TITLE 13 INSURANCE
CHAPTER 10 HEALTH INSURANCE
PART 37 DENTAL PLAN PROVIDER CREDENTIALING REQUIREMENTS

13.10.37.1 ISSUING AGENCY: Office of Superintendent of Insurance
[13.10.37.1 NMAC – N, 07/01/2026]

13.10.37.2 SCOPE:

A. Applicability. This rule applies to all dental health insurance carriers offering or selling any individual or group dental insurance plans with a network. The provisions of this rule shall apply equally to initial credentialing applications and applications for re-credentialing.

B. Timely Payments. This rule addresses the timely payment to dental providers by dental health insurance carriers for covered services that have been provided to the carrier's enrollees or covered persons, the credentialing process by which dental health insurance carriers review and select dental providers who apply to join carriers' networks, and a dispute resolution process to be utilized by dental providers and dental health insurance carriers to resolve differences pertaining to dental provider credentialing and payment for covered services.

C. Exclusions. This rule does not impose any requirement on dental health insurance carriers to credential or provisionally credential dental providers or to require that a dental provider must be accepted into a dental health insurance carrier's network, specify terms of contracts established between dental health insurance carriers and dental providers, establish standard reimbursement rates for payment by dental health insurance carriers to in-network or out-of-network dental providers for services, or interpret terms of any contract established between a dental health insurance carrier and its enrollees or covered persons.
[13.10.37.2 NMAC – N, 07/01/2026]

13.10.37.3 STATUTORY AUTHORITY: Sections 14-4-1 *et seq*., State Rules Act, and Sections 59A-2-9 and 59A-23G-13 NMSA 1978.
[13.10.37.3 NMAC – N, 07/01/2026]

13.10.37.4 DURATION: Permanent.
[13.10.37.4 NMAC – N, 07/01/2026]

13.10.37.5 EFFECTIVE DATE: July 1, 2026 unless a later date is cited at the of a section.
[13.10.37.5 NMAC – N, 07/01/2026]

13.10.37.6 OBJECTIVE: The purpose of this rule is to establish a uniform and efficient dental provider credentialing process and to ensure that dental providers receive prompt payment from dental health insurance carriers for clean claims and interest on unpaid claims. This rule also establishes a process for resolving payment-related credentialing disputes between dental health insurance carriers and dental providers.
[13.10.37.6 NMAC – N, 07/01/2026]

13.10.37.7 DEFINITIONS: As used in this rule:

A. "Business day" means Monday through Friday, excluding any days that state offices are officially closed.

B. "Claim" means a request from a dental provider for payment for health care services.

C. "Clean claim" means a manually or electronically submitted claim from an eligible dental provider that:

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

(2) is not materially deficient or improper, including lacking substantiating documentation currently required by the dental health insurance 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 dental health insurance carrier within 30 calendar days of the date of receipt if submitted electronically or 45 calendar days if submitted manually.

D. "Completed credentialing application" means a credentialing application that contains all of the information that, when later supplemented by verifications and documentation gathered by the dental health insurance carrier during the primary source verification process, is necessary for the dental health insurance carrier to make a credentialing decision.

E. "Covered benefits" means the specific health services provided under a dental health benefits plan.

F. "Credentialing" has the same meaning as defined in Paragraph (1) of Subsection L of Section 59A-23F-13 NMSA 1978.

G. "Credentialing application" means the application form provided by the council for affordable quality healthcare (CAQH) and one other type of form as approved by the superintendent upon request by the carrier.

H. "Credentialing intermediary" or **"agent"** means a person to whom a dental health insurance 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 U.S. mail, the dental health insurance 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 dental health insurance 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 dental health insurance carrier; or

(c) three business days after the postmark on the claim or application that is submitted through the U.S. mail.

J. "Day" or "days" means a calendar day, including weekends, holidays, and any other non-business days.

K. "Dental health benefits plan" or "dental insurance" means a policy, contract, certificate or agreement entered into, offered or issued by a dental health insurance carrier authorized to issue dental coverage in the state, to provide, deliver, arrange for, pay for or reimburse any of the costs of dental health care services.

