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AN ACT

RELATING TO MANAGED HEALTH CARE; AMENDING AND ENACTING SECTIONS OF THE NEW MEXICO INSURANCE CODE, THE HEALTH MAINTENANCE ORGANIZATION LAW AND THE NONPROFIT HEALTH CARE PLAN LAW TO ESTABLISH PROVIDER CREDENTIALING REQUIREMENTS AND DEFINE "CREDENTIALING"; REPEALING A SECTION OF THE NEW MEXICO INSURANCE CODE.

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

SECTION 1. A new section of Chapter 59A, Article 22 NMSA 1978 is enacted to read:

"PROVIDER CREDENTIALING--REQUIREMENTS--DEADLINE.--

A. The superintendent shall adopt and promulgate rules to provide for a uniform and efficient provider credentialing process. The rules shall establish a single credentialing application form for the credentialing of providers.

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

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

D. The rules that the superintendent adopts and

1 promulgates pursuant to Subsection A of this section shall
2 require primary credential verification no more frequently
3 than every three years.

4 E. The rules that the superintendent adopts and
5 promulgates pursuant to Subsection A of this section shall
6 establish that an insurer or an insurer's 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 F. Except as provided pursuant to Subsection G of

1 this section, an insurer shall reimburse a provider for
2 covered health care services, in accordance with the
3 carrier's standard reimbursement rate, for any claims from
4 the provider that the insurer receives with a date of service
5 more than forty-five calendar days after the date on which
6 the insurer received a complete credentialing application for
7 that 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 E of this
12 section;

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

17 (3) the provider has no past or current
18 license sanctions or limitations, as reported by the New
19 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 G. In cases where a provider is joining an

1 existing practice or group that has contracted reimbursement
2 rates with an insurer, the insurer shall pay the provider in
3 accordance with the terms of that contract.

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

9 I. An insurer shall reimburse a provider pursuant
10 to the circumstances set forth in Subsection F of this
11 section until the earlier of the following occurs:

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

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

17 J. As used in this section:

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

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

25 SECTION 2. A new section of Chapter 59A, Article 23

1 NMSA 1978 is enacted to read:

2 "PROVIDER CREDENTIALING--REQUIREMENTS--DEADLINE.--

3 A. The superintendent shall adopt and promulgate
4 rules to provide for a uniform and efficient provider
5 credentialing process. The rules shall establish a single
6 credentialing application form for the credentialing of
7 providers.

8 B. An insurer shall not require a provider to
9 submit information not required by the uniform credentialing
10 application established pursuant to Subsection A of this
11 section.

12 C. The provisions of this section apply equally to
13 credentialing applications and applications for
14 recredentialing.

15 D. The rules that the superintendent adopts and
16 promulgates pursuant to Subsection A of this section shall
17 require primary credential verification no more frequently
18 than every three years.

19 E. The rules that the superintendent adopts and
20 promulgates pursuant to Subsection A of this section shall
21 establish that an insurer or an insurer's agent shall:

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

1 the applicant approving or denying the credentialing
2 application; and

3 (2) within ten working days after receipt of
4 a credentialing application, send a written notification, via
5 United States certified mail, to the applicant requesting any
6 information or supporting documentation that the insurer
7 requires to approve or deny the credentialing application.

8 The notice to the applicant shall include a complete and
9 detailed description of all of the information or supporting
10 documentation required and the name, address and telephone
11 number of a person who serves as the applicant's point of
12 contact for completing the credentialing application process.
13 Any information required pursuant to this section shall be
14 reasonably related to the information in the application.

15 F. Except as provided pursuant to Subsection G of
16 this section, an insurer shall reimburse a provider for
17 covered health care services, in accordance with the
18 carrier's standard reimbursement rate, for any claims from
19 the provider that the insurer receives with a date of service
20 more than forty-five calendar days after the date on which
21 the insurer received a complete credentialing application for
22 that provider; provided that:

23 (1) the provider has submitted a complete
24 credentialing application and any supporting documentation
25 that the insurer has requested in writing within the time

1 frame established in Paragraph (2) of Subsection E of this
2 section;

3 (2) the insurer has failed to approve or
4 deny the applicant's complete credentialing application
5 within the time frame established pursuant to Paragraph (1)
6 of Subsection E of this section;

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

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

15 G. In cases where a provider is joining an
16 existing practice or group that has contracted reimbursement
17 rates with an insurer, the insurer shall pay the provider in
18 accordance with the terms of that contract.

