NMRE ADMINISTRATIVE MANUAL

SUBJECT Beneficiary Grievance and Appeal	ACCOUNTABILITY	Effective Date: February 27, 2019	Pages: 4
REQUIRED BY	BBA Section: 81 CFR 27853, 42 CFR 430-481, Social Security Act 1902(a)(3) and (4) and 1932(b)(4) PIHP Contract Section: II 6.3.1 (P.6.3.1.1) Other:	Last Review Date:	Past Review Date:
Policy: ☒ Procedure: ☐	Review Cycle: Author: Customer Services Specialist	Responsible Department: Quality & Customer Services	Reviewers: NMRE Board of Directors

Definitions

Adverse Benefit Determination: A decision that adversely impacts a Medicaid beneficiary's claim for services due to: (42 CFR 438.400)

a. Denial or limited authorization of a requested services, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. [42 CFR 438.400(b)(1)]
b. Reduction, suspension, or termination of a previously covered service. [42 CFR 438.400(b)(2)]
c. Denial, in whole or in part, of payment for a service. [42 CFR 438.400(b)(3)]
d. Failure to make a standard Service Authorization decision and provide notice about the decision within 14 calendar days from the date of receipt of a standard request for services. [42 CFR 438.210(d)(1)]
e. Failure to make an expedited Service Authorization decision within seventy-two (72) hours after receipt of a request for expedited Service Authorization. [42 CFR 438.210(d)(2)]
f. Failure to provide services within 14 calendar days of the start date agreed upon during person-centered planning and as authorized by the PIHP. [42 CFR 438.400(b)(4)]
g. Failure of the PIHP to resolve standard appeals and provide notice within 30 calendar days from the date of a request for a standard appeal. [42 CFR 438.408(b)(2)]
h. Failure of the PIHP to resolve expedited appeals and provide notice within 72 hours from the date of a request for an expedited appeal. [42 CFR 438.400(b)(5); 42 CFR 438.408(b)(3)]
i. Failure of the PIHP to resolve grievances and provide notice within 90 calendar days of the date of the request. [42 CFR 438.400(b)(5); 42 CFR 438.408(b)(1)]

j. For a resident of a rural area with only one Managed Care Organization (MCO), the denial of a beneficiary's request to exercise his/her right under §438.52(b)(2)(ii) to obtain services outside the network. [42 CFR 438.400(b)(6)]
k. Denial of a beneficiary's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other beneficiary financial responsibility. [42 CFR 438.400(b)(7)]

Adequate Notice of Adverse Benefit Determination: Written statement advising the beneficiary of a decision to deny or limit authorization of a Medicaid service requested, which notice must be provided to the Medicaid beneficiary on the same date the Adverse Benefit Determination takes effect. [42 CFR 438.404(c)(2)]

Advance Notice of Adverse Benefit Determination: Written statement advising the beneficiary of a decision to reduce, suspend, or terminate Medicaid services currently provided, which notice must be provided/mailed to the Medicaid beneficiary at least 10 calendar days prior to the proposed date the Adverse Benefit Determination is to take effect. [42 CFR 438.404(c)(1); 42 CFR 431.211]

Appeal: A review at the local level by the PIHP of an Adverse Benefit determination, as defined above. (42 CFR 438.400)

Authorization of Services: The processing of request for initial and continuing service delivery. [42CFR438.210(b)]

Beneficiary: A person served by the publicly funded behavioral health and substance use disorder system or his/her representative.

CMHSP: Community Mental Health Services Provider. For the purposes of this document, a CMHSP member is one or more of the following: AuSable Valley Community Mental Health Authority, Centra Wellness Network, North Country Community Mental Health, Northeast Michigan Community Mental Health Authority, and Northern Lakes Community Mental Health Authority.

Expedited Appeal: The expeditious review of an Adverse Benefit Determination, requested by a beneficiary or the beneficiary's provider, when the appropriate party determines that taking the time for a standard resolution could seriously jeopardize the beneficiary's life, physical or mental health, or ability to attain, maintain, or regain maximum function. If the beneficiary requests the expedited review, the PIHP determines if the request is warranted. If the beneficiary's provider makes the request, or supports the beneficiary's request, the PIHP must grant the request. [42 CFR 438.410(a)]

Grievance: Beneficiary's expression of dissatisfaction about PIHP/Network Provider issues, other than an Adverse Benefit Determination. Possible subjects for grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships between a service provider and the beneficiary, failure to respect the beneficiary's rights regardless of whether remedial action is requested, or a beneficiary's dispute regarding an extension of time proposed by the PIHP to make a service authorization decision. (42 CFR 438.400)

Grievance Process: Impartial local review of a beneficiary's grievance.

