New Mexico Insurance Code (2003)

59A-16-21.1. Health plan requirements.

A. As used in this section:

(1) "**clean claim**" means a manually or electronically submitted **claim** from a participating provider that:

(a) contains substantially all the required data elements necessary for accurate adjudication without the need for additional information from outside of the health plan's system;

(b) is not materially deficient or improper, including lacking substantiating documentation currently required by the health plan; or

(c) has no particular or unusual circumstances requiring special treatment that prevent payment from being made by the health plan within thirty days of the date of receipt if submitted electronically or forty-five days if submitted manually; and

(2) "health plan" means health maintenance organizations, provider service networks or third party payers or their agents.

B. A health plan shall provide for payment of interest on the plan's liability at the rate of one and one-half percent a month on:

(1) the amount of a **clean claim** electronically submitted by the participating provider and not paid within thirty days of the date of receipt; and

(2) the amount of a **clean claim** manually submitted by the participating provider and not paid within forty-five days of the date of receipt.

C. If a health plan is unable to determine liability for or refuses to pay a **claim** of a participating provider within the times specified in Subsection B of this section, the health plan shall make a good-faith effort to notify the participating provider by fax, electronic or other written communication within thirty days of receipt of the **claim** if submitted electronically or forty-five days if submitted manually of all specific reasons why it is not liable for the **claim** or that specific information is required to determine liability for the **claim**.

D. No contract between a health plan and a participating provider shall include a clause that has the effect of relieving either party of liability for its actions or inactions.

E. By December 1, 2000, the insurance division of the public regulation commission, with input from interested parties, including health plans and participating providers, shall promulgate rules to require health plans to provide:

(1) timely participating provider access to **claims** status information;

(2) processes and procedures for submitting **claims** and changes in coding for **claims**;

(3) standard **claims** forms; and

(4) uniform calculation of interest.