STATE COVERAGE INSURANCE (SCI)
MEMBER GRIEVANCE RESOLUTION
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TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 12 MEMBER GRIEVANCE RESOLUTION

8.306.12.1 ISSUING AGENCY: Human Services Department
[8.306.12.1 NMAC - N, 7-1-05]

8.306.12.2 SCOPE: This rule applies to the general public.
[8.306.12.2 NMAC - N, 7-1-05]

8.306.12.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the medicaid program. The State Coverage Insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 of the Social Security Act for the parent population and a medicaid demonstration waiver under section 1115 for the childless adult population, both subject to special terms and conditions.
[8.306.12.3 NMAC - N, 7-1-05; A, 6-1-10]

8.306.12.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver and the medicaid demonstration waiver, and subject to availability of funds.
[8.306.12.4 NMAC - N, 7-1-05; A, 6-1-10]

8.306.12.5 EFFECTIVE DATE: July 1, 2005, unless a later date is cited at the end of a section.
[8.306.12.5 NMAC - N, 7-1-05]

8.306.12.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico SCI program.
[8.306.12.6 NMAC - N, 7-1-05]

8.306.12.7 DEFINITIONS: See 8.306.1.7 NMAC.
[8.306.12.7 NMAC - N, 7-1-05]

8.306.12.8 MISSION STATEMENT: The mission of the medical assistance division is to reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.
[8.306.12.8 NMAC - N, 7-1-05; A, 7-1-09]

8.306.12.9 [RESERVED]
[8.306.12.9 NMAC - N, 7-1-05; Repealed, 6-1-08]

8.306.12.10 GENERAL REQUIREMENTS FOR GRIEVANCE AND APPEALS:

A. The MCO shall have a grievance system in place for members that includes a grievance process related to dissatisfaction, and an appeals process related to an MCO action, including the opportunity to request an HSD fair hearing.

B. A fair hearing may be requested only after the MCO grievance/appeal process has been exhausted. Issues of late premium payment or failure to pay the premium addressed through the MCO grievance and appeal process and not resolved at that level must next be taken to judicial appeal in the state district court at the appellant's expense.

C. The MCO shall implement written policies and procedures describing how the member may register a grievance or an appeal with the MCO or register a request for a fair hearing with HSD. The policy should include a description of how the MCO resolves the grievance or appeal.

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

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

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

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

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

H. Upon enrollment, the MCO shall provide members, at no cost, with a member information sheet or handbook that provides information on how they or their representative(s) can file a grievance or an appeal, and the resolution process. The member information shall also advise members of their right to file a request for an administrative hearing with the HSD hearings bureau following an appeal of the MCO action. The information shall meet the standards for communication specified in 8.305.8.15 NMAC.

I. The MCO must ensure that punitive or retaliatory action is not taken against a member or a provider that files a grievance or an appeal, or a provider that supports a member's grievance or appeal.

[8.306.12.10 NMAC - N, 7-1-05; A, 6-1-08]

8.306.12.11 GRIEVANCE: A grievance is an expression of dissatisfaction about any matter or aspect of the MCO or its operation other than an MCO action.

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

B. Within five (5) working days of receipt of the grievance, the MCO shall provide the grievant with written notice that the grievance has been received and the expected date of its resolution.

C. The investigation and final MCO resolution process for grievances shall be completed within thirty (30) calendar days of the date the grievance is received by the MCO and shall include a resolution letter to the grievant.

D. The MCO may request an extension from HSD of up to fourteen (14) calendar days if the member requests the extension, or the MCO demonstrates to HSD that there is need for additional information, and the extension is in the member's interest. For any extension not requested by the member, the MCO shall give the member written notice of the reason for the extension within two (2) working days of the decision to extend the timeframe.

E. Upon resolution of the grievance, the MCO shall mail a resolution letter to the member. The resolution letter must include, but not be limited to, the following:

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

[8.306.12.11 NMAC - N, 7-1-05; A, 6-1-08]

8.306.12.12 APPEALS: An appeal is a request for review by the MCO of an MCO action.

A. Action is defined as:

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

B. **Notice of MCO action:** The MCO shall mail a notice of action to the member or provider within 10 days of the date of an action for previously authorized services as permitted under 42 CFR 431.213 and 431.214 and within 14 days of the action for newly requested services. Denials of claims which may result in member financial liability require immediate notification. The notice must contain but not be limited to the following:

(1) the action the MCO has taken or intends to take;

(2) the reasons for the action;

(3) the member's or the provider's right, as applicable, to file an appeal of the MCO action through the MCO;

(4) the member's right to request an HSD fair hearing and what the process would be;

(5) the procedures for exercising the rights specified;

(6) the circumstances under which expedited resolution of an appeal is available and how to request it; and

(7) the member's right to have benefits continue pending resolution of an appeal or fair hearing, how to request the continuation of benefits, and the circumstances under which the member may be required to pay the costs of continuing these benefits.

C. Since value added services are not medicaid funded services, there is no appeal or fair hearing rights for SCI members regarding these services. A denial of a value added service will not be considered an action. The MCO shall send the member a notification letter if the value added services in not approved.

D. A member may file an appeal of an MCO action within 90 calendar days of receiving the MCO's notice of action. The legal guardian of the member for incapacitated adults, a representative of the member as designated in writing to the MCO, or a provider acting on behalf of the member with the member's written consent, have the right to file an appeal of an action on behalf of the member. The MCO/SE shall consider the member, representative or estate representative of a deceased member as parties to the appeal.

E. The MCO has 30 calendar days from the date the oral or written appeal is received by the MCO to resolve the appeal. The MCO shall appoint at least one person to review the appeal who is qualified to make the decision and was not involved in the initial decision.

