

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 – Rp, 8.308.15.1, ~~xx-xx-17~~]

8.308.15.2 SCOPE: This rule applies to the general public.
[8.308.15.2 NMAC - Rp, 8.308.15.2 NMAC, ~~xx-xx-17~~]

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 ~~Section 27-1-12 et seq NMSA 1978.~~ See NMSA 1978, Sections 27-2-12 et seq.
[8.308.15.3 NMAC - Rp, 8.308.15.3 NMAC, ~~xx-xx-17~~]

8.308.15.4 DURATION: Permanent.
[8.308.15.4 NMAC - Rp, 8.308.15.4 NMAC, ~~xx-xx-17~~]

8.308.15.5 EFFECTIVE DATE: [~~June 1, 2014,~~ XX, XX, 2017 unless a later date is cited at the end of a section.
[8.308.15.5 NMAC - Rp, 8.308.15.5 NMAC, ~~xx-xx-17~~]

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, ~~xx-xx-17~~]

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. [~~“Appeal” means:~~
~~(1) the process open to a managed care organization’s member when his or her managed care organization (MCO) has taken, or intends to take, an adverse action related to the member’s benefits or services; or~~
~~(2) a provider requested review by the MCO of his or her payment.]~~ “Adverse action against a member” is when a HSD managed care organization (MCO) intends or has taken action against a member of a 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) 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.

(3) 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 member appeal on behalf of the member. An authorized provider does not have the full range of authority as the authorized representative to make medical decisions on behalf of the member.

[C. "Authorized representative" means the individual designated to represent and act on the claimant's behalf during the appeal process. The claimant or authorized representative must provide formal 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 claimant.]

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, or 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 provider is allowed to file a MCO expedited or standard member appeal. The member's medical record must demonstrate that the member was incapacitated or the member's medical condition required immediate action prior to the authorized representative being located.

[D. "Grievance" means an expression of dissatisfaction by a member or contracted provider about any matter or aspect of the MCO or its operation with the exception of the MCO's notice of action and the member's appeal of an intended or taken adverse action.]

[E.] F. "HSD standard administrative hearing" or "fair hearing" [means a HSD administrative hearing which is an informal evidentiary hearing conducted by the HSD fair hearings bureau (FHB) so that evidence may be presented as it relates to an adverse action taken, or intended to be taken, by the MCO. A member may request a HSD administrative hearing only after exhausting his or her MCO appeal process.] means an 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 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.

G. "HSD expedited administrative hearing" means an expedited informal evidentiary hearing conducted by the 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. See 8.352.2 NMAC for a detailed description of the HSD expedited administrative hearing process.

H. “HSD PASRR administrative hearing” means a HSD administrative hearing process which is an informal evidentiary hearing conducted by the 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.

~~[F.]~~ I. “MAD” means the medical assistance division, which administers medicaid and other medical assistance programs under HSD.

~~[G.]~~ J. “MAP” means the medical assistance programs administered under MAD.

~~[H.]~~ 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 the authorized provider when the member’s MCO has taken or intends to take an adverse action against the member’s benefit.

(1) 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 full or in part or after the MCO has reconsidered any additional documentation or information from the authorized provider during the approval process.

~~[I.]~~ M. [“MCO appeal decision” means the MCO’s final decision regarding a member’s appealed adverse action it intends to take or has taken against its member.] “MCO member appeal” means:

(1) the process open to a member or his or her authorized representative, or the authorized provider 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 full or in part or after the MCO has reconsidered any additional documentation or information from the authorized provider during the approval process.

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 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.

~~[J.]~~ R. [“Member” means a MAP eligible recipient enrolled in a HSD contracted MCO; a member becomes a claimant after exhausting MCO’s appeal process and, being dissatisfied with the MCO’s appeal final decision, requests a HSD administrative hearing.] “Member” means an eligible recipient enrolled in a MCO.