L. "Dental health care services" means services, preventative services, supplies, and procedures for the diagnosis, prevention, treatments, cure or relief of a dental health condition, illness, injury, or disease, and includes, to the extent offered by the dental health benefits plan.

M. "Dental hygienist" has the same meaning as defined in Paragraph (2) of Subsection L of Section 59A-23G-13 NMSA 1978.

N. "Dental provider" means a dentist and a dental hygienist referenced collectively for the purposes of this rule only.

O. "Dentist" has the same meaning as defined in Paragraph (3) of Subsection L of Section 59A-23G-13 NMSA 1978.

P. "Electronic claim submission" means a request for payment that is submitted by a dental provider to a dental health insurance 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 dental health insurance carrier.

Q. "Enrollee or covered person" means an individual who is entitled to receive health care benefits provided by a dental health insurance 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 dental benefits plan.

R. "Dental health insurance carrier" means an entity that is properly licensed to offer dental insurance in the state and that is subject to the insurance laws and regulations of this state, including a dental health insurance company, a health maintenance organization, a hospital and health service corporation, a dental 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 dental health care services, or that provides, offers or administers dental health benefit policies in this state.

S. "Manual claim submission" means a request for payment that is submitted by a dental provider to a health carrier via US mail, facsimile, email, or hand delivery.

T. "Network" means the group of participating dental providers who provide dental health care services under a network plan.

U. "Network plan" means a dental health plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care insurance carriers managed, owned, under contract with or employed by the health carrier.

V. "OSI" means the office of superintendent of insurance.

W. "Participating dental provider" means a dental provider, dental health care professional engaged in the delivery of health care services that is licensed or authorized to practice in the state, or facility who under express contract with a dental health insurance carrier or with its contractor or subcontractor, has agreed to provide dental health care services to enrollees with an expectation n of receiving payment directly or indirectly from the dental health insurance carrier, subject to co-payments, co-insurance deductibles, or other cost-sharing provisions.

X. "Provisional acceptance" means a dental provider that is treated by a dental health insurance carrier as a participating dental provider for a period of up to one-year, based on the results of credentialing.

Y. "Standard reimbursement rate" means the usual, customary, and reasonable reimbursement rate paid to dental providers for dental health care services that is at or near the median rate paid for similar dental health care services.

Z. "Superintendent" has the same meaning as defined in Section 59A-1-12 NMSA 1978.

AA. "Uniform credentialing forms" means the forms used by CAQH or another form as agreed to between the dental provider and the carrier, and approved by the superintendent, including revisions and electronic versions of such forms.

BB. "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, dental or dental hygiene school, teaching hospital, specialty certification board, health care facility or institution, state licensing board (New Mexico board of dental health care), federal agency or department, professional liability insurer, or the national practitioner data bank.

[13.10.37.7 NMAC – N, 07/01/2026]

13.10.37.8 CLAIM SUBMISSION AND CODING CHANGES:

A. General.

(1) Dental health insurance 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 dental health insurance carrier that has entered into a contract with one or more credentialing intermediaries to conduct dental provider credentialing or provide payments to dental providers shall require the intermediary to indicate the name of the intermediary and the name of the dental health insurance carrier for which it is conducting the work when contacting a dental provider on behalf of the dental health insurance carrier.

B. Electronic submission.

(1) Dental health insurance carriers shall make available to participating dental providers a process and procedure for submitting claims electronically.

(2) Dental health insurance carriers shall make available to participating dental providers a process and procedure for electronically filing an amendment to claims after original submission.

(3) Claims that are transmitted electronically are deemed to be received by the dental health insurance carrier on the date of receipt unless the dental provider receives immediate notice of a transmission error.

(4) When a claim is submitted electronically and the dental health insurance carrier subsequently determines that there is an error or omission with the submission that will delay or prevent payment to the participating dental provider, the health carrier shall make a good faith effort to notify the participating dental provider by facsimile, electronic, or other written communication within 30 calendar days following the date of receipt.

(5) Any notification from a dental health insurance carrier to a dental 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 dental health insurance carrier shall make a good faith effort to convey all of the errors or omissions to the dental provider at one time. Dental health insurance carriers shall avoid a pattern of repetitive requests for the same information from a dental provider.

