



STATE OF NEW MEXICO OFFICE OF SUPERINTENDENT OF INSURANCE (OSI)

Utilization Management Frequently Asked Questions (FAQ)

Key filing information: The 2026 Utilization Management filing is due October 31, 2026. This FAQ explains how OSI will apply the revised guidance and transition accommodations for this filing cycle.

This FAQ responds to carrier feedback on the draft Utilization Management Guidance Chart and supporting workbooks. It explains OSI's interpretation and administration of 13.10.22.9 NMAC and related requirements. It does not amend or replace applicable statutes or rules. If this FAQ conflicts with controlling law, controlling law governs.

Applicability and filing administration

Q1. What is the purpose of the revised UM guidance?

The guidance organizes the filing around 13.10.22.9 NMAC and identifies the documentation OSI will use to evaluate whether a carrier has established and implemented a compliant utilization management program. The guidance does not independently create substantive legal requirements.

Q2. Which plans are subject to the guidance?

The guidance applies to health care insurers and fully insured managed health care plans subject to 13.10.22 NMAC, including applicable individual, small-group, and large-group coverage. A carrier must clearly identify the plans, products, networks, benefit types, and delegated entities included in the filing. Products excluded from the definition of a managed health care plan are not brought within scope solely by this guidance.

Q3. What is the filing deadline?

The 2026 UM filing is due October 31, 2026. Carriers remain responsible for compliance with all currently effective New Mexico statutes and rules during the transition to the revised filing structure.

Q4. How will OSI address new workbooks and evidence formats introduced after carriers began their 2026 reviews?

For the 2026 filing, OSI will distinguish existing substantive legal requirements from newly introduced administrative formats. OSI will accept substantially equivalent evidence when it demonstrates the applicable legal standard. A carrier that cannot fully use a new format should identify the affected item, submit the available equivalent evidence, and briefly explain the difference.

Note: Transition flexibility applies to a new filing format or evidence method. It does not excuse an underlying violation of an existing statute or rule.

Q5. Must carriers add every definition in the guidance to their UM policies?

No. The definitions in 13.10.22.7 NMAC apply by operation of law and are reproduced in the guidance to support consistent interpretation. A carrier is not required to restate every definition in its UM plan or policies, but the terms used in submitted documents must be consistent with applicable New Mexico law.

Evidence and document submission

Q6. Why does OSI require exact document and page citations?

Exact citations allow OSI to locate and evaluate evidence consistently and efficiently. For each applicable requirement, the carrier should identify the document name, section, and page number. A citation alone does not demonstrate compliance; the cited material must substantively address the requirement.

Q7. Are naming conventions, workbooks, and screenshots legal requirements?

They are administrative filing instructions used to organize and verify the submission; they are not independent substantive standards in 13.10.22.9 NMAC. Carriers should follow the required format. When a requested screenshot is intended to verify online availability, OSI may accept a functioning direct link or other reliable evidence unless access restrictions prevent verification. General or vague statements in response to requirements are not sufficient to show compliance.

Q8. Must carriers submit both redlined and final versions of all documents?

No. A carrier may submit the current final document with either a redlined version or a detailed change log. The change documentation must identify the affected section, effective date, nature and reason for each substantive change, and approving authority. Formatting-only changes may be summarized. OSI may request a prior version or additional information if the submitted documentation is insufficient to evaluate the changes.

Q9. What happens when a field is incomplete or not applicable?

Incomplete information may result in an objection or request for correction when OSI cannot determine compliance. A carrier may enter “Not Applicable” only when the requirement does not apply and must provide a brief explanation. An incomplete item does not automatically establish a substantive violation, but the filing must contain sufficient information for OSI to complete its review.

Prior-authorization audits

Q10. Must the 2026 PA audit contain 50 cases for each benefit type?

