15-11/17	11/14-11/16	ORX-1-107	5	ES
Rhodes canyon	12/2-12/4	11/30-12/2	11/29-12/1	11/28-11/30	ORX-1-108	70	ES
Rhodes canyon **I/A vets**	12/2-12/4	11/30-12/2	11/29-12/1	11/28-11/30	ORX-1-109	5	ES
Stallion range	1/13-1/15	1/11-1/13	1/10-1/12	1/9-1/11	ORX-1-110	70	ES
Stallion range **I/A vets**	1/13-1/15	1/11-1/13	1/10-1/12	1/9-1/11	ORX-1-111	5	ES
Rhodes canyon	1/27-1/29	1/25-1/27	1/24-1/26	1/23-1/25	ORX-1-112	70	ES
Rhodes canyon **I/A vets**	1/27-1/29	1/25-1/27	1/24-1/26	1/23-1/25	ORX-1-113	5	ES
Stallion range	2/10-2/12	2/8-2/10	2/7-2/9	2/6-2/8	ORX-1-114	70	ES
Stallion range **I/A vets**	2/10-2/12	2/8-2/10	2/7-2/9	2/6-2/8	ORX-1-115	5	ES
Rhodes canyon	2/24-2/26	2/22-2/24	2/21-2/23	2/20-2/22	ORX-1-116	70	ES
Rhodes canyon **I/A vets**	2/24-2/26	2/22-2/24	2/21-2/23	2/20-2/22	ORX-1-117	5	ES

B. Oryx restricted on-range hunts, shall be as indicated below or as specific dates and hunt areas are determined by the department. The following hunts have restrictions that must be met prior to application. These hunts are not once-in-a-lifetime oryx hunts. Oryx WSMR security-badged hunts are available only to personnel with official valid security badges, or their guests, in accordance with White Sands missile range provisions and pursuant to 19.31.3.11 NMAC. Youth hunters must provide hunter education certificate number on application. Only military personnel stationed at WSMR can apply for the military only (MO) security badged hunt.

open areas	2011-2012 hunt dates	2012-2013 hunt dates	2013-2014 hunt dates	2014-2015 hunt dates	hunt code	lic.	bag limit
WSMR security badged: TBA/**MO**	TBD	TBD	TBD	TBD	ORX-1-118	15	ES
WSMR security badged: TBA	8/1-8/31	8/1-8/31	8/1-8/31	8/1-8/31	ORX-1-119	30	ES
WSMR security badged: TBA	9/1-9/30	9/1-9/30	9/1-9/30	9/1-9/30	ORX-1-120	30	ES
WSMR security badged: TBA	10/1-10/31	10/1-10/31	10/1-10/31	10/1-10/31	ORX-1-121	30	ES
WSMR security badged: TBA	11/1-11/30	11/1-11/30	11/1-11/30	11/1-11/30	ORX-1-122	30	ES
WSMR security badged: TBA	12/1-12/31	12/1-12/31	12/1-12/31	12/1-12/31	ORX-1-123	30	ES
WSMR security badged: TBA	1/1-1/31	1/1-1/31	1/1-1/31	1/1-1/31	ORX-1-124	30	ES
WSMR security badged: TBA	2/1-2/29	2/1-2/28	2/1-2/28	2/1-2/28	ORX-1-125	30	ES

WSMR security badged: TBA	3/1-3/31	3/1-3/31	3/1-3/31	3/1-3/31	ORX-1-126	30	ES
Stallion range	9/23-9/25	9/21-9/23	9/20-9/22	9/19-9/21	ORX-1-127	10	BHO
Rhodes canyon	10/7-10/9	10/5-10/7	10/4-10/6	10/3-10/5	ORX-1-128	10	BHO
Stallion range	11/18-11/20	11/16-11/18	11/15-11/17	11/14-11/16	ORX-1-129	10	BHO
Rhodes canyon	12/2-12/4	11/30-12/2	11/29-12/1	11/28-11/30	ORX-1-130	10	BHO
Stallion range	1/13-1/15	1/11-1/13	1/10-1/12	1/9-1/11	ORX-1-131	10	BHO
Rhodes canyon	1/27-1/29	1/25-1/27	1/24-1/26	1/23-1/25	ORX-1-132	10	BHO
Stallion range	2/10-2/12	2/8-2/10	2/7-2/9	2/6-2/8	ORX-1-133	10	BHO
Rhodes canyon	2/24-2/26	2/22-2/24	2/21-2/23	2/20-2/22	ORX-1-134	10	BHO

C. Oryx hunts off of White Sands missile range shall be as indicated below, listing the open areas, eligibility requirements or restrictions, hunt dates, hunt code, number of licenses and bag limit. The department shall issue military only oryx hunting licenses for McGregor range to full time military personnel providing a valid access authorization issued by Fort Bliss (McGregor range MO).

