TITLE 13 INSURANCE
CHAPTER 10 HEALTH INSURANCE
PART 31 PRIOR AUTHORIZATION

13.10.31.1 ISSUING AGENCY: Office of Superintendent of Insurance ("OSI").
[13.10.31.1 NMAC - N, 01/01/2022]

13.10.31.2 SCOPE: These rules apply to every:

A. health insurer as defined in Subsection H of Section 59A-22B-2 NMSA 1978;

B. multiple employer welfare arrangement; and

C. Medicaid managed care organization, that requires prior authorization as a condition to payment for a medical service, pharmaceutical, or medical supply benefit. The subject entities are referred to collectively herein as "carriers" and individually as a "carrier." The requirements of these rules supersede any conflicting provision of any rule previously adopted by the superintendent, and are superseded by any conflicting provision of federal or state law applicable to a Medicaid managed care organization.
[13.10.31.2 NMAC - N, 01/01/2022]

13.10.31.3 STATUTORY AUTHORITY: Section 59A-2-9.8 NMSA 1978, Section 59A-15-20 NMSA 1978; Sections 59A-22B-1 through 59A-22B-5 NMSA 1978; and Sections 59A-57-1 through 59A-57-11 NMSA 1978.
[13.10.31.3 NMAC - N, 01/01/2022]

13.10.31.4 DURATION: Permanent.
[13.10.31.4 NMAC - N, 01/01/2022]

13.10.31.5 OBJECTIVE: To establish and standardize oversight, reporting, transparency and confidentiality procedures for prior authorization processes.
[13.10.31.5 NMAC - N, 01/01/2022]

13.10.31.6 EFFECTIVE DATE: January 1, 2022, unless a later date is cited at the end of a section.
[13.10.31.6 NMAC - N, 01/01/2022]

13.10.31.7 DEFINITIONS: Terms used in these rules are as defined in Section 59A-22B-2 NMSA 1978, and in 13.10.29 NMAC, except as supplemented and superseded below.

A. "Benefit" means any medical service, medical service location, medical provider selection, pharmaceutical, or medical supply that is the subject of a prior authorization request.

B. "Utilization review organization" or "URO" means an entity engaged by a carrier to determine medical necessity for covered services. A URO includes a pharmacy benefits manager ("PBM") who determines medical necessity for a carrier's prescription drug coverage.
[13.10.31.7 NMAC - N, 01/01/2022]

13.10.31.8 GENERAL REQUIREMENTS: A carrier shall comply with the standard prior authorization processes specified in these rules.

A. Responsibility for requesting prior authorization.

(1) A carrier shall accept a prior authorization request submitted by a provider or by a covered person.

(2) If a covered person directly submits, or attempts to submit, a prior authorization request, the carrier shall provide the covered person all assistance required to properly submit the request, including assistance with obtaining required documentation and information to meet clinical guidelines.

(3) A carrier shall prohibit its participating providers from billing a covered person for a delivered benefit for which prior authorization was required if the provider failed to obtain the required authorization without the covered person's informed and documented consent.

(4) A carrier shall allow non-participating providers to:

(a) request prior authorizations and submit supporting documentation by all submission methods authorized by these rules; and

(b) receive confirmations and tracking numbers as required by these rules.

B. Requests for multiple benefits.

(1) A carrier shall allow a provider to submit a single request for multiple benefits that will be delivered contemporaneously to the same covered person.

(2) If a carrier does not grant prior authorization for all of the benefits in a multiple benefit request, the carrier must clearly state which benefits are approved and which are denied.

(3) A carrier shall permit a provider or covered person to appeal the denial of any benefits regardless of the number of benefits requested at one time.

C. Changes to prior authorization requirements.

(1) After inception of coverage, a carrier shall not expand the list of benefits for which prior authorization is required except when a new covered benefit is added to the plan, when safety or other concerns have arisen with respect to the benefit, when authorized by a state or federal regulatory agency, or as indicated by changes in nationally recognized clinical guidance.

(2) After inception of coverage, a carrier shall notify its network providers before adding a prior authorization requirement.

(3) A carrier may remove a prior authorization requirement at any time. A carrier who removes a prior authorization requirement during a plan year shall notify its network providers of the change as soon as practicable, and no more than 60 days after the requirement is removed.

D. Retroactive denials. A carrier shall not retroactively deny authorization if a provider relied upon a written prior authorization from the carrier received prior to providing the benefit, except in those cases where there was material misrepresentation or fraud by the provider.

E. Retrospective Authorization Requests. A carrier shall establish written policies and guidance for the process and circumstances under which it will consider a retrospective authorization. A carrier's policies shall not unreasonably limit the ability of a provider to request or obtain a retrospective authorization.

F. Mental health parity. A carrier shall not apply more restrictive prior authorization requirements for covered behavioral health services than for covered medical and surgical services.

