

TITLE 8 SOCIAL SERVICES
CHAPTER 349 COORDINATED SERVICE CONTRACTORS
PART 2 APPEALS AND GRIEVANCE PROCESS

8.349.2.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.349.2.1 NMAC - Rp 8.349.2.1 NMAC, 7/1/2024]

8.349.2.2 SCOPE: The rule applies to the general public.
[8.349.2.2 NMAC - Rp 8.349.2.2 NMAC, 7/1/2024]

8.349.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). 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.
[8.349.2.3 NMAC - Rp 8.349.2.3 NMAC, 7/1/2024]

8.349.2.4 DURATION: Permanent.
[8.349.2.4 NMAC - Rp 8.349.2.4 NMAC, 7/1/2024]

8.349.2.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.349.2.5 NMAC - Rp 8.349.2.5 NMAC, 7/1/2024]

8.349.2.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[8.349.2.6 NMAC - Rp 8.349.2.6 NMAC, 7/1/2024]

8.349.2.7 DEFINITIONS: [RESERVED]

8.349.2.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[8.349.2.8 NMAC - Rp 8.349.2.8 NMAC, 7/1/2024]

8.349.2.9 COORDINATED SERVICE CONTRACTORS (CSC): CSCs that manage some services of the medicaid program are responsible for any or all aspects of program management, prior authorization, utilization review, claims processing, and issuance of remittance advices and payments.

A. The CSC shall have a grievance system in place for recipients that include a grievance process related to dissatisfaction and an appeals process related to a CSC's action, including the opportunity to request an HCA fair hearing.

B. A grievance is a recipient's expression of dissatisfaction about any matter or aspect of the CSC or its operation, other than a CSC's action, as defined below.

C. An appeal is a request for review by the CSC of a CSC's action. An action is the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; or the failure to provide services in a timely manner. An untimely service authorization constitutes a denial and is thus considered an action.

D. The recipient, legal guardian of the recipient for a minor or an incapacitated adult, or a representative of the recipient as designated in writing to the CSC, has the right to file a grievance or an appeal of the CSC's action on behalf of the recipient. A provider acting on behalf of the recipient, with the recipient's written consent, may file a grievance or an appeal of a CSC's action.

E. In addition to the CSC's grievance and appeal process described above, a recipient, legal guardian of the recipient for a minor or an incapacitated adult, or the representative of the recipient has the right to request a fair hearing on behalf of the recipient with HCA directly as described in 8.352.2 NMAC, *Recipient Hearings*, if a CSC's decision results in termination, modification, suspension, reduction, or denial of services to the recipient or if

the recipient believes the CSC has taken an action erroneously. A fair hearing may be requested prior to, concurrent with, subsequent to, or in lieu of a grievance or appeal to the CSC.
[8.349.2.9 NMAC - Rp 8.349.2.9 NMAC, 7/1/2024]

8.349.2.10 GENERAL REQUIREMENTS FOR GRIEVANCE AND APPEALS:

A. The CSC shall implement written policies and procedures describing how the recipient may submit a request for a grievance or an appeal with the CSC or submit a request for a fair hearing with the HCA. The policy shall include a description of how the CSC resolves the grievance or appeal.

B. The CSC shall provide to all service providers and subcontractors in the CSC's network a written description of the CSC's grievance and appeal process and how the provider can submit a grievance or appeal.

C. The CSC shall have available reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

D. The CSC shall name a specific individual(s) designated as the CSC's medicaid recipient grievance coordinator with the HCA to administer the policies and procedures for resolution of a grievance or an appeal, to review patterns/trends in grievances or appeals, and to initiate corrective action.

E. The CSC shall ensure that the individuals that make the decisions on grievances or appeals are not involved in any previous level of review or decision-making. The CSC shall also ensure that health care professionals with appropriate clinical expertise shall make decisions for the following:

- (1) an appeal of a CSC denial that is based on lack of medical necessity;
- (2) a CSC denial that is upheld in an expedited resolution;
- (3) a grievance or appeal that involves clinical issues.