C. Manual submission.

(1) Dental health insurance carriers shall make standard forms available to dental providers for submitting claims manually via US mail, facsimile, email, or hand delivery.

(2) Dental health insurance carriers shall make standard forms available to dental providers for manual coding changes to be submitted via U.S. mail, fax, email, or hand delivery.

(3) Claims that are submitted via certified U.S. mail or hand delivered are deemed to be received by the dental health insurance carrier on the date of receipt. Claims that are electronically transmitted, or transmitted via facsimile or email are deemed to be received by the dental health insurance carrier on the date of receipt unless the dental provider receives immediate notice of a transmission error.

(4) When a claim is submitted manually and the dental health insurance carrier subsequently determines that there is an error or omission with the submission that will delay or prevent payment to the dental provider, the dental health insurance carrier shall make a good faith effort to notify the participating dental provider in writing within 45 calendar days following the date of receipt.

(5) Any notification from a dental health insurance carrier to a dental 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 dental provider at one time. Dental health insurance carriers shall avoid a pattern of repetitive requests for the same information from a dental provider.

D. Access to claims status information.

(1) Dental health insurance carriers shall provide an electronic means whereby participating dental providers or covered persons 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 dental provider or covered person 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 dental health insurance carrier and agreed to by the dental 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 dental health insurance carrier has requested additional information from the dental 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.

[13.10.37.8 NMAC – N, 07/01/2026]

13.10.37.9 PAYMENT OF CLAIMS, OVERDUE CLAIMS AND CALCULATION OF INTEREST:

A. Payment of claims - timeliness.

(1) **Claim payment**. Dental health insurance carriers shall promptly pay participating dental providers upon receipt of clean claims for covered dental health care services that the dental provider has supplied.

(2) **Timeliness**. The dental health insurance carrier shall reimburse for covered services provided by credentialed dental provider within 30 calendar days of the date of receipt if the clean claim has been submitted electronically or within 45 calendar 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 dental health insurance carrier or its intermediary to the dental provider; or

(b) an electronic transfer of funds is made by the dental health insurance carrier or its intermediary to the dental provider.

(4) Standard reimbursement rate. The dental health insurance carrier shall make payment to the dental provider based on the standard reimbursement rate as specified within the contractual agreement, or as otherwise agreed upon between the dental health insurance carrier and the dental provider.

(5) Multi-claim payments. A single payment made to a dental 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 dental 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 dental health insurance carrier shall pay interest as set forth in Subsection D of 13.10.37.9 NMAC on the amount of any clean claim that has not been paid within the time specified in Subsection A of 13.10.37.9 NMAC.

C. Pending claims.

(1) Specialty treatment claims.

(a) If upon receipt of a claim, a dental health insurance carrier is unable to determine liability for, or otherwise refuses to pay a claim or a portion of a claim of an eligible dental provider within the time specified in Subsection A of 13.10.37.9 NMAC, the dental health insurance carrier shall notify the eligible dental provider electronically, in writing, or by another method, as agreed between the dental health insurance carrier and dental provider, within 30 calendar days of the date of receipt of the claim if submitted electronically and within 45 calendar days of the date of receipt of the claim if submitted manually.

(b) If, upon receipt of a claim, a dental health insurance carrier cannot make a coverage determination because the claim or a portion of the claim involves particular or unusual circumstances as defined by the carrier, that require additional review, and such circumstances will delay payment beyond the time specified in Subsection A of 13.10.37.9 NMAC, the carrier shall notify the eligible dental provider electronically, in writing, or by other agreed method within 15 calendar days of receipt of an electronic claim or within 30 calendar days of receipt of a manual claim.

(2) Notification of pending claims. The notification required by Subsection C of 13.10.37.9 NMAC, shall:

(a) Specify the reason(s) why the dental health insurance carrier is declining payment of the claim and specify what information or records are required to determine payment of the claim;

(b) clearly indicate the specific services associated with a claim that are subject to the untimely payment or claim denial; and

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

(3) Carriers shall not withhold payment for covered services that have been approved or require no further documentation, even when other components of the same claim remain under review.

(4) Payment of resolved issues. The date on which coverage 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 of covered services requirement described in Subsection A of 13.10.37.9 NMAC.