G. Expiration of prior authorization. A carrier's prior authorization shall expire no sooner than 60 days from the date of approval unless an earlier expiration is warranted by the clinical criteria. A carrier shall allow a request for the extension of an authorization as supported by the clinical criteria.

H. Reasonable prior authorization requirements. A carrier shall not impose a prior authorization requirement that deters or unreasonably delays the delivery of medically necessary and covered benefits warranted by prevailing standards of care. A carrier shall only require prior authorization for a benefit to the extent reasonably necessary to contain inappropriate or unnecessary costs or implement demonstrably effective medical management services.

[13.10.31.8 NMAC - N, 01/01/2022]

13.10.31.9 PRIOR AUTHORIZATION SUBMISSION:

A. A carrier shall:

(1) accept prior authorization requests submitted at any time prior to the delivery of service;

(2) accept prior authorization requests telephonically and by facsimile;

(3) offer at least one bi-directional electronic prior authorization portal;

(4) allow a provider to upload in a secure manner the supporting documentation associated with an electronic prior authorization request, subject to reasonable limits on file type and size;

(5) accept and consider any information from a provider that will assist in the review;

(6) require only the information necessary to evaluate the request;

(7) not reject a request solely on the basis of documentation or submission errors that do not prevent substantive review;

(8) ensure that the system it operates for receiving electronic prior authorization requests and supporting documentation satisfies all applicable Health Insurance Portability and Accountability Act ("HIPAA") transaction requirements and operating rules no later than the effective date that such requirements and rules are established;

(9) make its system available for accepting electronic prior authorization requests and supporting documentation 24-hours per day, seven-days per week. Planned maintenance or down time of the system shall be performed during historically low-utilization periods; and

(10) notify providers of planned maintenance or downtime of the system at least 24-hours in advance. A carrier shall notify providers of any unplanned system downtime as soon as practicable.

B. Confirmation of receipt and tracking numbers.

(1) Within one business day of receipt, a carrier shall confirm receipt of a prior authorization request and any supporting documentation to the submitter. The carrier also shall assign a unique tracking number to the request. The tracking number shall identify the request throughout the processing cycle, including after approval or denial.

(2) The confirmation that includes the tracking number shall be communicated by electronic portal, fax or email.

(3) A carrier shall provide the tracking number of a prior authorization request to the covered person upon request.

(4) A carrier may assign other identifiers to a prior authorization request.

[13.10.31.9 NMAC - N, 01/01/2022]

13.10.31.10 DOCUMENTATION AND TRANSPARENCY:

A. Prior authorization forms.

(1) A carrier shall accept the uniform prior authorization request form(s) developed by the superintendent and found on the superintendent's website at www.osi.state.nm.us.

(2) A carrier may ask the superintendent to approve a non-uniform prior authorization request form. If the superintendent approves the non-uniform request form, the carrier shall prominently publish the form to providers on its website.

B. Document retention. A carrier shall maintain a record of each prior authorization request and its associated documentation. The carrier shall store the records in compliance with all applicable state and federal privacy and security laws and regulations. The record shall be retained for as long as required by federal and state document retention guidelines, laws and regulations.

C. Access to information about services requiring prior authorization.

(1) A carrier shall make available on its member and provider websites a list of all benefits for which a prior authorization is required. The list shall be presented clearly and in readily understandable language appropriate for the intended audience. The list shall be updated at least annually and upon notification to providers of any change.

(2) Prior authorization information presented on the provider website shall include general clinical criteria requirements and shall list supporting documentation that is expected to accompany the prior authorization request. If a prior authorization is denied, the criteria used to deny the request shall be supplied to the provider in full upon request.

(3) Information on benefits requiring prior authorization, associated clinical criteria and supporting documentation may be located in an area(s) of a website(s) that is not accessible to a covered person, including the carrier's prior authorization portal.

(4) A carrier shall provide an on-line search tool for any provider to use to search the list of benefits that require prior authorization.

[13.10.31.10 NMAC - N, 01/01/2022]

13.10.31.11 AUTO-ADJUDICATION:

A. No later than January 1, 2022, a carrier shall implement a process to auto-adjudicate electronically submitted prior authorization requests.

(1) A carrier shall comply with all statutory timelines applicable to prior authorization review. A list of all statutory prior authorization review timelines is posted on the OSI website.

(2) A carrier may reject for correction an auto-adjudicated prior authorization request for reasons other than medical necessity as long as the rejection is completed within statutory timelines.

(3) A carrier may pend an auto-adjudicated prior authorization request if it requires manual review, as long as the review is completed within statutory timelines.

(4) A carrier shall not automatically deny an auto-adjudicated prior authorization request. A carrier shall only deny a prior authorization request based on a live review.

B. Incomplete information. If a provider fails to supply sufficient information to evaluate a prior authorization request, the carrier shall allow the provider a reasonable amount of time, taking into account the circumstances of the covered person, but not less than 4 hours for expedited requests and two calendar days for standard requests, to provide the specified information.