F. Upon enrollment, the CSC shall provide recipients, at no cost, with an information sheet or handbook that provides information on how they or their representative(s) can file a grievance or an appeal, and the resolution process. The recipient information shall also advise recipients of their right to file a request for an administrative hearing with the HCA hearings bureau, upon notification of a CSC action, or concurrent with or following an appeal of the CSC action.

G. The CSC shall ensure that punitive or retaliatory action is not taken against a recipient or a provider that files a grievance or an appeal, or a provider that supports a recipients' grievance or appeal.

[8.349.2.10 NMAC - Rp 8.349.2.10 NMAC, 7/1/2024]

8.349.2.11 GRIEVANCE: A grievance is a recipient's expression of dissatisfaction about any matter or aspect of the CSC or its operation.

A. A recipient may file a grievance either orally or in writing with the CSC within 90 calendar days of the date the event causing the dissatisfaction occurred. The legal guardian of the recipient for a minor or an incapacitated adult, a representative of the recipient as designated in writing to the CSC, and a provider acting on behalf of the recipient and with the recipient's written consent, have the right to file a grievance on behalf of the recipient.

B. Within five working days of receipt of the grievance, the CSC shall provide the grievant with written notice that the grievance has been received and the expected date of its resolution.

C. The investigation and final CSC resolution process for grievances shall be completed within 30 calendar days of the date the grievance is received by the CSC and shall include a resolution letter to the grievant or the grievant's representative.

D. The CSC may request an extension from HCA up to 14 calendar days if the grievant requests the extension, or the CSC demonstrates to HCA that there is need for additional information, and the extension is in the recipient's interest. For any extension not requested by the grievant, the CSC shall give the grievant written notice of the reason for the extension within two working days of the decision to extend the timeframe.

E. Upon resolution of the grievance, the CSC shall mail a resolution letter to the grievant, legal guardian, representative, and provider acting on behalf of the recipient. The resolution letter shall include, but not be limited to, the following:

- (1) all information considered in investigating the grievance;
- (2) findings and conclusions based on the investigation; and
- (3) the disposition of the grievance.

[8.349.2.11 NMAC - Rp 8.349.2.11 NMAC, 7/1/2024]

8.349.2.12 APPEALS: An appeal is a request for review by the CSC of a CSC action.

A. An action is defined as:

- (1) the denial or limited authorization of a requested service, including the type of level of service;
- (2) the reduction, suspension, or termination of a previously authorized service;
- (3) the denial, in whole or in part, of payment for a service;
- (4) the failure of the CSC to provide services in a timely manner, as defined by HCA; or
- (5) the failure of the CSC to complete the authorization request in a timely manner as defined in 42 CFR 438.408.

B. The CSC shall mail a notice of action to the recipient and provider within 10 days of the date of the action, except for denial of claims that may result in recipient financial liability, which requires immediate notification. The notice shall contain, but not be limited, to the following:

- (1) the action CSC has taken or intends to take;
- (2) the reasons for the action;
- (3) the recipient's or the provider's right to file an appeal of the CSC action through the CSC;
- (4) the recipient's right to request an HCA fair hearing and what the process would be;
- (5) the procedures for exercising the rights specified;
- (6) the circumstances under which expedited resolution of an appeal is available and how to request it; and
- (7) the recipient's right to have benefits continue pending resolution of an appeal, how to request the continuation of benefits, and the circumstances under which the recipient may be required to pay the costs of continuing these benefits.

C. A recipient may file an appeal of a CSC action within 90-calendar days of receiving the CSC's notice of action. The legal guardian of the recipient for a minor or an incapacitated adult, a representative of the recipient as designated in writing to the CSC, or a provider acting on behalf of the recipient with the recipient's written consent, have the right to file an appeal of an action on behalf of the recipient.

D. The CSC has 30-calendar days from the date the initial oral or written appeal is received by the CSC to resolve the appeal.

E. The CSC shall have a process in place that ensures that an oral or written inquiry from a recipient seeking to appeal an action is treated as an appeal (to establish the earliest possible filing date for the appeal). The CSC shall use its best efforts to assist recipients as needed with the written appeal.