Grievance and Appeal System: The process the PIHP implements to handle appeals of Adverse benefit Determinations and grievances, as well as the process for collecting and tracking information about them. (42 CFR 438.400)

Medicaid Services: Services provided to a beneficiary under the authority of the Medicaid State Plan, 1915(c) Habilitation Supports Waiver, and/or Section 1915(b)(3) of the Social Security Act.

Network Provider: Any provider that receives Medicaid funding directly or indirectly to order, refer, or render covered services as a result of the state's contract with the NMRE, its member CMHSPs, and the Substance Use Disorder provider panel.

NMRE: Northern Michigan Regional Entity/Region 2 PIHP covering Alcona, Alpena, Antrim, Benzie, Charlevoix, Cheboygan, Crawford, Emmet, Grand Traverse, Iosco, Kalkaska, Leelanau, Manistee, Missaukee, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle Roscommon, and Wexford counties in northern Lower Michigan.

Notice of Resolution: Written statement of the PIHP of the resolution of a grievance or appeal, which must be provided the beneficiary as within 30 calendar days in the case of a standard appeal, 72 hours in the case of an expedited appeal, 90 days in the case of a standard grievance, unless the criteria for an extension has been met. (42 CFR 438.408)

PIHP: Prepaid Inpatient Health Plan, a term contained in federal regulations from the Centers for Medicare & Medicaid Services. Michigan has ten (10) PIHPs, responsible for managing the Medicaid resources for behavioral health and intellectual/developmental disabilities services for Medicaid and Healthy Michigan enrollees.

Recipient Rights Complaint: Written or verbal statement by a beneficiary, or anyone acting on behalf of the beneficiary, alleging a violation of a Michigan Mental Health Code protected right cited in Chapter 7, which is resolved through the processes established in Chapter 7A.

Service Authorization: PIHP processing of requests for initial and continuing authorization of services, either approving or denying as requested, or authorizing in an amount, duration or scope less than requested, all as required under applicable law, including but not limited to 42 CFR 438.210.

State Fair Hearing: Impartial State-level review of a Medicaid beneficiary's appeal of an Adverse Benefit Determination presided over by an MDHHS Administrative Law Judge. Also referred to as "Administrative Hearing." The State Fair Hearing Process is set forth in detail in 42 CFR 431, Subpart E.

SUD Provider Network: Refers to a substance use disorder provider that is directly under contract with the PIHP to provide services and supports.

Purpose

The Purpose of this policy is to allow beneficiaries to dispute adverse actions whenever their benefits are denied, reduced, or terminated, or to voice any disagreements, complaints, or dissatisfaction related to the provision of publicly funded behavioral health or substance use disorder services.

Policy

The NMRE Beneficiary Grievance and Appeal Policy will comply with MDHHS-PIHP Contract P.6.3.1.1 "Appeal and Grievance Resolution Processes Technical Requirement", 42 CFR 438, part F, and all required rules, laws, and regulations including:

(1) Section 1902(a)(3) of the Social Security Act which requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly.
(2) Section 1902(a)(4) of the Social Security Act which requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.
(3) Section 1932(b)(4) of the Social Security Act which requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

Approval Signature

NMRE Chief Executive Officer

2/27/19

Date

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Policy ☐ Procedure ☒	Review Cycle: Annual Author:	Responsible Department: Quality & Customer Services	Reviewers: NMRE Operations

General Requirements

A. <u>The grievance and appeal system</u>
The NMRE will have a grievance and appeal system in place for beneficiaries.

B. <u>Level of appeals</u>
The NMRE will have only one level of appeal for beneficiaries.

C. <u>Filing requirement</u>
A beneficiary may file a grievance and request an appeal with NMRE. A beneficiary may request a State fair hearing after receiving notice (under §438.408) that the adverse benefit determination is upheld.

1. If the notice and timing requirements set forth in the NMRE Beneficiary Grievance and Appeal Policy and 42 CFR 438.408 are not met, the beneficiary is deemed to have exhausted the NMRE's appeals process. The beneficiary may initiate a State fair hearing.