open areas	2011-12 hunt dates	2012-13 hunt dates	2013-14 hunt dates	2014-15 hunt dates	hunt code	lic.	bag limit
statewide, off-range	6/1-6/30	6/1-6/30	6/1-6/30	6/1-6/30	ORX-1-204	60	ES
statewide, off-range, **YO**	6/1-6/30	6/1-6/30	6/1-6/30	6/1-6/30	ORX-1-205	18	ES
statewide, off-range	7/1-7/31	7/1-7/31	7/1-7/31	7/1-7/31	ORX-1-206	60	ES
statewide, off-range, **YO**	7/1-7/31	7/1-7/31	7/1-7/31	7/1-7/31	ORX-1-207	18	ES
statewide, off-range	8/1-8/31	8/1-8/31	8/1-8/31	8/1-8/31	ORX-1-208	60	ES
statewide, off-range, **YO**	8/1-8/31	8/1-8/31	8/1-8/31	8/1-8/31	ORX-1-209	18	ES
statewide, off-range	9/1-9/30	9/1-9/30	9/1-9/30	9/1-9/30	ORX-1-210	60	ES
statewide, off-range, **YO**	9/1-9/30	9/1-9/30	9/1-9/30	9/1-9/30	ORX-1-211	18	ES
statewide, off-range	10/1-10/31	10/1-10/31	10/1-10/31	10/1-10/31	ORX-1-212	60	ES
statewide, off-range, **YO**	10/1-10/31	10/1-10/31	10/1-10/31	10/1-10/31	ORX-1-213	18	ES
statewide, off-range	11/1-11/30	11/1-11/30	11/1-11/30	11/1-11/30	ORX-1-214	60	ES
statewide, off-range, **YO**	11/1-11/30	11/1-11/30	11/1-11/30	11/1-11/30	ORX-1-215	18	ES
statewide, off-range	12/1-12/31	12/1-12/31	12/1-12/31	12/1-12/31	ORX-1-216	60	ES
statewide, off-range, **YO**	12/1-12/31	12/1-12/31	12/1-12/31	12/1-12/31	ORX-1-217	18	ES
statewide, off-range	1/1-1/31	1/1-1/31	1/1-1/31	1/1-1/31	ORX-1-218	60	ES
statewide, off-range, **YO**	1/1-1/31	1/1-1/31	1/1-1/31	1/1-1/31	ORX-1-219	18	ES
statewide, off-range	2/1-2/29	2/1-2/28	2/1-2/28	2/1-2/28	ORX-1-220	60	ES
statewide, off-range, **YO**	2/1-2/29	2/1-2/28	2/1-2/28	2/1-2/28	ORX-1-221	18	ES
statewide, off-range	3/1-3/31	3/1-3/31	3/1-3/31	3/1-3/31	ORX-1-222	60	ES
statewide, off-range, **YO**	3/1-3/31	3/1-3/31	3/1-3/31	3/1-3/31	ORX-1-223	18	ES
McGregor range	1/7-1/8	1/12-1/13	1/11-1/12	1/10-1/11	ORX-1-224	25	ES
McGregor range, **MO**	1/7-1/8	1/12-1/13	1/11-1/12	1/10-1/11	ORX-1-225	25	ES
McGregor range	12/10-12/11	12/8-12/9	12/7-12/8	12/6-12/7	ORX-1-226	25	ES
McGregor range, **MO**	12/10-12/11	12/8-12/9	12/7-12/8	12/6-12/7	ORX-1-227	25	ES

D. Private land-only oryx hunts: Private land-only oryx licenses shall be valid only on deeded private land and restricted to the season dates, eligibility requirements or restrictions, sporting arms type, and bag limit that corresponds to the public land hunt codes listed 19.31.12.12 NMAC above. Hunts on private land for April and May are restricted to the season dates, eligibility requirements or restrictions, sporting arms type, and bag limit that corresponds to the hunt codes listed below. The number of private land-only oryx licenses shall be unlimited and available only through department offices or department's web site.

open areas	2012-13 hunt dates	2013-14 hunt dates	2014-15 hunt dates	hunt code	bag limit
statewide, off-range	4/1-4/30	4/1-4/30	4/1-4/30	ORX-1-2000	ES
statewide, off-range	5/1-5/31	5/1-5/31	5/1-5/31	ORX-1-2020	ES

E. Oryx population management hunts:

(1) The respective area chief may authorize population management hunts for oryx when justified in writing by department personnel.

(2) The respective area chief shall designate the sporting arms, season dates, season lengths, bag limits, hunt boundaries, and number of licenses. No qualifying license holder shall take more than one oryx per license year.

(3) The specific hunt dates, hunt area, the name of the department representative providing the information and the date and time of notification shall be written on the license after notification by telephone.

(4) Application may be made either on-line or through the special hunt application form provided by the department. On-line applications must be submitted by the deadline date set by the department. Application forms postmarked by the deadline date will be accepted up to five working days after the deadline date.

(5) Applications for licenses may be rejected, and fees returned to an applicant, if such applications are not on the proper form or do not supply adequate information.

(6) In the event that an applicant is not able to hunt on the dates specified, the applicant's name shall be moved to the bottom of the list and another applicant may be contacted for the hunt.

(7) No more than one person may apply under each application.

(8) Population management hunts for oryx may be anywhere in the state with dates, number of licenses, bag limit, and specific hunt areas to be determined by the department. The hunt codes to apply for oryx population management hunts shall be as indicated in the table below.

open areas	hunt dates	hunt code	licenses	bag limit
standard management hunt, TBA	TBA	ORX-5-510	250	ES
Fort Bliss (west of US highway 54) management hunt, TBA	TBA	ORX-5-511	30	ES

(9) Military only hunters must be full time active military and proof of military status must accompany application or, if applying online, forwarded to the department by the application deadline date.

(10) The oryx population management hunt ORX-5-511 is restricted to Fort Bliss military personnel only. Proof of assignment to Fort Bliss must accompany application or, if applying online, forwarded to the department by the application deadline.

(11) In those instances where a population management hunt is warranted on deeded private lands, the landowner may suggest eligible hunters of their choice by submitting a list of prospective hunter's names to the department for licensing consideration. No more than one-half of the total number of licenses authorized shall be available to landowner identified hunters. The balance of prospective hunters shall be identified by the department.