[K.] S. “Notice of action” [means the notice of an adverse action as outlined in Section A of 8.308.15.14 NMAC. If the adverse action is in the form of a termination, suspension, change or reduction of an existing service including level of care (LOC), 10 calendar days prior to the intended adverse action, the MCO must send the member or the member’s authorized representative its 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 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, xx-xx-17]

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. **RESERVED**
[8.308.15.8 NMAC - Rp, 8.308.15.8 NMAC, xx-xx-17]

8.308.15.9 ~~GENERAL REQUIREMENTS:~~ The HSD MCO shall have a grievance system in place for its members and its MCO 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 Section 438 Subpart F to dispute adverse actions taken or intended to be taken by the MCO against its members.]

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 procedure. 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 its authorized 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, xx-xx-17]

8.308.15.10 ~~GENERAL INFORMATION ON A CONTRACTED MCO PROVIDER GRIEVANCE:~~

A. Upon a provider's contracting with the MCO, the MCO shall provide, at no cost, a written description of its grievance 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 and the resolution process;
- (2) time frames for each step of the grievance process through its final resolution; and
- (3) a description of how the MCO provider's grievance is resolved.

B. A contracted MCO 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's operation. The provider may file the grievance either orally or in writing in accordance with his or her MCO's procedures and processes.]

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 to the provider. The MCO will update in writing each of its providers with any changes to these policies and procedures.

- (1) The description shall include:
 - (a) information on how the provider can file a MCO provider appeal and the resolution process;
 - (b) timeframes 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 actions is not taken against any provider that files an 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 its authorized 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, xx-xx-17]

[8.308.15.11 GENERAL INFORMATION ON MEMBER GRIEVANCES:

A. Upon a member's enrollment, the MCO shall provide, at no cost, a written description of its grievance 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 and the resolution process;

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

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

B. Member rights:

(1) A member 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; the member may file the grievance either orally or in writing in accordance with his or her MCO's procedures and processes. The member must file the grievance within 30 calendar days of the occurrence of the event for which the member wishes to register his or her dissatisfaction.

(2) The member's MCO will provide him or her with its resolution to the member's grievance.

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

(1) the member's authorized representative; or

(2) the member or the member's authorized representative may also choose a relative, friend or other spokesperson to represent or assist him or her through the MCO grievance process with or without designating that spokesperson with the right to make decisions on his or her behalf. A member or member's authorized representative will provide the MCO a signed release of information in order for a designated spokesperson to assist or represent the member or the member's authorized representative during the MCO's grievance process.

D. A member or the member's representative may have legal counsel assist him or her during the MCO grievance process.]

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, his or her authorized representative and all MCO providers at no cost a written description of its member grievance and member 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 and all MCO providers any changes to these procedures and processes. The description shall include:

(a) information on how the member, his or her authorized representative, or the authorized provider can file a MCO member grievance and request a MCO expedited or standard member appeal, 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 initiate a HSD 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, 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 a requesting provider for more information or justification regarding a request if lack of information or justification is likely leading 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 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, 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.

(4) **MCO expedited or standard appeal:** A member, his or her authorized representative or the authorized provider has the right to request a MCO standard member appeal either orally and in writing in accordance with his or her MCO procedures within 60 calendar days of the date of the notice of action of an intended or taken adverse action. 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 his or her MCO procedures within 13 calendar days of the date of the notice of action of an intended or taken adverse action.

(a) The member, 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 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, his or her authorized representative or authorized provider elects to request a continuation of the disputed current benefit or other action, 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 or other action within 10 calendar days of the mailing of the MCO's notice of action. The member, 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, authorized representative or authorized provider chooses to have his or her 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, xx-xx-17]

[8.308.15.12 — MCO MEMBER GRIEVANCE PROCESS:

A. — The MCO shall provide reasonable member 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 as its member 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 related to grievances are not involved in any previous level of review or decision-making as to the matter that is grieved.

D. — The MCO shall provide the member 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 any member that files a grievance, or a provider that supports the member's grievance.]

