This is an amendment to 13.10.29 NMAC, Section 7, effective 2/12/2019.

13.10.29.7 DEFINITIONS:

A. Terms beginning with the letter "A":

(1) "Accrued liability" means liabilities established on the date an injury is sustained or an illness commences.

(2) "Ambulance service" means any transportation service designated and used or intended to be used for the transportation of sick or injured persons.

(3) "Ambulatory surgical center" means a facility where health care providers perform surgeries, including diagnostic and preventive surgeries that do not require hospital admission.

(4) "Appointment waiting time" means the time from the initial request for health care services by a covered person or the covered person's treating provider to the earliest date offered for the appointment for services inclusive of the time for obtaining authorization from the health insurance carrier or completing any other condition or requirement of the carrier or its participating providers.

(5) "Authorized representative of a covered person" means an individual selected and authorized in writing by a covered person to represent the covered person's interests in matters related to the provision of services under a health benefits plan. Health care professionals and health insurance agents and brokers may serve as authorized representatives of covered persons.

(6) "Authorized representative of a health insurance carrier" means an individual or organization that is selected by the insurance company to represent its interests in an aspect of the regulatory or hearing process.

B. Terms beginning with the letter "B":

(1) "Behavioral health services" means assessment, diagnosis, treatment or counseling in the context of a professional relationship to assist an individual or group alleviate behavioral symptoms, conditions or disorders, including mental health diagnoses and substance use disorders, as well as other services to address developmental disability or developmental delay.

(2) "Blanket health insurance" is a form of health insurance covering special groups of not fewer than ten persons that meets the criteria outlined in Section 59A-23-2 NMSA 1978.

(3) "Business day" means a consecutive 24-hour period, excluding weekends or state holidays.

C. Terms beginning with the letter "C":

(1) "Certificate" means any certificate issued under an individual or group accident and health insurance policy that has been delivered or issued for delivery in this state, regardless of the state in which the policyholder is domiciled.

(2) "Certification of service" means a determination by a health insurance carrier that a health care service requested by a health care professional or covered person has been reviewed and, based upon the information available, is a covered benefit and meets the carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness, and the requested health care service is therefore approved. The certification of service can take place following the health carrier's utilization review process.

(3) "Certified nurse-midwife" means any person who is licensed by the board of nursing as a registered nurse and who is licensed by the New Mexico department of health as a certified nurse-midwife.

(4) "Certified nurse practitioner" means a registered nurse whose qualifications are endorsed by the board of nursing for expanded practice as a certified nurse practitioner and whose name and pertinent information are entered on the list of certified nurse practitioners maintained by the board of nursing.

(5) "Claim" means a request from a provider for payment for health care services rendered.

(6) "Clinical peer" means a physician or other health care professional who holds a similar non-restricted license in a state or territory of the United States and in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review.

(7) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by a health insurance carrier to determine the medical necessity and appropriateness of health care services.

(8) "Co-insurance" is a cost-sharing method that requires a covered person to pay a stated percentage of medical or pharmaceutical expenses after the deductible amount, if any, is paid; co-insurance rates

may differ for different types of services under the same health benefits plan.

(9) "Copayment" is a cost-sharing method that requires a covered person to pay a fixed dollar amount when a medical or pharmaceutical service is received, with the health insurance carrier paying the allowed balance; there may be different copayment amounts for different types of services under the same health benefits plan.

(10) "Continuous quality improvement" means ongoing and systematic efforts to measure, evaluate, and improve a health insurance carrier's processes and procedures in order to continually improve the quality of health care services provided to covered persons.

(11) "Cost-sharing" means a copayment, co-insurance, deductible, or any other form of financial obligation of a covered person other than premium or share of premium, or any combination of any of these financial obligations as defined by the terms of the health benefits plan.

(12) "Covered benefits" means those health care services to which a covered person is entitled under the terms of a health benefits plan.

(13) "Covered person" or **"enrollee"** means a subscriber, policyholder or subscriber's enrolled dependent or dependents, or other individual participating in a health benefits plan.

(14) "Credentialing" means the process of obtaining, verifying and evaluating information about a provider when the provider applies to become a participating provider within a health insurance carrier's network.

