

**TITLE 8            SOCIAL SERVICES**  
**CHAPTER 350 RECONSIDERATION OF UTILIZATION REVIEW**  
**PART 2            RECONSIDERATION OF UTILIZATION REVIEW DECISIONS**

**8.350.2.1            ISSUING AGENCY:** New Mexico Health Care Authority.  
[8.350.2.1 NMAC - Rp, 8.350.2.1 NMAC, 8/1/2014; A, 7/1/2024]

**8.350.2.2            SCOPE:** The rule applies to the general public.  
[8.350.2.2 NMAC - Rp, 8.350.2.2 NMAC, 8/1/2014]

**8.350.2.3            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 Section 27-1-12 et seq. NMSA 1978. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.  
[8.350.2.3 NMAC - Rp, 8.350.2.3 NMAC, 8/1/2014; A, 7/1/2024]

**8.350.2.4            DURATION:** Permanent.  
[8.350.2.4 NMAC - Rp, 8.350.2.4 NMAC, 8/1/2014]

**8.350.2.5            EFFECTIVE DATE:** August 1, 2014 unless a later date is cited at the end of a section.  
[8.350.2.5 NMAC - Rp, 8.350.2.5 NMAC, 8/1/2014]

**8.350.2.6            OBJECTIVE:** The objective of this rule is to provide instructions for the service portion of the New Mexico medicaid programs.  
[8.350.2.6 NMAC - Rp, 8.350.2.6 NMAC, 8/1/2014]

**8.350.2.7            DEFINITIONS:** [RESERVED]

**8.350.2.8            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.  
[8.350.2.8 NMAC - Rp, 8.350.2.8 NMAC, 8/1/2014]

**8.350.2.9            UTILIZATION REVIEW DECISIONS:**

**A.** Utilization review (UR) decisions are those decisions the medical assistance division (MAD), its utilization review (UR) contractor or a MAD designee makes regarding the medical necessity of services or items that require authorization for medical necessity or a level of care (LOC) determination prior to reimbursement by MAD and its fee-for-service program. For applicable rules for services and items provided through a MAD managed care organization (MCO), refer to 8.308.15 NMAC. For applicable rules for services and items provided through coordinated service contractors, refer to 8.349.2 NMAC.

**B.** For services for which payment has already been made for which MAD is recouping payment due to a post payment review of medical necessity or LOC, the applicable rule is 8.532.3 NMAC.

**C.** Decisions are based on information submitted by the provider in a format specified by MAD, its UR contractor, or a MAD designee, and applicable New Mexico Administrative Code (NMAC) MAD rules.

**D.** Prior to making a decision, MAD, its UR contractor or a MAD designee may issue a request for information (RFI) to the provider requesting clarification or additional information in order to have sufficient information to render an appropriate decision. The provider must submit the clarification or additional information within 21 calendar days of issuance of the request or a technical denial may be issued.

**E.** MAD, its UR contractor or a MAD designee may deny or reduce the authorized services or items in frequency, intensity, duration, quantity, scope or level of care after considering the submitted documentation or NMAC MAD rules. An eligible provider or eligible recipient who is dissatisfied with the decision may proceed as detailed in Section 10 of this rule.

[8.350.2.9 NMAC - Rp, 8.350.2.9 NMAC, 8/1/2014]

**8.350.2.10 RECONSIDERATION OF UTILIZATION REVIEW DECISIONS:** A provider who is dissatisfied with a medical necessity or LOC decision by MAD, its UR contractor or a MAD designee, can request reconsideration. An eligible recipient who is dissatisfied with a medical necessity or LOC decision by MAD, its UR contractor or a MAD designee, can request the provider to pursue reconsideration on his or her behalf.

**A. Time constraints and submission requirements:** Requests for reconsideration must be in writing and received by MAD, its UR contractor or a MAD designee within 30 calendar days after the date on the initial notice of action.

