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 (OSI), Life and Health (L&H)
[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, non-profit healthcare plans and third-party payers or their agents that provide, offer or administer health benefit 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 or covered persons, the credentialing process by which health carriers review and select providers who apply to join carriers' 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 its enrollees or covered persons.
[13.10.28.2 NMAC - N, 01/01/17]

13.10.28.3 STATUTORY AUTHORITY: Sections 59A-16-20; 59A-16-21.1, 59A-22-54, 59A-23-14, 59A-46-54, and 59A-47-48 NMSA 1978.
[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-related 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 information that, when later supplemented by verifications and documentation

gathered by the health carrier during the primary source verification process, is necessary for the health carrier to make a credentialing decision.

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 application form to be used for the credentialing of providers.

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 is deemed received, as follows:

(1) for claims and credentialing applications submitted electronically or sent via fax and unless the sender is notified immediately of a transmission error, the date of receipt is the date on which a claim or credentialing application is submitted or, for claims that arrive on a non-business day, the date of the first business day thereafter;

(2) for claims and credentialing applications that are hand delivered, the date of receipt is the date of delivery; or

(3) for claims and credentialing applications submitted through the US mail, the health carrier may select and shall consistently administer one of the following options:

(a) the first business day following the date of actual receipt by a person or organization that has been designated by the health carrier to manage incoming mail;

(b) if no person or organization has been designated to manage incoming mail, then the first business day following the date of actual receipt by the health carrier; or

(c) three business days after the postmark on the claim or application that is submitted through 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 provider to a health carrier via an electronic portal or using another on-line 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 or 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 an individual engaged in the delivery of health care services that 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 non-profit 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, e-mail, or hand delivery.

R. "Network" means the group(s) 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 professional, 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 an 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 a provider that is treated by a health carrier as a participating provider for a period of up to one-year, based on the results of credentialing.

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 by the hospital services corporation (HSC), the counsel for affordable quality healthcare datasource (CAQH), or another form as approved by the superintendent provided that the form is used only for the credentialing of facility and ancillary providers, or other credentialing forms as specified by a bulletin posted on the OSI website, including any revisions thereto and as developed and updated from time to time and including electronic versions of such forms.

AA. "Verification or verification supporting statement" means documentation confirming the information submitted by an applicant for credentialing by a specifically named entity or by a regional, national, or general data depository providing primary source verification, including but not limited to a college, university, medical school, teaching hospital, specialty certification board, 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 provide payments 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 of receipt 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 make a good faith effort to notify the participating provider by fax, electronic, or other written communication within 30 days following the date of receipt.

(5) Any notification from a health carrier to a provider that there is an error or omission in a claim submission must contain a specific statement regarding all information sought to rectify the error or omission. The carrier shall make a good faith effort to convey all of the errors or omissions to the provider at one time. A pattern of repetitive requests for the same information from a health carrier to a provider is a violation of Article 16 of the Insurance Code, as defined at §59A-16-20.

C. Manual submission.

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

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

(3) Claims that are submitted via US mail are deemed to be received by the health carrier on the date of receipt. Claims that are transmitted via fax, E-mail or hand delivery are deemed to be received by the health carrier on the date of receipt 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 make a good faith effort to notify the participating provider in writing within 45 days following the date of receipt.

(5) Any notification from a health carrier to a provider that there is an error or omission in a claim submission must contain a specific statement regarding all information sought to rectify the error or omission. The carrier shall make a good faith effort to convey all of the errors or omissions to the provider at one time. A pattern of repetitive requests for the same information from a health carrier to a provider is violation of Article 16 of the Insurance Code, as defined at §59A-16-20.

D. Access to Claims Status Information.

(1) Health carriers shall provide an electronic means whereby participating providers can access claim information within three business days of the date of receipt for electronic claims and within 10 business days of the date of receipt for manual claims.

(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 of receipt;

(b) identifying claim information, which may include enrollee/covered persons 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 of receipt if the clean claim has been submitted electronically or within 45 days of the date of receipt if the clean claim has been submitted manually.

