

TITLE 13 INSURANCE
CHAPTER 10 HEALTH INSURANCE
PART 28 PROVIDER PAYMENT AND PROVIDER CREDENTIALING REQUIREMENTS

13.10.28.1 ISSUING AGENCY: Office of Superintendent of Insurance, Life and Health
[13.10.28.1 NMAC - N, 01-01-17]

13.10.28.2 SCOPE:

A. Applicability. This rule applies to all health carriers, including health maintenance organizations, individual health plans, group and blanket plans, provider service networks, nonprofit healthcare plans and third-party payers or their agents that provide, offer or administer health benefits plans, including health benefit plans and managed health care plans subject to the insurance laws and regulations of this state. This rule also applies to all health care providers who are licensed to provide health-related services in this state.

B. Timely Payments. This rule addresses the timely payment to providers by health carriers for covered services that have been provided to the carrier's enrollees/covered persons, the credentialing process by which health carriers review and select providers who apply to join carrier's networks, and a dispute resolution process to be utilized by providers and health carriers to resolve differences pertaining to provider credentialing and payment for covered services.

C. Exclusions. This rule does not impose any requirement on health carriers as to which providers must be accepted into health carriers' networks, specify terms of contracts established between health carriers and providers, establish standard reimbursement rates for payment by health carriers to in- or out-of-network providers for services, or interpret terms of any contract established between a health carrier and the its enrollees/covered persons.

[13.10.28.2 NMAC - N, 01-01-17]

13.10.28.3 STATUTORY AUTHORITY: NMSA 1978 Sections 59A-16-21.1, 59A-22-54, 59A-23-14, 59A-46-54, and 59A-47-48.

[13.10.28.3 NMAC - N, 01-01-17]

13.10.28.4 DURATION: Permanent.

[13.10.28.4 NMAC - N, 01-01-17]

13.10.28.5 EFFECTIVE DATE: January 1, 2017, unless a later date is cited at the end of a section.

[13.10.28.5 NMAC - N, 01-01-17]

13.10.28.6 OBJECTIVE: The purpose of this rule is to establish a uniform and efficient provider credentialing process and to ensure that providers receive prompt payment from health carriers for clean claims and interest on unpaid claims. This rule also establishes a process for resolving payment and credentialing disputes between health carriers and providers.

[13.10.28.6 NMAC - N, 01-01-17]

13.10.28.7 DEFINITIONS: As used in this rule:

A. "Business day" means a consecutive 24-hour period, excluding weekends or holidays.

B. "Claim" means a request from a provider for payment for health care services.

C. "Clean claim" means a manually or electronically submitted claim from an eligible provider that:

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

(2) is not materially deficient or improper, including lacking substantiating documentation currently required by the health carrier; and

(3) has no particular or unusual circumstances requiring special treatment – such as, but not limited to, coordination of benefits, pre-existing conditions, subrogation, or suspected fraud – that prevents payment from being made by the health carrier within 30 days of the date of receipt if submitted electronically or 45 days if submitted manually.

D. "Completed credentialing application" means a credentialing application that is free of defects and contains all of the documentation and information necessary for the health carrier to decide whether the health carrier will offer a contract to add the provider to the health carrier's network, including all verifications or

verification supporting statements required to comply with credentialing requirements and generally accepted industry practices and provisions to obtain reasonable applicant-specific information relative to the particular or precise services proposed to be rendered.

E. “Covered benefits” means the specific health services provided under a health benefits plan.

F. “Credentialing” means the process of obtaining and verifying information about a provider and evaluating that provider when that provider applies to become a participating provider within a health carrier’s network.

G. “Credentialing application” means the process whereby a provider submits a completed credentialing application to a health carrier, in which the provider seeks to contract with the health carrier to become a participating provider within the health carrier’s network.

H. “Credentialing intermediary” means a person to whom a health carrier has delegated credentialing or re-credentialing authority and responsibility.

I. “Date of receipt” means the date on which a claim or credentialing application arrives at a health carrier or, for claims that arrive on a non-business day, the date of the first business day thereafter. For claims or applications that are submitted electronically, sent via fax or hand delivered, the date of receipt is the day submitted or delivered, unless the sender is notified immediately of a transmission error. For claims or applications that are submitted via US mail, the date of receipt is calculated as the third business day following the date that the item is placed in the US mail.

