AN ACT

RELATING TO HEALTH INSURANCE; AMENDING SECTIONS OF THE NEW MEXICO INSURANCE CODE, THE HEALTH MAINTENANCE ORGANIZATION LAW AND THE NONPROFIT HEALTH CARE PLAN LAW TO REFINE THE REQUIREMENTS FOR CREDENTIALING OF HEALTH CARE PROVIDERS BY HEALTH INSURERS; MAKING REQUIREMENTS APPLICABLE TO OUT-OF-STATE PROVIDERS; ENSURING THAT ALL ELIGIBLE PROVIDERS RECEIVE PROMPT PAYMENT FOR CLEAN CLAIMS AND INTEREST ON UNPAID CLAIMS.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. Section 59A-16-21.1 NMSA 1978 (being Laws 2000, Chapter 58, Section 1, as amended) is amended to read:

"59A-16-21.1. HEALTH PLAN REQUIREMENTS.--

A. As used in this section:

(1) "clean claim" means a manually or electronically submitted claim from an eligible 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; and

(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;

(2) "eligible provider" means an individual or entity that:

(a) is a participating provider;

(b) a health plan has credentialed after assessing and verifying the provider's qualifications; or

(c) a health plan is obligated to reimburse for claims in accordance with the provisions of: 1) Subsection G of Section 59A-22-54 NMSA 1978; 2) Subsection G of Section 59A-23-14 NMSA 1978; 3) Subsection G of Section 59A-46-54 NMSA 1978; or 4) Subsection G of Section 59A-47-49 NMSA 1978;

(3) "health plan" means one of the following entities or its agent: health maintenance organization, nonprofit health care plan, provider service network or third-party payer; and

(4) "participating provider" means an individual or entity participating in a health plan's provider network.

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 eligible provider and not paid within thirty days of the date of receipt; and

(2) the amount of a clean claim manually submitted by the eligible 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 an eligible provider within the times specified in Subsection B of this section, the health plan shall make a good-faith effort to notify the eligible 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. The office of superintendent of insurance, with input from interested parties, including health plans and eligible providers, shall promulgate rules to require health

plans to provide:

(1) timely eligible 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."

SECTION 2. Section 59A-22-54 NMSA 1978 (being Laws 2015, Chapter 111, Section 1) is amended to read:

"59A-22-54. PROVIDER CREDENTIALING--REQUIREMENTS--DEADLINE.--

A. The superintendent shall adopt and promulgate rules to provide for a uniform and efficient provider credentialing process. The superintendent shall approve no more than two forms of application to be used for the credentialing of providers.

B. An insurer shall not require a provider to submit information not required by a credentialing application established pursuant to Subsection A of this section.

C. The provisions of this section apply equally to initial credentialing applications and applications for recredentialing.

D. The rules that the superintendent adopts and promulgates shall require primary credential verification no

more frequently than every three years and allow provisional credentialing for a period of one year.

E. Nothing in this section shall be construed to require an insurer to credential or provisionally credential a provider.

F. The rules that the superintendent adopts and promulgates shall establish that an insurer or an insurer's agent shall:

(1) assess and verify the qualifications of a provider applying to become a participating provider within forty-five calendar days of receipt of a complete credentialing application and issue a decision in writing to the applicant approving or denying the credentialing application; and

(2) within ten working days after receipt of a credentialing application, send a written notification, via United States certified mail, to the applicant requesting any information or supporting documentation that the insurer requires to approve or deny the credentialing application. The notice to the applicant shall include a complete and detailed description of all of the information or supporting documentation required and the name, address and telephone number of a person who serves as the applicant's point of contact for completing the credentialing application process. Any information required pursuant to this section shall be

reasonably related to the information in the application.

G. An insurer shall reimburse a provider for covered health care services for any claims from the provider that the insurer receives with a date of service more than forty-five calendar days after the date on which the insurer received a complete credentialing application for that provider; provided that:

(1) the provider has submitted a complete credentialing application and any supporting documentation that the insurer has requested in writing within the time frame established in Paragraph (2) of Subsection F of this section;

(2) the insurer has approved, or has failed to approve or deny, the applicant's complete credentialing application within the time frame established pursuant to Paragraph (1) of Subsection F of this section;

(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.

H. A provider who, at the time services were

rendered, was not employed by a practice or group that has contracted with the insurer to provide services at specified rates of reimbursement shall be paid by the insurer in accordance with the insurer's standard reimbursement rate.

I. A provider who, at the time services were rendered, was employed by a practice or group that has contracted with the insurer to provide services at specified rates of reimbursement shall be paid by the insurer in accordance with the terms of that contract.

J. The superintendent shall adopt and promulgate rules to provide for the resolution of disputes relating to reimbursement and credentialing arising in cases where credentialing is delayed beyond forty-five days after application.

