Policy and Standards

The below corporate policy has been customized for **New Mexico** using the *modification* (text changed within the body of the corporate policy) customization method.

Policy Number:	**CO.274.09-2023.NM**
Policy Name:	**Commercial Benefit Certification Determination**
Review Type:	No Changes
Contract or Regulatory Reference: (include citation if applicable)	*N/A*

Product Applicability: *(For Health Insurance Marketplaces, policies and procedures are the same, unless contractual requirements dictate a more stringent variation in which case customized documents are created.)*

Commercial

Business Division and Entity Applicability:

Magellan Healthcare

Magellan Healthcare (Behavioral)

Magellan Health policies apply to all subsidiaries where applicable to the subsidiaries' business. This specific customized policy only applies to New Mexico.

Policy Statement

The properly licensed affiliates and subsidiaries of Magellan Health, Inc. (Magellan) conduct the utilization management (UM) program(s) with the goal of optimizing the use of healthcare resources. State regulations and/or account contractual requirements that are more stringent or that provide an additional aspect to one or more of the standards in this policy will be addressed in a customized version of this policy.

Purpose

To describe the initiation and processing of a benefit certification request for members in a commercial managed care product.

Policy Terms & Definitions Glossary

Key Terms *(as used in this policy)*

Day or Days (per NMAC 13.10.29.7):

Unless otherwise specified:

a) 1-5 days means only working days and excludes weekends and state holidays; and

b) 6 days or more means calendar days, including weekends and holidays.

Member

This term is used interchangeably with: beneficiary; consumer; enrollee; covered person; policyholder; subscriber; and recipient.

Policy Terms & Definitions are available should the reader need to inquire as to the definition of a term used in this policy.

To access the *Policy Terms & Definitions Glossary* in C360, click on the below link: *(internal link(s) available to Magellan Health employees only)*

Policy Terms & Definitions Glossary

Standards

I. Standards of this policy are applied in conjunction with relevant standards of its companion policy, *Benefit Certification and Appeal General Guidelines*.

II. Minimal Filing Requirements of a Benefit Certification Request

A. A request for benefit certification is assessed upon receipt of minimal acceptable filing requirements.

B. Elements of minimal acceptable filing requirements include: member name, specific disorder/diagnosis or symptom, and the specific service related to the benefit/coverage being requested. May include more specific identifier information, to prevent Protected Health Information (PHI) breach with any subsequent required written notice related to the request for benefit, such as the insured's insurance identification number and /or date of birth, or the requesting/treating provider identifiers such as name, and/or National Provider Identifier.

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C. If a benefit certification request is found not to meet the minimal acceptable filing requirements, the requestor is notified as soon as possible and is informed of what is needed to meet the filing requirements. This notice is verbal unless the member or member's authorized representative asks for a written notice or one is required by state regulation or customer plan contractual requirement. The notice is given within the following time frames:

1. Five (5) calendar days of the receipt of the request; or
2. Twenty-four (24) hours if the request is identified for expedited processing. The requestor is afforded forty-eight (48) hours to respond to the filing requirement need. If the requestor does not respond within the forty-eight (48) hour period, an administrative-based adverse benefit/coverage determination is issued due to the benefit/coverage request's not meeting the minimal acceptable filing requirements.

III. Benefit Certification Process

A. The process is initiated when the request meets minimal filing requirements. Certification of a benefit can be requested before a diagnostic service, treatment, or course of treatment is started or during a course of inpatient treatment (sometimes referred to as concurrent or continued stay) for another certification for services beyond the time that services were previously certified.