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; 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, xx-xx-17]

~~**[8.308.15.13 — GENERAL INFORMATION ON A CONTRACTED MCO PROVIDER APPEALS:**~~

~~A. Upon contracting with the MCO, the MCO shall provide, at no cost, a written description of its 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 appeal and the resolution process;~~
- ~~(2) timeframes for each step of the appeal process through its final resolution; and~~
- ~~(3) a description of how the MCO provider's appeal is resolved.~~

~~B. Provider rights and limitations:~~

~~(1) A provider may file an appeal either orally or in writing in accordance with the 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.~~

~~(3) A provider may act as a spokesperson for a member during the member's MCO appeal process; however, the provider who is also the spokesperson may not file an appeal on his or her own concerning an adverse action intended or taken against a member; this remains the sole responsibility of the member or the member's authorized representative.~~

~~(4) The MCO shall ensure that punitive or retaliatory action is not taken against any provider that files an appeal.~~

~~(5) A MCO provider does not have the right to request a HSD administrative hearing following the MCO appeal decision.]~~

~~**[8.308.15.14 — GENERAL INFORMATION ON A MEMBER APPEAL:**~~

~~A. Any of the following actions by an MCO constitute an adverse action for which a member may request a MCO appeal:~~

~~(1) the denial or reduction by the MCO of an authorized service or item, including level of care (with the exception of a MCO value-added service);~~

~~(2) the denial in whole or in part of a member's provider claim by the MCO which results in the member becoming liable for payment of all or part of the claim;~~

~~(3) the failure of the MCO to approve a service or item in a timely manner;~~

~~(4) the failure of the MCO to act on an appeal within the timeframes specified in 42 CFR Section 438.408 (b);~~

~~(5) a determination that a member be transferred or discharged; or~~

~~(6) the belief of a member or his or her authorized representative that the MCO's preadmission or annual resident review (PASRR) requirements determination is erroneous; when a claimant requests a HSD administrative hearing due to an adverse PASRR determination the parties to the hearing will comply with 8.354.2 NMAC in place of this rule.~~

~~B. Upon the member's enrollment, the MCO shall provide, at no cost, a written description of its 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 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 appeal decision;~~

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

~~(4) a description of how the member's appeal is resolved.~~

~~C. Member rights:~~

~~(1) A member shall have the right to file an appeal with the MCO within 90 calendar days of receiving a notice of action of an intended or taken adverse action.~~

~~(2) The member's MCO will provide him or her with its decision of an appealed adverse action.~~

_____ (3) _____ 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 information on the HSD administrative hearing process.

_____ (4) _____ A member requesting a HSD administrative hearing must do so within 30 calendar days of the date of the letter that contains the MCO's appeal final decision.

_____ D. _____ A member or the member's authorized representative may have legal counsel assist him or her during the MCO appeal process.]

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, 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, his or her authorized representative or authorized provider requests a MCO expedited member appeal and the member, his or her authorized representative or authorized provider requests a continuation of the member's disputed current benefit or other action, the MCO will grant a continuation of the disputed current benefit or other action until the MCO expedited member appeal final decision is rendered by the MCO. 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, his or her authorized representative or authorized provider in accordance with his or her MCO procedures has the right to request within 60 calendar days after the MCO's notice of action a MCO expedited member appeal orally or in writing.

(1) If a member, his or her authorized representative or authorized provider elects to request a continuation of the disputed current benefit or other action, the member, 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 or other action within 10 calendar days of the mailing of the MCO's notice of action. See 8.308.15.15 NMAC for a detailed description of the continuation of the disputed benefit or other action process.

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

(a) The authorized provider may request a MCO expedited member appeal when the provider believes that the MCO has made an incorrect decision concerning the member's disputed benefit if the member or his or her authorized representative agrees in writing to allow the provider to be an authorized provider.

(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 his or her 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, 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, 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 provided) 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 process.

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, 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 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, 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, his or her authorized representative or the authorized provider of the possibility of a hearing extension of up to an additional 14 calendar days when:
 - (i) the member, 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, 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, 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, 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, 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, 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.

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 or other action 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 provided) 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 provided) 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, the authorized provider, or another provider of the member.

[8.308.15.13 NMAC - Rp, 8.308.15.13 NMAC, xx-xx-17]

[8.308.15.15 — MCO MEMBER APPEAL PROCESS:

A. The MCO shall provide reasonable member 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 an appeal are not involved in any previous level of review or decision-making.

