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

8.308.15.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.308.15.1 NMAC - Rp, 8.308.15.1 NMAC, 5/1/2018; A, 7/1/2024]

8.308.15.2 SCOPE: This rule applies to the general public.
[8.308.15.2 NMAC - Rp, 8.308.15.2 NMAC, 5/1/2018]

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 Sections 27-2-12 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.
[8.308.15.3 NMAC - Rp, 8.308.15.3 NMAC, 5/1/2018; A, 7/1/2024]

8.308.15.4 DURATION: Permanent.
[8.308.15.4 NMAC - Rp, 8.308.15.4 NMAC, 5/1/2018]

8.308.15.5 EFFECTIVE DATE: May 1, 2018 unless a later date is cited at the end of a section.
[8.308.15.5 NMAC - Rp, 8.308.15.5 NMAC, 5/1/2018]

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 - Rp, 8.308.15.6 NMAC, 5/1/2018]

8.308.15.7 DEFINITIONS:

A. "Administrative law judge (ALJ)" means the hearing officer appointed by the HSD fair hearings bureau (FHB) to oversee the claimant's administrative hearing process, to produce an evidentiary record and render a recommendation to the medical assistance division (MAD) director.

B. "Adverse action against a member" is when a HSD managed care organization (MCO) intends or has taken action against a member of his or her MCO as in one or more of the following situations.

(1) An adverse benefit determination is the denial, reduction, limited authorization, suspension, or termination of a newly requested benefit or benefit currently being provided to a member including determinations based on the type or level of service, medical necessity criteria or requirements, appropriateness of setting, or effectiveness of a service other than a value-added service. It includes the following:

(a) a change to a level of care (LOC) benefit currently being received through a MCO, including a reduction or other change in the member's LOC, and a transfer or discharge of a nursing facility (NF) resident;

(b) the retrospective denial, reduction, or limited authorization of a benefit rendered which was provided on a presumed emergency basis, whether in or out of network, or provided without having received any required authorization or LOC determination prior to the service being rendered, with the exception of a MCO value-added service;

(c) the denial in whole or in part of a member's provider claim by the MCO regardless of whether the member is being held responsible for payment;

(d) the failure of the MCO, or its designee:

(i) to make a benefit determination in a timely manner;

(ii) to provide a benefit in a timely matter;

(iii) to act within the timeframes regarding the MCO's established member appeal requirements;

(e) the belief of a member, his or her authorized representative or authorized provider that the MCO's admission determination, LOC determination, or preadmission screening and annual resident review (PASRR) requirements determination is not accurate or the belief that the frequency, intensity or duration of the benefit is insufficient to meet the medical needs of the member. When the issue stems from a

PASRR determination, the member will request a HSD PASRR administrative hearing governed by 8.354.2 NMAC instead of a MCO member appeal or a HSD administrative hearing; and

(f) the denial of a request to dispute a financial liability, including co-payments, premiums or other member financial liabilities.

(2) Other actions include:

(a) a budget or allocation for which a member, his or her authorized representative, or authorized provider believes the member's home and community-based waiver benefit or the member's budget or allocations were erroneously determined or is insufficient to meet the member's needs; and

(b) a denial, limitation, or non-payment of emergency or non-emergency transportation, or meals and lodging.

C. "Adverse action against a provider" means when a MCO intends or has taken adverse action against a provider based on the MCO denial of the provider's payment, including a denial of a claim for lack of medical necessity or as not a covered benefit.

D. "Authorized provider" means the member's provider who has been authorized in writing by the member or his or her authorized representative to request a MCO expedited member appeal or a MCO standard member appeal on behalf of the member. An authorized provider does not have the full range of authority to make medical decisions on behalf of the member.

E. "Authorized representative" means the individual designated by the member or legal guardian to represent and act on the member's behalf.

(1) The member or authorized representative must provide documentation authorizing the named individual or individuals to access the identified case information for a specified purpose and time-frame. An authorized representative may be an attorney representing a person or household, a person acting under the authority of a valid power of attorney, a guardian, or any other individual or individuals designated in writing by the member.

(2) If a member, due to his or her medical incapacity, is unable to appoint an authorized representative and the authorized representative is unable to be reached and immediate medical care is needed, the member's treating provider may act as the member's authorized representative until such time as the member's authorized representative is available or until such time as the member is able to appoint an authorized representative. In this case, the authorized provider is allowed to file a MCO expedited or standard member appeal. The member's medical record must demonstrate that the member was incapacitated and the member's medical condition required immediate action prior to the authorized representative being located.

F. "HSD expedited administrative hearing" means an expedited informal evidentiary hearing conducted by the HSD fair hearings bureau (FHB) in which evidence may be presented as it relates to an adverse action taken or intended to be taken, by the MCO. A member or his or her authorized representative may request a HSD expedited administrative hearing only after exhausting his or her MCO expedited or standard member appeal process and unless the request for a HSD expedited administrative hearing is because the MCO has denied the member's request for a member appeal to be expedited. See 8.352.2 NMAC for a detailed description of the HSD expedited administrative hearing process and Subsection B of 8.308.15.13 NMAC.