F. The MCO shall have a process in place that assures that an oral inquiry from a member seeking to appeal an action is treated as an appeal (to establish the earliest possible filing date for the appeal). An oral appeal must be followed by a written appeal within 10 calendar days that is signed by the member. The MCO will make best efforts to assist members as needed with the written appeal.

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

H. The MCO may extend the 30 day timeframe by 14 calendar days if the member requests the extension, or the MCO demonstrates to HSD that there is need for additional information, and the extension is in the member's interest. For any extension not requested by the member, the MCO must give the member written notice of the extension and the reason for the extension within two working days of the decision to extend the timeframe.

I. The MCO shall provide the member or the member's representative a reasonable opportunity to present evidence, and allegations of the fact or law, in person as well as in writing.

J. The MCO shall provide the member or the representative the opportunity, before and during the appeals process, to examine the member's case file, including medical or clinical records, and any other documents and records considered during the appeals process. The MCO shall include as parties to the appeal the member and his or her representative, or the legal representative of a deceased member's estate.

K. For all appeals, the MCO shall provide written notice within the 30-calendar day timeframe of the appeal resolution to the member or the provider, if the provider filed the appeal.

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

(a) the result(s) of the appeal resolution; and

(b) the date it was completed.

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

(a) the right to request an HSD fair hearing and how to do so;

(b) the right to request receipt of benefits while the hearing is pending, and how to make the request; and

(c) that the member may be held liable for the cost of those benefits if the hearing decision upholds the MCO's action.

L. The MCO may continue benefits while the appeal or the HSD fair hearing process is pending.

(1) The MCO must continue the member's benefits if all of the following are met:

(a) the member or the provider files a timely appeal of the MCO/SE action or asks for a fair hearing within 13 days from the date on the MCO/SE notice of action;

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

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

(d) the time period covered by the original authorization has not expired; and

(e) the member requests extension of the benefits.

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

(a) the member withdraws the appeal;

(b) 13 days have passed since the date of the resolution letter, provided the resolution of the appeal was against the member and the member has taken no further action;

(c) HSD issues a hearing decision adverse to the member; and

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

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

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

(5) If the MCO or HSD reverses a decision to deny, limit or delay services and the member received the disputed services while the appeal was pending, the MCO must pay for these services.

(6) If HSD reverses a decision to deny eligibility, the potential member can enroll with the MCO, but there will be no retroactive enrollment or benefit coverage under such circumstances.

[8.306.12.12 NMAC - N, 7-1-05; A, 4-16-07; A, 6-1-08; A, 7-1-09]

8.306.12.13 EXPEDITED RESOLUTION OF APPEALS: An expedited resolution of an appeal is an expedited review by the MCO of an MCO action.

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

(1) a request from the member;

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

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

(4) the MCO's independent determination.

B. The MCO shall ensure that the expedited review process is convenient and efficient for the member.

C. The MCO shall resolve the appeal within three working days of receipt of the request for an expedited appeal, if the request meets the definition of expedited. In addition to written resolution notice, the MCO/SE shall also make reasonable efforts to provide and document oral notice.

D. The MCO may extend the timeframe by up to 14 calendar days if the member requests the extension, or the MCO demonstrates to HSD that there is need for additional information and the extension is in the member's interest. For any extension not requested by the member, the MCO shall give the member written notice of the reason for the delay.

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

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

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

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

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

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

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

[8.306.12.13 NMAC - N, 7-1-05; A, 4-16-07; A, 6-1-08]

8.306.12.14 SPECIAL RULE FOR CERTAIN EXPEDITED SERVICE AUTHORIZATION DECISIONS: In the case of expedited service authorization decisions that deny or limit services, the MCO shall, within 72 hours of receipt of the request for service, automatically file an appeal on behalf of the member, make a best effort to give the member oral notice of the decision on the automatic appeal, and make a best effort to resolve the appeal.

[8.306.12.14 NMAC - N, 7-1-05]

8.306.12.15 OTHER RELATED MCO PROCESSES:

A. **Information about grievance system to providers and subcontractors:** The MCO must provide information specified in 42 CFR Section, 438.10(g)(1) about the grievance system to all providers and subcontractors at the time they enter into a contract.

B. **Grievance and/or appeal files:**

(1) All grievance and/or appeal files shall be maintained in a secure and designated area and be accessible to HSD, upon request, for review. Grievance and/or appeal files shall be retained for 10 years following the final decision by the MCO, HSD, if applicable, an administrative law judge, judicial appeal, or closure of a file, whichever occurs later.

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

(3) Documentation regarding the grievance shall be made available to the member, if requested.

[8.306.12.15 NMAC - N, 7-1-05; A, 4-16-07]

8.306.12.16 MCO PROVIDER GRIEVANCE AND APPEAL PROCESS: The MCO shall establish and maintain written policies and procedures for the filing of provider grievances and appeals. A provider shall have the right to file a grievance or an appeal with the MCO regarding utilization management decisions and/or provider payment issues. Provider grievances or appeals shall be resolved within 30 calendar days. If the grievance or appeal is not resolved with 30 days, the MCO/SE shall request a 14 day extension from the provider. If the provider requests the extension, the extension shall be approved by the MCO/SE. A provider may not file a grievance or an appeal on behalf of a member without written designation by the member as the member's representative. See 8.306.12.13 NMAC for special rules for certain expedited service authorizations.

[8.306.12.16 NMAC - N, 7-1-05; A, 4-16-07]

HISTORY OF 8.306.12 NMAC: [RESERVED]