J. “Day” means a calendar day, including weekends, holidays, and any other non-business days;

K. “Electronic claim submission” means a request for payment that is submitted by a provided to a health carrier via an electronic portal or using another online form or submission process that complies with state and federal patient privacy protection requirements and links or transmits directly to the health carrier.

L. “Enrollee/covered person” means an individual who is entitled to receive health care benefits provided by a health carrier for covered health-related services, subject to out-of-network costs, deductibles, co-payments, co-insurance deductibles or other cost-sharing provisions provided by the health benefits plan.

M. “Health benefits plan” means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

N. “Health care professional” means a professional engaged in the delivery of health care services who is licensed or authorized to practice in this state.

O. “Health care services” means services, supplies, and procedures for the diagnosis, prevention, treatments, cure or relief of a health condition, illness, injury, or disease, and includes, to the extent offered by the health benefits plan, physical and mental health services, including community-based mental health services, and services for developmental disability or developmental delay.

P. “Health insurer or health carrier” means an entity subject to the insurance laws and regulations of this state, including a health insurance company, a health carrier, a health maintenance organization, a hospital and health service corporation, a provider service network, a nonprofit health care plan, a third-party, or any other entity that contracts or offers to contract, or enters into agreements to provide, deliver, arrange for, pay for or reimburse any costs of health care services, or that provides, offers or administers health benefit policies and managed health care plans in this state.

Q. “Manual claim submission” means a request for payment that is submitted by a provider to a health carrier via US mail, fax, email, and/or hand delivery.

R. “Network” means the group or groups of participating providers who provide services under a network plan or managed health care plan.

S. “Network plan” means a health benefits plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier.

T. “Participating provider” means a provider, health care practitioner, or facility who under express contract with a health carrier or with its contractor or subcontractor, has agreed to provide health care services to enrollees with and expectation of receiving payment directly or indirectly from the health carrier, subject to co-payments, co-insurance deductibles, or other cost-sharing provisions.

U. “Provider” means a physician, hospital or other health care professional licensed or otherwise authorized to furnish health care services in this state.

V. “Practice Group” means an incorporation or other legal collaboration of providers who work together sharing responsibility for providing care, liability and resources.

W. “Provisional acceptance” means an agreement by a health carrier to enter into a short-term contract to add a provider to the health carrier’s network based on results of the credentialing process.

X. “Standard reimbursement rate” means the usual, customary and reasonable reimbursement rate paid to providers for health care services that is at or near the median rate paid for similar health care services within the surrounding geographic area where the charges were incurred.

Y. “Superintendent” means the superintendent of insurance, acting on behalf of the office of the superintendent, or anyone acting in an official capacity on the superintendent’s behalf.

Z. “Uniform credentialing forms” means the version current at the time of the application or re-application process of forms used either by the hospital services corporation (HSC) or counsel for affordable quality healthcare datasource (CAQH), or other credentialing forms as specified by a bulletin posted on the website of the office of superintendent of insurance, including any revisions thereto and as developed and updated from time to time and including electronic versions of such forms; and

AA. “Verification” or “verification supporting statement” means documentation confirming the information submitted by an applicant for a credentialing application from a specifically named entity or a regional, national, or general data depository providing primary source verification, including but not limited to a college, university, medical school, teaching hospital, health care facility or institution, state licensing board, federal agency or department, professional liability insurer, or the national practitioner data bank.

[13.10.28.7 NMAC - N, 01-01-17]

13.10.28.8 CLAIM SUBMISSION AND CODING CHANGES:

A. General.

(1) Health carriers shall comply with both the provisions of this section and with the provisions of 13.10.12 NMAC, which provides for standardization of health claim forms.

(2) Claims information, including claim status information shall be subject to state and federal patient privacy protection laws.

(3) A health carrier that has entered into a contract with one or more intermediaries to conduct provider credentialing or payment to providers shall require the intermediary to indicate the name of the intermediary and the name of the health carrier for which it is conducting the work when contacting a provider on behalf of the health carrier.

B. Electronic submission.

(1) Health carriers shall make available to participating providers a process and procedure for submitting claims electronically.

(2) Health carriers shall make available to participating providers a process and procedure for electronically making coding changes for claims after submission.

(3) Claims that are transmitted electronically are deemed to be received by the health carrier on the date transmitted unless the provider receives immediate notice of a transmission error.