G. "HSD PASRR administrative hearing" means a HSD administrative hearing process which is an informal evidentiary hearing conducted by FHB in which evidence may be presented as it relates to an adverse action taken or intended to be taken by a MCO of a member's disputed PASRR determination, or a member's disputed transfer or discharge from a NF. See 8.354.2 NMAC for a detailed description of the HSD PASRR administrative hearing process.

H. "HSD standard administrative hearing" means an informal evidentiary hearing conducted by FHB in which evidence may be presented as it relates to an adverse action taken or intended to be taken, by the MCO. A member or his or her authorized representative may request a HSD standard administrative hearing only after exhausting his or her MCO expedited or standard member appeal process. See 8.352.2 NMAC for a detailed description of the HSD standard administrative hearing process.

I. "MAD" means the medical assistance division, which administers medicaid and other medical assistance programs under HSD.

J. "MAP" means the medical assistance programs administered under MAD.

K. "MCO" means the member's HSD contracted managed care organization.

L. "MCO expedited member appeal" means the process open to a member or his or her authorized representative or authorized provider when the member's MCO has taken or intends to take an adverse action against the member's benefit.

(1) A request for an expedited appeal is appropriate when the MCO, the member, his or her authorized representative, or the authorized provider believes that allowing the time for a standard member appeal resolution could seriously jeopardize the member's life, health, or his or her ability to attain, maintain, or regain maximum function.

(2) The process open to an authorized provider who has requested an authorization or other approval for the disputed benefit, including a LOC for a member which the MCO has denied in whole or in part or after the MCO has reconsidered any additional documentation or information from the authorized provider during the approval process.

M. "MCO standard member appeal" means:

(1) the process open to a member or his or her authorized representative when the member's MCO has taken or intends to take an adverse action against the member's benefit; or

(2) the process open to an authorized provider who has requested an authorization or other approval for the disputed benefit, including a LOC for a member which the MCO has denied in whole or in part or after the MCO has reconsidered any additional documentation or information from the authorized provider during the approval process.

(3) A MCO cannot change a member's, or his authorized representative's or authorized provider's request for a MCO expedited or standard member appeal to a MCO member grievance without the written consent of the appeal requestor.

N. "MCO member grievance" means an expression of dissatisfaction by a member or his or her authorized representative about any matter or aspect of the MCO or its operation that is not included in the definition of an adverse action. A MCO member grievance final decision does not provide a member the right to request a HSD expedited or standard administrative hearing, unless the reason for the request is based on the assertion by the member or his or her authorized representative that the MCO failed to act within the MCO member grievance time frames.

O. "MCO provider appeal" means the process open to a provider requesting a review by the MCO of his or her payment, including denial of a claim for lack of medical necessity or as not a covered benefit.

P. "MCO expedited or standard member appeal final decision" means the MCO's final decision regarding a member's or his or her authorized representative's or authorized provider's request for a MCO expedited or standard member appeal of the MCO's adverse action it intends to take or has taken against its member.

Q. **"MCO provider grievance"** means an expression of dissatisfaction by a provider about any matter or aspect of the MCO or its operation that is not included in the definition of an adverse action. The MCO provider grievance final decision does not allow a provider to request a HSD provider administrative hearing.

R. "Member" means an eligible recipient enrolled in a MCO.

S. "Notice of action" means the notice of an adverse action intended or taken by the member's MCO.

T. "Provider" means a practitioner or entity which has delivered or intends to provide a service or item whether the provider is contracted or not contracted with the member's MCO at the time services or items are to be provided.

U. "Valued added services" means services offered by a MCO that are not part of the MCO's required benefit package. Disputes concerning value-added services are not eligible for a MCO appeal or a HSD administrative hearing.

[8.308.15.7 NMAC - Rp, 8.308.15.7 NMAC, 5/1/2018]

8.308.15.8 [**RESERVED**]

[8.308.15.8 NMAC - Rp, 8.308.15.8 NMAC, 5/1/2018]

8.308.15.9 MCO PROVIDER GRIEVANCE:

A. Upon a provider contracting with the MCO, the MCO shall provide at no cost a written description of its provider grievance policies and procedures to the provider. The MCO will notify each of its providers in writing of any changes to these policies and procedures. The description shall include:

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

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

(3) a description of how the provider's grievance is resolved.

B. A provider or its authorized representative shall have the right to file a grievance with its MCO to express dissatisfaction about any matter or aspect of the MCO's operation. The provider or representative may file the grievance either orally or in writing in accordance with its MCO's policies and procedures.

C. The MCO shall designate a specific employee as its provider grievance manager with the authority to:

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

(2) review patterns and trends in grievances and initiate corrective action as necessary; and

(3) shall ensure that punitive or retaliatory action is not taken against any provider that files a grievance.