F. Oryx incentive authorizations: The director may annually allow up to two oryx authorizations to be issued by drawing to elk and deer hunters reporting their prior year's harvest information as well as trappers reporting their trapping activities by the published deadline using the department's established website. These incentives may also be available for deer and elk hunters submitting their legally harvested animal for CWD testing. Authorization certificates to purchase the license may be used either by the applicant or any individual of the selected applicant's choice and may be transferred through sale, barter, or gift. Oryx incentive hunts shall be any one premier oryx season (excluding population management hunts) of the hunter's choice. Bag limit shall be either sex with the legal sporting arms and hunt area of the selected hunt.

G. Wounded warrior project oryx hunt: The department shall annually issue three authorizations to the wounded warrior project for hunting by injured service men and women as identified by the wounded warrior project on White Sands missile range. Authorization as used in this subsection shall mean the document or number generated by the department that authorizes the holder to purchase a specified license to hunt oryx. Hunt dates for each authorization to be determined annually.

[19.31.12.12 NMAC - Rp, 19.31.12.12 NMAC, 4-1-11; A, 2-15-12; A/E, 4-19-12]

NEW MEXICO PUBLIC REGULATION COMMISSION

INSURANCE DIVISION

This is an amendment to 13.10.17 NMAC, Sections 2, 7, 9 -12, 14 - 24, 26 - 31, 35 and 37, effective May 15, 2012.

13.10.17.2 SCOPE:

A. Applicability. This rule applies to all health care insurers that provide, offer, or administer health benefits plans including health benefits plans:

(1) with a point-of-service option that allows [~~covered person~~] grievant to obtain health care services out of network;

(2) provided by an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act [~~; and~~] (NMSA 1978 Sections 13-7-1 through 13-7-11);

(3) utilizing a preferred provider network, as defined under NMSA 1978 Section 59A-22A-3; and

(4) traditional fee-for-service indemnity plans.

B. Exemptions. This rule does not apply to policies or certificates that provide coverage for:

[~~**(1)** traditional fee-for-service indemnity plans;~~]

[~~**(2)**~~] **(1)** only short-term travel, accident-only, student health, specified disease, or other limited benefits; or

[~~**(3)**~~] **(2)** credit, disability income, hospital indemnity, long-term care insurance, vision care or any other limited supplemental benefit.

C. Conflicts. For purposes of this rule, if any provision in this rule conflicts with any provision in 13.10.13 NMAC, Managed Health Care or 13.10.16 NMAC, Provider Grievances, the provisions in this rule shall apply.

[13.10.17.2 NMAC - Rp, 13.10.17.2 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12]

13.10.17.7 DEFINITIONS: As used in this rule:

A. administrative grievance means an oral or written complaint submitted by or on behalf of a [~~covered person~~] grievant 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 the health care insurer that affects the availability, delivery, or quality of health care services;

(2) claims payment, handling or reimbursement for health care services; and

(3) terminations of coverage;

B. adverse determination [~~means a decision made either pre-service or post-service, by a health care insurer that a health care service requested by a provider or covered person has been reviewed and, based upon the information available, does not meet the health care insurer's requirements for coverage or medical necessity, and the requested health care service is therefore denied, reduced or terminated;~~] 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;

C. adverse determination grievance means an oral or written complaint submitted by or on behalf of a [~~covered person~~] grievant regarding an adverse determination;

D. certification means a decision by a health care insurer that a health care service requested by a provider or [~~covered person~~] grievant has been reviewed and, based upon the information available, meets the health care insurer's requirements for coverage and medical necessity, and the requested health care service is therefore approved;

E. culturally and linguistically appropriate manner of notice means:

(1) notice that meets the following requirements:

(a) the health care insurer 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) the health care insurer must provide, upon request, a notice in any applicable non-English language;

(c) the health care insurer 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 the health care insurer; 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://cciio.cms.gov/resources/factsheets/clas-data.html and any necessary changes to this list are posted by HHS annually;

[~~E.~~] F. [~~covered person~~] grievant means any of the following:

(1) a policyholder, subscriber, enrollee, or other individual [~~entitled to receive health care benefits provided by a health benefits plan, and includes medicaid recipients enrolled in a health care insurer's medicaid plan and 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;~~], 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 the health care plan;

(2) an individual, or that person's authorized representative, who may be entitled to receive health care benefits provided by the health care plan;

(3) medicaid recipients enrolled in a health care insurer's medicaid plan; or

(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;

[~~F. grievant~~ ~~means a covered person, a covered person's authorized representative, or a provider acting on behalf of a covered person with the covered person's consent;~~]

G. health benefits plan means a health plan or a policy, contract, certificate or agreement offered or issued by a health care insurer or plan administrator to provide, deliver, arrange for, pay for, or reimburse the costs of health care services; this includes a traditional fee-for-service health benefits plan [~~as defined under NMSA 1978 Section 59A-22A-3(D) as "the health insurance policy or subscriber agreement between the covered person or the policyholder and the health care insurer which defines the covered services and benefit levels available"~~];

H. 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;

I. 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;

J. 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;

K. 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;

L. medical necessity or medically necessary means health care services determined by a provider, in consultation with the health care insurer, 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 the health care insurer 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;

M. 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;

N. 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;

[~~N.~~] O. summary of benefits means the written materials required by NMSA 1978 Section 59A-57-4 to be given to the [~~covered person~~] grievant by the

health care insurer or group contract holder;

[O.] P. termination of coverage means the cancellation or non-renewal of coverage provided by a health care insurer to a [covered person] grievant but does not include a voluntary termination by a [covered person] grievant or termination of a health benefits plan that does not contain a renewal provision;

[P.] Q. traditional fee-for-service indemnity benefit means a fee-for-service indemnity benefit, not associated with any financial incentives that encourage [covered persons] grievants to utilize preferred providers, to follow pre-authorization 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;

[Q.] R. 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 the health care insurer consistent with the federal, national, and professional practice guidelines that are used by a health care insurer in determining whether to certify or deny a requested health care service.