(4) When a claim is submitted electronically and the health carrier subsequently determines that there is an error or omission with the submission that will delay or prevent payment to the participating provider, the health carrier shall notify the participating provider electronically within one business day of determining the error, but no more than five business days following the date of receipt.

C. Manual Submission.

(1) Health carriers shall make standard forms available to providers for submitting claims manually via US mail, fax, email, or hand delivery.

(2) Health carriers shall make standard forms available to providers for manual coding changes to be submitted via US mail, fax, email, or hand delivery.

(3) Claims that are submitted via US mail are deemed to be received by the health carrier within 3 days of the date the claim is placed in the US mail. Claims that are transmitted via fax, email or hand delivery are deemed to be received by the health carrier on the date transmitted unless the provider receives immediate notice of a transmission error.

(4) When a claim is submitted manually and the health carrier subsequently determines that there is an error or omission with the submission that will delay or prevent payment to the provider, the health carrier shall notify the provider in writing within one business day of determining the error, but no more than five days following the date of receipt.

(5) Any health carrier notification to a provider that there is an error or omission in the claim submission must contain a certain specific statement regarding information sought to rectify the error or omission.

D. Access to Claims Status Information.

- (1) Health carriers shall provide an electronic means whereby eligible providers can access claim information within three business days of the date of receipt.
 - (2) The information that is available to the provider shall indicate the status of the request for payment, including, but not limited to the following:
 - (a) date claim was received;
 - (b) identifying claim information, which may include enrollee/covered person identifiers, date(s) of service, and appropriate coding, as required by the health carrier and agreed to by the provider;
 - (c) whether the claim is pending or if it has been accepted or rejected for payment;
 - (d) if the claim is pending, whether the health carrier has requested additional information from the provider to complete processing of the claim;
 - (e) if the claim has been accepted, the payment amount that has been approved; and
 - (f) a clear explanation of the circumstances if the claim has been found to involve particular or unusual circumstances that require special treatment and that are likely to delay payment.
- [13.10.28.8 NMAC - N, 01-01-17]

13.10.28.9 PAYMENT OF CLAIMS, OVERDUE CLAIMS AND CALCULATION OF INTEREST:

A. Payment of claims – timeliness.

- (1) **Claim payment.** Health carriers shall promptly pay providers upon receipt of clean claims for uncontested covered health care services that the provider has supplied.
- (2) **Timeliness.** The health carrier shall reimburse the eligible provider within 30 days of the date the claim has been submitted electronically or within or within 45 days if the claim has been submitted manually, unless special treatment of the claim is required.
- (3) **Prompt payment.** For purposes of prompt payment, a claim shall be deemed to have been “paid” upon one of the following:
 - (a) a check is mailed by the health carrier or its intermediary to the health care provider; or
 - (b) an electronic transfer of fund is made by the health carrier or its intermediary to the provider.
- (4) **Reimbursement rate.** The health carrier shall make payment to the provider based on the standard reimbursement rate as specified within the contractual agreement, or as otherwise agreed upon between the health carrier and the provider.
- (5) **Multi-claim payments.** A single payment made to a provider can serve as payment for multiple claims, but must clearly identify each claim and the amount of the claim that has been satisfied by the payment.

B. Interest on unpaid clean claims.

A health carrier shall pay interest as set forth in Subsection D of 13.10.28.9 NMAC on:

- (1) the amount of any clean claim electronically submitted by an eligible provider and not paid within 30 days of the date of receipt; or
- (2) the amount of any clean claim manually submitted by an eligible provider and not paid within 45 days of the date of receipt.

C. Pending claims.

(1) Questionable liability.

(a) If, upon receipt of a claim, a health carrier is unable to determine liability for, or otherwise refuses to pay a claim of an eligible provider within the time specified in Subsection B of 13.10.28.9 NMAC, the health carrier shall notify the eligible provider electronically, in writing, or by another method within one day of determining that it may not be liable or is refusing to make payment for other reasons. Such determination shall be made within five days of date of receipt of the claim.

(b) The notification shall specify the reason or reasons why the health carrier is refusing to pay for the claim or has determined it is not liable for the claim or shall specify what information is required to determine liability for the claim.

(c) The health carrier shall clearly indicate when only certain charges associated with the claim are contested.

(d) The prompt payment requirement in Section A of 13.10.28.9 NMAC applies to the uncontested portion of a contested claim.

