TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 15 GRIEVANCES AND APPEALS

8.308.15.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.308.15.1 NMAC - N, 2-14-14]

8.308.15.2 SCOPE: This rule applies to the general public.
[8.308.15.2 NMAC - N, 2-14-14]

8.308.15.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.308.15.3 NMAC - N, 2-14-14]

8.308.15.4 DURATION: Permanent.
[8.308.15.4 NMAC - N, 2-14-14]

8.308.15.5 EFFECTIVE DATE: February 14, 2014, unless a later date is cited at the end of a section.
[8.308.15.5 NMAC - N, 2-14-14]

8.308.15.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance division programs.
[8.308.15.6 NMAC - N, 2-14-14]

8.308.15.7 DEFINITIONS:

A. ***"Adverse action"*** or ***"action"*** means:

(1) a termination, modification, reduction, or suspension of a covered medical assistance division (MAD) service;

(2) the denial or limiting of an authorized service, including type or level of service (with the exception of a managed care value-added service), requests for a prior approval or a utilization review (UR) action following a reconsideration hearing decision; see 8.350.2 NMAC;

(3) the denial in whole or in part of a provider's claim which results in the claimant's becoming liable for the payment;

(4) the failure to approve a service in a timely manner;

(5) the failure of a contractor to act on grievance and appeals within the timeframes specified in 42 CFR 438.408 (b);

(6) the denial of a value added service will not be considered an action or adverse action; value added services are not included in the managed care medicaid benefit package; value added services shall not be construed as Medicaid funded services, and therefore, there is no appeal or fair hearing rights for members regarding these services.

B. ***"Appeal"*** means a request by the member for review by the MCO of an MCO action or adverse action.

C. ***"Authorized representative"*** means an individual that has been legally appointed by the appropriate court to act on behalf of the claimant.

D. ***"Denial"*** means the decision not to authorize the member's requested service, prior approval, utilization review decision, or level of care (LOC).

E. ***"Grievance"*** means an expression of dissatisfaction about any matter or aspect of the MCO or its operation other than an MCO action.

F. ***"Hearing"*** or ***"administrative hearing"*** or ***"fair hearing"*** means an evidentiary hearing that is conducted so that evidence may be presented as it relates to an adverse action by MAD, its designee or contractor. This hearing is conducted by the HSD fair hearings bureau (FHB).

G. ***"HSD"*** or ***"the department"*** means the New Mexico human services department.

H. ***"Notice"*** means a written statement from the member or provider's managed care organization (MCO) which states the intended action to be taken or an action has been taken, the reasons for the intended or taken

action, the specific MAD rule that requires this action, and an explanation of the member and provider's right to request an administrative hearing, along with an explanation of the circumstances under which the service or LOC may be continued if an administrative hearing is requested.
[8.308.15.7 NMAC - N, 2-14-14]

8.308.15.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.308.15.8 NMAC - N, 2-14-14]

8.308.15.9 GENERAL REQUIREMENTS: The HSD managed care organization (MCO) shall have a grievance system in place for its members and providers to express dissatisfaction about any matter or aspect of the MCO operation. The MCO shall have an appeal system in place that meets the requirements of 42 CFR 438 subpart F to dispute the MCO's planned or taken adverse action for its members and providers.
[8.308.15.9 NMAC - N, 2-14-14]

8.308.15.10 GENERAL INFORMATION ON PROVIDER GRIEVANCE AND APPEALS:

A. Upon a provider's contracting with an MCO, the MCO shall provide, at no cost, a written description of its grievance and appeal procedure and process to the provider. The MCO will update each of its providers with any changes to these procedures and processes. The description shall include:

(1) information on how the provider can file a MCO grievance or appeal and the resolution process;

(2) time frames for each step of the grievance or appeal process through its final resolution; and

(3) a description of how the MCO provider's grievances or appeals are resolved.

B. Provider rights.

(1) A provider shall have the right to file a grievance with his or her MCO to express dissatisfaction about any matter or aspect of the MCO operation. The provider may file the grievance either orally or in writing following his or her MCO's procedures and processes.

(2) A provider shall have the right to file an appeal with the MCO related to the provider's payment and the utilization review decisions on behalf of a member.

C. A MCO provider does not have the right to request a HSD administrative hearing.
[8.308.15.10 NMAC - N, 2-14-14]

8.308.15.11 GENERAL INFORMATION ON MEMBER GRIEVANCE AND APPEALS:

A. Upon the member's enrollment, the MCO shall provide, at no cost, a written description of its grievance and appeal procedures and processes. The MCO will promptly provide each member with any changes to these procedures and processes. The description shall include:

(1) information on how the member can file a MCO grievance or appeal and the resolution process;

(2) information of the member's right to file a request for a HSD administrative hearing if the member is appealing the MCO's final appeal decision letter;

(3) timeframes for each step of the grievance or appeal process through its final resolution; and

(4) a description of how MCO member grievances or appeals are resolved.

B. Member rights.

(1) A member shall have the right to file a grievance within 30 days of the date the dissatisfaction occurred with his or her MCO to express dissatisfaction about any matter or aspect of his or hers MCO operation. The member may file the grievance either orally or in writing following his or her MCO's procedures and processes.

