This is an amendment to 13.10.31 NMAC, Section 12, effective 01/01/2023.

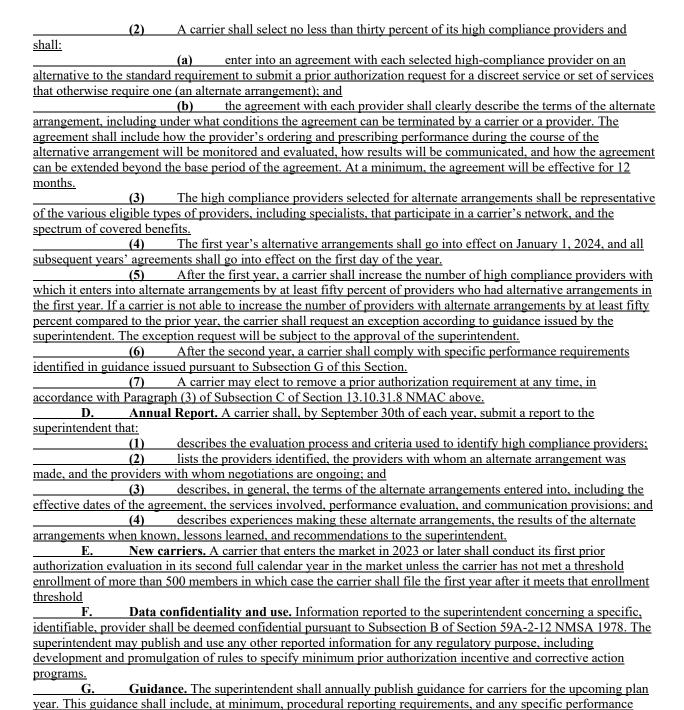
## [FRESERVED] EVALUATION OF PRIOR AUTHORIZATION POLICY AND 13.10.31.12 **PROVIDER PERFORMANCE:** Applicability. This section of the rule shall only apply to fully-insured commercial coverages regulated by the superintendent. Review of covered benefits that require prior authorizations. Annually, beginning in 2023, a carrier shall review its prior authorization requirements for all covered benefits, except for inpatient admissions to acute-care hospitals, including transfers, in order to assess the continued utility of each requirement. At a minimum, a carrier's assessment shall consider the following elements: **(1)** the approval rate for each covered benefit for which a prior authorization was (a) required; (b) whether, based on demonstrable evidence, including claims and clinical data, the prior authorization requirement for each covered benefit protects patient safety or generates better health outcomes, or both; whether, based on demonstrable evidence, including claims and clinical data, the prior authorization requirement for each covered benefit prevents the need for higher cost services; whether based on demonstrable evidence, including claims and clinical data, the (d) prior authorization requirement of each covered benefit has deterred any reasonable suspicion of insurance fraud, waste, or abuse; whether, based on demonstrable evidence, including claims, clinical and operational data, and considering both the providers' and the carrier's experience, the costs and other administrative burdens associated with the prior authorization requirement for a covered benefit outweigh the demonstrated benefits of the requirement; and whether the prior authorization requirement for a covered benefit, based on **(f)** demonstrable evidence including provider and member grievances, appeals and complaints, and claims and clinical data, contributed to unreasonable or unnecessary delays in treatment or adverse health outcomes for a covered person. A carrier shall conduct and complete the review by the end of the second quarter of each calendar year, beginning in 2023, and shall evaluate the prior authorizations issued during the prior calendar year. **(3)** A carrier shall identify those covered benefits, with the exception of inpatient admissions to acute care hospitals, for which ninety percent of the prior authorization requests for that benefit are approved. **(4)** A carrier shall prepare a report of its annual assessment that, at a minimum, contains its findings based on the elements listed above, and identifies any change in prior authorization requirements. The report shall be submitted to the superintendent no later than October 31, (a) 2023 and no later than September 30<sup>th</sup> of every year thereafter, beginning in 2024. (b) The report shall be submitted in the form and manner proscribed by annual guidance issued pursuant to Subsection G of this Section. A carrier that enters the market in 2023 or later shall conduct its first prior authorization **(5)** evaluation during its second full calendar year in the market. If no protection of patient safety or no better health outcomes related to prior authorization of a covered benefit can be shown by the carrier, the prior authorization requirement must be eliminated for 12 months or until the carrier is able to demonstrate additional evidence to support its position. Assessment of prior authorization request outcomes. Beginning in the first quarter of 2023, a carrier shall annually evaluate its network providers' patterns of adherence to the carrier's prior authorization criteria

(1) A carrier shall identify providers who are the most frequent submitters of prior authorizations, and who have a consistent pattern of adherence to prior authorization requirements and criteria as evidenced by prior authorization approval rates of ninety percent or greater (a "high compliance provider").

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and policies in the preceding calendar year. For the first year, prior authorization requests for admissions to general acute care hospitals, psychiatric hospitals, and rehabilitation hospitals, and durable medical equipment, including oxygen and disposable medical supplies, shall be excluded from this evaluation. The superintendent may include these services in subsequent years pursuant to the annual guidance issued in accordance with Subsection G of this

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requirements.

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