D. Untimely payments, calculation of interest.

(1) When payment is not made by the dental health insurance carrier to the dental provider within the time specified in Subsection A of 13.10.37.9 NMAC and there is no question of coverage determination issue or special treatment as described in Subsection C of 13.10.37.9 NMAC or coverage determination issues or special treatment have been resolved, interest shall be calculated and paid to the dental provider, 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 dental health insurance 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 dental health insurance 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 calendar 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 dental health insurance 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 coverage determination issue or special treatment is ultimately resolved in favor of the dental provider and is not paid within 30 or 45 calendar days of becoming an

electronic or manual clean claim, respectively, the dental health insurance carrier shall pay all of the interest due on the unpaid covered services, to be calculated as described in Paragraph (1) of Subsection D of 13.10.37.9 NMAC. [13.10.37.9 NMAC – N, 07/01/2026]

13.10.37.10 GENERAL DENTAL 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 dental health insurance carrier shall establish a program as approved by the superintendent and in accordance with this rule.

(2) The credential verification program established by each dental health insurance 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 dental health insurance carrier shall not be required to approve all applications for credentialing and may deny any application based on existing network adequacy, issues with an application, failure by dental provider to provide a complete credentialing application, or another reason.

(4) No contract between a dental health insurance carrier and a participating dental provider shall include a clause that has the effect of relieving either party of liability for respective actions or inactions.

B. Delegation of credential verification activities.

(1) Whenever a dental health insurance carrier delegates credential verification activities to a contracting entity, whether a credentialing intermediary, agent, or subcontractor, the dental health insurance 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 dental health insurance carrier shall monitor the contracting entity's credential certification activities.

(3) The dental health insurance 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 dental health insurance 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 dental health insurance carrier shall develop and adopt a written credentialing plan that contains policies and procedures to support the credentialing verification program.

(2) Each dental health insurance 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 dental 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 dental provider credentialing be retained for at least six years.

(3) Each dental health insurance carrier's credentialing verification plan shall include a process to assess and verify the qualifications of a dental provider who is applying to become a participating dental provider within 30 calendar days of receipt of a complete credentialing application and issue a decision in writing to the applicant approving or denying the credentialing application. The dental health insurance carrier or dental health insurance carrier's agent shall be permitted to extend the credentialing period to assess and issue a determination by an additional 15 calendar days if upon a review of a completed application, it is determined that the circumstances presented, including the following matters that may require additional consideration:

(a) an issuance of sanctions by the board of dental health care; or

(b) an investigation or background check; or

(c) a felony conviction; or

(d) a revocation of clinical privileges or a denial of insurance coverage.

D. Reporting requirements. Each dental health insurance carrier shall submit a report to the superintendent regarding its credentialing process for the six-month period of July 1 to December 31, 2026, on May

1, 2027. Then, beginning December 31, 2028, and for all even numbered years thereafter, each dental health insurance carrier shall submit a report to the superintendent regarding its credentialing process for the prior two-year period on May 1, 2029, and on May 1 in odd 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 dental provider;

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

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

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

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

E. Required information. A dental health insurance carrier shall not require a dental provider to submit information not required by the uniform credentialing or re-credentialing forms or this regulation, other than information or documentation that is reasonably related to information on the application. Information is reasonably related to the application if it is connected to the nationally recognized credentialing standards for dental providers.

F. Accreditation by nationally recognized accrediting entity.

(1) Nothing in this section shall require a dental health insurance carrier to violate or fail to meet a standard or requirement of a nationally recognized accrediting entity, for example national committee for quality assurance (NCQA) or utilization review accreditation commission (URAC).

(2) A dental health insurance carrier may seek a waiver of these requirements from OSI by submitting accreditation by a nationally recognized entity as evidence of compliance with the requirements of this section to the contact email address as posted on the OSI website, under the life and health division.

(3) In those instances where a dental health insurance carrier seeks to meet the requirements of this section through accreditation by a private accrediting entity, the dental health insurance 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 dental health insurance 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 dental health insurance carrier and upon which accreditation of the dental health insurance carrier was based.