[13.10.17.7 NMAC - Rp, 13.10.17.7 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12]

13.10.17.9 GENERAL REQUIREMENTS REGARDING GRIEVANCE PROCEDURES:

A. Written grievance procedures required. Every health care insurer shall establish and maintain separate written procedures to provide for the presentation, review, and resolution of:

(1) adverse determination grievances; a health care insurer 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; a health care insurer 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 the health care insurer shall initiate separate complaints for each issue; with an explanation of the insurer's actions contained in one acknowledgement letter.

B. Assistance to [covered persons] grievants. In those instances where a [covered person] grievant makes an oral grievance or request for internal review to the health care insurer, or expresses interest in pursuing a written grievance, the health care insurer shall assist [the covered person] grievant to complete all the forms required to pursue internal review and shall advise [the covered person] grievant that the managed health care bureau of the insurance division is available for assistance.

C. Retaliatory action prohibited. No person shall be subject to retaliatory action by the health care insurer for any reason related to a grievance.

[13.10.17.9 NMAC - Rp, 13.10.17.9 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12]

13.10.17.10 INFORMATION ABOUT GRIEVANCE PROCEDURES:

A. For [covered persons] grievants. A health care insurer shall:

(1) include a clear and concise description of all grievance procedures, both internal and external, in boldface type in the enrollment materials, including in member handbooks or evidences of coverage, issued to [covered persons] grievants;

(2) for a person who has been denied coverage, provide him or her with a copy of the grievance procedures;

[(2)] (3) notify [covered persons] grievants that a representative of the health care insurer and the managed health care bureau of the insurance division are available upon request to assist [covered persons] grievants 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 [covered persons] grievants;

[(3)] (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 a [covered person] grievant, provider or other interested person;

[(4)] (5) provide a detailed written explanation of the appropriate grievance procedure and a copy of the grievance form to a grievant or provider when the health care insurer makes either an adverse determination or adverse administrative decision; the written explanation shall describe how the health care insurer reviews and resolves grievances and provide a toll-free telephone number, facsimile number, e-mail address, and mailing address of the health care insurer's consumer assistance office; and

[(5)] (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 as defined in Subsection E of 13.10.17.7 NMAC;

(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 the grievant sufficiently in advance of the reduction or termination to allow the grievant 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.

B. For providers. A health care insurer shall inform all providers of the grievance procedures available to [covered persons] grievants and providers acting on behalf of [covered persons] grievants, 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.

C. 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.

[13.10.17.10 NMAC - Rp, 13.10.17.10 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12]

13.10.17.11 CONFIDENTIALITY OF A [COVERED PERSON'S] GRIEVANT'S RECORDS AND MEDICAL INFORMATION:

A. Confidentiality. Health care insurers, the superintendent, independent co-hearing officers, and all others who acquire access to identifiable medical records and information of [covered person] grievants when reviewing grievances shall treat and maintain such records and information as confidential except as otherwise provided by federal and New Mexico law.

B. Procedures required. The superintendent and health care insurers shall establish procedures to ensure the confidential treatment and maintenance of identifiable medical records and information of [covered persons] grievants submitted as part of any grievance.

[13.10.17.11 NMAC - Rp, 13.10.17.11 NMAC, 5-3-04; A, 5-15-12]

13.10.17.12 RECORD OF GRIEVANCES:

A. Record required. The

health care insurer 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.

B. 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 the [~~covered person~~] grievant;

(5) identify by name and member number the [~~covered person~~] grievant making the grievance or for whom the grievance was made;

(6) indicate whether the grievant's 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 the health care insurer 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 the [~~covered person~~] grievant was notified of the outcome.

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

D. Retention. The health care insurer shall maintain such records for at least [~~three (3)~~] six (6) years.

E. Submittal. The health care insurer shall submit information regarding all grievances involving quality of care issues to the health care insurer's continuous quality improvement committee and to the superintendent and shall document the qualifications and background of the continuous quality improvement committee members.

F. Examination. The health care insurer shall make such record available for examination upon request and provide such documents free of charge to a grievant, or state or federal agency officials, subject to any applicable federal or state law regarding disclosure of personally identifiable health information.

[13.10.17.12 NMAC - Rp, 13.10.17.12 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12]

13.10.17.14 TIMEFRAMES FOR INITIAL DETERMINATIONS:

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

(1) the life or health of a [~~covered person~~] grievant would be jeopardized;

(2) the [~~covered person's~~] grievant's 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 the grievant's medical condition, would subject the grievant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim;

[**~~(4)~~**] **(5)** the medical exigencies of the case require an expedited decision; or

(6) the grievant's claim involves urgent care.

B. Standard decision. A health care insurer shall make all other initial utilization management decisions within five (5) working days. The health care insurer 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 the [~~covered person~~] grievant; and

(3) provides a written progress report and explanation for the delay to the [~~covered person~~] grievant and provider within the original five (5) working day review period.