(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 provider; or

(b) an electronic transfer of funds 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. If non-claim payments to a provider are included in a multi-claim payment, the nature of those payments must also be clearly identified.

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 the amount of any clean claim that has not been paid within the time specified in Subsection A of 13.10.28.9 NMAC.

C. Pending claims.

(1) Questionable liability and special treatment claims.

(a) If, upon receipt of a claim, a health carrier is unable to determine liability for, or otherwise refuses to pay a claim or a portion of a claim of an eligible provider within the time specified in Subsection A of 13.10.28.9 NMAC, the health carrier shall make a good faith effort to notify the eligible provider electronically, in writing, or by another method, as agreed between the health carrier and provider, within 30 days of the date of receipt of the claim if submitted electronically and within 45 days of the date of receipt of the claim if submitted manually.

(b) If, upon receipt of a claim, a health carrier determines that a claim or a portion of a claim requires special treatment due to particular or unusual circumstances that will delay payment beyond the time specified in Subsection A of 13.10.28.9 NMAC, the health carrier shall make a good faith effort to notify the eligible provider electronically, in writing, or by another method, as agreed between the health carrier and provider, within 30 days of the date of receipt of the claim if submitted electronically and within 45 days of the date of receipt of the claim if submitted manually.

(2) Notification of pending claims. The notification required by Subsection C of 13.10.28.9 NMAC, shall:

(a) specify the reason(s) why the health carrier is refusing to pay the claim, has determined it is not liable for the claim, or shall specify what information is required to determine liability for the claim;

(b) clearly indicate if only certain charges associated with a claim are contested; and

(c) shall be repeated by the health carrier at least monthly until the matter is resolved.

(3) Uncontested portion of pending claims. The timely payment requirement described in Section A of 13.10.28.9 NMAC applies to any uncontested portion of a contested claim.

(4) Liability resolved. The date on which liability or special treatment issues are resolved for a pending claim is the date that the claim becomes a clean claim and shall initiate the timely payment requirement described in Subsection A of 13.10.28.9 NMAC.

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 A of 13.10.28.9 NMAC and there is no question of liability or special treatment as described in Subsection C of 13.10.28.9 NMAC or questions of liability or special treatment have been resolved, 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 31st day after the claim has been submitted electronically and on the 46th day for claims submitted manually, the health carrier shall calculate and pay interest in the amount of one and one-half percent 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 dollars ($2.00). 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 identifying 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 and is not paid within 30 or 45 days of becoming an electronic or manual clean claim, respectively, the health carrier shall pay 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 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(s) to be responsible for all credential verification activities, which person(s) 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 an application, failure by provider to provide a complete credentialing application, or another reason.

(4) No contract between a health carrier and a participating provider shall include a clause that has the effect of relieving either party 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;

(b) include written criteria and procedures for initial enrollment, renewal, restrictions, and termination of providers;

(c) be provided to the superintendent upon request;

(d) provide an organized system to manage and protect confidentiality of credentialing files and records; and

(e) require that records and documents relating to provider credentialing be retained for at least six years.

(3) 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 provider's request for credentialing or a provider's completed uniform credentialing form, whichever is earlier. The plan shall allow for the following to take place within this 45 calendar days:

(a) time required to obtain the completed uniform credentialing form in electronic format, if necessary;

(b) time 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;

(c) a final decision by a credentialing committee if the health carrier's plan requires such review; and

(d) time to notify the provider of the health carrier's decision.

D. Reporting requirements. Each health carrier shall submit a report to the superintendent regarding its credentialing process for the prior two-year period beginning December 31, 2018, and on December 31 for all even numbered years thereafter, or as otherwise directed by the superintendent. The report shall include the following:

(1) the number of applications made to the plan for each type of provider;

(2) the number of applications approved by the plan for each type of provider;

(3) the number of applications rejected by the plan for each type of provider;

(4) the number of providers terminated for reasons of quality; and

(5) the amount of time taken to review and reach a determination on an application.

E. Use of uniform credentialing forms required:

(1) Beginning January 1, 2017, a health carrier shall not use any provider credentialing application form other than uniform credentialing forms, as that term is defined in 13.10.28.7 NMAC.

