

STATE OF NEW MEXICO OFFICE OF SUPERINTENDENT OF INSURANCE



INTERIM SUPERINTENDENT OF INSURANCE
Jennifer A. Catechis

BULLETIN 2023-003

February 3, 2023

**TO: ALL MAJOR MEDICAL HEALTH INSURERS SUBJECT TO THE
JURISDICTION OF THE OFFICE OF SUPERINTENDENT OF INSURANCE**

**RE: REQUIREMENTS FOR MARCH 1st MEMBER GRIEVANCE COMPLIANCE
FILING**

I. FILING REQUIREMENTS

All major medical health insurers subject to the jurisdiction of the Office of Superintendent of Insurance shall file their annual member grievance compliance filing on March 1st of each year. This compliance filing requirement shall apply to all major medical insurers currently offering comprehensive major medical coverage with 250 or more insureds. Null filings are not required. These filings shall be submitted to the Managed Health Care Compliance Bureau via SERFF. The filing shall include a health insurer's:

A. Member grievance plan, including all current internal member grievance policies. If filing a previously reviewed plan, please redline any changes made since prior approval.

B. Redacted letters issued to a member within the past six months for:

1. administrative denials at the initial decision level and first level appeal;
2. adverse denials at the initial decision level and first level appeal;

Redacted information shall only include the member's name and personally identifiable information. Insurers shall not redact the date the benefit was requested or the denial was issued.

C. Template member grievance response letters that reflect the following required changes:

Main Office: 1120 Paseo de Peralta, Room 428, Santa Fe, NM 87501
Satellite Office: 6200 Uptown Blvd NE, Suite 400, Albuquerque, NM 87110
Main Phone: (505) 827-4601 | Satellite Phone: (505) 322-2186 | Toll Free: (855) 4 - ASK - OSI

www.osi.state.nm.us

1. In **BOLD, UPPERCASE FONTS of 12 points or greater.**

a. Deadlines placed on the top half of the first page of any written denial of coverage or review that upholds a denial;

b. A header stating the level of grievance addressed in the letter, i.e. “Initial Denial” or “First Level Appeal Denial.”

2. In the revised template letters, insurers must provide notice to grievants of all the following deadlines.

a. **For Grievances of Administrative Determinations**

- 180 days from the initial denial to request that the insurer review that denial; see 13.10.17.12(B)(4) NMAC.
- 20 days from receipt of the first level review decision to request that the insurer reconsider that decision; see 13.10.17.27 (E)(6) NMAC.
- 20 days from receipt of the reconsideration committee decision to request that the Superintendent review the committee’s decision; see 13.10.17.29(C)(6) NMAC.

b. **For Grievances of Adverse Determinations**

- 180 days from the initial denial to request that the insurer review that denial; see 13.10.17.12(A)(5) NMAC.
- 5 days from the first level review decision to request that the insurer’s panel review that decision (see 13.10.17.15(B)(7)(a) NMAC); OR 4 months from the first level review decision to request that an Independent Review Organization (IRO) or that the Superintendent review that decision (see 13.10.17.15(B)(7)(b) NMAC).
- 4 months from the reviewing panel’s decision to request that an IRO review the panel’s decision (see 13.10.17.17 (B)(8) NMAC); OR 4 months from the reviewing

panel's decision to request that the Superintendent review that decision; (see 13.10.17.24(A)(2) NMAC).

D. The revised template letters shall contain a signature block requiring the name and credentials of any physician making any decision to deny or limit benefits requested by an insured in accordance with the Medical Practice Act, Chapter [61](#), Article [6](#) NMSA 1978.

E. Revised template letters must use the Managed Health Care Bureau (MHCB) current fax number: **505-827-4253**; the fax number listed in 13.10.17 NMAC (the Grievance Procedures Rule) is no longer valid.

F. Revised template letters shall attach the correct forms for requiring the next level of appeal.

1. Because a grievant's first action following an insurer's initial denial of coverage is to request an internal review by the insurer, OSI grievance forms must NOT be attached to the initial written denial. 13.10.17.12(A)(5) and (B)(4) NMAC and 13.10.17.27(A) NMAC. Instead, an insurer must attach the request form for an internal review.

2. When an insurer's internal review upholds a denial, and the Grievance Procedures Rule provides for external review by the Superintendent, insurers shall attach both the correct OSI review form (administrative or adverse) AND both the OSI Complaint form and the link to the OSI Complaint form on the OSI website. 13.10.17.15(C) NMAC, 13.10.17.17(C) NMAC, and 13.10.17.29(C)(8) NMAC.

G. Following an internal review by the insurer, for those grievants whose health benefits plans are provided by an entity that purchases or is authorized to purchase health care benefits pursuant to the **Health Care Purchasing Act** (HCPA), NMSA 1978, Chapter 13, Article 7, the insurer must direct them to the grievants' specific review board prior to the grievants requesting an external or IRO review. 13.10.17.18(C) NMAC.

H. The revised templates required by this Bulletin shall include the following: *“A request for **expedited external review** filed with the OSI must include a statement from the grievant's treating physician. The insurer must respond within 24 hours of the filing of the grievance with OSI.”*

II. REGULATORY SUPPORT

A. This mandate for sufficient notice to grievants is consistent with the requirements of the Insurance Code and the OSI's rules for clear, easy-to-read, conspicuous language in insurance documents. *See* NMSA 1978, Section 59A-19-4 (1984) ("Minimum language simplification standards"); Section 59A-57-4(B)(1) (1998) of the Patient Protection Act; and 13.10.23.8 NMAC ("INFORMATION PROVIDED TO COVERED PERSONS AND READABILITY OF MANAGED HEALTH CARE PLAN CONTRACTS").

B. In adverse grievance determinations, insurers shall ensure that a doctor practicing in the same field as that of the case being reviewed makes the determination.

1. This requirement applies under 13.10.17.14(E) NMAC, the rule that governs first-level reviews based on a utilization review, which is defined at 13.10.17.7(OO) NMAC.

2. This requirement also applies under 13.10.17.16(D)(1)(a) NMAC, the rule that governs second-level reviews of a determination that the requested service is not a medical necessity, is experimental or investigational, or is not considered a covered benefit.

3. The New Mexico Practice of Medicine Act, Section 61-6-6 NMSA 1978, requires New Mexico licensure of any physician rendering medical necessity denials. OSI warns insurers that it will be checking the licensure status of named physicians rendering decisions to limit or deny benefits requested by members.

Failure to comply with this Bulletin may lead to the imposition of fines and penalties pursuant to NMSA 1978, § 59A-1-18. OSI warns that these fines and penalties may include an issuance of a daily fine for any incomplete or late filed response to an MHCB request in relation to a member grievance. However, as always, OSI thanks insurers for their partnership and cooperation.

Any questions can be directed to the Healthcare Policy Manager at paige.duhamel@osi.nm.gov or (505)-660-7108.

ISSUED this 3rd day of February, 2023.



JENNIFER A. CATECHIS
Interim Superintendent of Insurance