**B. Requirement for filing an extension:** MAD, its UR contractor or a MAD designee will accept a request for reconsideration filed up to 14 calendar days past the 30 calendar day limit if MAD finds that there was good cause for the provider's or the eligible recipient's failure to file a timely request. The provider or the eligible recipient must furnish written documentation of good cause. Good cause includes a death in the family, a disabling personal illness or another significant emergency or other exceptional circumstance.

**C. Information required in the request for reconsideration:** The request for reconsideration must include the following:

- (1) reference to the challenged decision or action;
- (2) basis for the challenge;
- (3) copies of any document(s) pertinent to the challenged decision or action;
- (4) copies of claim form(s) if the challenge involves a claim for payment which is denied due to an UR decision; and
- (5) a statement that a reconsideration of the decision is requested.

**D. Individuals conducting reconsideration review:** Individuals employed by MAD, its UR contractor or a MAD designee who were not participants in the initial UR decision conduct the reconsideration review.

**E. Information used in reconsideration process:** MAD, its UR contractor or a MAD designee reviews the information and findings upon which the initial action was based and any additional information submitted to, or otherwise obtained by MAD, its UR contractor or a MAD designee. The information can include the following:

- (1) case records and other applicable documents submitted to MAD, its UR contractor or a MAD designee by the provider when the request for services was initially submitted;
- (2) findings of the reviewer resulting in the initial decision;
- (3) complete record of the service(s) provided, including hospital or medical records; and
- (4) additional documents submitted by the provider to support a reconsideration review.

**F. Decision deadline:** MAD, its UR contractor or a MAD designee performs the reconsideration and furnishes the reconsideration decision within 10 business days of receipt of the reconsideration request.

**G. Notification of reconsideration decision:** MAD, its UR contractor or a MAD designee gives the provider and the eligible recipient written notice of the reconsideration determination. If the decision is adverse to the eligible recipient, the notice also includes information on the eligible recipient's right to a HSD administrative hearing and timeframes to file for a hearing and request for a continuation of his or her current benefit.

[8.350.2.10 NMAC - Rp, 8.350.2.10 NMAC, 8/1/2014]

**8.350.2.11 CLAIMANT HEARINGS:** MAD has established a process to determine if an individual is eligible to request a HSD administrative hearing. MAD has also established a process for an individual or the individual's authorized representative to request an HSD administrative hearing when an UR reconsideration decision results in an adverse action that is intended or has been taken by MAD, its UR contractor or a MAD designee. See 8.352.2 NMAC for the definition of an authorized representative. MAD must grant an individual or his or her authorized representative the opportunity for a HSD administrative hearing under specific circumstances pursuant to 42 CFR Section 431.220(a) and Section 27-3-3 NMSA 1978. A request for a HSD administrative hearing must be received within 30 days of the date of its UR reconsideration decision. A HSD administrative hearing occurs telephonically between the parties to the hearing and the assigned ALJ. See 8.352.2 NMAC for detailed description of a HSD administrative claimant hearing process. At the time the eligible recipient or his or her authorized representative requests a HSD administrative hearing, the eligible recipient is referred to as the claimant.

**A. Record preservation:** To preserve a record for review, MAD, its UR contractor or a MAD designee documents and retains a record of the reconsideration determination.

**B. Documentation requirements:** The record preserved by MAD, its UR contractor or a MAD designee includes all documentation of the initial UR decision, copies of any documents relevant to the initial

decision, any additional evidence presented during the reconsideration, and a copy of the reconsideration determination.

[8.350.2.11 NMAC - Rp, 8.350.2.11 NMAC, 8/1/2014]

**HISTORY OF 8.350.2 NMAC:**

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:

ISD 306.1000, Reconsideration Procedures for Ambulatory Care, filed 1/7/1980.

ISD 306.1000, Reconsideration Procedures for Ambulatory Care, filed 7/8/1982.

ISD 306.2000, Reconsideration Procedures for Delegated Hospitals, filed 1/7/1980.

ISD 306.3000, Reconsideration Procedures for Non-Delegated and Non-Designated Hospitals, filed 1/7/1980.

**History of Repealed Material:**

8.350.2 NMAC, Reconsideration of Utilization Review Decisions - Repealed 8/1/2014.