(e) The prompt payment requirement in Section A of 13.10.28.9 NMAC applies to the payment of any claim for which the health carrier has resolved that it is liable. The date on which liability on behalf of a health carrier is determined shall be the prompt plan timeline.

(2) Special treatment claims.

(a) If a health carrier determines that a claim or a portion of a claim requires special treatment due to particular or unusual circumstances, the health carrier shall notify the provider within one day of determining that the claim requires special treatment. Such determination shall be made within five days of date of receipt.

(b) The notice of delay in payment to provider shall be repeated by the health carrier at least monthly until the matter is resolved.

D. Overdue payments, calculation of interest.

(1) When payment is not made by the health carrier to the provider within the time specified in Subsection B of 13.10.28.9 NMAC and there is no question of liability or special treatment as described in Subsections C and D of 13.10.28.9 NMAC, interest shall be calculated and paid to the provider, on the unpaid portion of the claim as follows:

(a) for any full or partial month, beginning on the thirty-first day after the claim has been submitted electronically and on the forty-sixth day for claims submitted manually, the health carrier shall calculate and pay interest in the amount of one and one-half percent (1.5%) for each full or partial month. For purposes of this section, any 30 day period is the equivalent of one month, excepting that a calendar year shall only be equal to 12 months; and

(b) interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The health carrier shall not be required to pay any interest calculated to be less than two (\$2.00) dollars. The interest shall be paid within 30 days of the payment of the claim. Interest can be paid on the same check or electronic transfer as the claim payment or on a separate check or electronic transfer. If the health carrier combines interest payments for more than one late clean claim, the check or electronic transfer shall include information listing each claim covered by the check or electronic transfer and the specific amount of interest being paid for each claim;

(2) When a claim that involves a question of liability or special treatment is ultimately resolved in favor of the provider, the health carrier shall immediately include with the payment to the provider all of the interest due on the unpaid claim, to be calculated as described in Paragraph (1) of Subsection D of 13.10.28.9 NMAC.

[13.10.28.9 NMAC - N, 01-01-17]

13.10.28.10 PAYMENT DISPUTE RESOLUTION

A. Inquiry to Health carrier

(1) A provider may dispute payment of a claim that has not been paid or has not been paid according to the standard reimbursement rate, subject to the enrollee's responsibility for out-of-network costs, deductibles, co-payments, co-insurance or other cost-sharing provisions, if:

(a) the prompt payment deadline described in Paragraph (2) of Subsection A of 13.10.28.9 NMAC has passed; and

(b) the health carrier has not contacted the provider regarding questions of liability, special handling, or missing information that have delayed payment.

(2) To initiate a payment dispute, the provider shall contact the health carrier in writing to determine the status of a claim, to ensure that sufficient documentation supporting the claim has been provided, and to determine whether the claim is considered by the health carrier to be a clean claim.

B. Health carrier's response.

(1) The health carrier shall respond in writing to a provider's inquiry regarding the status of an unpaid claim within 10 days of receiving the inquiry.

(2) The health carrier's response shall explain its failure or refusal to pay, and the expected date of payment if payment is pending.

C. Complaint filed with Superintendent

(1) If the health carrier fails to respond, as described in Section B of 13.10.28.10 NMAC, or the provider believes that payment is being denied, delayed, or calculated in error, then the provider may file a complaint, either individually or in batches, with the superintendent using the form found on the website of the superintendent of insurance.

(2) Complaints to the superintendent regarding prompt payment or failure to pay claims by a health carrier shall contain the following information:

(a) the provider's name, identification number, address, daytime telephone number and the claim number;

(b) the name and address of the health carrier;

(c) the name of the patient and employer (if known);
(d) the date(s) of service and the date(s) the claims were submitted to the health carrier;
(e) relevant correspondence between the provider and the health carrier, including requests for additional information from the health carrier; and
(f) additional information which the provider believes would be of assistance in the superintendent's review.

(3) The superintendent will review the matter, based on documents and other materials that are submitted to the superintendent by the provider and health carrier for this purpose.

(4) The superintendent may issue an order resolving the dispute, with or without a hearing.

(5) If the superintendent determines, at his sole discretion, that a hearing is necessary, then the provider and the health carrier may appear and may elect to be represented by counsel at the hearing.

(6) The superintendent may designate one or more persons to act as hearing officer. The hearing officer shall prepare a recommendation for the superintendent's review.

(7) The superintendent's decision will be issued within 30 days of receiving a payment complaint if no hearing is required or within 30 days of the hearing, if a hearing is held.