[8.308.15.9 NMAC - Rp, 8.308.15.9 NMAC, 5/1/2018]

8.308.15.10 MCO PROVIDER APPEALS:

A. Upon a provider contracting with the MCO, the MCO shall provide at no cost a written description of its provider appeal policies and procedures and instructions on how to act as a member's authorized provider to the provider. The MCO will update in writing each of its providers with any changes to these policies and procedures. The MCO will additionally provide to a non-contracted provider who is seeking to or has rendered services or items to the MCO's member, policies and procedures informing the provider of his or her rights and responsibilities to be designated by a member or the member's authorized representative to act as his or her authorized provider, and how to request a MCO expedited or standard member appeal as the authorized provider.

(1) The description shall include:

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

(b) time frames for each step of the MCO provider appeal process through its final resolution; and

(c) a description of how the provider's MCO appeal is resolved.

(2) The MCO shall designate a specific employee as its provider appeal manager with the authority to:

(a) administer the policies, procedures and processes for a resolution of an appeal;

(b) review patterns and trends in appeals and initiate corrective action; and

(c) ensure that punitive or retaliatory action is not taken against any provider that files a MCO provider appeal.

B. Standing to request a MCO provider appeal: A provider or its authorized representative may request a MCO provider appeal for an intended or taken adverse action against a provider based on the MCO denial of the provider's payment, including a denial of a claim for lack of medical necessity or as not a covered benefit.

C. Provider rights and limitations:

(1) A provider or representative may request a MCO provider appeal either orally or in writing in accordance with the MCO's policies and procedures.

(2) A provider or his or her authorized representative may have its legal counsel or a spokesperson be a party to the MCO provider appeal process.

(3) If the MCO upholds its adverse action in the MCO's provider appeal final decision, the appeal process will be considered exhausted. The provider is not eligible to request a HSD provider administrative hearing. The loss of the appeal does not make the member liable for any payment to the provider.

[8.308.15.10 NMAC - Rp, 8.308.15.10 NMAC, 5/1/2018]

8.308.15.11 GENERAL INFORMATION ON MCO MEMBER GRIEVANCES AND APPEALS PROCESSES:

A. Upon a member's enrollment:

(1) the MCO shall provide to the member and his or her authorized representative at no cost a written description of its member grievance and member expedited and standard appeal system and member expedited appeal system procedures and processes;

(2) the MCO will promptly provide in writing to each member, his or her authorized representative any changes to these procedures and processes. The description shall include:

(a) information on how the member or his or her authorized representative or authorized provider can request a MCO expedited or standard appeal, or how the member or his or her authorized representative can file a MCO member grievance; and the resolution processes for each;

(b) time frames for each step of the MCO member grievance and the MCO expedited and standard member appeal processes through to their final resolution;

(c) a description of how a MCO member's grievance or MCO expedited or standard member appeal is resolved;

(d) information that the MCO may have only one level of appeal for the member;

(e) in the case of a MCO that fails to adhere to the time frames for each step of its procedures and process, the member or his or her authorized representative is deemed to have exhausted the MCO's expedited or standard member appeal process and the member or his authorized representative may request a HSD expedited or standard administrative hearing.

(f) The MCO shall designate a specific employee as its member grievance and appeal manager with the authority to:

(i) administer the policies and procedures for resolution of a MCO member grievance and a MCO expedited or standard member appeal;

(ii) review patterns and trends in MCO member grievances, and MCO expedited or standard member appeals; and

(iii) ensure that punitive or retaliatory action is not taken against any member or his or her authorized representative that files a MCO member grievance or any member, his or her authorized representative or the authorized provider who requests a MCO expedited or standard member appeal.

(g) Prior to the MCO taking an adverse action, in order to avoid incomplete information during the MCO expedited or standard member appeal process or the HSD expedited or standard administrative hearing process, the MCO must contact the requesting provider for more information or justification regarding the request if lack of information or justification is likely to lead to the adverse action.

B. MCO member grievance and MCO expedited and standard member appeal rights and responsibilities:

(1) Standing to file a MCO member grievance:

(a) The member or his or her authorized representative may file a MCO member grievance concerning dissatisfaction with the MCO's operation.

(b) The member or his or her authorized representative may choose a relative, friend or other spokesperson to advocate or assist him or her through the MCO member grievance process; however, the spokesperson is limited to a supporting role and cannot act on behalf of the member or his or her authorized representative. The member or his or her authorized representative must provide the MCO a signed release-of-information in order for the designated spokesperson to have access to information to aid the spokesperson to assist or advocate for the member or his or her authorized representative during the MCO's member grievance process. A member or his or her authorized representative may elect not to sign such a release, but utilize the spokesperson during the MCO member grievance process.

(2) The member or his or her authorized representative may have legal counsel assist him or her during the MCO member grievance process.

(3) Grievance: A member or his or her authorized representative shall have the right to file a grievance with his or her MCO to express dissatisfaction about any matter or aspect of his or her MCO's operation other than an adverse benefit determination without time limitations. A MCO member grievance final decision cannot be appealed through the MCO member appeal process or the HSD administrative hearing process. If the member or his or her authorized representative or the authorized provider wishes to appeal an intended or taken adverse action against the member, the member, his or her authorized or the authorized provider must comply with all requirements to request a MCO expedited or standard member appeal including applicable time frames in which to request a MCO expedited or standard member appeal. A member may file both a MCO member grievance and a MCO expedited or standard member appeal, but the MCO appeal must meet all applicable filing time requirements which are not changed by the filing of a grievance.

