TITLE 13 INSURANCE
CHAPTER 10 HEALTH INSURANCE
PART 16 PROVIDER GRIEVANCES

13.10.16.1 ISSUING AGENCY: Office of Superintendent of Insurance ("OSI").
[13.10.16.1 NMAC - Rp, 13.10.16.1 NMAC, 01/01/2023]

13.10.16.2 SCOPE:

A. This rule applies to every:

(1) health insurance carrier, as defined in Paragraph (2) of Subsection C of Section 59A-16-21.2 NMSA 1978;

(2) vision and dental plans that use a provider network; and

(3) multiple employer welfare arrangement (individually a "carrier" and collectively "carriers").

B. A carrier is not subject to this rule with respect to any "health benefits plan" or "plan" as defined in Paragraph (1) of Subsection C of Section 59A-16-21.2 NMSA 1978, which only provides "excepted benefits," as this term is defined in Subsection B of Section 59A-23G-2 NMSA 1978.
[13.10.16.2 NMAC - Rp, 13.10.16.2 NMAC, 01/01/2023]

13.10.16.3 STATUTORY AUTHORITY: Sections 59A-16-21.1, 59A-23-14, 59A-46-54, 59A-47-49 and 59A-57-6 NMSA 1978.
[13.10.16.3 NMAC - Rp, 13.10.16.3 NMAC, 01/01/2023]

13.10.16.4 DURATION: Permanent.
[13.10.16.4 NMAC - Rp, 13.10.16.4 NMAC, 01/01/2023]

13.10.16.5 EFFECTIVE DATE: January 1, 2023, unless a later date is cited at the end of a section.
[13.10.16.5 NMAC - Rp, 13.10.16.5 NMAC, 01/01/2023]

13.10.16.6 OBJECTIVE: The purpose of this rule is to mandate provider grievance processes that are fair, efficient and compliant with all applicable state and federal laws, and to specify practices and procedures for external OSI review of provider grievance appeals.
[13.10.16.6 NMAC - Rp, 13.10.16.6 NMAC, 01/01/2023]

13.10.16.7 DEFINITIONS:

A. Terms used in this rule are as defined in Section 59A-22B-2 NMSA 1978 and in 13.10.29 NMAC.

B. For the purposes of this rule, the subsequent term is supplemented and superseded as follows;
"Termination" means the discontinuance of a provider's employment, contractual relationship or other business relationship with, and initiated by, a carrier.
[13.10.16.7 NMAC - Rp, 13.10.16.7 NMAC, 01/01/2023]

13.10.16.8 GENERAL RULES: A carrier shall adopt and implement a provider grievance plan that complies with this rule. This rule does not preclude a carrier and provider from addressing or resolving a concern through any other process agreed on between them, but no such alternative process shall preclude a provider from presenting a grievance through a process that complies with this rule.

A. Allowed grievances. At a minimum, a carrier's provider grievance plan shall allow a provider to present any concern regarding:

(1) credentialing deadlines;

(2) claim payment amount or timing;

(3) claim submission requirements or compliance;

(4) network adequacy, including participation determinations based on network composition;

(5) network composition including provider qualifications;

(6) utilization management practices;

(7) provider contract construction or compliance;

(8) patient care standards or access to care;

(9) surprise billing reimbursement amount, rate or timing;

(10) termination;

(11) operation of the plan including compliance with any law enforceable by the superintendent, or of any directive of the superintendent; or

(12) Discrimination.

B. Timeline to file. A provider grievance plan shall allow a provider at least 90 days from the incident that is the subject of the grievance, to file a grievance.

C. Filing procedures and response. A provider grievance plan shall allow a provider to submit a written grievance electronically or manually. A carrier shall send a written acknowledgment of the grievance to the provider within five days of its receipt of the grievance using the provider's preferred communication method.

D. Point of contact. A provider grievance plan may require the submission of a complaint to a designated contact, as specified in the carrier's provider manual which shall identify the designated contact by name or position and provide a valid mailing address, phone number, and email address for the designated point of contact.

E. Request for supplemental information. A provider grievance plan may allow a carrier to request supplemental information pertinent to the resolution of a grievance from the provider. Any such request shall be made within 10 days of the carrier's receipt of a grievance, and shall require the provider to submit the requested supplemental information within the next 10 days.