D. The MCO shall provide the member with written notices:

- (1) when an appeal request has been received;
- (2) of the expected date of resolution; and
- (3) of the MCO appeal decision.

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

- (1) previously authorized in accordance with 42 CFR Sections 431.213 and 431.214;
- (2) newly requested services and the type of service or LOC; and
- (3) denials of claims that may result in the member becoming financially liable.

F. A member may request from the MCO a continuation of his or her benefit during the member's MCO appeal. The MCO and member must follow the provisions of 42 CFR Section 438.420 regarding the continuation of the benefit that is the subject of the appeal during his or her MCO appeal and HSD administrative hearing processes.

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

(2) If the MCO appeal decision upholds the MCO's action, the MCO may recover from the member the cost of the continued benefit furnished during the MCO appeal process, providing the member was advised that he or she could be responsible for cost of the benefit as part of the information provided to the member; see 8.352.2 NMAC outlining the MCO recovery process. If the member requests a HSD administrative hearing, the MCO will not take action to recover the costs of the continued benefit until there is an HSD administrative hearing final decision.

(3) If the member is a party to an HSD administrative hearing and the HSD administrative hearing final decision reverses the MCO's appeal decision and the member received the disputed benefit during the MCO appeal and the HSD administrative hearing processes, the MCO may not recover any of the cost of a continued benefit.

(4) If the member is a party to a HSD administrative hearing and the HSD administrative hearing final decision upholds the MCO's appeal decision, the MCO may recover from the member the cost of the benefit furnished during the MCO appeal process and the HSD administrative hearing process, providing the member was advised that he or she could be responsible for cost of the benefit as part of the information provided to the member; see 8.352.2 NMAC outlining 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.]

8.308.15.14 MCO STANDARD MEMBER APPEAL PROCESS:

A. A member, his or her authorized representative or the authorized provider in accordance with his or her MCO procedures has the right to request within 60 calendar days after the MCO's notice of action a MCO standard member appeal orally and in writing, or initially in writing.

(1) If a member, his or her authorized representative or authorized provider elects to request a continuation of the disputed current benefit or other action, the member, 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 or other action within 10 calendar days of the mailing of the MCO's notice of action. See 8.308.15.15 NMAC for a detailed description of the continuation of the disputed current benefit or other action process.

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

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

(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 his or her disputed benefit.

(c) 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, 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, 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 both types of member standard 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 a MCO standard member appeal, or a provider that supports the member's appeal.

C. The MCO shall provide reasonable assistance to the member, 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, his or her authorized representative, or the authorized provider in understanding the MCO rationale regarding the disputed benefit which was 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, his or her authorized representative and the member's provider (regardless if the provider is not the authorized provided) 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, 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, his or her authorized representative or the authorized provider of the possibility of a hearing extension of up to an additional 14 calendar days when:

_____ (i) _____ the member, 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, 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 14 calendar after receipt of a request for a MCO standard member appeal, and provide the member, his or her authorized representative and the authorized provider its MCO standard member appeal final decision. The MCO must also make reasonable efforts to provide oral notice.

_____ (2) _____ If the member, 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 14 calendar days to allow the member, 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 30 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, 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.

[8.308.15.14 NMAC - Rp, 8.308.15.14 NMAC, xx-xx-17]

8.308.15.15 CONTINUATION OF A DISPUTED CURRENT BENEFIT OR OTHER ACTION

DURING THE MCO EXPEDITED AND STANDARD MEMBER APPEAL PROCESS: A member, 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 or other action continue during the MCO expedited or standard member appeal process.

A. _____ A request for a continuation of the disputed current benefit or other action 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 or other action who also requests a MCO expedited or standard member appeal within 10 calendar days of the mailing of the notice of action.

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

_____ (1) _____ The continuation of the disputed current benefit or other action is the same as the member's current benefit or other action, 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, his or her authorized representative's or authorized provider's rights and responsibilities to continue the disputed current benefit or other action 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 or other action 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 or other action if the MCO's adverse action is upheld.