(a) The member or his or her authorized representative may file a MCO member grievance either orally or in writing in accordance with the MCO's procedures and processes.

(b) The member or his or her authorized representative may file a MCO member grievance at any time when he or she wishes to register his or her dissatisfaction.

(c) The MCO will provide the member or his or her authorized representative with its resolution to the member's grievance within the time frame specified in the MCO's medicaid managed care services agreement.

(4) MCO expedited or standard member appeal: A member or his or her authorized representative or the authorized provider has the right to request a MCO standard member appeal orally and in

writing in accordance with his or her MCO procedures within 60 calendar days of the date of notice of an intended or taken adverse action. If the request is orally, it must be followed up in writing within 13 calendar days of the oral request. A member, his or her authorized representative or authorized provider has the right to request a MCO expedited member appeal orally or in writing in accordance with the member's MCO procedures within 60 calendar days of the date of the notice of an intended or taken adverse action.

(a) The member or his or her authorized representative or the authorized provider may have legal counsel to assist him or her during the MCO expedited or standard member appeal process.

(b) Standing to request a MCO expedited or standard member appeal:

(i) The member or his or her authorized representative may request a MCO expedited or standard member appeal concerning his or her disputed benefit.

(ii) The member, his or her authorized representative or authorized provider may choose a relative, friend or other spokesperson to advocate or assist him or her through the MCO expedited or standard member appeal process; however, the spokesperson is limited to a supporting role and cannot act on behalf of the member or his or her authorized representative. The member or his or her authorized representative must provide the MCO a signed release-of-information in order for a designated spokesperson to have access to information to aid the spokesperson to assist and advocate for the member or his or her authorized representative during the MCO expedited or standard member appeal process.

(c) If a member or his or her authorized representative or authorized provider elects to request a continuation of the disputed current benefit, the member, his or her authorized representative or authorized provider must request a MCO expedited or standard member appeal and also request a continuation of the disputed benefit within 10 calendar days of the mailing of the MCO's notice of action or before the expected effective date of the MCO's proposed adverse action benefit determination, whichever is later. When the mailing date is disputed or there is a discrepancy between the mailing date and the postmarked date, the postmarked date will prevail. The member or his or her authorized representative or authorized provider does not have the right to request a HSD expedited or standard administrative hearing related to a value-added services offered by the MCO. If the member or his or her authorized representative or authorized provider chooses to request a MCO expedited or standard member appeal, the following apply.

(i) The member, his or her authorized representative or authorized provider cannot request separate appeals. Only one appeal can be filed.

(ii) If the MCO upholds its adverse action, regardless of who requested the MCO expedited or standard member appeal, the MCO expedited or standard member appeal process is considered exhausted and the member or his or her authorized representative may request a HSD expedited or standard administrative hearing concerning his or her disputed benefit. Once the member or his or her authorized representative requests a HSD expedited or standard administrative hearing, he or she is referred to as the claimant. The authorized provider is not eligible to request a HSD expedited or standard administrative hearing on the disputed benefit, unless the provider has been designated as the member's authorized representative. See 8.352.2 NMAC for a detailed description of the HSD expedited and standard administrative hearing processes.
[8.308.15.11 NMAC - Rp, 8.308.15.11 NMAC, 5/1/2018]

8.308.15.12 MCO MEMBER GRIEVANCE PROCESS:

A. The MCO shall provide to its member or his or her authorized representative reasonable assistance in completing grievance forms and completing 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 ensure that the individuals who make decisions related to grievances are not involved in any previous level of review or decision-making as to the matter that is grieved.

C. The MCO shall provide the member or his or her authorized representative with written notice:

(1) when a MCO member grievance request has been received;

(2) of the expected date of resolution which cannot be greater than 30 calendar days from the date of receipt of the grievance; and

(3) of the final resolution of the grievance.

D. The MCO shall ensure that punitive or retaliatory action is not taken against any member or authorized representative that files a grievance, or the member's provider that supports the member's grievance.
[8.308.15.12 NMAC - Rp, 8.308.15.12 NMAC, 5/1/2018]

8.308.15.13 MCO EXPEDITED MEMBER APPEAL PROCESS: The MCO shall establish and maintain an expedited review process for a MCO expedited member appeal when the MCO, the member or his or her authorized representative or authorized provider believes that allowing the time for a standard member appeal resolution could seriously jeopardize the member's life, health, or his or her ability to attain, maintain, or regain maximum function. Once a member or his or her authorized representative or authorized provider requests a MCO expedited member appeal and the member or his or her authorized representative or authorized provider requests a continuation of the member's disputed current benefit, the MCO will grant a continuation of the disputed current benefit until the MCO expedited member appeal final decision is rendered by the MCO. However, if the date of the MCO expedited member appeal final decision letter is prior to the notice of action's adverse action effective date, the MCO must continue the disputed current benefit up to the adverse action's effective date. The MCO shall ensure that health care professionals with appropriate clinical expertise in addressing the physical health, behavioral health, or long-term services and supports needs of the member are utilized during the MCO expedited member appeal process when the MCO notice of action for the disputed benefit is based on a lack of medical necessity.