D. Terms beginning with the letter "D":

(1) "Day" or **"Days"** shall be interpreted as follows, unless otherwise specified:

(a) one to five days means only working days and excludes weekends and state holidays; and

(b) six or more days means calendar days, including weekends and state holidays.

(2) "Deductible" means a fixed dollar amount that a covered person may be required to pay during a benefit period before the health insurance carrier begins payment for covered benefits; health benefits plans may have both individual and family deductibles and separate deductibles for specific services.

(3) "Designated rating area" means a geographic unit designated by the superintendent and used by insurers to determine health benefits plan premiums.

E. Terms beginning with the letter "E":

(1) "Emergency care" means health care procedures, treatments or services delivered to a covered person after the sudden onset of what reasonably appears to be a medical or behavioral health condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could be expected by a reasonable layperson to result in jeopardy to a person's physical or mental health or to the health or safety of a fetus or pregnant person, serious impairment of bodily function, serious dysfunction of a bodily organ or part or disfigurement to a person;

(2) "Enrollee" or **"covered person"** means a subscriber, policyholder or subscriber's enrolled dependent or dependents, or other individual participating in a health benefits plan.

(3) "Essential community provider (ECP)" means a provider as defined in 45 C.F.R. §156.235(c).

(4) "Evidence of coverage (EOC)" means a specific document containing a clear, conspicuous, concise and legible written statement of the essential features and services covered by a health benefits plan given to the covered person by the health insurance carrier or group contract holder, which may include a separate summary of benefits as defined in Paragraph [~~(6)~~] (7) of Subsection S of this [~~rule~~] section. The evidence of coverage may serve as a covered person's certificate as defined in Paragraph (1) of Subsection C of this [~~rule~~] section.

(5) "Exception" or **"exclusion"** means any provision in a health benefits plan whereby coverage for a specific hazard, condition, or situation is excluded entirely. It is a statement of a risk or risks not assumed by the health insurance carrier under the plan.

(6) "Exchange" means the New Mexico health insurance exchange, composed of an exchange for the individual market and a small business health options program (SHOP) exchange under a single governance and administrative structure. Also known as the health insurance marketplace.

F. Terms beginning with the letter "F":

(1) "Facility" means an entity providing a health care service, including:

(a) a general, specialized, psychiatric or rehabilitation hospital;

(b) an ambulatory surgical center;

(c) a cancer treatment center;

(d) a birth center;

(e) an inpatient, outpatient or residential drug and alcohol treatment center;

(f) a laboratory, diagnostic or other outpatient medical evaluation or testing center;

(g) a health care provider's office or clinic;

(h) an urgent care center; or

(i) any other therapeutic health care setting.

(2) "Federally qualified health center (FQHC)" means an entity as defined in 42 C.F.R. §405.2401.

(3) "FDA" means the United States food and drug administration.

G. Terms beginning with the letter "G": "Group health insurance" means a form of health insurance covering groups of persons, with or without their dependents, and issued upon the criteria outlined in Section 59A-23-3 NMSA 1978.

H. Terms beginning with the letter "H":

(1) "Health benefits plan" means a policy or agreement entered into, offered or issued by a health insurance carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

(2) "Health care professional" means a physician or other health care practitioner, including a pharmacist or practitioner of the healing arts, who is licensed, certified or otherwise authorized by the state to provide health care services consistent with state law.

(3) "Health care service" means a service, supply or procedure for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease, including, to the extent covered by the health benefits plan, a physical or behavioral health service.

(4) "Health insurance carrier," "health carrier," "carrier" or **"health insurer"** means an entity subject to the insurance laws and regulations of this state, including a health insurance company, a health maintenance organization, a hospital and health services corporation, a provider service network, a non-profit health care plan or any other entity that contracts or offers to contract, or enters into agreements to provide, deliver, arrange for, pay for or reimburse any costs of health care services, or that provides, offers health benefits plans or managed health care plans in this state.

(5) "Health maintenance organization (HMO)" is as defined in Subsection N of Section 59A-46-2 NMSA 1978.

(6) "Hospital" means a facility offering inpatient services, nursing and overnight care for three or more individuals on a 24-hours-per-day, seven-days-per-week basis for the diagnosis and treatment of physical, behavioral or rehabilitative health conditions.