(8) The superintendent may order a health carrier to reimburse a provider at the standard reimbursement rate for covered services provided to the health carrier's enrollees, subject to out-of-network costs, deductibles, co-payments, co-insurance or other cost-sharing provisions due from the enrollee.

(9) In addition to any applicable suspension, revocation or refusal to continue any certificate of authority or license under the insurance code, the superintendent may find that violators of the regulations set forth in this section are subject to the standard penalties for material violations of the insurance code, in accordance with sections 59A-1-18 and 59A-46-25 NMSA 1978.

(10) The provisions of this subsection do not prevent the superintendent from investigating a complaint when the provider has failed to contact the health carrier.

[13.10.28.10 NMAC - N, 01-01-17]

13.10.28.11 GENERAL PROVIDER CREDENTIALING:

The provisions of this section apply equally to initial credentialing applications and applications for re-credentialing.

A. Credential verification program.

(1) In order to ensure accessibility and availability of services, each health carrier shall establish a program in accordance with this regulation that verifies that its participating providers are credentialed before the health carrier accepts a provider into its network and lists a provider in the health carrier's provider directory, handbooks, or other marketing or member materials.

(2) The credential verification program established by each health carrier shall provide for an identifiable person or persons to be responsible for all credential verification activities, which person or persons shall be capable of carrying out that responsibility.

(3) A health carrier is not obligated to approve all applications for credentialing and may deny any application based on existing network adequacy, issues with application, failure by provider to provide a complete credentialing application, or another reason.

(4) No contact between a health carrier and a participating provider shall include a clause that has the effect of relieving either part of liability for its actions or inactions.

B. Delegation of credential verification activities.

(1) Whenever a health carrier delegates credential verification activities to a contracting entity, whether a credentialing intermediary or subcontractor, the health carrier shall review and approve the contracting entity's credential verification program before contracting and shall require that the entity comply with all applicable requirements of this regulation.

(2) The health carrier shall monitor the contracting entity's credential certification activities.

(3) The health carrier shall implement oversight mechanisms, including:

(a) reviewing the contracting entity's credential verification plans, policies, procedures, forms, and adherence to verification procedures; and

(b) conducting an evaluation of the contracting entity's credential verification program at least every two years.

(4) The health carrier's monitoring activities should at least meet the verification procedures and standards as defined by the national committee for quality assistance (NCQA).

C. Written credential verification plan.

- (1) Each health carrier shall develop and adopt a written credentialing plan that contains policies and procedures to support the credentialing verification program.
- (2) Each health carrier's written credential verification plan shall:
 - (a) include the purpose, goals and objectives of the credential verification program and the roles of those persons responsible for the credential verification program;
 - (b) include written criteria and procedures for initial enrollment, renewal, restrictions, and termination of credentials for all providers;
 - (c) be provided to the superintendent upon request; and
 - (d) provide an organized system to manage and protect confidentiality of personnel files and records. Records and documents relating to provider credentialing shall be retained for at least six years.
- (3) Each health carrier shall submit a report to the superintendent regarding its credentialing process every two years. The report shall include the following:
 - (a) the number of applications made to the plan;
 - (b) the number of applications approved by the plan;
 - (c) the number of applications rejected by the plan;
 - (d) the number of providers terminated for reasons of quality; and
 - (e) the amount of time taken to review and reach a determination on an application.

D. Use of uniform credentialing forms required:

- (1) Beginning January 1, 2017, a health carrier shall not use any health professional credentialing application form other than uniform hospital services corporation (HSC) or council for affordable quality healthcare (CAQH) credentialing or re-credentialing forms.
- (2) Should the superintendent determine that these forms no longer represent industry standards, the superintendent will issue a bulletin advising of alternative credentialing forms to be used to satisfy this requirement.
- (3) The uniform credentialing or re-credentialing forms may be used in electronic or paper format, as determined by the health carrier.
- (4) A health carrier or its credentialing or re-credentialing intermediary shall make the approved credentialing application forms available to any health care provider that seeks to be credentialed or re-credentialed by that health carrier or its credentialing intermediary.
- (5) A health carrier shall not require an applicant to submit information not required by the uniform credentialing or re-credentialing forms other than information or documentation that is reasonably related to information on the application.
- (6) Any request for additional information by the health carrier or its agent shall be sent to the provider via certified mail within 10 days of receipt of the initial application. This notice shall include a detailed description of what additional information or documentation is needed and contact information for this provider's credentialing application.
- (7) An exception to Paragraph (1) of Subsection D of 13.10.28.11 NMAC is made for health professionals who:
 - (a) are subject to credentialing under the health carrier's internal policy;
 - (b) practice outside of New Mexico; and
 - (c) prefer to use the credentialing forms required by their respective states. In such circumstances, the health carrier and its delegated entity, if any, may accept those forms.