K. An insurer shall reimburse a provider pursuant to Subsections G, H and I of this section until the earlier of the following occurs:

(1) the insurer's approval or denial of the provider's complete credentialing application; or

(2) the passage of three years from the date the insurer received the provider's complete credentialing application.

L. As used in this section:

(1) "credentialing" means the process of obtaining and verifying information about a provider and

evaluating that provider when that provider seeks to become a participating provider; and

(2) "provider" means a physician or other individual licensed or otherwise authorized to furnish health care services in a state."

SECTION 3. Section 59A-23-14 NMSA 1978 (being Laws 2015, Chapter 111, Section 2) is amended to read:

"59A-23-14. PROVIDER CREDENTIALING--REQUIREMENTS--DEADLINE.--

A. The superintendent shall adopt and promulgate rules to provide for a uniform and efficient provider credentialing process. The superintendent shall approve no more than two forms of application to be used for the credentialing of providers.

B. An insurer shall not require a provider to submit information not required by a credentialing application established pursuant to Subsection A of this section.

C. The provisions of this section apply equally to initial credentialing applications and applications for recredentialing.

D. The rules that the superintendent adopts and promulgates shall require primary credential verification no more frequently than every three years and allow provisional credentialing for a period of one year.

E. Nothing in this section shall be construed to require an insurer to credential or provisionally credential a provider.

F. The rules that the superintendent adopts and promulgates shall establish that an insurer or an insurer's agent shall:

(1) assess and verify the qualifications of a provider applying to become a participating provider within forty-five calendar days of receipt of a complete credentialing application and issue a decision in writing to the applicant approving or denying the credentialing application; and

(2) within ten working days after receipt of a credentialing application, send a written notification, via United States certified mail, to the applicant requesting any information or supporting documentation that the insurer requires to approve or deny the credentialing application. The notice to the applicant shall include a complete and detailed description of all of the information or supporting documentation required and the name, address and telephone number of a person who serves as the applicant's point of contact for completing the credentialing application process. Any information required pursuant to this section shall be reasonably related to the information in the application.

G. An insurer shall reimburse a provider for

covered health care services for any claims from the provider that the insurer receives with a date of service more than forty-five calendar days after the date on which the insurer received a complete credentialing application for that provider; provided that:

(1) the provider has submitted a complete credentialing application and any supporting documentation that the insurer has requested in writing within the time frame established in Paragraph (2) of Subsection F of this section;

(2) the insurer has approved, or has failed to approve or deny, the applicant's complete credentialing application within the time frame established pursuant to Paragraph (1) of Subsection F of this section;

(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.

H. A provider who, at the time services were rendered, was not employed by a practice or group that has contracted with the insurer to provide services at specified

rates of reimbursement shall be paid by the insurer in accordance with the insurer's standard reimbursement rate.

I. A provider who, at the time services were rendered, was employed by a practice or group that has contracted with the insurer to provide services at specified rates of reimbursement shall be paid by the insurer in accordance with the terms of that contract.

J. The superintendent shall adopt and promulgate rules to provide for the resolution of disputes relating to reimbursement and credentialing arising in cases where credentialing is delayed beyond forty-five days after application.

K. An insurer shall reimburse a provider pursuant to Subsections G, H and I of this section until the earlier of the following occurs:

(1) the insurer's approval or denial of the provider's complete credentialing application; or

(2) the passage of three years from the date the insurer received the provider's complete credentialing application.

L. As used in this section:

(1) "credentialing" means the process of obtaining and verifying information about a provider and evaluating that provider when that provider seeks to become a participating provider; and

(2) "provider" means a physician or other individual licensed or otherwise authorized to furnish health care services in the state."

SECTION 4. Section 59A-46-54 NMSA 1978 (being Laws 2015, Chapter 111, Section 4) is amended to read:

"59A-46-54. PROVIDER CREDENTIALING--REQUIREMENTS--DEADLINE.--

A. The superintendent shall adopt and promulgate rules to provide for a uniform and efficient provider credentialing process. The superintendent shall approve no more than two forms of application to be used for the credentialing of providers.

B. A carrier shall not require a provider to submit information not required by a credentialing application established pursuant to Subsection A of this section.

C. The provisions of this section apply equally to initial credentialing applications and applications for recredentialing.

D. The rules that the superintendent adopts and promulgates shall require primary credential verification no more frequently than every three years and allow provisional credentialing for a period of one year.

E. Nothing in this section shall be construed to require a carrier to credential or provisionally credential a

provider.

F. The rules that the superintendent adopts and promulgates shall establish that a carrier or a carrier's agent shall:

(1) assess and verify the qualifications of a provider applying to become a participating provider within forty-five calendar days of receipt of a complete credentialing application and issue a decision in writing to the applicant approving or denying the credentialing application; and

(2) within ten working days after receipt of a credentialing application, send a written notification, via United States certified mail, to the applicant requesting any information or supporting documentation that the carrier requires to approve or deny the credentialing application. The notice to the applicant shall include a complete and detailed description of all of the information or supporting documentation required and the name, address and telephone number of a person who serves as the applicant's point of contact for completing the credentialing application process. Any information required pursuant to this section shall be reasonably related to the information in the application.