1. ***Per NMAC 13.10.31.9.A:*** Magellan shall:
   a) accept prior authorization requests submitted at any time prior to the delivery of service;
   b) accept prior authorization requests telephonically and by facsimile;
   c) offer at least one bi-directional electronic prior authorization portal;
   d) allow a provider to upload in a secure manner the supporting documentation associated with an electronic prior authorization request, subject to reasonable limits on file type and size;
   e) accept and consider any information from a provider that will assist in the review;
   f) require only the information necessary to evaluate the request;
   g) not reject a request solely on the basis of documentation or submission errors that do not prevent substantive review;
   h) ensure that the system it operates for receiving electronic prior authorization requests and supporting documentation satisfies all applicable Health Insurance Portability and Accountability Act ("HIPAA") transaction requirements and operating rules no later than the effective date that such requirements and rules are established;
   i) make its system available for accepting electronic prior authorization requests and supporting documentation 24-hours per day, seven-days per week. Planned maintenance or down time of the system shall be performed during historically low-utilization periods; and
   j) notify providers of planned maintenance or downtime of the system at least 24-hours in advance. A carrier shall notify providers of any unplanned system downtime as soon as practicable.

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2. ***Per NMAC 13.10.31.9.B:*** Within one (1) business day of receipt, Magellan will confirm receipt of a prior authorization request and any supporting documentation to the submitter and assign a tracking number to the request. The confirmation, which includes the tracking number, will be communicated by electronic portal, fax or email. Magellan will provide the tracking number of a prior authorization request to the member upon request.
3. ***Per NMAC 13.10.31.10.A(1):*** Magellan shall accept the uniform prior authorization request form(s) developed by the superintendent and found on the superintendent's website at www.osi.state.nm.us.

B. Standard Time-to-Process a Benefit Certification

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 seven (7) days .
2. Per the Department of Labor/ Employee Retirement Income Security Act (ERISA) regulation, thirty (30) calendar days is the maximum processing time allowed when a claim for benefit is made "post-service" after services have been delivered, also called "retrospective", such as a late certification request or the receipt of a claim for payment.
3. ***Per NMAC 13.10.31.11.B:*** Incomplete information. If a provider fails to supply sufficient information to evaluate a prior authorization request, the carrier shall allow the provider a reasonable amount of time, taking into account the circumstances of the covered person, but not less than 4 hours for expedited requests and 2 calendar days for standard requests, to provide the specified information.
4. Allowable extension for pre-service and post-service requests
   a) The standard time may be extended one (1) time prior to the expiration of the standard processing time for one of the following:
      i. Fifteen (15) calendar days if it is determined that an extension is needed for reasons beyond the control of Magellan. The requestor must be notified of the circumstances requiring the extension and the date Magellan expects to render a determination; or
      ii. Forty-five (45) calendar days if more clinical information is needed to decide the medical necessity. The notice to the requestor includes a description of the required information and the requestor is given at least forty-five (45) days from receipt of the notice within which to provide the specified information. The initial notice should be given verbally or through another secure transmission mode (facsimile or secure internet portal). If the initial notice is verbal, it may be followed by written notice to the requestor.
   b) During the time the extension is in effect, the standard time frame is temporarily halted until the extension terminates as a result of: 1) the requestor responds to the request for information or 2) the extension expires.
   c) The standard time-to-process count resumes on the day that the extension terminates.

C. Expedited Time-to-Process a Benefit Certification

1. The member's clinical situation meets the need for application of the expedited benefit timeframe.

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2. ***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 24 hours for emergency care.
3. The maximum timeframe to complete the expedited certification process is within seventy-two (72) hours. If the expedited time is applied to a benefit request for a non-elective acute inpatient admission, completion of the benefit process within twenty-four (24) hours is preferred.
4. The benefit certification process is complete when a benefit certification determination is made and verbal notice is given to the requestor.
5. If the benefit determination is adverse, a written notice is issued in addition to the verbal notice, also within the seventy-two (72) hours after receipt of the request.
6. There is no extension of time allowed for expedited review.

D. ***Per NMAC 13.10.17.8:*** Computation of time

Whenever this policy requires that an action be taken within a certain period of time from receipt of a request or document, the request or document shall be deemed to have been received within 3 days after the date it was mailed.

E. ***Per N.M.S.A. § 59A-22B-3:*** Emergency care provided to a covered person, regardless of where the emergency care is provided, shall not be subject to prior authorization requirements.

