SENATE BILL 234

52ND LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2016

INTRODUCED BY

Cliff R. Pirtle

AN ACT

RELATING TO HEALTH INSURANCE; REFINING THE REQUIREMENTS FOR CREDENTIALING OF HEALTH CARE PROVIDERS BY HEALTH INSURERS; MAKING REQUIREMENTS APPLICABLE TO OUT-OF-STATE PROVIDERS; ENSURING THAT PROVIDERS AWAITING CREDENTIALING DECISIONS FROM A HEALTH PLAN RECEIVE PROMPT PAYMENT FOR CLEAN CLAIMS AND INTEREST ON UNPAID CLAIMS TO THE SAME EXTENT AS PROVIDERS PARTICIPATING IN THE HEALTH PLAN'S NETWORK.

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

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

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

A. As used in this section:

(1) "applicant" means a physician or other individual licensed or otherwise authorized to furnish health

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care services in this or another state who:

(a) has applied to be credentialed by the health plan in order to be included in the health plan's provider network; and

(b) meets the criteria for payment while awaiting a decision from the health plan approving or denying credentialing pursuant to Subsection G of Section 59A-22-54 NMSA 1978;

[~~(1)~~] (2) "clean claim" means a manually or electronically submitted claim from a participating provider that:

(a) contains substantially all the required data elements necessary for accurate adjudication without the need for additional information from outside of the health plan's system;

(b) is not materially deficient or improper, including lacking substantiating documentation currently required by the health plan; and

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

~~(2)~~] (3) "health plan" means health maintenance organizations, provider service networks or third-

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party payers or their agents; and

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

B. A health plan shall provide for payment of interest on the plan's liability at the rate of one and one-half percent a month on:

(1) the amount of a clean claim electronically submitted by the participating provider or applicant and not paid within thirty days of the date of receipt; and

(2) the amount of a clean claim manually submitted by the participating provider or applicant and not paid within forty-five days of the date of receipt.

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

D. No contract between a health plan and a participating provider shall include a clause that has the

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effect of relieving either party of liability for its actions or inactions.

E. [~~By December 1, 2000~~] The office of superintendent of insurance, with input from interested parties, including health plans and participating providers, shall promulgate rules to require health plans to provide:

(1) timely participating provider access to claims status information;

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

(3) standard claims forms; and

(4) uniform calculation of interest."

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

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

A. The superintendent shall adopt and promulgate rules to provide for a uniform and efficient provider credentialing process. The [~~rules shall establish a single credentialing application form~~] 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 the [~~uniform credentialing application established pursuant to Subsection A of this~~

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~~section~~] appropriate approved form of credentialing application.

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

D. Except as provided in Subsection E of this section, the rules that the superintendent adopts and promulgates [~~pursuant to Subsection A of this section~~] shall require primary credential verification no more frequently than every three years.

E. The superintendent shall promulgate rules to allow provisional credentialing for a period of one year of a provider who:

(1) has been licensed or otherwise authorized to furnish health care services in this or another state for less than two years as of the date upon which an application seeking credentialing is made;

(2) is on probation under the authority of a medical board or other pertinent licensing and regulatory entity for such provider as of the date upon which an application seeking credentialing is made; or

(3) within six months or less before the date upon which an application seeking credentialing is made, has been on probation under the authority of a medical board or other pertinent licensing and regulatory entity for such

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provider.

[~~E.~~] F. The rules that the superintendent adopts and promulgates [~~pursuant to Subsection A of this section~~] shall establish that an insurer or an insurer's agent shall:

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

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

[~~F.~~] G. Except as provided [~~pursuant to~~] in Subsection [~~G~~] H of this section, an insurer shall reimburse a provider for covered health care services, in accordance with the carrier's standard reimbursement rate, for any claims from

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

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

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

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

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

[~~G.~~] H. In cases where a provider is joining an existing practice or group that has contracted reimbursement rates with an insurer, the insurer shall pay the provider in accordance with the terms of that contract.

[~~H.~~] I. The superintendent shall adopt and

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

[~~I.~~] J. An insurer shall reimburse a provider pursuant to the circumstances set forth in Subsection [~~F~~] G 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 carrier received the provider's complete credentialing application.

[~~J.~~] K. 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~~] this or another state."

SECTION 3. TEMPORARY PROVISION.--The superintendent of insurance shall promulgate rules to implement the provisions of this act no later than September 1, 2016.

SECTION 4. APPLICABILITY.--

A. The provisions of Section 1 of this act apply to

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claims submitted for payment on or after January 1, 2017.

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

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