(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) A health carrier or its credentialing or re-credentialing intermediary shall make uniform 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 and also accept uniform credentialing applications electronically or through electronic transfer upon the request of any provider.

(4) An exception to Paragraph (1) of Subsection E of 13.10.28.10 NMAC is made for providers who:

(a) are licensed and also practice outside of New Mexico; and

(b) 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.

F. Required information. 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.

G. Accreditation by nationally recognized accrediting entity.

(1) Nothing in this section shall require a health carrier to violate or fail to meet a standard or requirement of a nationally recognized accrediting entity.

(2) A health carrier may seek a waiver of these requirements from the superintendent by submitting accreditation by a nationally recognized entity as evidence of compliance with the requirements of this section.

(3) In those instances where a health carrier seeks to meet the requirements of this section through accreditation by a private accrediting entity, the health carrier shall submit to the superintendent the following information:

(a) current standards of the private accrediting entity in order to demonstrate that the entity's standards meet or exceed the requirements of this rule;

(b) documentation from the private accrediting entity showing that the health carrier has been accredited by the entity; and

(c) a summary of the data and information that was presented to the private accrediting entity by the health carrier and upon which accreditation of the health carrier was based.

(4) A health carrier accredited by the private accrediting entity that has submitted all of the requisite information to the superintendent may then be determined by the superintendent to have met the requirements of the relevant provisions of this section where comparable standards exist, provided that the private accrediting entity from which the health carrier obtained accreditation is recognized and approved by the superintendent.

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

13.10.28.11 TIMELY CREDENTIALING DECISIONS:

A. Initiation of credentialing process. The credentialing process may be initiated by a provider, who either:

(1) provides a completed uniform credentialing form directly to the health carrier; or

(2) notifies the health carrier that the provider is requesting credentialing by the health carrier, that the provider's completed uniform credentialing form is in electronic format and is available to the health carrier for access via the credentialing form's website or on-line database, and that the health carrier is requested to obtain the provider's completed uniform credentialing form.

B. Initial verification upon receipt.

(1) Upon receiving a provider's request for credentialing or a provider's completed credentialing form, a health carrier or a health carrier's agent shall review the application to verify that the application includes all necessary information and documentation that is reasonably related to the information in the

application. The health carrier may initially attempt to obtain additional or missing information by informal means including but not limited to fax, telephone, or e-mail.

(2) A health carrier or a health carrier's agent shall notify the applicant by US certified mail within 10 days of receipt that the request for credentialing has been received, but that if the application is incomplete that the 45-day time period set forth in Subsection C of 13.10.28.11 NMAC shall not commence until the applicant provides all requested information or documentation.

(3) Any request for additional information that has not been met through an informal exchange and remains outstanding at the end of the initial 10-day review period shall also be sent to the provider via the same or separate certified mail within 10 business days of receipt of the 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; and

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

(c) notice that if an application remains incomplete and the applicant has been unresponsive to requests for information beyond 45 days, then the health carrier may deny the application for failure to respond and notify the applicant that the application is denied.

C. Timely decision.

(1) Within 45 calendar days of the date of receipt of a request for credentialing, 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 up to three years;

(b) provisionally accept the provider for the health carrier's network for a period of one-year, or the maximum duration up to one-year as allowed by the health carrier's accreditation organization; or

(c) deny the provider for the health carrier's network.

(3) The health carrier's decision must be issued to the provider in writing by US mail at the physical or mailing address listed in the application, and by e-mail if an e-mail 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 or at the conclusion of the shorter period if required by a health carrier's accreditation organization and approved by the superintendent.

(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) Except as may otherwise be required by a health carrier's accreditation organization 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.

E. Accreditation by nationally recognized accrediting entity.

(1) A health carrier may seek a waiver of these credentialing requirements from the superintendent by submitting accreditation by a nationally recognized entity as evidence of compliance with the requirements of this section.

