AN ACT

RELATING TO HEALTH INSURANCE; REQUIRING THE SUPERINTENDENT OF INSURANCE TO PROMULGATE RULES ESTABLISHING A TIME FRAME FOR INSURERS TO LOAD INFORMATION ON APPROVED PROVIDERS INTO THEIR PROVIDER PAYMENT SYSTEMS; REQUIRING INSURERS TO REIMBURSE APPROVED PROVIDERS IF THE INSURERS FAIL TO LOAD THAT INFORMATION WITHIN THIRTY DAYS OF RECEIVING A COMPLETE CREDENTIALING APPLICATION.

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

SECTION 1. Section 59A-22-54 NMSA 1978 (being Laws 2015, Chapter 111, Section 1, as amended) 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 thirty calendar days of receipt of a complete credentialing application and issue a decision in writing to the applicant approving or denying the credentialing application;

(2) be permitted to extend the credentialing period to assess and issue a determination by an additional fifteen calendar days if, upon review of a complete application, it is determined that the circumstance presented, including an admission of sanctions by the state licensing board, investigation or felony conviction, revocation of clinical privileges or denial of insurance coverage, requires additional consideration;

(3) 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; and

(4) no later than thirty calendar days as described in Paragraph (1) of this subsection or an additional fifteen days as described in Paragraph (2) of this subsection, load into the insurer's provider payment system all provider information, including all information needed to correctly reimburse a newly approved provider according to the provider's contract. The insurer or insurer's agent shall add the approved provider's data to the provider directory upon loading the provider's information into the insurer's provider payment system.

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

thirty calendar days after the date on which the insurer received a complete credentialing application for that provider if:

(1) the provider:

(a) has submitted a complete credentialing application and any supporting documentation that the insurer has requested in writing within the time frame established in Paragraph (3) of Subsection F of this section;

(b) 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

(c) has professional liability insurance or is covered under the Medical Malpractice Act; and

(2) the insurer:

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

(b) fails to load the approved applicant's information into the insurer's provider payment system in accordance with Paragraph (4) of Subsection F of

this section.

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 thirty 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 2. Section 59A-23-14 NMSA 1978 (being Laws 2015, Chapter 111, Section 2, as amended) 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 thirty calendar days of receipt of a complete credentialing application and issue a decision in writing to the applicant approving or denying the credentialing application;

(2) be permitted to extend the credentialing period to assess and issue a determination by an additional fifteen calendar days if, upon review of a complete application, it is determined that the circumstance presented, including an admission of sanctions by the state licensing board, investigation or felony conviction, revocation of clinical privileges or denial of insurance coverage, requires additional consideration;

(3) 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; and

(4) no later than thirty calendar days as described in Paragraph (1) of this subsection or an additional fifteen days as described in Paragraph (2) of this subsection, load into the insurer's provider payment system all provider information, including all information needed to correctly reimburse a newly approved provider according to the provider's contract. The insurer or insurer's agent shall add the approved provider's data to the provider directory upon loading the provider's information into the insurer's provider payment system.

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 thirty calendar days after the date on which the insurer received a complete credentialing application for that provider if:

(1) the provider:

(a) has submitted a complete credentialing application and any supporting documentation that the insurer has requested in writing within the time frame established in Paragraph (3) of Subsection F of this section;

(b) 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

(c) has professional liability insurance or is covered under the Medical Malpractice Act; and

(2) the insurer:

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

(b) fails to load the approved applicant's information into the insurer's provider payment system in accordance with Paragraph (4) of Subsection F of this section.

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 thirty 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 3. Section 59A-46-54 NMSA 1978 (being Laws 2015, Chapter 111, Section 4, as amended) 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 thirty calendar days of receipt of a complete credentialing application and issue a decision in writing to the applicant approving or denying the credentialing application;

(2) be permitted to extend the credentialing period to assess and issue a determination by an additional fifteen calendar days if, upon review of a complete application, it is determined that the circumstance presented, including an admission of sanctions by the state licensing board, investigation or felony conviction, revocation of clinical privileges or denial of insurance coverage, requires additional consideration;

(3) 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; and

(4) no later than thirty calendar days as described in Paragraph (1) of this subsection or an additional fifteen days as described in Paragraph (2) of this subsection, load into the carrier's provider payment system all provider information, including all information needed to correctly reimburse a newly approved provider according to the provider's contract. The carrier or carrier's agent shall add the approved provider's data to the provider directory upon loading the provider's information into the carrier's provider payment system.

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 thirty calendar days after the date on which the carrier received a complete credentialing application for that provider if:

(1) the provider:

(a) has submitted a complete credentialing application and any supporting documentation

that the carrier has requested in writing within the time frame established in Paragraph (3) of Subsection F of this section;

(b) 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

(c) has professional liability insurance or is covered under the Medical Malpractice Act; and

(2) the carrier:

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

(b) fails to load the approved applicant's information into the carrier's provider payment system in accordance with Paragraph (4) of Subsection F of this section.

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 thirty 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 4. Section 59A-47-49 NMSA 1978 (being Laws 2015, Chapter 111, Section 6, as amended) 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 thirty calendar days of receipt of a complete credentialing application and issue a decision in writing to the applicant approving or denying the credentialing application;

(2) be permitted to extend the credentialing period to assess and issue a determination by an additional fifteen calendar days if, upon review of a complete application, it is determined that the circumstance presented, including an admission of sanctions by the state licensing board, investigation or felony conviction, revocation of clinical privileges or denial of insurance coverage, requires additional consideration;

(3) 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; and

(4) no later than thirty calendar days as described in Paragraph (1) of this subsection or an additional fifteen days as described in Paragraph (2) of this subsection, load into the health care plan's provider payment system all provider information, including all information

needed to correctly reimburse a newly approved provider according to the provider's contract. The health care plan or health care plan's agent shall add the approved provider's data to the provider directory upon loading the provider's information into the health care plan's provider payment system.

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 thirty calendar days after the date on which the health care plan received a complete credentialing application for that provider if:

(1) the provider:

(a) 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 (3) of Subsection F of this section;

(b) 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

(c) has professional liability insurance or is covered under the Medical Malpractice Act;

and

(2) the health care plan:

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

(b) fails to load the approved applicant's information into the health care plan's provider payment system in accordance with Paragraph (4) of Subsection F of this section.

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 thirty days after

application.

K. A health care plan 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 health care plan received the provider's complete credentialing application."