F. Review panel. A provider grievance plan shall, at a minimum, require a carrier to form a review panel comprised of multiple members, at least one of whom is in a position of authority over the carrier operations that are the subject of a grievance. The review panel shall be responsible for reviewing and deciding the provider's grievance. If the grievance raises a quality-of-care concern the panel must include a New Mexico-licensed medical professional who practices in the general area of concern. A New Mexico-licensed physician shall be included on a review panel considering complex quality-of-care concerns. No person with a conflict of interest shall participate in a decision to resolve a grievance. Employment with the carrier, standing alone, does not present a conflict of interest.

G. Response. A provider grievance plan shall require a carrier to deliver a written response, to a grievance using the provider's preferred method of communication within 45 days of the later of receipt of the grievance, receipt of supplemental information requested to resolve the grievance, or the due date for submission of any requested supplemental information. The response shall include:

(1) the name(s), title(s), and qualification(s) of each person who participated in the grievance decision;

(2) a statement of issue(s) decided and of the ultimate decision(s);

(3) a clear and complete explanation of the rationale for the decision and a summary of the evidence relied upon to support the decision;

(4) a summary of any proposed remedial action; and

(5) information on the provider's appeal rights.

H. Extension of deadlines. If confirmed in a documented communication a carrier and provider may agree to extend any deadline imposed by this rule or a provider grievance plan.

I. Presentation of evidence. A provider grievance plan shall include reasonable procedures by which a provider may present oral or documentary evidence to the assigned grievance panel.

J. Bundled or group grievances. A provider grievance plan shall allow a provider to submit multiple related grievances simultaneously provided the grievances are not unduly duplicative or repetitive, and for a group of providers to assert a single grievance on behalf of multiple providers.

K. Non-participating providers. A carrier's provider grievance plan shall allow a non-participating provider to submit a grievance described in Paragraphs (1), (2), (4), (5), (6), (9) or (12) of Subsection A of this section. The grievance must assert and explain that the carrier's act or practice directly impacted the non-participating provider or a patient of that provider.

[13.10.16.8 NMAC - Rp, 13.10.16.8 NMAC, 01/01/2023]

13.10.16.9 PROVIDER TERMINATION: For a grievance that concerns a termination a provider grievance plan shall also comply with this section.

A. Terminations for cause. If a termination for cause, the provider grievance plan shall provide a fair hearing process that provides these minimum rights and protections:

(1) the right of the provider to appear in person at a hearing before the deciding panel;

(2) the right of the provider to present testimonial or documentary evidence at the hearing;

(3) the right of the provider to call witnesses, and cross-examine any witness;

(4) the right of the provider to be represented by an attorney or by any other person of the provider's choice;

(5) the right to an expedited hearing within 14 days of the termination in those instances where the carrier has not provided advance written notice of termination and the termination could result in imminent and significant harm to a covered person;

(6) a written decision within 20 days after the hearing, contemporaneously delivered via the provider's preferred method of communication; and

(7) if a group of providers is terminated for cause, each provider in the group shall have an individual right to a hearing. However, if any one of the providers in the group submits a grievance relating to the termination the carrier shall provide each similarly situated provider in the group with a notice of hearing, and each provider who receives such notice shall be bound by the carrier's determination subject to any appeal rights.

B. Other terminations. If a termination is not for cause, the provider grievance plan shall require the carrier to furnish the provider written notice at least 60 days before the effective date of termination. Such notice shall:

(1) be communicated in writing via the format preferred by the provider; and

(2) contain an explanation of the termination.

[13.10.16.9 NMAC - Rp, 13.10.16.9 NMAC, 01/01/2023]

13.10.16.10 APPEALS: At the request of a provider, the superintendent shall conduct an external review of a provider grievance as authorized by this section.

A. Types of grievances subject to appeal. The superintendent shall only review a provider grievance that pertains to:

(1) an alleged violation of a law enforceable by the superintendent;

(2) alleged noncompliance with an order of the superintendent; or

(3) a termination based on a provider's alleged failure to comply with a law or order enforceable by the superintendent.

B. Disposition. In the disposition of an appeal, the superintendent may only impose a remedy, penalty, or corrective action authorized by the Insurance Code.

C. Exhaustion of internal remedies required. The superintendent shall not review a provider grievance appeal unless the provider has exhausted the carrier's internal grievance process.