C. _____ A member, his or her authorized representative or authorized provider has the right to not request a continuation of the disputed current benefit or other action during the MCO expedited or standard member appeal process.

[8.308.15.15 NMAC - Rp, 8.308.15.15 NMAC, xx-xx-17]

[8.308.15.16 EXPEDITED MEMBER APPEAL PROCESS: 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. A member or the MCO may request an expedited MCO appeal process in cases involving a member's health, safety, or service availability issues. The request must be made in writing to the member's MCO; the reasons why an expedited MCO appeal process is necessary must be stated in detail in the request.

A. _____ 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, the MCO shall automatically file an appeal on behalf of the member, continue the benefit, make reasonable efforts to give the

member prompt oral notice of the automatic appeal, following up within two calendar days with a written notice. The MCO will use its best effort to involve the member in the expedited appeal process. There is a continuation of benefits until an expedited appeal decision is rendered by the MCO. An expedited appeal is not subject to MCO recoupment for the continuation of benefits if the MCO expedited appeal decision is against the member or if the HSD expedited administrative hearing decision is against the member.

B. If the MCO denies the member's request for an expedited MCO appeal process, the member may then request a HSD expedited administrative hearing regarding the issue of an expedited appeal process. The granting of an expedited HSD administrative hearing is at the discretion of the HSD FHB ALJ.

C. If the ALJ grants the member the right to a MCO expedited appeal process, the MCO will follow its procedures and processes to comply with the ALJ decision.

D. If the ALJ upholds the MCO's denial of an expedited MCO appeal process, the member must exhaust his or her MCO's appeal process before requesting an HSD administrative hearing.

E. The MCO shall ensure that punitive or retaliatory action is not taken against a member that files an appeal or a provider that supports a member's appeal.]

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

A. The MCO shall provide the member, 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 its 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 or other action 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 or other action 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, his or her authorized representative or authorized provider had requested and the member had received a continuation of the disputed current benefit or other action, the MCO may recover from the member the cost of the disputed current benefit or other action 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 or other action 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 or other action.

(3) A MCO cannot recover the cost of the continued disputed benefit or other action regardless if the final decision is upheld or reverses the MCO adverse action when the MCO initiated the MCO expedited member appeal process. See Section 13 Subsection E of this rule 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.

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) If the member or his or her authorized representative elects to request a continuation of the disputed current benefit or other action during the HSD administrative hearing process, he or she must request a HSD expedited or standard administrative hearing within 10 calendar days of the date of the MCO member appeal final decision letter.

(2) If the member received a continuation of his or her disputed current benefit or other action 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 or other action 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 or other action that was continued throughout the MCO expedited or standard member appeal process, the member or his or her authorized representative must notify the member's MCO in writing stating the date the disputed current benefit or other action will end.

G. When the MCO expedited or standard member appeal final decision upholds the MCO's adverse action in total or part and the member, his or her authorized representative or authorized provider had requested and the member had received the disputed current benefit or other action during the MCO member appeal, and the member or his or her authorized representative elects to continue the member's disputed current benefit or other action during his or her HSD expedited or standard administrative hearing process, the MCO must 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 or other action during MCO member appeal process and the HSD 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 requested and the member received the disputed current benefit or other action during the MCO member appeal, the MCO will not take action to recover the costs of the continued disputed current benefit or other action 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 or other action during the MCO expedited member appeal process, the MCO cannot take action to recover the costs of the continued disputed current benefit or other action if the MCO expedited member appeal final decision upholds the MCO's adverse action. However, if the member or his or her authorized representative elects to continue the member's disputed current benefit or other action during the HSD expedited or standard administrative hearing, the member could be responsible for the cost of the continued disputed current benefit or other action 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 or other action.

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, xx-xx-17]

HISTORY OF 8.308.15 NMAC:

History of Repealed Material:

8.308.15 NMAC, Grievances and Appeals - Repealed 6-15-14.

8.308.15 NMAC, Grievances and Appeals – Repealed xx-xx-17.