2018 Regular Session

HOUSE BILL NO. 775

BY REPRESENTATIVE DAVIS

INSURANCE/HEALTH: Provides relative to the reimbursement of healthcare providers

AN ACT

To amend and reenact R.S. 22:1874(A)(5)and R.S. 46:460.62, relative to the reimbursement of contracted healthcare providers; to provide for payment to a new provider in a contracted network of providers; to provide for recovery of certain amounts upon denial of an application for credentialing; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 22:1874(A)(5) is hereby amended and reenacted to read as follows:

§1874. Billing by contracted ~~health care~~ healthcare providers

A.

* * *

(5)(a) Under certain circumstances and when the provisions of Subparagraph (b) of this Paragraph are met, a health insurance issuer contracting with a group of ~~physicians~~ healthcare providers that bills a health insurance issuer utilizing a group identification number, such as the group federal tax identification number or the group National Provider Identifier as set forth in 45 CFR162.402 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 R.S. 22:1009. This provision shall apply in either of the following circumstances:

(i) When the new ~~physician~~ provider has already been credentialed by the health insurance issuer and the ~~physician~~ provider's credentialing is still active with the issuer.

(ii) When the health insurance issuer has received the required credentialing application and information, including proof of active hospital privileges, from the new ~~physician~~ provider and the issuer has not notified the ~~physician~~ provider group that credentialing of the new ~~physician~~ provider has been denied.

(b) A health insurance issuer shall comply with the provisions of Subparagraph (a) of this Paragraph no later than thirty days after receipt of a written request from the ~~physician~~ provider group. The written request shall include a statement that the ~~physician~~ provider group agrees that all contract provisions, including the provision holding covered persons harmless for charges beyond reimbursement by the issuer and deductible, coinsurance and copayments, apply to the new ~~physician~~ provider. Such compliance shall apply to any claims for covered services rendered by the new ~~physician~~ provider to covered persons on dates of service no earlier than the date of the written request from the ~~physician~~ provider group.

(c) Compliance by a health insurance issuer with the provisions of Subparagraph (a) of this Paragraph shall not be construed to mean that a ~~physician~~ provider has been credentialed by an issuer or that the issuer is required to list the ~~physician~~ provider in a directory of contracted ~~physicians~~ healthcare providers.

(d) If, upon compliance with Subparagraph (a) of this Paragraph, a health insurance issuer completes the credentialing process on the new ~~physician~~ provider and determines that the ~~physician~~ provider does not meet the issuer's credentialing requirements, the following actions shall be permitted:

(i) The health insurance issuer 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 health insurance issuer has notified the applicant ~~physician~~ provider of the adverse

determination and ~~provided that the health insurance issuer~~ has initiated action regarding ~~such~~ the recovery within thirty days of the adverse determination.

(ii) The ~~physician~~ provider or the ~~physician~~ provider group may retain any deductible, coinsurance, or copayment collected or in the process of being collected as of the date of receipt of the issuer's determination, so long as the amount is not in excess of the amount owed by the insured or enrollee for out-of-network services.

* * *

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.

DIGEST

The digest printed below was prepared by House Legislative Services. It constitutes no part of the legislative instrument. The keyword, one-liner, abstract, and digest do not constitute part of the law or proof or indicia of legislative intent. [R.S. 1:13(B) and 24:177(E)]

HB 775 Engrossed 2018 Regular Session Davis

Abstract: Provides for payment to a new provider in a contracted network of healthcare providers and authorizes recovery of certain amounts upon denial of an application for credentialing.

Present law requires a health insurance issuer or managed care organization (MCO) contracting with a group of physicians that bills the health insurance issuer using a group identification number to pay the contracted reimbursement rate of the physician group for covered healthcare services rendered by a new physician to the group, without healthcare provider credentialing, in either of the following circumstances:

(1) When the new physician has already been credentialed by the health insurance issuer or MCO and the physician's credentialing is still active with the issuer or MCO.

(2) When the health insurance issuer or MCO has received the required credentialing application and information, including proof of active hospital privileges, from the new physician and the issuer or MCO has not notified the physician group that credentialing of the new physician has been denied.

Proposed law retains present law but expands the applicability to healthcare providers.

Present law requires a health insurance issuer or MCO to comply with present law no later than 30 days after receipt of a written request from the physician group. Present law further requires the request to the health insurance issuer to contain a statement that the physician group agrees that all contract provisions apply to the new physician for any claims for covered services rendered by the new physician to covered persons on dates of service no earlier than the date of the written request from the physician group.

Proposed law retains present law but expands the applicability to healthcare providers.

Present law provides that compliance by a health insurance issuer or MCO shall not be construed to mean that a physician has been credentialed by an issuer or MCO or that the issuer or MCO is required to list the physician in a directory of contracted physicians.

Proposed law retains present law but expands the applicability to healthcare providers.

Present law authorizes a health insurance issuer or MCO, if the issurer or MCO completes the credentialing process on a new physician and determines that the physician does not meet the issuer's or MCO's credentialing requirements, to recover from the physician or the physician group an amount equal to the difference between appropriate payments for in-network benefits and out-of-network benefits if the health insurance issuer or MCO has notified the applicant physician of the adverse determination and initiated the recovery within 30 days of the adverse determination.

Proposed law retains present law but expands the applicability to healthcare providers.

Present law authorizes the physician or the physician group to retain any deductible, coinsurance, or copayment collected or in the process of being collected as of the date of receipt of the health insurance issuer's determination, so long as the amount is not in excess of the amount owed by the insured or enrollee for out-of-network services.

Proposed law retains present law but expands the applicability to healthcare providers.

(Amends R.S. 22:1874(A)(5) and R.S. 46:460.62)

Summary of Amendments Adopted by House

The Committee Amendments Proposed by House Committee on Insurance to the original bill:

1. Add provisions relative to provider reimbursement by managed care organizations.

2. Make technical changes.