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

24 I. An insurer shall reimburse a provider pursuant
25 to the circumstances set forth in Subsection F of this

1 section until the earlier of the following occurs:

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

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

7 J. As used in this section:

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

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

15 SECTION 3. Section 59A-46-2 NMSA 1978 (being Laws 1993,
16 Chapter 266, Section 2, as amended) is amended to read:

17 "59A-46-2. DEFINITIONS.--As used in the Health
18 Maintenance Organization Law:

19 A. "basic health care services":

20 (1) means medically necessary services
21 consisting of preventive care, emergency care, inpatient and
22 outpatient hospital and physician care, diagnostic
23 laboratory, diagnostic and therapeutic radiological services
24 and services of pharmacists and pharmacist clinicians; but

25 (2) does not include mental health services

1 or services for alcohol or drug abuse, dental or vision
2 services or long-term rehabilitation treatment;

3 B. "capitated basis" means fixed per member per
4 month payment or percentage of premium payment wherein the
5 provider assumes the full risk for the cost of contracted
6 services without regard to the type, value or frequency of
7 services provided and includes the cost associated with
8 operating staff model facilities;

9 C. "carrier" means a health maintenance
10 organization, an insurer, a nonprofit health care plan or
11 other entity responsible for the payment of benefits or
12 provision of services under a group contract;

13 D. "copayment" means an amount an enrollee must
14 pay in order to receive a specific service that is not fully
15 prepaid;

16 E. "credentialing" means the process of obtaining
17 and verifying information about a provider and evaluating
18 that provider when that provider seeks to become a
19 participating provider;

20 F. "deductible" means the amount an enrollee is
21 responsible to pay out-of-pocket before the health
22 maintenance organization begins to pay the costs associated
23 with treatment;

24 G. "enrollee" means an individual who is covered
25 by a health maintenance organization;

1 H. "evidence of coverage" means a policy, contract
2 or certificate showing the essential features and services of
3 the health maintenance organization coverage that is given to
4 the subscriber by the health maintenance organization or by
5 the group contract holder;

6 I. "extension of benefits" means the continuation
7 of coverage under a particular benefit provided under a
8 contract or group contract following termination with respect
9 to an enrollee who is totally disabled on the date of
10 termination;

11 J. "grievance" means a written complaint submitted
12 in accordance with the health maintenance organization's
13 formal grievance procedure by or on behalf of the enrollee
14 regarding any aspect of the health maintenance organization
15 relative to the enrollee;

16 K. "group contract" means a contract for health
17 care services that by its terms limits eligibility to members
18 of a specified group and may include coverage for dependents;

19 L. "group contract holder" means the person to
20 whom a group contract has been issued;

21 M. "health care services" means any services
22 included in the furnishing to any individual of medical,
23 mental, dental, pharmaceutical or optometric care or
24 hospitalization or nursing home care or incident to the
25 furnishing of such care or hospitalization, as well as the

1 furnishing to any person of any and all other services for
2 the purpose of preventing, alleviating, curing or healing
3 human physical or mental illness or injury;

4 N. "health maintenance organization" means any
5 person who undertakes to provide or arrange for the delivery
6 of basic health care services to enrollees on a prepaid
7 basis, except for enrollee responsibility for copayments or
8 deductibles;

9 O. "health maintenance organization agent" means a
10 person who solicits, negotiates, effects, procures, delivers,
11 renews or continues a policy or contract for health
12 maintenance organization membership or who takes or transmits
13 a membership fee or premium for such a policy or contract,
14 other than for that person, or a person who advertises or
15 otherwise makes any representation to the public as such;

16 P. "individual contract" means a contract for
17 health care services issued to and covering an individual and
18 it may include dependents of the subscriber;

19 Q. "insolvent" or "insolvency" means that the
20 organization has been declared insolvent and placed under an
21 order of liquidation by a court of competent jurisdiction;

22 R. "managed hospital payment basis" means
23 agreements in which the financial risk is related primarily
24 to the degree of utilization rather than to the cost of
25 services;

1 S. "net worth" means the excess of total admitted
2 assets over total liabilities, but the liabilities shall not
3 include fully subordinated debt;