For carriers that completed a methodologically sound 40-case random audit under the prior published guidance before the revised guidance was finalized, OSI will accept the completed 40-case sample for the 2026 filing. Other carriers should submit 50 cases for each benefit type: medical/surgical, behavioral health, and pharmacy. The 50-case standard will apply prospectively to all carriers beginning with the next filing cycle. It does not mean 50 cases for every product line unless OSI specifically directs otherwise.

Q11. What sampling information must accompany the PA audit?

The carrier should identify the review period, eligible case population, benefit category, exclusions, random-selection method, number of cases available, and number reviewed. If the required sample is unattainable, the carrier must explain why and provide the complete available population or another sample approved by OSI.

Q12. Which code should be reported for a pharmacy PA request?

Use the identifier applicable to the request and identify the coding system. The Pharmacy PA Audit may include an NDC, GPI, HCPCS/J-code, CPT code, or other identifier used to process the request. A CPT code is required only when applicable. No applicable identifier field should be left blank without an explanation.

Q13. How should the carrier evaluate whether appropriate clinical criteria were applied?

The retrospective review should use the clinical criteria and protocol in effect on the determination date. The carrier should determine whether the selected criteria applied to the requested service or drug, diagnosis, benefit, level of care, and member circumstances; whether the record contained the information needed to apply the criteria; and whether the outcome was consistent with the criteria.

Q14. What is a deviation from clinical review criteria?

A deviation occurs when the determination does not follow the result ordinarily indicated by the applicable criteria or applies the criteria differently from their stated terms. A deviation does not automatically establish noncompliance. The carrier must identify the reason, clinical justification, approving individual, reviewer qualifications, and supporting documentation so OSI can evaluate whether the deviation was authorized, clinically supported, and properly documented.

Clinical criteria and proprietary information

Q15. What does OSI mean by “proprietary threshold claims”?

The term was incorrect and will be removed. The applicable term in 13.10.22.9 B. NMAC is “internal or proprietary quantitative thresholds for utilization management.” It does not establish a separate type of claim.

Q16. What is an internal or proprietary quantitative threshold?

It is a numerical trigger, cutoff, limit, score, frequency, duration, or similar measurable value used in a utilization-management process or clinical protocol. The carrier should describe how it identifies and approves a proprietary designation, responds to requests for criteria, separates the proprietary threshold from otherwise disclosable criteria, and substantiates the designation when requested. The carrier bears the burden of demonstrating that withheld information is proprietary.

Q17. Must every clinical criterion be reviewed annually?

No. The written UM plan must be reviewed at least annually under 13.10.22.9 A. NMAC. Clinical criteria and protocols must be periodically reviewed and updated under 13.10.22.9 B. NMAC. The carrier should identify the applicable review cycle, most recent review date, responsible entity or individuals, and material updates since the prior filing.

Clinical criteria access

Q18. Must all clinical criteria be publicly posted?

No. Under 13.10.22.9 B. NMAC, clinical criteria and protocols generally must be readily available upon request to affected providers and covered persons, subject to the limited exception for internal or proprietary quantitative thresholds. The guidance does not require every criterion to be posted on an unrestricted public website. Carriers must also comply with the provider-access and disclosure requirements applicable under 13.10.31 NMAC, including providing the criteria used for a denial when required.

Q19. What evidence demonstrates physician and provider involvement in developing or selecting criteria?

The carrier may cite committee charters, rosters, meeting minutes, approval records, vendor-governance records, or other documentation showing involvement from practicing physicians and other health professionals and providers

within the MHCP's network. The evidence should identify the participants' roles and the criteria-development, selection, or review activity in which they participated.

Reviewer qualifications and availability

Q20. May a pharmacist conduct pharmacy clinical reviews?

Yes. A pharmacist or other qualified health professional may perform clinical-review activities within the applicable scope of practice and may render an authorization when permitted by 13.10.22.9 D. (1) NMAC. A final determination to deny or limit an admission, service, procedure, or extension of stay must be rendered by a physician in accordance with 13.10.22.9 D.(2) NMAC. The physician must act under the clinical direction of the medical director responsible for services provided to New Mexico covered persons.

Q21. Does the rule require every denial to be signed by a New Mexico-licensed reviewing physician?