(4) A dental health insurance carrier accredited by the private accrediting entity that has submitted all of the requisite information to OSI may then be determined by OSI 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 dental health insurance carrier obtained accreditation is recognized and approved by OSI.
[13.10.37.10 NMAC – N, 07/01/2026]

13.10.37.11 TIMELY CREDENTIALING DECISIONS:

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

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

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

B. Initial verification upon receipt.

(1) A dental health insurance carrier or a dental health insurance carrier's agent shall notify the applicant by U.S. certified mail or other method that evidences delivery confirmation that is agreed to in writing by the dental health insurance carrier and the provider, within 10 business days of receipt that the request for credentialing has been received, but that if the application is incomplete that the 30-day time period set forth in Subsection C of 13.10.37.11 NMAC shall not commence until the applicant provides all requested information or documentation.

(2) Within 30 calendar days of receipt of a complete credentialing application the dental health insurance carrier or a dental health insurance carrier's agent shall assess and verify the qualifications of a

dental provider who is applying to become a participating provider and issue a decision in writing to the applicant approving or denying the credentialing application.

(3) A dental health insurance carrier shall be permitted to extend the credentialing period to assess and issue a determination by an additional 15 calendar days if, upon review of a complete application, it is determined that certain circumstances require additional consideration, including:

(a) an issuance of sanctions by the board of dental health care; or

(b) an investigation or background check; or

(c) a felony conviction; or

(d) a revocation of clinical privileges or a denial of coverage.

(4) Within 10 business days after receipt of a credentialing application, A dental health insurance carrier or a dental health insurance carrier's agent shall send a written notification via United States certified mail or other method that evidences delivery confirmation to the applicant requesting any additional information or supporting documentation that the dental health insurance carrier requires to approve or deny the credentialing application. The notice to the applicant shall 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. Information is reasonably related to the application if it is connected to the nationally recognized credentialing standards for dental providers; and

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

(c) no later than 30 calendar days as described in Paragraph (1) above, or an additional 15 calendar days as described in Paragraph (2) above, load into the dental health insurance carrier's dental provider payment system all dental provider information, including all information needed to correctly reimburse a newly approved dental provider according to the dental provider's contract.

C. Timely decision.

(1) Within 30 calendar days of the date of receipt of a complete credentialing application the dental health insurance carrier or the dental health insurance carrier's agent shall:

(a) assess and verify the qualifications of a dental provider applying to become a participating dental provider; and load into the dental health insurance carrier's dental provider payment system all the dental provider information including all information needed to correctly reimburse a newly approved dental provider according to the dental provider's contract.

(b) review the application and determine whether to approve or deny the credentialing application.

(2) The dental health insurance carrier shall:

(a) approve the dental provider for the dental health insurance carrier's network for a period of up to three years. Upon approval, the dental health insurance carrier or dental health insurance carrier's agent shall add the approved dental provider's data to the dental provider directory within five business days upon loading the dental provider's information into the dental health insurance carrier's dental provider payment system; or

(b) provisionally accept the dental provider for the dental health insurance carrier's network for a period of one-year, or the maximum duration up to one year as allowed by the dental health insurance carrier's accreditation organization. Upon approval, the dental health insurance carrier or dental health insurance carrier's agent shall add the approved dental provider's data to the dental provider directory upon loading the dental provider's information into the dental health insurance carrier's dental provider payment system; or

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

(3) The dental health insurance carrier's decision must be issued to the dental provider in writing by certified U.S. mail at the physical or mailing address listed in the application or other method that evidences delivery confirmation such as email if an email 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 or as otherwise required by a nationally recognized accrediting entity such as the national committee for quality assurance (NCAQ) or the utilization review accreditation commission (URAC).

(2) In order to allow carriers to complete the recredentialing process prior to the 36-month expiration, carriers are permitted to initiate recredentialing efforts after 32 months have passed since the last

credentialing cycle or in the event a provider returns a recredentialing application prior to the expiration of the 36-month period set forth in Paragraph (1) of Subsection D of 13.10.37.11 NMAC.

(3) 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 dental health insurance carrier's accreditation organization and approved by the superintendent.

(4) Nothing in this section shall be construed to require a dental health insurance carrier to credential or provisionally credential any dental provider.

(5) Nothing in this section shall be construed to prevent a dental health insurance carrier from terminating its participation agreement with a dental provider for cause at any time; regardless of time remaining before re-credentialing is due.