[13.10.28.11 NMAC - N, 01-01-17]

13.10.28.12 TIMELY CREDENTIALING DECISIONS:

A. Verification of credentials:

- (1) Each health carrier's credentialing verification plan shall include a process to assess and verify the qualifications of providers applying to become participating providers within 45 calendar days of receipt of a completed uniform credentialing form.
- (2) Each health carrier's credentialing verification plan shall allow for the time required to request and obtain primary source verifications and other information that must be obtained from third parties in order to authenticate the applicant's credentials, and shall allow for the scheduling of a final decision by a credentialing committee if the health carrier's plan requires such review.

B. Initial verification upon receipt. Upon receipt of a uniform credentialing application, a health carrier or a health carrier's agent shall:

- (1) within 10 working days, notify the applicant by US certified mail that the uniform credentialing application has been received;

(2) verify that the application includes all information and documentation that is reasonably related to the information in the application;

(3) if the application is determined to be incomplete, send a written notification via US certified mail to the applicant within 10 working days of receipt of the uniform credentialing application, to include:

(a) a complete and detailed description of all of the information or supporting documentation that is reasonably related to information in the application that the insurer requires to approve or reject the credentialing application process; and

(b) the name, address, email, and telephone number of a person who serves as the applicant's point of contact for completing the credentialing application process;

(c) if additional information or documentation is required from the provider and is requested via certified mail as described in Paragraph (3) of Subsection B 13.10.28.12 NMAC, to inform the applicant that the 45 day time period set forth in Subsection C of 13.10.28.12 NMAC shall be tolled pending receipt of the requested information or documentation from the applicant;

(4) inform the applicant in the event that any needed verification or a verification supporting statement has not been received within 60 days of the date of the health carrier's request; and

(5) if at the end of 90 days, an application remains incomplete and the provider has been unresponsive to the health carrier's requests for information pursuant to Paragraph (3) of Subsection B of 13.10.28.12 NMAC, then the health carrier shall return the application and attached materials with a statement of rejection to the provider at the address listed in the application.

C. Timely decision.

(1) Within 45 calendar days of receipt of a completed uniform credentialing application, the health carrier or the health carrier's agent shall:

(a) assess and verify the qualifications of a provider applying to become a participating provider; and

(b) review the application and determine whether to approve or deny the credentialing application.

(2) The health carrier may:

(a) approve the provider for the health carrier's network for a period of three years;

(b) provisionally approve the provider for the health carrier's network for a period of one year; or

(c) reject the provider's credentialing application.

(3) The health carrier's decision must be issued to the provider in writing by US mail at the physical address listed in the application, and by email if an email address has been provided.

D. Timing for re-credentialing.

(1) If the credentialing application is approved, re-credentialing verification may not be required more frequently than every three years.

(2) If the application is approved provisionally, then re-credentialing shall be required annually.

(3) Nothing in this section shall be construed to require a health carrier to credential or provisionally credential any provider.

(4) Nothing in this section shall be construed to prevent a health carrier from terminating its participation agreement with a provider for cause at any time, regardless of time remaining before re-credentialing is due.

(5) A health carrier may not require a participating provider to be re-credentialed based on:

(a) a change in the provider's federal tax identification number;

(b) a change in the federal tax identification number of a provider's employer; or

(c) a change in the provider's employer, if the new employer:

(i) is a participating provider; or

(ii) also employs other participating providers.

(6) A health carrier may require that a participating provider or the provider's employer give written notice to the health carrier of a change in the provider's or the provider's employer's federal tax identification number not less than 45 calendar days before the effective date of the change.