(2) A member shall have the right to file an appeal with the MCO within 90 calendar days of receiving a notice of the action.

(3) The member's MCO will provide him or her with its decision on an appealed adverse action.

(4) A member shall have the right to request a HSD administrative hearing after the member has exhausted his or her MCO appeal process. See 8.352.2 NMAC for instructions on how a MCO member requests a HSD administrative hearing.

(5) A member must request a HSD administrative hearing within 30 calendar days of the date of his or her MCO's final decision letter.

C. The following individuals may file a MCO grievance or appeal on behalf of a member:

(1) the member's legal guardian;

(2) the member's authorized representative; an authorized representative is the individual that has been legally appointed by the appropriate court to act on behalf of the member; the member's authorized representative may attend the hearing with or without the member being present; or

(3) the member may appoint a personal representative or his or her provider to assist the member during the grievance and appeal process if a member has signed a written consent; provided that the administrative law judge determines the member fully understands the matters presented on grievance or appeal; the personal representative cannot make decisions on behalf of the member; and the member must attend the grievance and appeal hearings with his or her personal representative.

[8.308.15.11 NMAC - N, 2-14-14]

8.308.15.12 MCO GRIEVANCE PROCESS:

A. The MCO shall provide reasonable member or provider assistance in completing forms and procedural steps, including but not limited to:

(1) providing interpreter services; and

(2) providing toll-free numbers that have adequate TTY/TTD and interpreter capability.

B. The MCO shall designate a specific employee or subcontractor as its member or provider grievance coordinator with the authority to:

(1) administer the policies and procedures for resolution of a grievance; and

(2) review patterns and trends in grievances and initiate corrective action.

C. The MCO shall ensure that the individuals who make decisions on grievances are not involved in any previous level of review or decision-making.

D. The MCO shall provide the member or provider with written notice:

(1) when a grievance request has been received;

(2) of the expected date of resolution; and

(3) of the final resolution of the grievance.

E. The MCO shall ensure that punitive or retaliatory action is not taken against a member or a provider that files a grievance, or the provider that supports a member's grievance.

[8.308.15.12 NMAC - N, 2-14-14]

8.308.15.13 MCO APPEAL PROCESS:

A. The MCO shall provide reasonable member or provider assistance in completing forms and procedural steps, including but not limited to:

(1) providing interpreter services; and

(2) providing toll-free numbers that have adequate TTY/TTD and interpreter capability.

B. The MCO shall designate a specific employee or subcontractor as its member or provider appeal coordinator with the authority to:

(1) administer the policies and procedures for resolution of an appeal; and

(2) review patterns and trends in appeals and initiate corrective action.

C. The MCO shall ensure that the individuals who make decisions on grievances or appeals are not involved in any previous level of review or decision-making.

D. The MCO shall provide the member or provider with written notice:

(1) when an appeal request has been received;

(2) of the expected date of resolution; and

(3) of the final resolution of the appeal.

E. The MCO shall provide the member or provider with a notice of action for decisions related to:

(1) previously authorized services as permitted under 42 CFR 431.213 and 431.214;

(2) newly requested services; and

(3) denials of claims that may result in the member's financial liability.

F. The MCO must follow the provisions of 42 CFR 438.420 regarding continuation of the member's benefits while a MCO appeal or the HSD administrative hearing process is pending. A continuation of benefits will be provided to the member who requests a MCO appeal within 13 calendar days of the MCO's notice of an adverse action.

(1) If the MCO reverses the appealed adverse action and the disputed service was not furnished while the appeal was pending, the MCO shall authorize or provide the disputed service promptly and as expeditiously as the member's health condition requires.

(2) If the MAD director's final decision through the state's administrative hearing process reverses the MCO's appealed adverse action and the member received the disputed services while the administrative hearing decision or appeal was pending, the MCO shall pay for these services.

(3) If the MAD director's final decision through the state's administrative hearing process upholds the MCO's action, the MCO may recover from the member the cost of the services furnished while the administrative hearing decision or appeal was pending providing the member was advised that he or she could be responsible for cost of the services as part of the information provided to the member. See 8.352.2 NMAC considering the MCO recovery process.

G. The MCO shall ensure that health care professionals with appropriate clinical expertise make decisions for the following:

(1) an appeal that involves clinical issues;

(2) an appeal of a MCO denial that is based on lack of medical necessity; and

(3) the MCO's denial that is upheld in an expedited resolution.

H. The MCO shall establish and maintain an expedited review process for appeals when the MCO determines that allowing the time for a standard resolution could seriously jeopardize the member's life, health; or his or her ability to attain, maintain, or regain maximum function.

(1) In the case of expedited service authorization decisions that deny or limit services, the MCO shall automatically file an appeal on behalf of the member, and use its best effort to resolve the appeal and give the member oral notice of the decision on the automatic appeal.

(2) The MCO shall ensure that punitive or retaliatory action is not taken against a member or a provider that files an appeal, or a provider that supports a member's appeal.

[8.308.15.13 NMAC - N, 2-14-14]

HISTORY OF 8.308.15 NMAC: [RESERVED]