I. Terms beginning with the letter "I": "Initial determination" means a formal written disposition by a health insurance carrier affecting a covered person's rights to benefits, including full or partial denial of a claim or request for coverage or its initial administrative decision pursuant to the grievance procedures set forth at 13.10.17 NMAC.

J. Terms beginning with the letter "J": [RESERVED]

K. Terms beginning with the letter "K": [RESERVED]

L. Terms beginning with the letter "L":

(1) "Limitation" means any provision that restricts coverage under a health benefits plan other than an exception, exclusion or reduction.

(2) "Limited benefits plan" means a health benefits plan offered or marketed as supplemental health insurance coverage that pays specified amounts according to a schedule of benefits to defray the costs of care, services or cost-sharing amounts not covered by a major medical plan. "Limited benefits plan" does not include a short-term, limited-duration plan.

M. Terms beginning with the letter "M":

(1) "Major medical plan" or **"comprehensive plan"** means a health benefits plan, other than a limited benefits plan, that provides fully-insured, expense-based coverage, including a short-term, limited duration plan; a qualified health plan; a managed health care plan; a student health plan or a high-deductible or catastrophic plan.

[~~**(1)**~~] **(2) "Managed care"** means a system or technique(s) generally used by third-party payors or their agents to affect access to and control payment for health care services. Managed care techniques most often include one or more of the following:

(a) prior, concurrent and retrospective review of the medical necessity and appropriateness of services or site of services;

(b) contracts with selected health care providers;

(c) financial incentives or disincentives for covered persons to use specific providers, services, prescription drugs or service sites;

(d) controlled access to and coordination of health care services by a case manager; and

(e) payor efforts to identify treatment alternatives and modify benefit restrictions for high-cost patient care.

[~~(2)~~] **(3) "Managed health care bureau (MHCB)"** means the managed health care bureau within the office of superintendent of insurance.

[~~(3)~~] **(4) "Maternity benefits"** means covered benefits for prenatal, intrapartum, perinatal or postpartum care.

[~~(4)~~] **(5) "Medical necessity"** or **"medically necessary"** means health care services determined by a provider, in consultation with the health insurance carrier, to be appropriate or necessary, according to:

(a) any applicable generally accepted principles and practices of good medical care;

(b) practice guidelines developed by the federal government, national or professional medical societies, boards and associations; or

(c) any applicable clinical protocols or practice guidelines developed by the health insurance carrier consistent with such federal, national and professional practice guidelines. These standards shall be applied to decisions related to the diagnosis or direct care and treatment of a physical or behavioral health condition, illness, injury or disease.

[~~(5)~~] **(6) "Medical record"** means all information maintained by a provider relating to the past, present or future physical or behavioral health of a patient, and for other provision of health care services to a patient. This information includes, but is not limited to the provider's notes, reports and summaries, and x-rays, laboratory, and other diagnostic test results. A patient's complete medical record includes information generated and maintained by the provider, as well as other information provided to the provider by the patient, by any other provider who has consulted with or treated the patient in connection with the provision of health care services to the patient. A medical record does not include the patient's medical billing or health insurance records or forms or communications related thereto.

[~~(6)~~] **(7) "Medicare"** means Title 18 of the Social Security Amendments of 1965, *"Health Insurance for Aged and Disabled*," as then constituted or later amended.

[~~(7)~~] **(8) "Medicare supplement policy"** means a group or individual policy of insurance or a subscriber contract other than a policy issued pursuant to a contract under Section 1876 of the Social Security Act (42 U.S.C. Section 1395 et seq.) or an issued policy under a demonstration project specified in 42 U.S.C. Section 1395ss(g)(1) that is advertised, marketed or designed primarily as a supplement to reimbursements under medicare for the hospital, medical or surgical expenses of persons eligible for medicare; "medicare supplement policy" does not include medicare advantage plans established under medicare part C, outpatient prescription drug plans established under medicare part D or any health care prepayment plan (HCPP) that provides benefits pursuant to an agreement under 42 U.S.C. Section 1833(a)(1)(A) of the Social Security Act.

N. Terms beginning with the letter "N":

(1) "Network" means the group or groups of participating providers who provide health care services under a network plan.

