ENROLLED

2018 Regular Session

ACT No. 281

HOUSE BILL NO. 775

BY REPRESENTATIVE DAVIS

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.

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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.

SPEAKER OF THE HOUSE OF REPRESENTATIVES

PRESIDENT OF THE SENATE

GOVERNOR OF THE STATE OF LOUISIANA

APPROVED: _____