F. Within five working days of receipt of the appeal, the CSC shall provide the grievant with written notice that the appeal has been received and the expected date of its resolution. The CSC shall confirm in writing receipt of oral appeals, unless the recipient or the provider requests an expedited resolution.

G. The CSC may extend the 30 days time frame by 14 calendar days if the recipient requests the extension, or the CSC demonstrates to HCA that there is need for additional information, and the extension is in the recipient's interest. For any extension not requested by the recipient, the CSC shall give the recipient written notice of the extension and the reason for the extension within two working days of the decision to extend the time frame.

H. The CSC shall provide the recipient or the recipient's representative a reasonable opportunity to present evidence of the facts or law, in person as well as in writing.

I. The CSC shall provide the recipient or the representative the opportunity, before and during the appeals process, to examine recipient's case file, including medical or clinical records (subject to HIPAA requirements), and any other documents and records considered during the appeals process. The CSC shall include as parties to the appeal the recipient and their representative, or the legal representative of a deceased recipient's estate.

J. For all appeals, the CSC shall provide written notice within the 30-calendar-day timeframe for resolution to the grievant, legal guardian, representative, and provider acting on behalf of the recipient.

(1) The written notice of the appeal resolution shall include, but not be limited to, the following information:

- (a) the results of the appeal resolution; and
- (b) the date it was completed.

(2) The written notice of the appeal resolution for appeals not resolved wholly in favor of the recipient shall include, but not be limited to, the following information:

- (a) the right to request an HCA fair hearing and how to do so;
- (b) the right to request receipt of benefits while the hearing is pending, and how to make the request; and

(c) that the recipient may be held liable for the cost of continuing benefits if the hearing decision upholds the CSC's action.

K. The CSC may continue benefits while the appeal or the HCA fair hearing process is pending.

(1) The CSC shall continue the recipient's benefits if all of the following are met:

(a) the recipient or the provider files a timely appeal of the CSC action within 10 days of the date on the notice of action from the CSC);

(b) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment:

(c) the services are ordered by an authorized provider;

(d) the recipient requests extension of benefits.

(2) The CSC shall provide benefits until one of the following occurs:

(a) the recipient withdraws the appeal;

(b) 10 days have passed since the date of the resolution letter, provided the resolution of the appeal was against the recipient and the recipient has taken no further action;

(c) HCA issues a hearing decision adverse to the recipient;

(d) the time period or service limits of a previously authorized service has expired.

(3) If the final resolution of the appeal is adverse to the recipient, that is, the CSC's action is upheld, the CSC may recover the cost of the services furnished to the member while the appeal was pending, to the extent that services were furnished solely because of the requirements of this section and in accordance with the policy in 42 CFR 431.230(b).

(4) If the CSC or HCA reverses a decision to deny, limit, or delay services, and these services were not furnished while the appeal was pending the CSC shall authorize or provide the disputed services promptly and as expeditiously as the recipient's health condition requires.

(5) If the CSC or HCA reverses a decision to deny, limit or delay services and the recipient received the disputed services while the appeal was pending, the CSC shall pay for these services.

[8.349.2.12 NMAC - Rp 8.349.2.12 NMAC, 7/1/2024]

8.349.2.13 EXPEDITED RESOLUTION OF APPEALS: An expedited resolution of an appeal is an expedited review by the CSC of a CSC action.

A. The CSC shall establish and maintain an expedited review process for appeals when the CSC determines that allowing the time for a standard resolution could seriously jeopardize the recipient's life or health or ability to attain, maintain, or regain maximum function. Such a determination is based on:

(1) a request from the recipient;

(2) a provider's support of the recipient's request;

(3) a provider's request on behalf of the recipient; or

(4) the CSC's independent determination.

B. The CSC shall ensure that the expedited review process is convenient and efficient for the recipient.

C. The CSC shall resolve the appeal within three working days of receipt of the request for an expedited appeal, if the request meets the definition of expedited in 8.349.2.13 NMAC.