2. The State may offer and arrange for an external medical review if the following conditions are met.
    a. The review must be at the beneficiary's option and must not be required before or used as a deterrent to proceed to the State fair hearing.
    b. The review must be independent of both the State and the NMRE.
    c. The review must be offered without any cost to the enrollee.
    d. The review must not extend any of the timeframes specified in the NMRE Beneficiary Grievance and Appeal Policy and 42 CFR 438.408 and must not disrupt beneficiary's continuation of benefits.

With the written consent of the beneficiary, a provider or an authorized representative may request an appeal or file a grievance, or request a State fair hearing, on behalf of a beneficiary.

D. <u>Timing</u>
1. A beneficiary may file a grievance with the NMRE at any time.
2. Following receipt of a notification of an adverse benefit determination, an enrollee has 60 calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal.

E. Procedures
   1. The beneficiary may file a grievance either orally or in writing and, as determined by the State, either with the State or with the NMRE.
   2. The enrollee may request an appeal either orally or in writing. Unless the enrollee requests an expedited resolution, an oral appeal must be followed by a written, signed appeal.

Timely and adequate notice of adverse benefit determination

A. Notice
   The NMRE must give beneficiaries timely and adequate notice of an adverse benefit determination in writing consistent with the requirements of the NMRE Beneficiary Grievance and Appeal Policy and 42 CFR 438.10.

B. Content of notice
   The notice must explain the following:
   1. The adverse benefit determination the services provider has made or intends to make.
   2. An explanation that the beneficiary may represent him/herself or use legal counsel, a relative, a friend, or other spokesman to act on their behalf.
   3. The reasons for the adverse benefit determination, including the right of the beneficiary to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the beneficiary's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
   4. The language that 42 CFR 440.230(d) provides the basic legal authority for an agency to place appropriate limits on a service based on criteria as medical necessity or on utilization control procedures.
   5. The beneficiary's right to request an appeal of the adverse benefit determination, including information on exhausting the NMRE's one level of appeal and the right to request a State fair hearing described in the NMRE Beneficiary Grievance and Appeal Policy and 42 CFR 438.402(b) and 438.402(c).
   6. The procedures for exercising the rights specified under paragraph (2) of this section.
   7. The circumstances under which an appeal process can be expedited and how to request it.
   8. The beneficiary's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the enrollee may be required to pay the costs of these services.

C. Timing of notice
   The NMRE will monitor that advance notice is mailed to beneficiaries within the following timeframes:
   1. For termination, suspension, or reduction of previously authorized Medicaid-covered services, the State or local agency must send a notice at least 10 days before the date of action, unless:
      a. The agency has factual information confirming the death of the beneficiary;
      b. The agency receives a clear written statement from the beneficiary stating that:
         i. He/she no longer wishes services; or
         ii. Gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information;

c. The beneficiary has been admitted to an institution where he/she is ineligible under the plan for further services;
d. The beneficiary's whereabouts are unknown, and the post office returns agency mail directed to him/her indicating no forwarding address;
e. The agency establishes the fact that the beneficiary has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;
f. A change in the level of medical care is prescribed by the beneficiary's physician;
g. The notice involves an adverse determination made with regard to the preadmission screening requirements for nursing facilities set forth in section 1919(e)(7) of the Social Security Act; or
h. The date of action will occur in less than 10 days if a requirements for exception to the 30 day notice is met.
    i. The safety of an individual in a facility would be endangered;
    ii. The health of an individual in a facility would be endangered;
    iii. The individual's health improves sufficiently to allow more immediate transfer or discharge;
    iv. An immediate transfer or discharge is required by the individual's urgent medical needs;
    v. The individual has not resided in the nursing facility for30 days.
i. The agency may shorten the period of advance notice to 5 days before the date of action if:
    i. The agency has facts indicating that action should be taken because of probable fraud by the beneficiary; and
    ii. The facts have been verified, if possible, through secondary sources.

2. For denial of payment, at the time of any action affecting the claim.
3. For standard service authorization decisions that deny or limit services notice must be sent as expeditiously as the beneficiary's condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days if an extension is granted.
4. If the NMRE meets the criteria for extending the timeframe for standard service authorization decisions because it has justified (to the State agency upon request) a need for additional information and how the extension is in the beneficiary's best interest, it must:
    a. Give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he/she disagrees with that decision; and
    b. Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.
5. For service authorization decisions not reached within the timeframes specified in part (3) of this section (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire.
6. For expedited service authorization decisions:
    a. For cases in which a provider indicates, or the NMRE determines, that following the standard timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function, the NMRE will make an expedited authorization decision and provide notice as expeditiously as the beneficiary's health condition requires and no later than 72 hours after receipt of the request for service.

b. The NMRE may extend the 72 hour time period by up to 14 calendar days if the beneficiary requests an extension, or if the NMRE justifies (to the State agency upon request) a need for additional information and how the extension is in the beneficiary best interest.

