New Mexico supplement

New Mexico commercial plans — Health care provider grievance process

Based on New Mexico (NM) law NMAC 13.10.16, network health care professionals have the right to file a grievance for the following concerns:

- Credentialing deadlines
- Claim payment amount or timing
- Network adequacy, including participation determinations based on network composition
- Network composition including health care provider qualifications
- Utilization management practices
- Surprise billing reimbursement amount, rate or timing
- Discrimination

As part of the grievance process related to the concerns above, out-of-network healthcare providers must clearly state and explain how our actions or practices directly affected either themselves or 1 of their patients.

Network health care providers may also file a grievance for the following concerns:

- Claim submission requirements or compliance
- Provider contract construction or compliance
- Patient care standards or access to care
- Termination
- Operation of the plan, including compliance with any law enforceable by the superintendent, or of any directive of the superintendent

How the grievance process works

The grievance process applies to both in and out-of-network health care providers.

- **Timeline to file:** At least 90 days from the incident, which is the subject of the grievance, to file a grievance.
- **Filing procedures and response:** Submit a written grievance electronically or manually. We will send written acknowledgment of the grievance to you within 5 days of its receipt using your preferred communication method.
- **Request for supplemental information:** We may need supplemental information pertinent to the resolution of a grievance. We will request the information within 10 days of receipt of the grievance. We will also require you to submit the information within 10 days.
- **Review panel:** A review panel consists of several individuals, with at least one person holding a position of authority over the operations being addressed in the grievance; will review and decide upon your grievance.
  - A NM-licensed medical professional will be included on a review panel considering quality-of-care concerns. The medical professional will be 1 who practices in the general area of concern.
  - A NM-licensed physician will be included on a review panel considering complex quality-of-care concerns.
  - No person with a conflict of interest will participate in a decision to resolve a grievance. Employment with the carrier, standing alone, does not present a conflict of interest.
- **Response:** We will provide a written response to a grievance using your preferred method of communication within 45 days of the grievance receipt, the requested supplemental information receipt or the requested supplemental information submission due date. The response will include:
  - The name(s), title(s) and qualification(s) of each person who participated in the grievance decision
  - A statement of issue(s) decided and of the ultimate decision(s)
  - A clear and complete explanation of the rationale for the decision and a summary of the evidence relied upon to support the decision
  - A summary of any proposed remedial action
  - Information on the provider's appeal rights

- **Extension of deadlines:** We and you may agree, in a documented communication, to extend any deadline imposed by this grievance plan
- **Presentation of evidence:** You may present oral or documentary evidence to the assigned grievance panel
- **Bundled or group grievances:** You may submit multiple related grievances simultaneously provided the grievances are not unduly duplicative or repetitive. A group may assert a single grievance on behalf of multiple health care providers.

Terminations other than for cause

If a termination is not for cause, we will give you written notice at least 60 days before the effective date of termination. The notice will:

- Be communicated in writing through your preferred format
- Contain an termination explanation

Terminations for cause

For terminations based on cause, we will provide a fair hearing process that provides you the following minimum rights and protections:

- The right to appear in person at a hearing before the deciding panel
- The right to present testimonial or documentary evidence at the hearing
- The right to call witnesses and cross-examine any witness
- The right to be represented by an attorney or by any other person of your choice
- The right to an expedited hearing within 14 days of the termination in instances where we have not provided advance written termination notice and the termination could result in imminent and significant harm to a covered person
- You will receive a written decision within 20 days after the hearing, delivered through your preferred method of communication
- If a group of health care professionals is terminated for cause, each individual in the group has the right to a hearing. However, if any one of the health care professionals in the group files a termination grievance, we will notify all similarly affected individuals in the group about the hearing. Each health care professional who receives this notice will be bound by our decision unless they choose to exercise a right to appeal.

Addressing concerns

If you have not received a notification with specific contact information and you have the following concerns:

- Claim payment amount or timing
- Claim submission requirements or compliance
- Utilization management practices
- Patient care standards or access to care
- Surprise billing reimbursement amount, rate, or timing
- Discrimination
- Operation of the plan, including compliance with any enforceable laws or directives from the superintendent

Please contact the operational grievances team at:

UnitedHealthcare
Attn: PAO Appeals
P.O. Box 30559
Salt Lake City, UT 84130

For network grievances, including:

- Network adequacy, including participation determinations based on network composition
- Network composition including provider qualifications
- Provider contract construction or compliance
- Credentialing deadlines
- Terminations

Contact UnitedHealthcare

Attn: Provider Contract Appeals
P.O. Box 31376
Salt Lake City, UT 84131-0376

Appeals

If you are not satisfied with the results of our internal grievance procedure for 1 of the following issues, you may file a request for an external review with the superintendent based on the requirements in New Mexico Administrative Code, Section 13.10.16.10.:

- An alleged violation of a law enforceable by the superintendent
- Alleged noncompliance with an order of the superintendent
- A termination based on your alleged failure to comply with a law or order enforceable by the superintendent

You must file an appeal no later than 30 days after receipt of our written decision or the deadline for our decision, whichever is earlier.
The superintendent will only review a grievance that pertains to an appeal with the New Mexico Office of Superintendent of Insurance.

Questions?

For chat options and contact information, visit our Contact us page.