[13.10.28.12 NMAC - N, 01-01-17]

13.10.28.13 REIMBURSEMENT BY HEALTH CARRIER UPON DELAY IN CREDENTIALING PROCESS

A. Terms for reimbursement

A health carrier shall reimburse a provider, subject to co-payments, co-insurance, deductibles, or other cost-sharing provisions, for any clean claims for covered services provided that:

- (1) the date of service is more than 45 calendar days after the date on which the health carrier received a completed uniform credentialing application for that provider, including submission of any supporting documentation that the health carrier requested in writing;
- (2) the health carrier has approved, or has failed to approve or deny the applicant's completed uniform credentialing application within the time frame established pursuant to Subsection C of 3.10.28.12 NMAC.
- (3) the provider has no past or current license sanctions or limitations, as reported by the New Mexico medical board or another pertinent licensing and regulatory agency, or by a similar out-of-state licensing and regulatory entity for a provider licensed in another state; and
- (4) the provider has professional liability insurance or is covered under the Medical Malpractice Act.

B. Sole practitioner.

A provider who, at the time services were rendered, had been awaiting a credentialing decision pursuant to Subsection A of 13.10.28.13 NMAC and was not in a practice or group that has contracted with the health carrier to provide services at specified rates of reimbursement, shall be paid by the health carrier in accordance with the carrier's standard reimbursement rate.

C. Provider group reimbursement.

A provider who, at the time services were rendered, had been awaiting a credentialing decision pursuant to Subsection A of 13.10.28.13 NMAC and was in a provider group that has contracted with the health carrier to provide services at specified rates of reimbursement, shall be paid by the carrier in accordance with the terms of the provider group contract.

D. Reimbursement period. A health carrier shall reimburse a provider pursuant to Subsections, A, B and C of 13.10.28.13 NMAC until the earlier of the following occurs:

- (1) the health carrier's approval or denial of the provider's completed uniform credentialing application; or
- (2) the passage of three years from the date the insurer received the provider's completed uniform credentialing application.

[13.10.28.13 NMAC - N, 01-01-17]

13.10.28.14 CREDENTIALING DISPUTE RESOLUTION

A. Internal review process.

- (1) Each health carrier shall establish an internal process for resolving disputes regarding credentialing between the health carrier and providers.
- (2) When a provider has not received a decision regarding a credentialing application within 45 days of submitting the completed uniform credentialing application to the health carrier, the provider may request a review of the credentialing application according to the health carrier's internal dispute process.

B. External review process.

- (1) If the matter is not resolved using the health carrier's internal dispute process within a period of 20 days from the requested review date, the provider may request a review of pending claims by the superintendent. Forms for requesting a review may be found on the OSI webpage.
- (2) The superintendent will review the matter based on documents and other materials that are submitted to the superintendent by the provider and health carrier for this purpose.
- (3) For purposes of evaluating the dispute, the date that a completed uniform credentialing application was submitted by a provider to a health carrier shall be uncontroverted if confirmed by an acknowledgement of receipt from the health carrier or presentation of a certified or registered letter confirmation provided by the US Postal Service.
- (4) The superintendent may issue an order resolving the dispute, with or without a hearing.
- (5) If the superintendent determines, at his sole discretion, that a hearing is necessary, the provider and the health carrier may appear and may elect to be represented by counsel at the hearing.
- (6) The superintendent may designate one or more persons to act as a hearing officer. The hearing officer shall prepare a recommendation for the superintendent's review.
- (7) The superintendent's decision will be issued within 30 days of receiving a request for external review if no hearing is required or within 30 days of the hearing, if a hearing is held.
- (8) The superintendent will not order a health carrier to accept a provider as a participation provider or to establish a contract with a provider.

(9) The superintendent may order a health carrier to reimburse a provider at the standard reimbursement rate, provided that the provider satisfies the requirements found in Subsection A of 13.10.28.13 NMAC. The order for such reimbursement shall terminate three years from the date that the credentialing application was submitted to the health carrier or upon a decision by the health carrier to deny the provider's request for credentialing.

(10) In addition to any applicable suspension, revocation or refusal to continue any certificate of authority or license under the New Mexico Insurance Code, the superintendent may find that violators of the regulations set forth in this section are subject to the standard penalties for material violations of the insurance code, in accordance with Sections 59A-1-18 and 59A-46-59 NMSA 1978.
[13.10.28.15 NMAC - N, 01-01-17]

13. 10 28. 15 SEVERABILITY

If any section of this rule, or the applicability of any section to any person or circumstance, is for any reason held invalid by a court of competent jurisdiction, the remainder of the rule, or the applicability of such provisions to other persons or circumstances, shall not be affected.

[13.10.28.15 NMAC - N, 01-01-17]