Handling of grievances and appeals

A. General requirements

In handling grievances and appeals, the NMRE will give enrollees any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

B. Special requirements

The NMRE's process for handling beneficiary grievances and appeals of adverse benefit determinations must:

1. Acknowledge receipt of each grievance and appeal.
2. Ensure that the individuals who make decisions on grievances and appeals are individuals:
   a. Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.
   b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the beneficiary's condition or disease.
      i. An appeal of a denial that is based on lack of medical necessity.
      ii. A grievance regarding denial of expedited resolution of an appeal.
      iii. A grievance or appeal that involves clinical issues.
   c. Who considers all comments, documents, records, and other information submitted by the beneficiary or his/her representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.
3. Provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.
4. Provide the beneficiary a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The NMRE must inform the beneficiary of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in the NMRE Beneficiary Grievance and Appeal Policy and 42 CFR 438.408(b) and (c) in the case of expedited resolution.
5. Provide the beneficiary and his/her representative the beneficiary's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by NMRE (or at the direction of the NMRE) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in The NMRE Beneficiary Grievance and Appeal Policy and 42 CFR 438.408(b) and (c).
6. Include, as parties to the appeal:
   a. The beneficiary and his/her representative; or
   b. The legal representative of a deceased beneficiary's estate.

Resolution and notification: Grievances and appeals

A. Basic rule

The NMRE will resolve each grievance and appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State-established timeframes that may not exceed the timeframes specified in this section.

B. Specific timeframes

1. For standard resolution of a grievance and notice to the affected parties, the timeframe is established by the State but may not exceed 90 calendar days from the day the NMRE receives the grievance.
2. For standard resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 30 calendar days from the day the NMRE receives the appeal. This timeframe may be extended under paragraph (C) of this section.
3. For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 72 hours after the NMRE receives the appeal. This timeframe may be extended under paragraph (C) of this section.

C. Extension of timeframes

1. The NMRE may extend the timeframes from paragraph (b) of this section by up to 14 calendar days if:
   a. The beneficiary requests the extension; or
   b. The NMRE shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the beneficiary's interest.
2. If the NMRE extends the timeframes not at the request of the beneficiary, it must complete all of the following:
   a. Make reasonable efforts to give the beneficiary prompt oral notice of the delay.
   b. Within 2 calendar days, give the beneficiary written notice of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file a grievance if he/she disagrees with that decision.
   c. Resolve the appeal as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.
3. In the case that the NMRE fails to adhere to the notice and timing requirements in this section, the beneficiary is deemed to have exhausted the NMRE's appeals process. The beneficiary may initiate a State fair hearing.

D. Format of notice

1. The State must establish the method that the NMRE will use to notify a beneficiary of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described in the NMRE Beneficiary Grievance and Appeal Policy and 42 CFR 438.10.
2. Appeals:
   a. For all appeals, the NMRE will provide written notice of resolution in a format and language that, at a minimum, is easily understood and readily accessible. Notice of resolution will be provided in, or interpreter services will be provided to, a beneficiary with limited English proficiency or limited reading proficiency, or in large print, TTY/TDD format as the beneficiary’s needs determine, consistent with the standards described in 42 CFR 438.10.

b. For notice of an expedited resolution, the NMRE will also make reasonable efforts to provide oral notice.

E. Content of notice of appeal resolution

The written notice of the resolution must include the following:

1. The results of the resolution process and the date it was completed.
2. For appeals not resolved wholly in favor of the beneficiary:
   a. The right to request a State fair hearing, and how to do so.
   b. The right to request and receive benefits while the hearing is pending, and how to make the request.
   c. That the beneficiary may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the adverse benefit determination.

F. Requirements for State fair hearings

1. A beneficiary may request a State fair hearing only after receiving notice that the NMRE is upholding the adverse benefit determination.
   a. In the case that the NMRE fails to adhere to the notice and timing requirements in the NMRE Beneficiary Grievance and Appeal Policy and 42 CFR§438.408, the beneficiary is deemed to have exhausted the NMRE's appeals process. The beneficiary may initiate a State fair hearing.
   b. The State may offer and arrange for an external medical review if the following conditions are met.
      i. The review must be at the beneficiary's option and must not be required before or used as a deterrent to proceed to the State fair hearing.
      ii. The review must be independent of both the State and MCO, PIHP, or PAHP.
      iii. The review must be offered without any cost to the enrollee.
      iv. The review must not extend any of the timeframes specified in 42 CFR 438.408 and must not disrupt the continuation of benefits in 42 CFR 438.420, as stated in The NMRE Beneficiary Grievance and Appeal Policy.
   2. The beneficiary must request a State fair hearing no later than 120 calendar days from the date of the NMRE's notice of resolution.
   3. The parties to the State fair hearing include the NMRE as well as the beneficiary and his/her representative, or the representative of a deceased enrollee's estate.