A. A member or his or her authorized representative or authorized provider in accordance with the member's MCO procedures has the right to request within 60 calendar days after the mailing of the MCO's notice of action a MCO expedited member appeal orally or in writing. When the mailing date of the notice of action is disputed or there is a discrepancy between the mailing date and the postmarked date, the postmarked date will prevail.

(1) If a member, his or her authorized representative or authorized provider elects to request a continuation of the member's disputed current benefit, the member or his or her authorized representative or authorized provider must request a MCO expedited member appeal and request a continuation of the member's disputed current benefit within 10 calendar days of the mailing of the MCO's notice of action. When the mailing date of the notice of action is disputed or there is a discrepancy between the mailing date and the postmarked date, the postmarked date will prevail. The continuation of the disputed current benefits is not dependent on the approval to proceed to the MCO expedited appeal process. See 8.308.15.15 NMAC for a detailed description of the continuation of the disputed benefit process.

(2) If the member or authorized representative or authorized provider requests a MCO expedited member appeal, the following applies.

(a) If the member or his or her authorized representative designate in writing the member's provider to act as the member's authorized provider, the authorized provider may request a MCO expedited member appeal when the authorized provider believes that the MCO has made an incorrect decision concerning the member's disputed benefit.

(b) If the MCO upholds its adverse action, regardless of who requested the MCO expedited member appeal process, the MCO expedited member appeal process is considered exhausted and the member or his or her authorized representative may request a HSD expedited or standard administrative hearing concerning the member's disputed benefit.

(c) Once the member or his or her authorized representative request a HSD expedited or standard administrative hearing, he or she is referred to as the claimant.

(4) The member or his or her authorized representative or the authorized provider may have legal counsel or a spokesperson assist him or her during the MCO expedited member appeal process.

(5) The member or his or her authorized representative or the authorized provider does not have the right to request a MCO expedited or standard member appeal or a HSD expedited or standard administrative hearing related to a value-added service offered by the MCO.

(6) The authorized provider is not eligible to request a HSD expedited or standard administrative hearing on the disputed benefit, unless the provider has been designated as the member's authorized representative. See 8.352.2 NMAC for a detailed description of the HSD expedited and standard administrative hearing processes.

B. The request for a MCO expedited member appeal may be made orally or in writing to the member's MCO within the required time frame. The reasons why a MCO expedited member appeal is necessary must be detailed in the oral or written request. A member's provider (regardless if the provider is not the authorized provider) may assist the member or his or her authorized representative in stating the reasons and providing supporting documentation that a MCO expedited member appeal is medically necessary. There can only be one MCO member appeal request concerning the disputed benefit at one time. If the MCO denies the request for a MCO expedited member appeal, the member or his or her authorized representative may then request a HSD expedited or standard administrative hearing regarding the issue of the denial of a MCO expedited member appeal. See 8.352.2 NMAC for a detailed description of the HSD expedited and standard administrative hearing processes.

C. The MCO shall designate a specific employee as its MCO expedited member appeal manager with the authority to:

(1) administer the policies and procedures for resolution of a MCO expedited member appeal;

(2) review patterns and trends in member expedited appeals and initiate corrective action; and

(3) ensure there is no punitive or retaliatory action taken against any member, his or her authorized representative or authorized provider that files an expedited MCO member appeal, or a provider that supports the member's appeal.

D. The MCO shall provide reasonable assistance to the member or his or her authorized representative or the authorized provider requesting a MCO expedited member appeal in completing forms and completing procedural steps, including but not limited to:

(1) providing interpreter services;

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

(3) assisting the member, his or her authorized representative or the authorized provider in understanding the MCO rationale regarding the disputed benefit which was wholly denied, partially denied or that was limited in order to ensure that the issue under expedited appeal is sufficiently defined throughout the MCO expedited member appeal.

E. The MCO shall provide in writing to the member, his or her authorized representative, and the member's provider (regardless if the provider is not the authorized provider) with the following information once a request is made for a MCO expedited member appeal:

(1) the date the MCO expedited member appeal request was received by the MCO, and the MCO's understanding of what the member or his or her authorized representative or the authorized provider is appealing concerning the member's disputed benefit;

(2) the expected date of the MCO member appeal decision:

(a) that is not to exceed 72 hours from the date of the receipt of the request for a MCO expedited member appeal; and

(b) that alerts the member or his or her authorized representative or the authorized provider of the possibility of an appeal extension of up to an additional 14 calendar days when:

(i) the member or his or her authorized representative or authorized provider requests the extension; or

(ii) the MCO determines it requires additional information and provides a written justification to the member or his or her authorized representative or authorized provider, and also places in the member's MCO expedited member appeal file how the extension is in the best interest of the member.