IV. Notice of Approved Benefit Determination

A. An approved benefit determination notice is provided to the requestor.

1. Notice includes a reference identifier and indicates the service to which the coverage has been applied.
2. When notice is required by law or per account contract to be provided to the member, it may be provided verbally, via secure internet portal or in writing.
3. The ordering and/or rendering provider requesting the benefit on behalf of the member may be required to notify the member.
4. Typically, the requestor is an ordering and/or rendering provider acting on behalf of the member. When verbal notice of an approval is given to the ordering and/or rendering provider, the provider is reminded to inform the member that the benefit has been approved and the reminder is documented in the system.

B. ***Per NMAC 13.10.17.12.A:*** Magellan will send written notice to the member and provider of the certification by mail or electronic communication within one (1) day after the date the health care service was certified, unless earlier notice is required by the medical exigencies of the case.

V. Notice of Adverse (Not Approved/ Not Certified) Benefit Determination

A. ***Per NMAC 13.10.17.12:*** The notices will be provided to the member, the member's authorized representative, if applicable, and to a provider or other health care professional with knowledge of the member's medical condition.

B. The adverse benefit determination notice contains:

1. The principal reason written in easily understandable language:
   a) When the principal reason is based on a medical necessity decision, the notice contains an explanation of the clinical rationale, including a statement of the

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applicable scientific or clinical judgment used to decide medical necessity or a reference to the experimental exclusion or other similar exclusion or limit. The notice explains how the terms of the plan apply to the medical circumstances, such as by making a reference to the clinically-based benefit provision, requirement, protocol, criteria or criterion upon which the decision was based and also gives instruction as to how the member or member's authorized representative can obtain a copy, free of charge, of the actual specific clinical criteria or criterion relied upon to make the medical necessity decision. ***(NMAC 13.10.17.12.A(4)).***

b) ***Per NMAC 13.10.17.12.A(1):*** If an adverse determination is based on a determination that the requested service is experimental, investigational or not medically necessary, clearly and completely explain why the requested health care service is not medically necessary or is experimental or investigational; a statement that the health care service is not medically necessary, is experimental, or is investigational will not be sufficient.

c) When the principal reason for the adverse benefit determination is administrative, the reason for and the specific benefit provision, administrative procedures or regulatory limitations used to classify the denial as well as the source of the information is documented. Examples may include but are not limited to: The service was excluded from the Summary of Benefits or from the Certificate of Coverage, or the number of services requested exceeded allowable benefit limits. This information is included in the adverse benefit notice that is sent to the member or member's authorized representative. The notice also includes information as to how the member or member's authorized representative can obtain a copy, free of charge, of the actual benefit provision, requirement or protocol ***(NMAC 13.10.17.12.A(2))***.

d) ***Per NMAC 13.10.17.12.A(3):*** If the service has already been provided, then include the date of service, the provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

2. Description of any applicable additional material or information necessary to perfect the request for the benefit and an explanation of why such material or information is necessary;

3. Description of the member's available internal and external review appeal rights, including:

   a) The right to submit written comments, documents or other information relevant to the appeal;

   b) An explanation of the appeal review process, including:

      i. The right of a member to have representation;

      ii. How to initiate an appeal (expedited appeal for pre-service claims and standard appeal);

      iii. ***Per NMAC 13.10.17.12.A(5):*** Provide information stating that a request for review of an adverse determination must be filed with the health care insurer within 180 days; and

      iv. ***Per NMAC 13.10.17.12.A(6):*** If the adverse determination involves an urgent care situation, provide information that an expedited IRO review to be

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conducted at the same time as an expedited internal review may be requested. .

v. ***Per NMAC 13.10.17.10.A(2)(b) & 13.10.17.12.A(7):*** a copy of all necessary grievance forms for requesting internal review;

vi. ***Per NMAC 13.10.17.10.A(2)(c):*** a link to the full version of the grievance procedures, as found on the Office of Superintendent of Insurance (OSI) website;

vii. ***Per NMAC 13.10.17.10.A(2)(d):*** a toll-free telephone number, facsimile number, e-mail and mailing addresses of the health plan's consumer assistance office and for the Managed Health Care Bureau (MHCB):