D. Timeline for filing appeal. A provider appeal of a grievance shall be filed no later than 30 days after the provider receives a response to the grievance, or the deadline for the response, whichever is earlier.

E. Appeal content. The superintendent shall not review a provider grievance appeal that does not contain the following information:

(1) the provider's name, license number, address, daytime telephone number, email address, and any relevant claim number(s);

(2) the name and phone number of the carrier;

(3) certification that the grievance did not pertain to Medicaid or Medicare coverage, excluding Medicare supplement;

(4) a copy of the carrier's written disposition of the grievance, or certification by the provider that the carrier did not issue a written disposition within the time allowed by law;

(5) the date the provider received the carrier's written disposition of the grievance, or the date by which the carrier was required to provide a written disposition if no disposition was received; and

(6) a clear and concise statement of the issue on appeal, and the remedy requested on appeal.

F. Additional documentation. Within 45 days of receipt of a provider grievance appeal, the superintendent shall determine whether the appeal is authorized by this section and otherwise reviewable. The superintendent may request supplemental information from the provider or carrier to so determine. The time between any such request and the delivery of the requested information by the superintendent shall be excluded from the 45-day deadline imposed by this section.

(1) If the superintendent determines that an appeal is not authorized or reviewable, the superintendent shall issue an order dismissing the appeal and stating the reason for dismissal.

(2) If the superintendent determines that an appeal is authorized and reviewable, the superintendent shall schedule either a formal or an informal hearing pursuant to the superintendent's rules, as

appropriate to the issues, facts and circumstances presented in the appeal. The order setting the hearing shall authorize a designated hearing officer to take or authorize any action authorized by law to resolve the appeal.

G. Settlement. The superintendent may order the parties to an appeal to participate in formal or informal settlement discussions focused on resolving the issue on appeal. If all parties to an appeal consent, the assigned hearing officer may facilitate the settlement discussions without being disqualified from issuing a recommended decision on appeal.

H. Waiver. Upon an express finding of good cause, the superintendent may waive any deadline, format or process requirement imposed by this section.

[13.10.16.10 NMAC - Rp, 13.10.16.10 NMAC, 01/01/2023]

13.10.16.11 RETALIATORY ACTION PROHIBITED: No person shall be subject to retaliatory action by a carrier for submitting or supporting a grievance or appeal.

[13.10.16.11 NMAC - N, 01/01/2023]

13.10.16.12 PROVIDER MANUAL: A carrier's provider manual shall include a clear statement of a provider's right to grieve, the internal grievance process, the right of appeal and the appeal process. The carrier shall publish its provider grievance plan on a website accessible to any provider.

[13.10.16.12 NMAC - N, 01/01/2023]

13.10.16.13 REPORTING AND COMPLIANCE:

A. Provider grievance plan publication and changes. No carrier shall publish a provider grievance plan., or any amendment of a provider grievance plan., that has not been reviewed and approved by the superintendent. A provider grievance plan shall be deemed approved if the superintendent fails to expressly approve, disapprove, or object to the provider grievance plan within 60 days from submission.

B. Submission of provider grievance plan. In conjunction with the provider contract certificate, a carrier shall submit a provider grievance plan for the superintendent's review and approval. At a minimum, the provider grievance plan shall include:

(1) a description of the procedures used by the carrier to receive, review, and respond to a provider grievance;

(2) the criteria and process the carrier uses to select the persons responsible for reviewing and responding to a provider grievance;

(3) the procedures by which the carrier's governing body is informed of provider grievances and the carrier's responses; and

(4) the title of staff responsible for implementation and oversight of the provider grievance process.

C. Grievance log. A carrier shall maintain a detailed log of provider grievances and their resolutions for a period of no less than five years. The carrier shall make the log available to the superintendent upon request.

[13.10.16.13 NMAC - N, 01/01/2023]

13.10.16.14 SEVERABILITY: If any section of this rule, or the applicability of any section to any person or circumstance, is for any reason held invalid by a court of competent jurisdiction, the remainder of the rule, or the applicability of such provisions to other persons or circumstances, shall not be affected.

[13.10.16.14 NMAC – N, 01/01/2023]

History of 13.10.16 NMAC:

13.10.16 NMAC – Provider Grievances, filed 12/01/1998, Recompiled 11/30/2001, was repealed and replaced by 13.10.16 NMAC – Provider Grievances, effective 01/01/2023.