F. Time frames:

(1) The MCO must act as expeditiously as the member's condition requires, but no later than 72 hours after receipt of a request for a MCO expedited member appeal, and provide the member and his or her authorized representative and the authorized provider its MCO expedited member appeal final decision. The MCO must also make reasonable efforts to provide oral notice of the decision.

(2) If the member or his or her authorized representative or the authorized provider requests an extension of the decision date, the MCO shall extend the 72-hour time period up to 14 calendar days to allow the member or his or her authorized representative or the authorized provider to submit additional documentation to the MCO supporting the need for the MCO expedited member appeal.

(3) The MCO may itself extend the 72-hour time period when it determines there is a need to collect and review additional information prior to rendering its MCO expedited member appeal final decision. The MCO must provide justification in writing to the member or his or her authorized representative or the authorized provider and also place in the member's expedited member appeal file how the extension of time is in the member's best interest.

(4) A member or his or her authorized representative may file a MCO member grievance against the MCO's decision to extend the 72-hour time frame and up to an additional 14 calendar days.

G. MCO-initiated expedited MCO member appeal: When the MCO determines that allowing the time for a standard MCO member appeal process could seriously jeopardize the member's life, health, or his or her ability to attain, maintain, or regain maximum function, the MCO shall:

(1) automatically file a MCO-initiated expedited member appeal on behalf of the member and continue the disputed current benefit without cost to the member if the MCO-initiated expedited member appeal final decision upholds the MCO adverse action;

(2) make reasonable efforts to provide the member, his or her authorized representative and the member's provider (regardless if the provider is not the authorized provider) prompt oral notice of the automatic appeal, following up as expeditious as possible, but within 72 hours of the MCO expedited member appeal final decision; and

(3) use its best effort to involve the member, his or her authorized representative and the member's provider (regardless if the provider is not the authorized provider) in the member's MCO-initiated expedited member appeal. The member's MCO expedited appeal record will contain the dates, times, and methods the MCO utilized to contact the member, his or her authorized representative or the authorized provider, or another provider of the member. If the MCO-initiated member appeal final decision upholds the MCO's adverse action, the MCO member appeal process is exhausted and the member or his or her authorized representative may request a HSD expedited or standard administrative hearing.

[8.308.15.13 NMAC - Rp, 8.308.15.13 NMAC, 5/1/2018]

8.308.15.14 MCO STANDARD MEMBER APPEAL PROCESS:

A. A member or his or her authorized representative or the authorized provider in accordance with the member's MCO procedures has the right to request within 60 calendar days after the mailing of the MCO's notice of action a MCO standard member appeal orally and in writing. When the mailing date of the notice of action is disputed or there is a discrepancy between the mailing date and the postmarked date, the postmarked date will prevail. If orally requested, the request must be followed up in writing within 13 calendar days of the oral request.

(1) If a member or his or her authorized representative or authorized provider elects to request a continuation of the member's disputed current benefit, the member or his or her authorized representative or the authorized provider must request a MCO standard member appeal and request a continuation of the member's disputed current benefit within 10 calendar days of the mailing of the MCO's notice of action. When the mailing date of the notice of action is disputed or there is a discrepancy between the mailing date and the postmarked date, the postmarked date will prevail. See 8.308.15.15 NMAC for a detailed description of the continuation of the disputed current benefit process.

(2) If the member or his or her authorized representative or the authorized provider requests a MCO standard member appeal, the following apply.

(a) If the member or his or her authorized representative designate in writing the member's provider to act as the member's authorized provider, the authorized provider may request a MCO standard member appeal when the authorized provider believes that the MCO has made an incorrect decision concerning the member's disputed benefit.

(b) If the MCO upholds its adverse action, regardless of who requested the MCO standard member appeal process, the MCO standard member appeal process is considered exhausted and the member or his or her authorized representative may request a HSD expedited or standard administrative hearing concerning the member's disputed benefit.

(c) If a member or his or her authorized representative elects not to request a HSD expedited or standard administrative hearing, and if the date of the MCO standard member appeal final decision letter is prior to the notice of action's adverse action effective date, the MCO must continue the disputed current benefit up to the notice of action's adverse action effective date.

(d) Once the member or his or her authorized representative requests a HSD expedited or standard administrative hearing, he or she is referred to as the claimant.

(3) The member or his or her authorized representative or the authorized provider may have legal counsel or a spokesperson assist him or her during the MCO standard member appeal process.

(4) The member or his or her authorized representative or the authorized provider does not have the right to request a MCO expedited or standard member appeal or a HSD expedited or standard administrative hearing related to a value-added service offered by the MCO.

(5) The authorized provider is not eligible to request a HSD expedited or standard administrative hearing on the disputed benefit, unless the provider has been designated as the member's authorized representative. See 8.352.2 NMAC for a detailed description of the HSD expedited or standard administrative hearing processes.