4 T. "participating provider" means a provider as
5 defined in Subsection X of this section who, under an express
6 contract with the health maintenance organization or with its
7 contractor or subcontractor, has agreed to provide health
8 care services to enrollees with an expectation of receiving
9 payment, other than copayment or deductible, directly or
10 indirectly from the health maintenance organization;

11 U. "person" means an individual or other legal
12 entity;

13 V. "pharmacist" means a person licensed as a
14 pharmacist pursuant to the Pharmacy Act;

15 W. "pharmacist clinician" means a pharmacist who
16 exercises prescriptive authority pursuant to the Pharmacist
17 Prescriptive Authority Act;

18 X. "provider" means a physician, pharmacist,
19 pharmacist clinician, hospital or other person licensed or
20 otherwise authorized to furnish health care services;

21 Y. "replacement coverage" means the benefits
22 provided by a succeeding carrier;

23 Z. "subscriber" means an individual whose
24 employment or other status, except family dependency, is the
25 basis for eligibility for enrollment in the health

1 maintenance organization or, in the case of an individual
2 contract, the person in whose name the contract is issued;
3 and

4 AA. "uncovered expenditures" means the costs to
5 the health maintenance organization for health care services
6 that are the obligation of the health maintenance
7 organization, for which an enrollee may also be liable in the
8 event of the health maintenance organization's insolvency and
9 for which no alternative arrangements have been made that are
10 acceptable to the superintendent."

11 SECTION 4. A new section of the Health Maintenance
12 Organization Law is enacted to read:

13 "PROVIDER CREDENTIALING--REQUIREMENTS--DEADLINE.--

14 A. The superintendent shall adopt and promulgate
15 rules to provide for a uniform and efficient provider
16 credentialing process. The rules shall establish a single
17 credentialing application form for the credentialing of
18 providers.

19 B. A carrier shall not require a provider to
20 submit information not required by the uniform credentialing
21 application established pursuant to Subsection A of this
22 section.

23 C. The provisions of this section apply equally to
24 credentialing applications and applications for
25 recredentialing.

1 D. The rules that the superintendent adopts and
2 promulgates pursuant to Subsection A of this section shall
3 require primary credential verification no more frequently
4 than every three years.

5 E. The rules that the superintendent adopts and
6 promulgates pursuant to Subsection A of this section shall
7 establish that a carrier or a carrier's agent shall:

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

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

1 F. Except as provided pursuant to Subsection G of
2 this section, a carrier shall reimburse a provider for
3 covered health care services, in accordance with the
4 carrier's standard reimbursement rate, for any claims from
5 the provider that the carrier receives with a date of service
6 more than forty-five calendar days after the date on which
7 the carrier received a complete credentialing application for
8 that provider; provided that:

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

14 (2) the carrier has failed to approve or
15 deny the applicant's complete credentialing application
16 within the time frame established pursuant to Paragraph (1)
17 of Subsection E of this section;

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

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

1 G. In cases where a provider is joining an
2 existing practice or group that has contracted reimbursement
3 rates with a carrier, the carrier shall pay the provider in
4 accordance with the terms of that contract.

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

10 I. A carrier shall reimburse a provider pursuant
11 to the circumstances set forth in Subsection F of this
12 section until the earlier of the following occurs:

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

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

18 SECTION 5. Section 59A-47-3 NMSA 1978 (being Laws 1984,
19 Chapter 127, Section 879.1, as amended) is amended to read:

20 "59A-47-3. DEFINITIONS.--As used in Chapter 59A,
21 Article 47 NMSA 1978:

22 A. "health care" means the treatment of persons
23 for the prevention, cure or correction of any illness or
24 physical or mental condition, including optometric services;

25 B. "item of health care" includes any services or

1 materials used in health care;

2 C. "health care expense payment" means a payment
3 for health care to a purveyor on behalf of a subscriber, or
4 such a payment to the subscriber;

5 D. "purveyor" means a person who furnishes any
6 item of health care and charges for that item;

7 E. "service benefit" means a payment that the
8 purveyor has agreed to accept as payment in full for health
9 care furnished the subscriber;

10 F. "indemnity benefit" means a payment that the
11 purveyor has not agreed to accept as payment in full for
12 health care furnished the subscriber;