C. Notice. A carrier shall provide written notice to the provider and covered person of a determination to approve or deny authorization. The Notice shall contain the reasons for a denial.

D. Delegation. A carrier may delegate one or more of the obligations mandated by these rules to a qualified third party, including a URO. A carrier who delegates any obligation mandated by these rules remains responsible for compliance with the delegated obligation.

E. Reporting. At least annually, a carrier shall report to the superintendent data and information about the auto-adjudication process, when and as directed by the superintendent.

[13.10.31.11 NMAC - N, 01/01/2022]

13.10.31.12 EVALUATION OF PRIOR AUTHORIZATION POLICY AND PROVIDER PERFORMANCE:

A. Applicability. This section of the rule shall only apply to fully-insured commercial coverages regulated by the superintendent.

B. 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.

(1) At a minimum, a carrier's assessment shall consider the following elements:

(a) the approval rate for each covered benefit for which a prior authorization was 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;

(c) 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;

(d) whether based on demonstrable evidence, including claims and clinical data, the prior authorization requirement of each covered benefit has deterred any reasonable suspicion of insurance fraud, waste, or abuse;

(e) 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

(f) whether the prior authorization requirement for a covered benefit, based on 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.

(2) 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.

(a) The report shall be submitted to the superintendent no later than October 31, 2023 and no later than September 30th 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.

(5) A carrier that enters the market in 2023 or later shall conduct its first prior authorization evaluation during its second full calendar year in the market.

(6) 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.

C. 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 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 Section.

(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").

(2) A carrier shall select no less than thirty percent of its high compliance providers and shall:

(a) enter into an agreement with each selected high-compliance provider on an alternative to the standard requirement to submit a prior authorization request for a discreet service or set of services that otherwise require one (an alternate arrangement); and

(b) the agreement with each provider shall clearly describe the terms of the alternate arrangement, including under what conditions the agreement can be terminated by a carrier or a provider. The agreement shall include how the provider's ordering and prescribing performance during the course of the alternative arrangement will be monitored and evaluated, how results will be communicated, and how the agreement can be extended beyond the base period of the agreement. At a minimum, the agreement will be effective for 12 months.

(3) The high compliance providers selected for alternate arrangements shall be representative of the various eligible types of providers, including specialists, that participate in a carrier's network, and the spectrum of covered benefits.

(4) The first year's alternative arrangements shall go into effect on January 1, 2024, and all subsequent years' agreements shall go into effect on the first day of the year.

(5) After the first year, a carrier shall increase the number of high compliance providers with which it enters into alternate arrangements by at least fifty percent of providers who had alternative arrangements in the first year. If a carrier is not able to increase the number of providers with alternate arrangements by at least fifty percent compared to the prior year, the carrier shall request an exception according to guidance issued by the superintendent. The exception request will be subject to the approval of the superintendent.

(6) After the second year, a carrier shall comply with specific performance requirements identified in guidance issued pursuant to Subsection G of this Section.

(7) A carrier may elect to remove a prior authorization requirement at any time, in accordance with Paragraph (3) of Subsection C of Section 13.10.31.8 NMAC above.

D. Annual Report. A carrier shall, by September 30th of each year, submit a report to the superintendent that:

(1) describes the evaluation process and criteria used to identify high compliance providers;

(2) lists the providers identified, the providers with whom an alternate arrangement was made, and the providers with whom negotiations are ongoing; and

(3) describes, in general, the terms of the alternate arrangements entered into, including the effective dates of the agreement, the services involved, performance evaluation, and communication provisions; and

(4) describes experiences making these alternate arrangements, the results of the alternate arrangements when known, lessons learned, and recommendations to the superintendent.

E. New carriers. A carrier that enters the market in 2023 or later shall conduct its first prior authorization evaluation in its second full calendar year in the market unless the carrier has not met a threshold enrollment of more than 500 members in which case the carrier shall file the first year after it meets that enrollment threshold

F. Data confidentiality and use. Information reported to the superintendent concerning a specific, identifiable, provider shall be deemed confidential pursuant to Subsection B of Section 59A-2-12 NMSA 1978. The superintendent may publish and use any other reported information for any regulatory purpose, including development and promulgation of rules to specify minimum prior authorization incentive and corrective action programs.

G. Guidance. The superintendent shall annually publish guidance for carriers for the upcoming plan year. This guidance shall include, at minimum, procedural reporting requirements, and any specific performance requirements.

[13.10.31.12 NMAC - N, 01/01/2022; A, 01/01/2023]

13.10.31.13 PENALTIES: In addition to any applicable suspension, revocation or refusal to continue any certificate of authority or license under the Insurance Code, a penalty for any violation of this rule may be imposed against an insurer in accordance with Sections 59A-1-18 and 59A-46-25 NMSA 1978.

[13.10.31.13 NMAC - N, 01/01/2022]

13.10.31.14 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.
[13.10.31.14 NMAC - N, 01/01/2022]

History of 13.10.31 NMAC: [RESERVED]