Expedited resolution of appeals

A. General rule

The NMRE will establish and maintain an expedited review process for appeals, when the NMRE determines (for a request from the enrollee) or the provider indicates (in making the request on the beneficiary's behalf or supporting the beneficiary's request) that taking the time for a standard resolution could seriously jeopardize the beneficiary's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

B. Punitive action

The NMRE will ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a beneficiary's appeal.

C. Action following denial of a request for expedited resolution
If the NMRE denies a request for expedited resolution of an appeal, it must transfer the appeal to the timeframe for standard resolution in accordance with the NMRE Beneficiary Grievance and Appeal Policy and 42 CFR 438.408(b)(2).

Information about the grievance and appeal system to providers and subcontractors
The NMRE will provide information specified in the NMRE Beneficiary Grievance and Appeal Policy and 42 CFR 438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract.

Recordkeeping requirements.

A. The State must require the NMRE to maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the State quality strategy.
B. The record of each grievance or appeal must contain, at a minimum, all of the following information:
    1. A general description of the reason for the appeal or grievance.
    2. The date received.
    3. The date of each review or, if applicable, review meeting.
    4. Resolution at each level of the appeal or grievance, if applicable.
    5. Date of resolution at each level, if applicable.
    6. Name of the covered person for whom the appeal or grievance was filed.
C. The record must be accurately maintained in a manner accessible to the state and available upon request to the Centers for Medicare and Medicaid Services.

Continuation of benefits while the NMRE appeal and the State fair hearing are pending

A. Definition
As used in this section
    1. **Timely files:** Files for continuation of benefits on or before the later of the following:
        a. Within 10 calendar days of the NMRE sending the notice of adverse benefit determination.
        b. The intended effective date of the NMRE's proposed adverse benefit determination.

B. Continuation of benefits
The NMRE will continue the beneficiary's services if all of the following occur:
    1. The beneficiary files the request for an appeal in accordance with the timelines specified in the NMRE Beneficiary Grievance and Appeal Policy and 42 CFR 438.402(c)(2)(ii);
    2. The appeal involves the termination, suspension, or reduction of previously authorized services;
    3. The services were ordered by an authorized provider;
    4. The period covered by the original authorization has not expired; and
    5. The beneficiary timely files for continuation of benefits.

C. Duration of continued or reinstated benefits
If, at the beneficiary's request, the NMRE continues or reinstates the beneficiary's services while the appeal or state fair hearing is pending, the benefits must be continued until one of following occurs:
    1. The beneficiary withdraws the appeal or request for state fair hearing.

2. The beneficiary fails to request a state fair hearing and continuation of benefits within 10 calendar days after the NMRE sends the notice of an adverse resolution to the beneficiary's appeal in accordance with the NMRE Beneficiary Grievance and Appeal Policy and 42 CFR 438.408(d)(2).
3. A State fair hearing office issues a hearing decision adverse to the enrollee.

E. Enrollee responsibility for services furnished while the appeal or state fair hearing is pending
If the final resolution of the appeal or state fair hearing is adverse to the beneficiary, that is, upholds the NMRE's adverse benefit determination, the NMRE will, consistent with the state's usual policy on recoveries under 42 CFR 431.230(b) and as specified in the MDHHS-PIHP Contract, recover the cost of services furnished to the beneficiary while the appeal and state fair hearing was pending, to the extent that they were furnished solely because of the requirements of this section.

Effectuation of reversed appeal resolutions.

A. Services not furnished while the appeal is pending
If the NMRE, or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the NMRE will authorize or provide the disputed services promptly and as expeditiously as the beneficiary's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.

B. Services furnished while the appeal is pending
If the NMRE or the State fair hearing officer reverses a decision to deny authorization of services, and the beneficiary received the disputed services while the appeal was pending, the NMRE, or the State must pay for those services, in accordance with State policy and regulations.

Approval Signature

NMRE Chief Executive Officer

2/27/19

Date