G. A carrier shall reimburse a provider for covered health care services for any claims from the provider that the carrier receives with a date of service more than

forty-five calendar days after the date on which the carrier received a complete credentialing application for that provider; provided that:

(1) the provider has submitted a complete credentialing application and any supporting documentation that the carrier has requested in writing within the time frame established in Paragraph (2) of Subsection F of this section;

(2) the carrier has approved, or has failed to approve or deny, the applicant's complete credentialing application within the time frame established pursuant to Paragraph (1) of Subsection F of this section;

(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.

H. A provider who, at the time services were rendered, was not employed by a practice or group that has contracted with the carrier to provide services at specified rates of reimbursement shall be paid by the carrier in accordance with the carrier's standard reimbursement rate.

I. A provider who, at the time services were rendered, was employed by a practice or group that has contracted with the carrier to provide services at specified rates of reimbursement shall be paid by the carrier in accordance with the terms of that contract.

J. The superintendent shall adopt and promulgate rules to provide for the resolution of disputes relating to reimbursement and credentialing arising in cases where credentialing is delayed beyond forty-five days after application.

K. A carrier shall reimburse a provider pursuant to Subsections G, H and I of this section until the earlier of the following occurs:

(1) the carrier's approval or denial of the provider's complete credentialing application; or

(2) the passage of three years from the date the carrier received the provider's complete credentialing application."

SECTION 5. Section 59A-47-49 NMSA 1978 (being Laws 2015, Chapter 111, Section 6) is amended to read:

"59A-47-49. PROVIDER CREDENTIALING--REQUIREMENTS--DEADLINE.--

A. The superintendent shall adopt and promulgate rules to provide for a uniform and efficient provider credentialing process. The superintendent shall approve no

more than two forms of application to be used for the credentialing of providers.

B. A health care plan shall not require a provider to submit information not required by a credentialing application established pursuant to Subsection A of this section.

C. The provisions of this section apply equally to initial credentialing applications and applications for recredentialing.

D. The rules that the superintendent adopts and promulgates shall require primary credential verification no more frequently than every three years and allow provisional credentialing for a period of one year.

E. Nothing in this section shall be construed to require a health care plan to credential or provisionally credential a provider.

F. The rules that the superintendent adopts and promulgates shall establish that a health care plan or a health care plan's agent shall:

(1) assess and verify the qualifications of a provider applying to become a participating provider within forty-five calendar days of receipt of a complete credentialing application and issue a decision in writing to the applicant approving or denying the credentialing application; and

(2) within ten working days after receipt of a credentialing application, send a written notification, via United States certified mail, to the applicant requesting any information or supporting documentation that the insurer requires to approve or deny the credentialing application. The notice to the applicant shall include a complete and detailed description of all of the information or supporting documentation required and the name, address and telephone number of a person who serves as the applicant's point of contact for completing the credentialing application process. Any information required pursuant to this section shall be reasonably related to the information in the application.

G. A health care plan shall reimburse a provider for covered health care services for any claims from the provider that the insurer receives with a date of service more than forty-five calendar days after the date on which the health care plan received a complete credentialing application for that provider; provided that:

(1) the provider has submitted a complete credentialing application and any supporting documentation that the health care plan has requested in writing within the time frame established in Paragraph (2) of Subsection F of this section;

(2) the health care plan has approved, or has failed to approve or deny, the applicant's complete

credentialing application within the time frame established pursuant to Paragraph (1) of Subsection F of this section;

(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.

H. A provider who was not, at the time services were rendered, employed by a practice or group that has contracted with the health care plan to provide services at specified rates of reimbursement shall be paid by the health care plan in accordance with the health care plan's standard reimbursement rate.

I. A provider who was, at the time services were rendered, employed by a practice or group that has contracted with the health care plan to provide services at specified rates of reimbursement shall be paid by the health care plan in accordance with the terms of that contract.

J. The superintendent shall adopt and promulgate rules to provide for the resolution of disputes relating to reimbursement and credentialing arising in cases where credentialing is delayed beyond forty-five days after

application.

K. A health care plan shall reimburse a provider pursuant Subsections G, H and I of this section until the earlier of the following occurs:

(1) the insurer's approval or denial of the provider's complete credentialing application; or

(2) the passage of three years from the date the health care plan received the provider's complete credentialing application."

SECTION 6. TEMPORARY PROVISION.--The superintendent of insurance shall promulgate rules to implement the provisions of this act no later than September 1, 2016.

SECTION 7. APPLICABILITY.--

A. The provisions of Section 1 of this act apply to claims submitted for payment on or after January 1, 2017.

B. The provisions of Sections 2 through 5 of this act apply to applications for provider credentialing made on or after January 1, 2017.