(2) In those instances where a health carrier seeks to meet the requirements of this section through accreditation by a private accrediting entity, the health carrier shall submit to the superintendent the following information:

(a) current standards of the private accrediting entity in order to demonstrate that the entity's standards meet or exceed the requirements of this rule;

(b) documentation from the private accrediting entity showing that the health carrier has been accredited by the entity; and

(c) a summary of the data and information that was presented to the private accrediting entity by the health carrier and upon which accreditation of the health carrier was based.

(3) The superintendent will determine whether a health carrier that has been accredited by a private accrediting entity and has submitted all of the requisite information has met the requirements of the relevant provisions of this section where comparable standards exist.

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

13.10.28.12 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 the provider requested credentialing from the health carrier and either the provider supplied a completed uniform credentialing application or made the completed uniform credentialing application available for electronic access by the health carrier, including submission of any supporting documentation that the health carrier requested in writing during the initial 10-day review period;

(2) the health carrier has approved, or has failed to approve or deny the applicant's completed uniform credentialing application within the timeframe established pursuant to Subsection C of 13.10.28.11 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 has been approved by a health carrier for credentialing or who has been awaiting a credentialing decision pursuant to Subsection C of 13.10.28.11 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 or at an agreed upon rate.

C. Provider group reimbursement. A provider who, at the time services were rendered, has been approved by a health carrier for credentialing or who has been awaiting a credentialing decision pursuant to Subsection C of 13.10.28.11 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 13.10.28.12 NMAC until the earlier of the following occurs:

(1) the health carrier denies the provider's credentialing application;

(2) the health carrier approves the provider's credentialing application and the provider and health carrier enter a contract to replace a previously agreed upon rate, or

(3) the passage of three years from the date the insurer received the provider's completed uniform credentialing application.

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

13.10.28.13 CREDENTIALING AND PAYMENT DISPUTE RESOLUTION:

A. Internal review process.

(1) Each health carrier shall establish an internal process for resolving disputes regarding payment of claims between the health carrier and providers arising when a credentialing decision is delayed beyond the timeline found in Subsection C of 13.10.28.11 NMAC, the prompt payment deadline described in Paragraph (2) of Subsection A of 13.10.28.9 NMAC has passed, and payment has not been made.

(2) The internal process shall include required notification regarding pending claims and calculation and payment of interest on overdue claims, as described in Subsections C and D of 13.10.28.9 NMAC.

(3) The internal process shall provide for resolution of disputes regarding reimbursement rates as described in 13.10.28.12 NMAC.

(4) At a minimum, the internal review process shall provide for the following:

(a) 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) The health carrier shall respond in writing to a provider's inquiry regarding the status of an unpaid claim within 15 days of receiving the inquiry.

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

(5) The internal review process may provide specific procedures for resolving payment disputes, including by not limited to, the use of medication.

B. Complaint filed with Superintendent.

(1) If the health carrier fails to respond or the provider believes that payment is being denied, delayed, or calculated in error and the matter has not been successfully resolved at the internal level within 45 days, then the provider may file a complaint, either individually or in batches, with the superintendent using the form found on the OSI website.

(2) Complaints filed with the superintendent shall contain the following information:

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

(b) the date that the provider's request for credentialing was complete;

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

(d) the name of the patient and employer (if known);

(e) the date(s) of service and the date(s) the claims were submitted to the health carrier;

(f) relevant correspondence between the provider and the health carrier, including requests for additional information from the health carrier;

(g) additional information which the provider believes would be of assistance in the superintendent's review; and

(h) only those excerpts from provider contracts that are minimally necessary to resolve the dispute shall be submitted to the superintendent, who shall maintain the confidentiality of such excerpts to the fullest extent allowed by applicable law.

(3) The complaining provider shall furnish the health carrier with a complete copy of the complaint and submitted documentation concurrently with the provider's submission to the superintendent.

(4) The health carrier shall be afforded 10 business days after the provider's submission to resolve the matter or to submit additional information that the health carrier believes would be of assistance to the superintendent's review.

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

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

(7) 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.

(8) 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.

(9) 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.

(10) 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.

(11) 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.

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

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

13.10.28.14 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.

[13.10.28.14 NMAC - N, 01/01/17]

HISTORY OF 13.10.28 NMAC: [RESERVED]