(6) Except as may otherwise be required by a dental health insurance carrier's accreditation organization a dental health insurance carrier may not require a participating dental provider to be re-credentialed based on:

(a) a change in the dental provider's federal tax identification number;

(b) a change in the federal tax identification number of a dental provider's employer; or

(c) a change in the dental provider's employer, if the new employer:

(i) is a participating dental provider; or

(ii) also employs other participating dental providers.

(7) A dental health insurance carrier may require that a participating dental provider or the dental provider's employer give written notice to the dental health insurance carrier of a change in the dental provider's or the dental 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 dental health insurance carrier may seek a waiver of these credentialing requirements from the superintendent by submitting accreditation by a nationally recognized entity for credentialing, as evidence of compliance with the requirements of this section.

(2) In those instances where a dental health insurance carrier seeks to meet the requirements of this section through accreditation by a private accrediting entity, the dental health insurance carrier shall submit to contact email listed on the OSI website under the life and health division, 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 dental health insurance 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 dental health insurance carrier and upon which accreditation of the dental health insurance carrier was based.

(3) OSI will determine whether a dental health insurance 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.

[13.10.37.11 NMAC – N, 07/01/2026]

13.10.37.12 REIMBURSEMENT BY DENTAL HEALTH INSURANCE CARRIER UPON DELAY IN DENTAL CREDENTIALING PROCESS:

A. Terms for reimbursement. A dental health insurance carrier shall reimburse a dental 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 30 calendar days or if the dental health insurance carrier extended the credentialing period another 15 calendar days then no more than 45 calendar days after the date the dental provider requested credentialing from the dental health insurance carrier and either the dental provider supplied a completed uniform credentialing application or made the completed uniform credentialing application available for electronic access by the dental health insurance carrier, including submission of any supporting documentation that the dental health insurance carrier requested in writing during the initial 10 business day review period;

(2) the dental health insurance 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 13.10.37.11 NMAC;

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

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

(5) the dental health insurance carrier fails to load the approved applicants' information into the dental health insurance carrier's dental provider payment system in accordance with Subsection C of Section 13.10.37.11 NMAC; and

(6) A dental health insurance carrier may only provide retroactive reimbursement to providers that hold an active license in good standing and maintain appropriate malpractice coverage. In the event of a pending credentialing application, a dental health insurance carrier shall notify a dental health provider that if the provider application is denied, the dental health carrier will not reimburse the dental health provider on a pending claim.

B. Sole practitioner. A dentist or dental hygienist who, at the time services were rendered has been approved by a dental health insurance carrier for credentialing or who has been awaiting a credentialing decision pursuant to Subsection C of 13.10.37.11 NMAC and was not in a practice or group that has contracted with the dental health insurance carrier to provide services at specified rates of reimbursement, shall be paid by the dental health insurance carrier in accordance with the carrier's standard reimbursement rate or at an agreed upon rate.

C. Dental provider group reimbursement. A dentist or dental hygienist who, at the time services were rendered, has been approved by a dental health insurance carrier for credentialing or who has been awaiting a credentialing decision pursuant to Subsection C of 13.10.37.11 NMAC and was in a dental provider group that has contracted with the dental health insurance carrier to provide services at specified rates of reimbursement, shall be paid by the carrier in accordance with the terms of the dental provider group contract.

D. Reimbursement period. A dental health insurance carrier shall reimburse a dental provider pursuant to Subsections A, B, and C of 13.10.37.12 NMAC until the earlier of the following occurs:

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

(2) the dental health insurance carrier approves the dental provider's credentialing application and the dental provider and dental health insurance 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 dental provider's completed uniform credentialing application.

[13.10.37.12 NMAC – N, 07/01/2026]

13.10.37.13 CREDENTIALING AND PAYMENT DISPUTE RESOLUTION: Dental provider credentialing disputes shall be resolved pursuant to 13.10.16 NMAC.

[13.10.37.13 NMAC – N, 07/01/2026]

13.10.37.14 SEVERABILITY: If any section of this rule, or the applicability of any section to any person or circumstance, is for any reason held to be 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.

[13.10.37.14 NMAC – N, 07/01/2026]

History of 13.10.37 NMAC: [RESERVED]