HOUSE COMMITTEE AMENDMENTS

2018 Regular Session

Amendments proposed by House Committee on Insurance to Original House Bill No. 775 by Representative Davis

AMENDMENT NO. 1

On page 1, line 2, after "R.S. 22:1874(A)(5)" and before the comma "," insert "and R.S. 46:460.62"

AMENDMENT NO. 2

On page 3, after line 7, add the following:

"Section 2. R.S. 46:460.62 is hereby amended and reenacted to read as follows:

§460.62. Interim credentialing requirements

A. Under certain circumstances and when the provisions of this Subsection are met, a managed care organization contracting with a group of ~~physicians~~ healthcare providers that bills a managed care organization utilizing a group identification number, such as the group federal tax identification number or the group National Provider Identifier as set forth in 45 CFR 162.402 et seq., shall pay the contracted reimbursement rate of the ~~physician~~ provider group for covered ~~health care~~ healthcare services rendered by a new ~~physician~~ provider to the group without ~~health care~~ healthcare provider credentialing as described in this Subpart. This provision shall apply in either of the following circumstances:

(1) When the new ~~physician~~ provider has already been credentialed by the managed care organization, and the ~~physician's~~ provider's credentialing is still active with the managed care organization.

(2) When the managed care organization has received the required credentialing application that is correctly and fully completed and information, including proof of active hospital privileges from the new ~~physician~~ provider, and the managed care organization has not notified the ~~physician~~ provider group that credentialing of the new ~~physician~~ provider has been denied.

B. A managed care organization shall comply with the provisions of Subsection A of this Section no later than thirty days after receipt of a written request from the ~~physician~~ provider group.

C. Compliance by a managed care organization with the provisions of Subsection A of this Section shall not be construed to mean that a ~~physician~~ provider has been credentialed by the managed care organization, or the managed care organization shall be required to list the ~~physician~~ provider in a directory of contracted ~~physicians~~ healthcare providers.

D. If, after compliance with Subsection A of this Section, a managed care organization completes the credentialing process on the new ~~physician~~ provider and determines the ~~physician~~ provider does not meet the managed care organization's credentialing requirements, the managed care organization may recover from the ~~physician~~ provider or the ~~physician~~ provider group an amount equal to the difference between appropriate payments for in-network benefits and out-of-network benefits, ~~provided that~~ if the managed care organization has notified the applicant ~~physician~~ provider of the adverse determination and ~~provided that~~ the prepaid entity has initiated action regarding ~~such~~ the recovery within thirty days of the adverse determination."