(2) "Network plan" means a health benefits plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers and facilities managed, owned or under contract with or employed by the health insurance carrier.

(3) "Nonparticipating provider" means a provider who is not a participating provider as defined in Paragraph (1) of Subsection P of this [~~rule~~] section. Also known as an out-of-network provider or non-contracted provider.

O. Terms beginning with the letter "O": "Obstetrician-gynecologist" means a physician who is eligible to be or who is board certified by the American board of obstetricians and gynecologists or by the American college of osteopathic obstetricians and gynecologists.

P. Terms beginning with the letter "P":

(1) "Participating provider" means a provider who, under an express contract with a health insurance carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment directly or indirectly from the carrier, subject to any cost-sharing required by the health benefits plan. Also known as an in-network provider or contracted provider.

(2) "Physician assistant (PA)" means a skilled person who is a graduate of a physician assistant or surgeon assistant program approved by a nationally recognized accreditation body or who is currently

certified by the national commission on certification of physical assistants, and who is licensed to practice medicine, usually under the supervision of a licensed physician.

(3) "Post-service claim" means a claim submitted to a health insurance carrier by or on behalf of a covered person after health care services have been provided to the covered person.

(4) "Practitioner of the healing arts" means a health care professional as defined in Paragraph (2) of Subsection B of Section 59A-22-32 NMSA 1978.

(5) "Preventive care" means health care services provided for prevention and early detection of disease, illness, injury or other health condition.

(6) "Primary care" means health care services for a range of common physical or behavioral health conditions provided by a physician or non-physician primary care practitioner.

(7) "Primary care practitioner (PCP)" means a health care professional who, within the scope of the professional license, supervises, coordinates and provides initial and basic care to covered persons; who initiates the patient's referral for specialist care and who maintains continuity of patient care. Primary care practitioners include general practitioners, family practice physicians, geriatricians, internists, pediatricians, obstetrician-gynecologists, physician assistants and nurse practitioners. Pursuant to 13.10.21.7 NMAC, other health care professionals may also serve as primary care practitioners.

(8) "Prior authorization" or **"pre-certification"** means a pre-service determination made by a health insurance carrier regarding a covered person's eligibility for health care services based on medical necessity, health benefits coverage and the appropriateness and site of services pursuant to the terms of the health benefits plan.

(9) "Private health insurance cooperative" means a nonprofit corporation formed to arrange for health benefits coverage with health insurance carriers for its participating members, including large and small employers.

(10) "Product" means a discrete package of health insurance benefits that is offered using a particular network type within a service area.

(11) "Prospective enrollee" means:

(a) in the case of an individual who is a member of a group, an individual eligible for enrollment in a health benefits plan through the group; or

(b) in the case of an individual who is not a member of a group or whose group has not purchased or does not intend to purchase a health benefits plan, an individual who has expressed an interest in purchasing individual plan coverage.

(12) "Prospective review" means utilization review conducted prior to the provision of health care services by the health insurance carrier.

(13) "Provider" means a licensed health care professional, hospital or other facility authorized to furnish health care services.

(14) "Provider group" means an incorporation or other legal association of providers who work together in proximity and share resources for as well liability that may result from the provision of patient care.

Q. Terms beginning with the letter "Q":

(1) "Qualified health plan (QHP)" means a major medical plan that has been reviewed and deemed by the superintendent to provide essential health benefits, follow established limits on cost-sharing, provide "minimum essential coverage" and meet the other requirements of the Affordable Care Act.

[~~**(1)**~~] **(2) "Quality assurance plan"** means the ongoing, internal quality assurance program of a health insurance carrier to monitor and evaluate the carrier's health care services, including its system for credentialing health care professionals to become participating providers with a health benefits plan or otherwise provide services to the carrier's covered persons.

R. Terms beginning with "R":

(1) "Reduction" means any provision that reduces the amount of a benefit; a risk of loss is assumed but payment upon the occurrence of the loss is limited to some amount or period less than otherwise would be payable and the reduction has not been used.

(2) "Registered lay midwife" means any person who practices lay midwifery and is registered as a lay midwife by the New Mexico department of health.

(3) "Retrospective review" means utilization review that is conducted following the provision of health care services.