D. The CSC may extend the time frame by up to 14 calendar days if the recipient requests the extension, or the CSC demonstrates to HCA that there is need for additional information and the extension is in the recipient's interest. For an extension not requested by the recipient, the CSC shall give the recipient written notice of the reason for the delay.

E. The CSC shall ensure that punitive action is not taken against a recipient or a provider who requests an expedited resolution or supports a recipient's expedited appeal.

F. The CSC shall provide an expedited resolution, if the request meets the definition of an expedited appeal, in response to an oral or written request from the recipient or provider on behalf of the recipient.

G. The CSC shall inform the recipient of the limited time available to present evidence and allegations in fact or law.

H. If the CSC denies a request for an expedited resolution of an appeal, it shall:

(1) transfer the appeal to the 30-day timeframe for standard resolution, in which the 30-day period begins on the date the CSC received the original request for appeal;

(2) make reasonable efforts to give the recipient prompt oral notice of the denial, and follow up with a written notice within two calendar days; and

(3) inform the grievant in the written notice of the right to file an appeal or request an HCA fair hearing if the recipient is dissatisfied with the CSC's decision to deny an expedited resolution.

I. The CSC shall document in writing all oral requests for expedited resolution and shall maintain the documentation in the case file.

[8.349.2.13 NMAC - Rp 8.349.2.13 NMAC, 7/1/2024]

8.349.2.14 SPECIAL RULE FOR CERTAIN EXPEDITED SERVICE AUTHORIZATION

DECISIONS: In the case of expedited service authorization decisions that deny or limit services, the CSC shall, within 72 hours of receipt of the request for service, automatically file an appeal on behalf of the recipient, use its best effort, to give the recipient oral notice of the decision on the automatic appeal and to resolve the appeal.

[8.349.2.14 NMAC - Rp 8.349.2.14 NMAC, 7/1/2024]

8.349.2.15 OTHER RELATED COORDINATED SERVICE CONTRACTOR (CSC) PROCESSES:

A. Information about grievance system to providers and subcontractors: The CSC shall provide information specified in 42 CFR438.10(g) (1) about the grievance system to all providers and subcontractors at the time that they enter into a contract.

B. Grievance or appeal files:

(1) All grievance or appeal files shall be maintained in a secure and designated area and accessible to HCA, upon request, for review. Grievance or appeal files shall be retained for six years following the final decision by the CSC, HCA, and administrative law judge, judicial appeal, or closure of a file, whichever occurs later.

(2) The CSC shall have procedures for assuring that files contain sufficient information to identify the grievance or appeal, the date it was received, the nature of the grievance or appeal, notice to the recipient of receipt of the grievance or appeal, all correspondence between the CSC and the recipient, the date the grievance or appeal is resolved, the resolution, the notices of final decision to the recipient, and all other pertinent information.

(3) Documentation regarding the grievance shall be made available to the grievant, legal guardian representative, or provider acting on behalf of the recipient if requested.

[8.349.2.15 NMAC - Rp 8.349.2.15 NMAC, 7/1/2024]

8.349.2.16 COORDINATED SERVICE CONTRACTOR (CSC) PROVIDER GRIEVANCE

PROCESS: The CSC shall establish and maintain written policies and procedures for the filing of provider grievances. A provider shall have the right to file a grievance with the CSC regarding utilization management decisions or provider payment issues. Grievances shall be resolved within 30 calendar days. A provider may not file a grievance on behalf of a recipient without written designation by the recipient as the recipient's representative. See 8.349.2.14 NMAC for special rules for certain expedited service authorizations.

[8.349.2.16 NMAC - Rp 8.349.2.16 NMAC, 7/1/2024]

History of 8.349.2 NMAC: [RESERVED]

History of Repealed Material: 8.349.2 NMAC, Appeals And Grievance Process, filed 12/13/2006 - Repealed effective 7/1/2024.

Other: 8.349.2 NMAC, Appeals And Grievance Process, filed 12/13/2006 Replaced by 8.349.2 NMAC, Appeals And Grievance Process, effective 7/1/2024.