[13.10.17.14 NMAC - Rp, 13.10.17.14 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12]

13.10.17.15 INITIAL DETERMINATION:

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

B. Medical necessity.

(1) If the health care insurer 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 [~~covered person~~] grievant, 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 a health care insurer denies a health care service requested by a provider or [~~covered person~~] grievant 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 the health care insurer. The physician shall be under the clinical authority of the medical director responsible for health care services provided to [~~covered persons~~] grievants.

[13.10.17.15 NMAC - Rp, 13.10.17.13 NMAC & 13.10.17.16 NMAC, 5-3-04; A, 5-15-12]

13.10.17.16 NOTICE OF INITIAL DETERMINATION:

A. Certification. The health care insurer shall notify the [~~covered person~~] grievant 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.

B. 24-hour notice of adverse determination; explanatory contents. The health care insurer shall notify a [~~covered person~~] grievant and 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 the grievant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan or have insurance coverage. If the grievant fails to provide such information, he or she 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, the health care insurer shall notify the covered person and provider of the adverse

determination by written or electronic communication sent within one (1) working day of the telephone notice. [~~The notice shall:~~]

C. 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) [~~advise the covered person that he or she may request internal review of the health care insurer's adverse determination; and~~] 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) [~~describe the procedures and provide all necessary forms to the covered person for requesting internal review~~] include a description of the health care insurer standard that was used in denying the claim;

(5) provide a summary of the discussion which triggered the final determination;

(6) advise the grievant that he or she may request internal or external review of the health care insurer's adverse determination; and

(7) describe the procedures and provide all necessary forms to the grievant for requesting internal appeals and external reviews.

[13.10.17.16 NMAC - Rp, 13.10.17.17 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12]

13.10.17.17 RIGHTS REGARDING INTERNAL REVIEW OF ADVERSE DETERMINATIONS:

A. Right to internal review. Every grievant who is dissatisfied with an adverse determination shall have the right to request internal review of the adverse determination by the health care insurer.

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

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

D. Conflict of interest. The health care insurer 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 such 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.

[13.10.17.17 NMAC - Rp, 13.10.17.18 NMAC, 5-3-04; A, 5-15-12]

13.10.17.18 TIMEFRAMES FOR INTERNAL REVIEW OF ADVERSE DETERMINATIONS: Upon receipt of a request for internal review of an adverse determination, the health care insurer shall conduct either a standard or expedited review, as appropriate.

A. Expedited review. A health care insurer 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) the life or health of a [~~covered person~~] grievant would be jeopardized; [~~or~~]

(2) the [~~covered person~~] grievant's 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 the grievant's medical condition, would subject the grievant 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.

B. Standard review. A health care insurer 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. The health care insurer 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 the [~~covered person~~] grievant; and

(3) provides a written progress report and explanation for the delay to the [~~covered person~~] grievant 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 the health care insurer shall initiate separate complaints for each decision.

C. Failure to comply with deadline. If the health care insurer fails to comply with the deadline for completion of an internal review, the requested health care service shall be deemed approved unless the grievant, after being fully informed of his or her rights, has agreed in writing to extend the deadline.

[13.10.17.18 NMAC - Rp, 13.10.17.19 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12]

13.10.17.19 FIRST AND SECOND INTERNAL REVIEW OF ADVERSE DETERMINATIONS [~~BY MEDICAL DIRECTOR~~] FOR GROUP HEALTH PLANS:

A. Applicability. This section applies only to health care insurers that offer group health care benefits plans and entities subject to the Health Care Purchasing Act that conduct the first level of the internal appeal, and health care insurers who offer group health care benefits plans that conduct the second level of the internal appeal.

[~~A.~~] B. Scope of review. [~~The medical director, or an appropriate person designated by the medical director,~~] Health care insurers that offer group health care benefits plans and entities subject to the Health Care Purchasing Act shall complete [~~his or her~~] the review of the adverse determination within the timeframes [~~required by the medical exigencies of the case~~] established in 13.10.17.18 NMAC.

(1) Coverage. If the initial adverse determination was based on a lack

of coverage, the [~~medical director, or an appropriate person designated by the medical director,~~] health care insurer 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, the [~~medical director~~] health care insurer 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 the health care insurer.

[~~B.~~] C. Decision to reverse. If the [~~medical director~~] health care insurer reverses the initial adverse determination and certifies the requested health care service, the health care insurer shall notify the [~~covered person~~] grievant and provider as required by 13.10.17.16 NMAC.

[~~C.~~] D. Decision to uphold. If the [~~medical director~~] health care insurer upholds the initial adverse determination to deny the requested health care service, the health care insurer shall notify the [~~covered person~~] grievant and provider as required by 13.10.17.16 NMAC and shall ascertain whether the grievant wishes to pursue the grievance.

(1) If the grievant does not wish to pursue the grievance, the health care insurer shall mail written notification of the [~~medical director's~~] health care insurer's decision, and confirmation of the grievant's decision not to pursue the matter further, to the grievant within three (3) working days of the [~~medical director's~~] health care insurer's decision.

(2) If the health care insurer is unable to contact the grievant by telephone within seventy-two (72) hours of making the decision to uphold the determination, the health care insurer shall notify the grievant by mail of the [~~medical director's~~] health care insurer's decision and shall include in the notification a self-addressed stamped response form which asks the grievant whether he or she wishes to pursue the grievance further and provides a box for checking "yes" and a box for checking "no." If the grievant does not return the response form within ten (10) working days, the health care insurer shall again contact the grievant by telephone.