S. Terms beginning with the letter "S":

(1) "Second opinion" means an opportunity or requirement for a covered person to obtain a

clinical evaluation to assess the medical necessity and appropriateness of the initial proposed health service, by a provider other than one who originally recommended or denied it.

(2) "**Short-term, limited-duration plan**" or **"short-term plan**" means a nonrenewable major medical plan with a specified duration of not more than three months that is issued only to individuals who have not been enrolled in a plan providing the same or similar nonrenewable coverage from any carrier within the past twelve months and which so states in all advertisements, marketing materials and application and policy forms.

[~~**(2)**~~] **(3) "Specialist"** means a physician or non-physician health care professional who:

(a) focuses on a specific area of physical or behavioral health or a specific group of patients; and

(b) has successfully completed required training and is recognized by the state in which the health care professional practices to provide specialty care.

[~~**(3)**~~] **(4) "Specialty care"** means advanced, medically necessary care and treatment by a specialist, preferably in coordination with a primary care practitioner or other health care professional, of specific physical or behavioral health conditions or health conditions that may manifest in a particular age group or other subpopulation.

[~~**(4)**~~] **(5) "Stabilize"** means to provide physical or behavioral health treatment of a condition as may be necessary to ensure, within a reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual to or from a facility or, with respect to an emergency birth with no complications resulting in a continuing emergency, to deliver the child and the placenta.

[~~**(5)**~~] **(6) "Subscriber"** means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health benefits plan, or in the case of an individual contract, the person in whose name the contract is issued.

[~~**(6)**~~] **(7) "Summary of benefits"** means a summary of the benefits and exclusions required to be given prior to or at the time of enrollment to a prospective subscriber or covered person by the health insurance carrier.

[~~**(7)**~~] **(8) "Superintendent"** means the superintendent of insurance, the office of superintendent of insurance (OSI), or employees of OSI acting with the superintendent's authorization.

T. Terms beginning with the letter "T":

(1) "Telemedicine" or **"Telehealth"** means the use by a health care professional of interactive, simultaneous audio and video or store-and-forward technology using information and telecommunications technologies to deliver health care services at a site other than the site where the patient is located, including the use of electronic media for consultation relating to the diagnosis or treatment of the patient in real time or through the use of store-and-forward technology.

(2) "Tertiary care facility" means a hospital unit that provides complete perinatal care and intensive care of intrapartum and perinatal high-risk patients with responsibilities for coordination of transport, communication, education and data analysis systems for the geographic area served.

(3) "Third-party administrator (TPA)" is as defined in Subsection B of Section 59A-12A-2 NMSA 1978.

(4) "Tiered network" means a network that supports a health benefits plan in which there are at least two quantitatively different cost-sharing levels for participating providers who or which furnish the same covered services.

(5) "Traditional fee-for-service indemnity benefit" means a fee-for-service indemnity benefit as defined in Subsection LL of 13.10.17.7 NMAC, as a fee-for-service indemnity benefit, not associated with any financial incentives that encourage covered persons 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.

U. Terms beginning with the letter "U":

(1) "Urgent care situation" means a situation in which a prudent layperson in that circumstance, possessing an average knowledge of medicine and health would believe that he or she does not have an emergency medical condition but needs care expeditiously because:

(a) the life or health of the covered person would otherwise be jeopardized;

(b) the covered person's ability to regain maximum function would otherwise be jeopardized;

(c) in the opinion of a physician with knowledge of the covered person's medical condition, delay would subject the covered person to severe pain that cannot be adequately managed without care or

treatment; [~~or~~]

(d) the medical exigencies of the case require expedited care; [~~and~~] or

(e) the covered person's claim otherwise involves urgent care.

(2) **"Utilization review"** means a system for reviewing the appropriate and efficient allocation of health care services given or proposed to be given to a patient or group of patients.

V. Terms beginning with the letter "V": [RESERVED]

W. Terms beginning with the letter "W": [RESERVED]

X. Terms beginning with the letter "X": [RESERVED]

Y. Terms beginning with the letter "Y": [RESERVED]

Z. Terms beginning with the letter "Z": [RESERVED]

[13.10.29.7 NMAC - N, 10/01/2018; A, 2/1/2019]