

Addendum Attachment (AA)

Corporate Policy Name: Benefit Certification & Appeal General Guidelines

AA Number: CO.272.22.NM.AA.05

Compliant with Requirements of the: State of New Mexico

Corporate Compliance Approvals: *(required for initial regulatory AA or if AA requires a revision due to a change in regulations)*

<p>Kelly Mason Associate Legal Counsel 12-12-2025</p>	<p>Joe Thompson Senior Director, Global Compliance & Ethics 12-11-2025</p>
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Other Approvals *(optional; for contractual AA or annual maintenance of regulatory AA):*

<p>Mary C. Shorter Sr. Director, Clinical Project and Program Management 12-11-2025</p>	<p>Ritha Plancher Compliance Manager 12-30-2025</p>
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Addendum Attachment

A. Re: Key Terms

Utilization Management, dates of receipt and written notification

The organization defines the dates of receipt and written notification for utilization management denial determinations resulting from medical necessity review consistent with the requirements in NCQA UM 5: “Timeliness of UM Decisions.”

Per NM SB 273, Section 14:

Generally Recognized Standards

Standards of care and clinical practice established by evidence-based sources, including clinical practice guidelines and recommendations from mental health and substance use disorder care provider professional associations and relevant federal government agencies, that are generally recognized by providers practicing in relevant clinical specialties, including psychiatry, psychology, social work, clinical counseling, addiction medicine and counseling, or family and marriage counseling.

Mental Health or Substance Use Disorder Services

Professional services, including inpatient and outpatient services and prescription drugs, provided in accordance with generally recognized standards of care for the identification, prevention, treatment, minimization of progression, habilitation and rehabilitation of conditions or disorders listed in the current edition of the American psychiatric association’s Diagnostic and Statistical Manual of Mental Disorders, including substance use disorder; or Professional talk therapy services, provided in accordance with generally recognized standards of care, provided by a marriage and family therapist licensed pursuant to the Counseling and Therapy Practice Act.”

- B. Add as Standard I.E. ***per NM SB 273, Sections 6, 19 30 & 40*** Prohibited Exclusions of Coverage for Mental Health or Substance Use Disorder Service. Magellan will not exclude court ordered treatment.

C. Re: Standard II.D.: Health Benefit Certification and Appeal General Principles. Time to Process

1. ***Per NMAC 13.10.22.9.D(3)***: All determinations shall be made on a timely basis as required by the exigencies of the situation and in accordance with sound medical principles, which, in any event, shall not exceed twenty-four (24) hours for emergency care and seven (7) days for all other determinations. If Magellan is unable to complete a referral within ten (10) days due to unforeseen circumstances, Magellan shall inform the covered person in writing about the reasons for the delay and when a decision may be expected.
2. Replace language of Standard II.D.4. with ***Per N.M.S.A. § 59A-22B-5 B***: Prior authorization shall be deemed granted for determinations not made within seven (7) days; provided that:
 - (1) A determination shall be made within twenty-four (24) hours, or shall be deemed approved if not made within twenty-four (24) hours, when a member's ordering or rendering provider requests an expedited prior authorization and submits to Magellan a statement that, in the health care professional's opinion that is based on reasonable medical probability, delay in the treatment for which prior authorization is requested could seriously jeopardize the member's life or overall health; affect the member's ability to regain maximum function; or subject the member to severe and intolerable pain; and
 - (2) The processing timeframe shall commence with the request, verbal or written, (written may be required in situations such as a claim appeal) by the member or a valid representative of the member, but after Magellan receives all necessary and relevant documentation supporting the prior authorization request.

D. Re: Standard II.E.2 Health Benefit Certification and Appeal General Principles. Benefit Certification and Appeal Notice Guidelines. ***Per NMAC 13.10.22.9.D(5)***:

1. An enrollee's notice shall contain the reasons why coverage or authorization was denied, and shall be subject to review in accordance with the specific grievance procedures outlined in NMAC 13.10.17.
2. The written notice shall advise the covered person that review of the Magellan's denial of coverage or authorization is available. In addition, the notice shall describe the procedures necessary for commencing an internal review as outlined in 13.10.17 NMAC.