B. The MCO shall designate a specific employee as its MCO standard member appeal manager with the authority to:

(1) administer the policies and procedures for resolution of a MCO standard member appeal;

(2) review patterns and trends in standard member appeals and initiate corrective action; and

(3) ensure there is no punitive or retaliatory action taken against any member or his or her authorized representative or authorized provider that files a MCO standard member appeal, or a provider that supports the member's appeal.

C. The MCO shall provide reasonable assistance to the member or his or her authorized representative or the authorized provider requesting a MCO standard member appeal in completing forms and completing procedural steps, including but not limited to:

(1) providing interpreter services;

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

(3) assisting the member or his or her authorized representative or the authorized provider in understanding the MCO rationale regarding the disputed benefit which was wholly denied, partially denied or that was limited in order that the issue under appeal is sufficiently defined throughout the MCO standard member appeal.

D. The MCO shall provide the member or his or her authorized representative, and the member's provider (regardless if the provider is not the authorized provider) with the following information once a request is made for a MCO standard member appeal.

(1) The date the MCO standard member appeal request was received by the MCO, and the MCO's understanding of what the member or his or her authorized representative or the authorized provider is appealing concerning the member's disputed benefit;

(2) The expected date of the MCO standard member appeal decision:

(a) that is not to exceed 30 calendar days from the date of the receipt of the request for a MCO standard member appeal; and

(b) that alerts the member or his or her authorized representative or the authorized provider of the possibility of an appeal extension of up to an additional 14 calendar days when:

(i) the member or his or her authorized representative or authorized provider requests the extension; or

(ii) the MCO determines it requires additional information and provides to the member or his or her authorized representative or authorized provider, and also places in the member's MCO standard member appeal file how the extension is in the best interest of the member.

E. Time frames:

(1) The MCO must act as expeditiously as the member's condition requires, but no later than 30 calendar days after receipt of a request for a MCO standard member appeal, and provide the member or his or her authorized representative or the authorized provider its MCO standard member appeal final decision.

(2) If the member or his or her authorized representative or the authorized provider requests an extension of the decision date, the MCO shall extend the 30 calendar day time period up to an additional 14 calendar days to allow the member or his or her authorized representative or the authorized provider to submit additional documentation to the MCO supporting the medical necessity for the disputed benefit.

(3) The MCO may itself extend the final decision up to the additional 14 calendar day time period when it determines there is a need to collect and review additional information prior to rendering its MCO standard member appeal final decision. The MCO must provide justification in writing to the member or his or her authorized representative or the authorized provider and also place in the member's clinical file how the extension of time is in the member's best interest.

(4) A member or his or her authorized representative may file a MCO member appeal or grievance against the MCO's decision to extend the 30 calendar day time frame up to an additional 14 calendar days.

[8.308.15.14 NMAC - Rp, 8.308.15.14 NMAC, 5/1/2018]

8.308.15.15 CONTINUATION OF A DISPUTED CURRENT BENEFIT DURING THE MCO EXPEDITED AND STANDARD MEMBER APPEAL PROCESSES: A member or his or her authorized representative or authorized provider requesting a MCO expedited or standard member appeal of an adverse action may request that the disputed current benefit continue during the MCO expedited or standard member appeal process. However, if the date of the MCO expedited or standard member appeal final decision letter is prior to the effective date of the notice of action's adverse action effective date, the MCO must continue the disputed current benefit up to the notice of action's adverse action effective date.

A. A request for a continuation of the disputed current benefit shall be accorded to any member who or through the member's authorized representative or authorized provider requests the continuation of the disputed current benefit who also requests a MCO expedited or standard member appeal within 10 calendar days of the mailing of the notice of action or prior to the date the notice of action states the benefit will be terminated. When

the mailing date of the notice of action is disputed or there is a discrepancy between the mailing date and the postmarked date, the postmarked date will prevail.

B. The continuation of a disputed current benefit is only available to a member who is currently receiving the disputed benefit at the time of the MCO's notice of action.

(1) The continuation of the disputed current benefit is the same as the member's current benefit, which includes the member's current allocation, budget or LOC.

(2) The MCO must provide written information in its notice of action of the member's or his or her authorized representative's or authorized provider's rights and responsibilities to continue the disputed current benefit during the MCO expedited or standard member appeal process and of the possible responsibility of the member to repay the MCO for the disputed current benefit if the MCO expedited or standard member appeal final decision upholds the MCO's adverse action. If it was a MCO-initiated expedited member appeal, the MCO cannot recover the cost of the disputed current benefit if the MCO's adverse action is upheld.

C. A member or his or her authorized representative or authorized provider has the right to not request a continuation of the disputed current benefit during the MCO expedited or standard member appeal process. [8.308.15.15 NMAC - Rp, 8.308.15.15 NMAC, 5/1/2018]

8.308.15.16 MCO EXPEDITED MEMBER APPEAL AND MCO STANDARD MEMBER APPEAL FINAL DECISION AND IMPLEMENTATION:

A. The MCO shall provide the member or his or her authorized representative and the provider (regardless if the provider was not the one requesting the MCO member appeal) with its MCO expedited or standard member appeal final decision within the required time frames and provide supporting documentation substantiating the MCO's decision.