13 G. "subscriber" means any individual who, because
14 of a contract with a health care plan entered into by or for
15 the individual, is entitled to have health care expense
16 payments made on the individual's behalf or to the individual
17 by the health care plan;

18 H. "underwriting manual" means the health care
19 plan's written criteria, approved by the superintendent, that
20 defines the terms and conditions under which subscribers may
21 be selected. The underwriting manual may be amended from
22 time to time, but amendment will not be effective until
23 approved by the superintendent. The superintendent shall
24 notify the health care plan filing the underwriting manual or
25 the amendment thereto of the superintendent's approval or

1 disapproval thereof in writing within thirty days after
2 filing or within sixty days after filing if the
3 superintendent shall so extend the time. If the
4 superintendent fails to act within such period, the filing
5 shall be deemed to be approved;

6 I. "acquisition expenses" includes all expenses
7 incurred in connection with the solicitation and enrollment
8 of subscribers;

9 J. "administration expenses" means all expenses of
10 the health care plan other than the cost of health care
11 expense payments and acquisition expenses;

12 K. "health care plan" means a nonprofit
13 corporation authorized by the superintendent to enter into
14 contracts with subscribers and to make health care expense
15 payments;

16 L. "agent" means a person appointed by a health
17 care plan authorized to transact business in this state to
18 act as its representative in any given locality for
19 soliciting health care policies and other related duties as
20 may be authorized;

21 M. "solicitor" means a person employed by the
22 licensed agent of a health care plan for the purpose of
23 soliciting health care policies and other related duties in
24 connection with the handling of the business of the agent as
25 may be authorized and paid for the person's services either

1 on a commission basis or salary basis or part by commission
2 and part by salary;

3 N. "chiropractor" means any person holding a
4 license provided for in the Chiropractic Physician Practice
5 Act;

6 O. "doctor of oriental medicine" means any person
7 licensed as a doctor of oriental medicine under the
8 Acupuncture and Oriental Medicine Practice Act;

9 P. "pharmacist" means a person licensed as a
10 pharmacist pursuant to the Pharmacy Act;

11 Q. "pharmacist clinician" means a pharmacist who
12 exercises prescriptive authority pursuant to the Pharmacist
13 Prescriptive Authority Act;

14 R. "credentialing" means the process of obtaining
15 and verifying information about a provider and evaluating
16 that provider when that provider seeks to become a
17 participating provider; and

18 S. "provider" means a physician or other
19 individual licensed or otherwise authorized to furnish health
20 care services in the state."

21 SECTION 6. A new section of Chapter 59A, Article 47
22 NMSA 1978 is enacted to read:

23 "PROVIDER CREDENTIALING--REQUIREMENTS--DEADLINE.--

24 A. The superintendent shall adopt and promulgate
25 rules to provide for a uniform and efficient provider

1 credentialing process. The rules shall establish a single
2 credentialing application form for the credentialing of
3 providers.

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

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

11 D. The rules that the superintendent adopts and
12 promulgates pursuant to Subsection A of this section shall
13 require primary credential verification no more frequently
14 than every three years.

15 E. The rules that the superintendent adopts and
16 promulgates pursuant to Subsection A of this section shall
17 establish that a health care plan or a health care plan's
18 agent shall:

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

25 (2) within ten working days after receipt of

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

12 F. Except as provided pursuant to Subsection G of
13 this section, a health care plan shall reimburse a provider
14 for covered health care services, in accordance with the
15 carrier's standard reimbursement rate, for any claims from
16 the provider that the insurer receives with a date of service
17 more than forty-five calendar days after the date on which
18 the insurer received a complete credentialing application for
19 that provider; provided that:

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

25 (2) the insurer has failed to approve or

1 deny the applicant's complete credentialing application
2 within the time frame established pursuant to Paragraph (1)
3 of Subsection E of this section;

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

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

12 G. In cases where a provider is joining an
13 existing practice or group that has contracted reimbursement
14 rates with a health care plan, the insurer shall pay the
15 provider in accordance with the terms of that contract.

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

21 I. A health care plan shall reimburse a provider
22 pursuant to the circumstances set forth in Subsection F of
23 this section until the earlier of the following occurs:

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

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

SECTION 7. REPEAL.--Section 59A-2-9.5 NMSA 1978 (being Laws 2003, Chapter 235, Section 3) is repealed. _____