Section 13.10.22.9 D. (2) requires the denial or limitation to be rendered by a physician under the clinical direction of the New Mexico medical director. The subsection does not expressly require the reviewing physician to hold a New Mexico license or physically sign the denial letter. The carrier must be able to identify the physician who rendered the decision and demonstrate that the required clinical direction and qualifications were present.

Q22. What does 24/7 UM staff availability require?

A registered professional nurse or physician must be immediately available by telephone seven days a week, 24 hours a day, to render UM determinations for providers. Voicemail alone does not demonstrate immediate availability. The carrier may use an on-call arrangement if it provides timely direct access to an RN or physician and the person who renders the determination is authorized and appropriately qualified.

Q23. How should carriers complete the "clinical review activity" field in the Section 5 Workbook Determinations?

Identify the activity the listed individual is authorized or assigned to perform and distinguish that activity from final decision authority. Examples include initial clinical review, authorization, physician adverse determination, specialist consultation, peer-to-peer consultation, reconsideration, appeal review, formulary-exception review, step-therapy exception review, retrospective review, and quality-audit review. Also identify the applicable benefit type and whether the person may approve, recommend an adverse determination, render a final adverse determination, or act in an advisory capacity only.

IRR, delegation, and accreditation

Q24. Must an inter-rater reliability study be limited to New Mexico cases?

Not necessarily. OSI will accept an enterprise-wide IRR study when the carrier demonstrates that it covers the reviewers, criteria, systems, and delegated entities used for New Mexico members. The carrier must identify material New Mexico-specific differences. If New Mexico decisions use different reviewers, criteria, systems, or delegated entities, supplemental New Mexico-specific evidence may be required.

Q25. What must the IRR submission include?

The submission should identify the study period, reviewer population and qualifications, criteria evaluated, sample-selection methodology, scoring method, carrier-established passing standard, results, identified deficiencies,

corrective action, retraining or retesting, and follow-up results. The rule does not establish a universal passing percentage; the carrier must disclose and support the threshold it uses.

Q26. Does delegation to a URO, UMO, PBM, affiliate, or vendor transfer the carrier's responsibility?

No. The carrier remains responsible for demonstrating compliance with applicable New Mexico requirements. The filing should identify each delegated entity, delegated function, applicable benefit type, responsible carrier personnel, contractual responsibility, reviewer qualifications, and the carrier's monitoring and corrective-action process.

Q27. Is NCQA certification mandatory, and will OSI consider URAC or another accrediting entity?

NCQA certification is not mandatory under 13.10.22.9 E. NMAC. A carrier may submit accreditation from a nationally recognized accrediting entity as evidence of compliance. The carrier must provide the entity's current relevant standards, documentation of current accreditation, and a summary of the information supporting the accreditation. OSI will determine whether the entity is recognized and approved and whether comparable standards exist. Accreditation does not automatically establish compliance with every New Mexico requirement.

Q28. What happened to subjects that were separate sections in the prior guidance?

Some topics were consolidated into broader NMAC-based sections or are reviewed through another filing. Reorganization does not repeal or waive an independently applicable statute or rule. OSI will use a crosswalk to identify where prior requirements are addressed, whether they are verified elsewhere, or whether a prior evidence request was removed because it was duplicative or lacked a sufficient connection to the cited authority.

Controlling authorities

The principal authorities for this FAQ are:

- 13.10.22.9-.10 NMAC - Utilization Management and CQI:
<https://www.srca.nm.gov/parts/title13/13.010.0022.html>
- 13.10.31 NMAC - Prior Authorization and Gold Carding:
<https://www.srca.nm.gov/parts/title13/13.010.0031.html>
- 13.10.17 NMAC - Grievance Procedures: <https://www.srca.nm.gov/parts/title13/13.010.0017.html>

Questions

Carriers may submit questions regarding the UM Guidance Chart or workbooks to the Managed Health Care Policy and Compliance Bureau through the contact identified in the published guidance.