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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

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

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

8 (a) is a participating provider;

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

12 (c) a health plan is obligated to  
13 reimburse for claims in accordance with the provisions of:  
14 1) Subsection G of Section 59A-22-54 NMSA 1978; 2) Subsection  
15 G of Section 59A-23-14 NMSA 1978; 3) Subsection G of Section  
16 59A-46-54 NMSA 1978; or 4) Subsection G of Section 59A-47-49  
17 NMSA 1978;

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

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

25 B. A health plan shall provide for payment of

1 interest on the plan's liability at the rate of one and  
2 one-half percent a month on:

3 (1) the amount of a clean claim  
4 electronically submitted by the eligible provider and not  
5 paid within thirty days of the date of receipt; and

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

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

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

23 E. The office of superintendent of insurance, with  
24 input from interested parties, including health plans and  
25 eligible providers, shall promulgate rules to require health

1 plans to provide:

2 (1) timely eligible provider access to  
3 claims status information;

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

6 (3) standard claims forms; and

7 (4) uniform calculation of interest."

8 SECTION 2. Section 59A-22-54 NMSA 1978 (being Laws  
9 2015, Chapter 111, Section 1) is amended to read:

10 "59A-22-54. PROVIDER CREDENTIALING--REQUIREMENTS--  
11 DEADLINE.--

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

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

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

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

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

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

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

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

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

1 reasonably related to the information in the application.

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

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

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

17 (3) the provider has no past or current  
18 license sanctions or limitations, as reported by the  
19 New Mexico medical board or another pertinent licensing and  
20 regulatory agency, or by a similar out-of-state licensing and  
21 regulatory entity for a provider licensed in another state;  
22 and

23 (4) the provider has professional liability  
24 insurance or is covered under the Medical Malpractice Act.

25 H. A provider who, at the time services were

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

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

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

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

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

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

23 L. As used in this section:

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

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

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

6 SECTION 3. Section 59A-23-14 NMSA 1978 (being Laws  
7 2015, Chapter 111, Section 2) is amended to read:

8 "59A-23-14. PROVIDER CREDENTIALING--REQUIREMENTS--  
9 DEADLINE.--

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

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

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

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

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

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

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

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

25           G. An insurer shall reimburse a provider for

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

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

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

15 (3) the provider has no past or current  
16 license sanctions or limitations, as reported by the  
17 New Mexico medical board or another pertinent licensing and  
18 regulatory agency, or by a similar out-of-state licensing and  
19 regulatory entity for a provider licensed in another state;  
20 and

21 (4) the provider has professional liability  
22 insurance or is covered under the Medical Malpractice Act.

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

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

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

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

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

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

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

21 L. As used in this section:

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

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

4 SECTION 4. Section 59A-46-54 NMSA 1978 (being Laws  
5 2015, Chapter 111, Section 4) is amended to read:

6 "59A-46-54. PROVIDER CREDENTIALING--REQUIREMENTS--  
7 DEADLINE.--

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

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

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

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

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

1 provider.

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

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

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

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

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

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

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

13 (3) the provider has no past or current  
14 license sanctions or limitations, as reported by the  
15 New Mexico medical board or another pertinent licensing and  
16 regulatory agency, or by a similar out-of-state licensing and  
17 regulatory entity for a provider licensed in another state;  
18 and

19 (4) the provider has professional liability  
20 insurance or is covered under the Medical Malpractice Act.

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

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

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

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

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

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

19 SECTION 5. Section 59A-47-49 NMSA 1978 (being Laws  
20 2015, Chapter 111, Section 6) is amended to read:

21 "59A-47-49. PROVIDER CREDENTIALING--REQUIREMENTS--  
22 DEADLINE.--

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

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

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

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

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

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

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

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

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

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

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

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

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

3 (3) the provider has no past or current  
4 license sanctions or limitations, as reported by the  
5 New Mexico medical board or another pertinent licensing and  
6 regulatory agency, or by a similar out-of-state licensing and  
7 regulatory entity for a provider licensed in another state;  
8 and

9 (4) the provider has professional liability  
10 insurance or is covered under the Medical Malpractice Act.

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

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

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

1 application.

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

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

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

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

13 SECTION 7. APPLICABILITY.--

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

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

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