E. **Re:** Standard II.F.1. Basis of a Benefit Certification Determination and Appeal Decision, ***per NM SB273, Sections 5B, 18B, 28B & 39B***: Magellan will apply criteria in accordance with generally recognized standards of care.

Per OSI Bulletin 2024-013 (July 30, 2024): Generally recognized standards used in medical necessity determinations incorporate the most recent versions of clinical practice guidelines developed by nonprofit professional associations for the relevant clinical specialty. Acceptable examples that would be in compliance with SB 273 are:

- For a primary diagnosis of a substance use disorder in adolescents and adults, The *ASAM Criteria* developed by the American Society of Addiction Medicine.
- For a primary diagnosis of a mental health condition in adults, the *Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS)* developed by the American Association for Community Psychiatry (AAP).
- For a primary diagnosis of a mental health condition in children ages 6-18, the *Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII)* developed by AAP and the American Academy of Child & Adolescent Psychiatry (AACAP).
- For a primary diagnosis of a mental health condition in children ages 5 and younger, the *Early Childhood Service Intensity Instrument (ECSII)* developed by AACAP.

- For coverage determinations involving services for gender dysphoria, the most recent version of the *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* developed by The World Professional Association for Transgender Health

Add as Standard II.F.3, **per NM SB 273, Sections 5A, 18A, 29A & 39A**: Magellan will, at least monthly, review and update its UR process to reflect the most recent evidence and generally recognized standards of care.

F. Add as Standard II.F.4, **per NM SB 273, Sections 7, 20, 31 & 41**: Level of Care Determinations for the Provision of Mental Health or Substance Use Disorder Services.

1. Magellan shall provide coverage for all in-network mental health/substance use disorder services, consistent with generally recognized standards of care, including place a member into a medically necessary level of care.
2. Changes in level and duration of care will be determined in consultation with the member's provider.
3. Level of care determinations will include placement of a member into a facility that provides detoxification services, a hospital, an inpatient rehabilitation treatment facility, or an outpatient treatment program.
4. Level of care services for a member with a mental health/substance use disorder will be based on the mental health/substance use disorder needs of the member rather than arbitrary time limits.

G. Re: Standard IV.B.: Initiating the Benefit Certification Process: **Per NMAC 13.10.31.9.A(9)**: Magellan will maintain an electronic portal system for the secure electronic transmission of prior authorization requests on a twenty-four-(24) hour, seven (7) day-a-week basis.

H. Re: Standard V.: Role of Staff in the Benefit Certification and Appeal Process

1. **Per NMAC 13.10.22.9.A**: The utilization management program will be under the direction of a medical director who is a licensed physician in New Mexico.
2. **Per N.M.S.A. § 61-6-6 (J)(6) & NMAC 13.10.22.9.D(1)**: All determinations to authorize an admission, service, procedure, or extension of stay shall be rendered by either a physician, registered professional nurse, or other qualified health professional licensed in New Mexico.
3. **Per N.M.S.A. § 61-6-6 (J)(6) & NMAC 13.10.22.9.D(2)**: All determinations to deny or limit an admission, service, procedure or extension of stay shall be rendered by a physician licensed in New Mexico, either after application of uniform criteria established by the plan in consultation with specialists acting within the scope of their license or after consultation with specialists acting within the scope of their license.

I. Re: Standard VI.: Processing of Benefit Certification and Appeal

1. Add as Standard VI. B. Initial Clinical Review 6. **Per N.M.S.A. § 59A-22B-5 E**: An auto-adjudicated prior authorization request based on medical necessity that is pended or denied shall be reviewed by a health care professional who has knowledge or consults with a specialist who has knowledge of the medical condition or disease of the covered person for whom the authorization is requested.
2. Add as Standard VI.C. Peer Clinical Review 8: **Per N.M.S.A. § 59A-22B-5 E**: The health care professional shall make a final determination of the request. If the request is denied after review by a health care professional, notice of the denial shall be provided to the covered person and covered person's provider with the grounds for the denial and a notice of the right to appeal and describing the process to file an appeal.

Associated Forms & Attachments

None

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