(3) If the grievant responds affirmatively to the telephone inquiry or by response form, the health care insurer will select a medical panel to further review the adverse determination as described in 13.10.17.20 NMAC.

(4) If the grievant does not respond to the health care insurer's telephone inquiries or return the response form, the health care insurer shall [~~:~~

~~**(a)** when the review is an expedited review,~~] select a medical panel to further review the adverse determination when the review is an expedited review [~~;~~

~~**(b)** when the review is a standard review, close the file if the health care insurer can document its efforts to contact the grievant and the grievant has not responded within twenty (20) working days~~].

[~~D.~~] E. Extending the timeframe for standard review. If the grievant does not make an immediate decision to pursue the grievance, or the grievant has requested additional time to supply supporting documents or information, or postponement pursuant to Subsection [~~E~~] G of 13.10.17.20 NMAC, the timeframe described in Subsection B of 13.10.17.18 NMAC shall be extended to include the additional time required by the grievant.

[13.10.17.19 NMAC - Rp, 13.10.17.20 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12]

13.10.17.20 INTERNAL PANEL REVIEW OF ADVERSE DETERMINATIONS:

A. 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, the issuer shall select an internal review panel to review the adverse determination or the decision to uphold the adverse determination.

[~~A.~~] B. Notice of review. Unless the grievant chooses not to pursue the grievance, the health care insurer shall notify the grievant of the date, time, and place of the internal panel review. The notice shall advise the grievant of the rights specified in Subsection [~~E~~] G of this section. If the health care insurer indicates that it will have an attorney represent its interests, the notice shall advise the grievant that an attorney will represent the health care insurer and that the grievant may wish to obtain legal representation of their own.

[~~B.~~] C. Panel membership. The health care insurer shall select one or more representatives of the health care insurer 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 review 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 the grievant and the health care insurer.

[~~C.~~] D. 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 the health care insurer.

[~~D.~~] E. Information to grievant. No fewer than three (3) working days prior to the internal panel review, the health care insurer shall provide to the grievant copies of:

(1) the [~~covered persons's~~] grievant's pertinent medical records;

(2) the treating provider's recommendation;

(3) the [~~covered person's~~] grievant's health benefits plan;

(4) the health care insurer's notice of adverse determination;

(5) uniform standards relevant to the grievant's 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 the health care insurer; and

(7) all other evidence or documentation relevant to reviewing the adverse determination.

[~~E.~~] F. Request for postponement. The health care insurer shall not unreasonably deny a request for postponement of the internal panel review made by the grievant. The timeframes for internal panel review shall be extended during the period of any postponement.

[~~F.~~] G. Rights of grievant. A grievant has the right to:

(1) attend and participate in the internal panel review;

(2) present his or her case to the internal panel;

(3) submit supporting material both before and at the internal panel review;

(4) ask questions of any representative of the health care insurer;

(5) ask questions of any health care professionals on the internal panel;

(6) be assisted or represented by a person of her choice, including legal representation; and

(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.

[~~G.~~] H. Timeframe for review; attendance. The internal review panel will complete its review of the adverse determination as required by the medical exigencies of the case and within the timeframes set forth in 13.10.17.18 NMAC. Internal review panel members must be present physically or by video or telephone conferencing to hear the grievance. [~~A~~] 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.
[13.10.17.20 NMAC - Rp, 13.10.17.21 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12]

13.10.17.21 ADDITIONAL REQUIREMENTS FOR EXPEDITED INTERNAL REVIEW OF ADVERSE DETERMINATIONS:

A. In an expedited review, all information required by Subsection D of 13.10.17.20 NMAC shall be transmitted between the health care insurer and the grievant by the most expeditious method available.

B. If an expedited review is conducted during a patient's hospital stay or course of treatment, health care services shall be continued without cost (except for applicable co-payments and deductibles) to the [~~covered person~~] grievant until the health care insurer makes a final decision and notifies the grievant.

C. A health care insurer shall not conduct an expedited review of an adverse determination made after health care services have been provided to a [~~covered person~~] grievant.
[13.10.17.21 NMAC - Rp, 13.10.17.22 NMAC, 5-3-04; A, 5-15-12]

13.10.17.22 NOTICE OF INTERNAL PANEL DECISION:

A. Notice required. Within the time period allotted for completion of its internal review, the health care insurer shall notify the grievant and provider of the internal review 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.

B. 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;

[~~(3)~~] (4) a clear and complete explanation of the rationale for the internal review panel's decision;

(a) the notice shall identify every provision of the grievant's 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 the grievant's 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;

[~~**(4)** reference to any other evidence or documentation considered by the internal panel in making its decision;~~]

(5) notice of the grievant's 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 the grievant's right to request external review is in addition to the same notice provided the grievant in the summary of benefits and health benefits plan.
[13.10.17.22 NMAC - Rp, 13.10.17.23 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12]

13.10.17.23 EXTERNAL REVIEW OF ADVERSE DETERMINATIONS:

A. Right to external review. Every grievant who is dissatisfied with the results of a medical panel review of an adverse determination by a health care insurer 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, may request external review by the superintendent at no cost to the grievant. There shall be no minimum dollar amount of a claim before a grievant may exercise this right to external review.

B. Exhaustion of [~~remedies~~] internal appeals process. The superintendent may require the grievant to exhaust any grievance procedures adopted by the health care insurer 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.

C. 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) the health care insurer waives the exhaustion requirement;

(2) the health care insurer is considered to have exhausted the internal appeals process by failing to comply with the requirements of the internal appeals process; or

(3) the grievant simultaneously requests an expedited internal appeal and an expedited external review.