B. When the MCO expedited or standard member appeal final decision reverses the MCO's adverse action in total and the disputed benefit was not furnished during the member's expedited or standard member appeal process, the MCO shall authorize or provide the disputed benefit promptly and as expeditiously as the member's health condition requires.

C. When the MCO expedited or standard member appeal final decision reverses the MCO's adverse action in total and the member, his or her authorized representative or authorized provider had requested and the member had received a continuation of the disputed current benefit during the MCO expedited or standard member appeal process, the MCO may not recover from the member the cost of the continued disputed current benefit furnished during the MCO expedited or standard member appeal process.

D. When the MCO expedited or standard member appeal final decision upholds the MCO's adverse action and the member or his or her authorized representative or authorized provider had requested and the member had received a continuation of the disputed current benefit, the MCO may recover from the member the cost of the disputed current benefit furnished during the MCO expedited or standard member appeal process if:

(1) the member, his or her authorized representative or authorized provider was informed in writing by the MCO that the member could be responsible for the cost of the disputed current benefit if the MCO expedited or standard member appeal final decision upholds the MCO adverse action; and

(2) the member or his or her authorized representative elects not to request a HSD expedited or standard administrative hearing of the disputed current benefit.

(3) A MCO cannot recover the cost of the continued disputed benefit regardless if the final decision is upheld or reverses the MCO adverse action when the MCO initiated the MCO expedited member appeal process. See Subsection E of 8.308.15.13 NMAC for detailed description of a MCO-initiated expedited member appeal process.

E. A member or his or her authorized representative may request a HSD expedited or standard administrative hearing if the MCO expedited or standard member appeal decision does not reverse in total the MCO's adverse action as the member or his or her authorized representative has now exhausted the MCO expedited or standard member appeal process. The authorized provider cannot request a HSD expedited or standard administrative hearing on his or her own; this right is accorded only to the member or his or her authorized representative, unless the provider has been designated as the member's authorized representative.

F. A member or his or her authorized representative must request a HSD expedited administrative hearing within 30 calendar days of the date of the MCO member appeal final decision letter or request a HSD standard administrative hearing within 90 days of the date of the MCO member appeal final decision.

(1) A member or his or her authorized representative or authorized provider may request and the member receive a continuation of the disputed current benefit at any time prior to the MCO notice of action's intended date the disputed benefit will be terminated. The request may be made even after the MCO expedited or

standard member appeal final decision letter is issued if issued before the date the disputed benefit will be terminated.

(2) If the member received a continuation of his or her disputed current benefit during the MCO member appeal process, the member or his or her authorized representative does not need to request another continuation of the disputed current benefit when requesting a HSD expedited or standard administrative hearing. It is automatically continued by the member's MCO.

(3) If the member or his or her authorized representative chooses to discontinue the disputed current benefit that is being provided during the MCO expedited or standard member appeal process or during the HSD expedited or standard administrative hearing process, the member or his or her authorized representative must notify the member's MCO in writing stating the date the disputed current benefit will end.

G. When the MCO expedited or standard member appeal final decision upholds the MCO's adverse action in total or in part and the member or his or her authorized representative or authorized provider had requested and the member had received the disputed current benefit during the MCO member appeal, and the member or his or her authorized representative elects to continue the member's disputed current benefit during the member's HSD expedited or standard administrative hearing process, the MCO must in writing inform the member or his or her authorized representative that if the HSD expedited or standard administrative hearing final decision upholds the MCO's adverse action, the member could be responsible for the cost of the disputed current benefit during MCO expedited or standard member appeal process and the HSD expedited or standard administrative hearing process.

H. If the member or his or her authorized representative requests a HSD expedited or standard administrative hearing and the member or his or her authorized representative or authorized provider requested and the member received the disputed current benefit during the MCO member appeal process, the MCO will not take action to recover the costs of the continued disputed current benefit until there is a HSD expedited or standard administrative hearing final decision upholding the MCO adverse action.

I. If the member's MCO had automatically filed a MCO-initiated expedited member appeal on behalf of the member to continue the disputed current benefit during the MCO expedited member appeal process, the MCO cannot take action to recover the costs of the continued disputed current benefit if the MCO expedited member appeal final decision upholds the MCO's adverse action. However, if the member or his or her authorized representative wants to continue the disputed current benefit during the HSD expedited or standard administrative hearing, the member could be responsible for the cost of the continued disputed current benefit starting on the first calendar day the member or the authorized representative requested a HSD expedited or standard administrative hearing and requested the continuation of the disputed current benefit.

J. See 8.352.2 NMAC for a detailed description of the HSD expedited and standard administrative hearing processes and for a detailed description of the MCO recovery process.

[8.308.15.16 NMAC Rp, 8.308.15.16 NMAC, 5/1/2018]

HISTORY OF 8.308.15 NMAC:

History of Repealed Material:

8.308.15 NMAC, Grievances and Appeals - Repealed 6/15/2014.

8.308.15 NMAC - Managed Care Program, Grievances and Appeals, filed 5/27/2014 Repealed effective 5/1/2018.