Office of Superintendent of Insurance - MHCB
P.O. Box 1689
1120 Paseo de Peralta
Santa Fe, NM 87504-1689

Telephone: 1-(505) 827-4601 or toll free at 1-(855) 427-5674
FAX #: (505) 827-6341, Attn: MHCB
E-mail: mhcb.grievance@state.nm.us

c) Availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with their benefits and with the internal and external appeal review process; and

d) The following elements:

i. Date(s) of service;

ii. Provider's name;

iii. Claim amount (if applicable);

iv. Denial code and its corresponding meaning (if applicable);

v. A statement that diagnosis codes and the corresponding meanings and treatment codes and the corresponding meanings will be provided upon request and free of charge;

vi. Foreign language availability statements in the four (4) languages identified from the Department of Health and Human Services' list of Culturally and Linguistically Appropriate Services County Data (or smaller number of languages, as applicable) where members reside,

vii. Some customer health plans subject to Section 1557 of the ACA wish to continue providing the notices called for in that Rule despite the repeal of that requirement. If directed by a customer to do so, written notices will be provided with the *Notice of Nondiscrimination* and taglines in at least the top 15 languages spoken by limited English proficient speakers in the state or, where appropriate, the aggregate languages for multiple plan states or nationwide. Where directed to do so by a customer these taglines and the *Notice of Nondiscrimination* will also be included on any web content that contains information that is critical for coverage or access to services; and

viii. A description of the plans standard, if any, that was used as the basis of the non-payment of the claim.

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4. A description of an available peer to peer conversation and any other applicable provider dispute options available to allow an ordering and/or rendering provider to personally dispute an adverse benefit determination for subsequent payment;
5. A statement that the member may present evidence and testimony as part of the appeal process; and
6. Other elements as required by state regulation and/or contract.

D. If the member has benefit/coverage with a health plan under the scope of ERISA, the member's non-certification determination notice also contains a statement that the member has the right to bring civil suit under section 502(a) of ERISA against the plan for the benefit/coverage in question after exhausting the mandatory levels of internal appeals.

VI. ***Per NMAC 13.10.17.12.B:*** Notice of Administrative Decision.

A. If the decision involves claims payment, handling or reimbursement for health care services, identify the provisions of the plan that were relied upon in making the decision, including cost-sharing provisions such as co-payments, co-insurance and deductibles.

B. If the decision involves termination of coverage, identify the provisions of the plan that were relied upon in making the determination.

C. If the service has already been provided, then include the date of service, the provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

D. Provide information that a request for an internal review of an administrative decision must be filed with the health care insurer within 180 days.

E. Describe the procedures and provide all necessary grievance forms for requesting internal review of the decision.

VII. Retroactive Denials ***Per NMAC 13.10.22.9.D(4):***

A. Magellan may not retroactively deny reimbursement for a covered service provided to a member by a provider who relied upon the verbal or written authorization of Magellan or its agents prior to providing the service to the member, except in those cases where there was material misrepresentation or fraud.

B. Retroactive reimbursement for a covered service shall not be denied when the member provides authorization information, such as a Magellan referral number, directly to the provider, except in those cases where there was material misrepresentation or fraud

Cross Reference(s)

Benefit Certification and Appeal General Guidelines; Nondiscrimination and Language Access

Corporate Policy Life History

Date of Inception:	Previous Review Date:	Current Review Date:
December 29, 2010	January 11, 2022	April 24, 2023
Previous Corporate Approval Date:	**Current Corporate Approval Date:**	**Unit Effective Date:**
March 01, 2022	April 24, 2023	May 24, 2023

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Associated Corporate Forms & Attachments *(internal link(s) available to Magellan Health employees only)*

None

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