D. Exception to exhaustion requirement.

(1) Notwithstanding Subsection B of this section, the internal claims and appeals process will not be deemed exhausted based on violations by the health care insurer that are *de minimus* and do not cause, and are not likely to cause, prejudice or harm to the grievant, so long as the health care insurer demonstrates that the violation was for good cause or due to matters beyond the control of the health care insurer, and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the grievant. This exception is not available if the violation is part of a pattern or practice of violations by the health care insurer.

(2) The grievant may request a written explanation of the violation from the health care insurer, and the health care insurer must provide such explanation within ten (10) days, including a specific description of its bases, 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 the grievant's request for immediate review under Subsection B of this section on the basis that the health care insurer met the standards for the exception under Paragraph (1) of Subsection D of this section, the grievant has 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), the health care insurer shall provide the grievant 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 grievant's receipt of such notice.
[13.10.17.23 NMAC - Rp, 13.10.17.24 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12]

13.10.17.24 FILING REQUIREMENTS FOR EXTERNAL REVIEW OF ADVERSE DETERMINATIONS:

A. Deadline for filing request.

(1) When required by the medical exigencies of the case. If required by the medical exigencies of the case, a [~~covered person~~] grievant or 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, a grievant must file a written request for external review with the superintendent within [~~twenty (20) working~~] one hundred twenty (120) calendar days from receipt of the written notice of internal review decision unless extended by the superintendent for good cause shown. The cost of the external review will be borne by the health care insurer or health care plan. 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 NMPRC, Division of Insurance Complaint Form available at http://www.nmprc.state.nm.us.

B. Documents required to be filed by the grievant. The grievant shall file the request for external review on the forms provided to the grievant by the health care insurer or entity that purchases health care benefits pursuant to the New Mexico Health Care Purchasing Act pursuant to Paragraph (5) of Subsection B of 13.10.17.22 NMAC, 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 the health care insurer 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 Subsection B of 13.10.17.28 NMAC.

C. Other filings. The grievant may also file any other supporting documents or information the grievant wishes to submit to the superintendent for review.

D. Extending timeframes for external review. If a grievant wishes 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 90 days from the receipt of the complaint form, or until the grievant submits all supporting documents, whichever occurs first.

[13.10.17.24 NMAC - Rp, 13.10.17.25 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12]

13.10.17.26 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.

A. Expedited review.

(1) 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)**~~] **(a)** the life or health of a [~~covered person~~] grievant would be jeopardized; or

[~~**(2)**~~] **(b)** the [~~covered person's~~] grievant's ability to regain maximum function would be jeopardized.

(2) 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.

B. 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 the grievant and health care insurer 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 [~~thirty (30)~~] 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 the [~~covered person~~] grievant.

[13.10.17.26 NMAC - Rp, 13.10.17.27 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12]

13.10.17.27 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:

A. the grievant has provided the documents required by Subsection B of 13.10.17.24 NMAC;

B. the individual is or was a [~~covered person~~] grievant of the health care insurer at the time the health care service was requested or provided;

C. the [~~covered person~~] grievant has exhausted the health care insurer'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

D. the health care service that is the subject of the grievance reasonably appears to be a covered benefit under the health benefits plan.

[13.10.17.27 NMAC - Rp, 13.10.17.28 NMAC, 5-3-04; A, 5-15-12]

13.10.17.28 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:

A. coverage; the recommended or requested health care service:

(1) reasonably appears to be a covered benefit under the [~~covered person's~~] grievant's health benefit plan except for the health care insurer'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 the [~~covered person~~] grievant's health benefit plan; and

B. medical necessity; the [~~covered person~~] grievant's treating provider has certified that:

(1) standard health care services have not been effective in improving the [~~covered person~~] grievant's condition; or

(2) standard health care services are not medically appropriate for the [~~covered person~~] grievant; or

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

(a) recommended by the [~~covered person's~~] grievant's treating provider that the treating provider certifies in writing is likely to be more beneficial to the [~~covered person~~] grievant, in the treating provider's opinion, than standard health care services; or

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

[13.10.17.28 NMAC - Rp, 13.10.17.29 NMAC, 5-3-04; A, 5-15-12]

13.10.17.29 INITIAL EXTERNAL REVIEW OF ADVERSE DETERMINATION BY INSURANCE DIVISION STAFF:

A. Request incomplete. If the request for external review is incomplete, insurance division staff shall immediately notify the grievant and require the grievant to submit the information required by Subsection B of 13.10.17.25 NMAC within a specified period of time.

B. Request does not meet criteria. If the request for external review

does not meet the criteria prescribed by 13.10.17.27 and, if applicable, 13.10.17.28 NMAC, insurance division staff shall so inform the superintendent. The superintendent shall notify the grievant and the health care insurer that the request does not meet the criteria for external review and is thereby denied, and that the grievant has the right to request a hearing in the manner provided by NMSA 1978 Sections 59A-4-15 and 59A-4-18 within thirty-three (33) days from the date the notice was mailed.

C. Request meets criteria. If the request for external review is complete and meets the criteria prescribed by 13.10.17.27 and, if applicable, 13.10.17.28 NMAC, insurance division staff shall so inform the superintendent. The superintendent shall notify the grievant and the health care insurer that the request meets the criteria for external review and that an informal hearing pursuant to NMSA 1978 Section 59A-4-18 and 13.10.17.30 NMAC has been set to determine whether, as a result of the health care insurer's adverse determination, the [~~covered person~~] grievant was deprived of medically necessary covered services. Prior to the hearing, insurance division staff shall attempt to informally resolve the grievance in accordance with NMSA 1978 Section 12-8-10.

D. 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 the grievant and the health care insurer of the rights specified in Subsection G of 13.10.17.30 NMAC. The superintendent shall not unreasonably deny a request for postponement of the hearing made by the grievant or the health care insurer.

[13.10.17.29 NMAC - Rp, 13.10.17.30 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12]

13.10.17.30 HEARING PROCEDURES FOR EXTERNAL REVIEW OF ADVERSE DETERMINATIONS:

A. 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.

B. Co-hearing officers. The superintendent may designate two (2) independent co-hearing officers who shall be licensed health care professionals and who shall maintain independence and impartiality in the process. 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.

C. 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 the grievant or health care insurer fails to appear, proceed with the hearing or adjourn the proceedings to a future date, giving notice of the adjournment to the absent party.

D. 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.

E. Testimony. Testimony at the hearing shall be taken under oath. The superintendent or hearing officers may call and examine the grievant, the health care insurer, and other witnesses.

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

G. Rights of parties. Both the grievant and the health care insurer have the right to:

(1) attend the hearing; the health care insurer shall designate a person to attend on its behalf and the grievant may designate a person to attend on [~~her~~] grievant's behalf if the grievant chooses 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 the health care insurer and the MHCB staff.

H. Stipulation. The grievant and the health care insurer 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.

[13.10.17.30 NMAC - Rp, 13.10.17.31 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12]

13.10.17.31 INDEPENDENT CO-HEARING OFFICERS (ICOs):

A. Identification of ICOs. The superintendent shall provide for maintenance of a list of licensed professionals qualified to serve as independent co-hearing officers. The superintendent shall [~~consult with~~] select 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.

B. 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 the [~~covered person~~] grievant or to the health care insurer or providers involved in a particular external review.

C. 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 the [~~covered person's~~] grievant's health care insurer.

(3) Direct payment to ICOs. Within thirty (30) days of receipt of the statement of ICO compensation, the [~~covered person's~~] grievant's health care insurer 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.

D. 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.

[13.10.17.31 NMAC - Rp, 13.10.17.32 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12]

13.10.17.35 RECONSIDERATION OF INTERNAL REVIEW OF ADMINISTRATIVE GRIEVANCE:

A. Committee. Upon receipt of a request for reconsideration, the health care insurer shall appoint a reconsideration committee consisting of one or more employees of the health care insurer who have not participated in the initial decision. The health care insurer may include one or more [~~covered person~~] employees other than the grievant to participate on the reconsideration committee.

B. 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 the grievant, and the health care insurer shall offer the grievant the opportunity to communicate with the committee, at the health care insurer's expense, by conference call, video conferencing, or other appropriate technology. The health care insurer shall not unreasonably deny a request for postponement of the hearing made by a grievant.

C. Notice. The health care insurer shall notify the grievant in writing of the hearing date, time and place at least ten (10) working days in advance. The notice shall advise the grievant of the rights specified in Subsection E of this section. If the health care insurer will have an attorney represent its interests, the notice shall advise the grievant that the health care insurer will be represented by an attorney and that the grievant may wish to obtain legal representation of her own.

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

E. Rights of grievant. A grievant has the right to:

(1) attend the reconsideration committee hearing;

(2) present their case to the reconsideration committee;

(3) submit supporting material both before and at the reconsideration committee hearing;

(4) ask questions of any representative of the health care insurer; and

(5) be assisted or represented by a person of their choice.

[13.10.17.35 NMAC - Rp, 13.10.17.36 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12]

13.10.17.37 EXTERNAL REVIEW OF ADMINISTRATIVE GRIEVANCES:

A. Right to external review. Every grievant who is dissatisfied with the results of the internal review of an administrative decision shall have the right to request external review by the superintendent.

B. Exhaustion of remedies. The superintendent may require the [~~covered person~~] grievant to exhaust any grievance procedures adopted by [~~an~~] the health care insurer or the entity that purchases [~~or is authorized to purchase~~] health care benefits pursuant to the New Mexico Health Care Purchasing Act, [~~or a health care insurer,~~] as appropriate, before accepting [~~an administrative~~] a grievance for external review.

C. 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) the health care insurer waives the exhaustion requirement;

(2) the health care insurer is considered to have exhausted the internal appeals process by failing to comply with the requirements of the internal appeals process; or

(3) the grievant simultaneously requests an expedited internal appeal and an expedited internal appeal and an expedited external review.

D. Exception to exhaustion requirement.

(1) Notwithstanding Subsection B of this section, the internal claims and appeals process will not be deemed exhausted based on violations by the health care insurer that are *de minimus* and do not cause, and are not likely to cause, prejudice or harm to the grievant, so long as the health care insurer demonstrates that the violation was for good cause or due to matters beyond the control of the health care insurer, and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the grievant. This exception is not available if the violation is part of a pattern or practice of violations by the health care insurer.

(2) The grievant may request a written explanation of the violation from the health care insurer, and the health care insurer must provide such explanation within ten (10) days, including a specific description of its bases, 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 the grievant's request for immediate review under Subsection B of this section on the basis that the health care insurer met the standards for the exception under Paragraph (1) of Subsection D of this section, the grievant has 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 ten (10) days), the health care insurer shall provide the grievant 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 grievant receipt of such notice.

[13.10.17.37 NMAC - Rp, 13.10.17.38 NMAC, 5-3-04; A, 5-15-12]

End of Adopted Rules Section

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