RÉSUMÉ DIGEST

ACT 281 (HB 775) **2018 Regular Session** **Davis**

Prior law required a health insurance issuer or managed care organization (MCO) contracted 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 had already been credentialed by the health insurance issuer or MCO and the physician's credentialing was still active with the issuer or MCO.

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

New law retains prior law but expands the applicability to healthcare providers.

Prior law required a health insurance issuer or MCO to comply with prior law no later than 30 days after receipt of a written request from the physician group. Prior law further required the request to the health insurance issuer to contain a statement that the physician group agreed 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.

New law retains prior law but expands the applicability to healthcare providers.

Prior law provided that compliance by a health insurance issuer or MCO shall not be construed to mean that a physician had been credentialed by an issuer or MCO or that the issuer or MCO was required to list the physician in a directory of contracted physicians.

New law retains prior law but expands the applicability to healthcare providers.

Prior law authorized a health insurance issuer or MCO, if the issurer or MCO completed the credentialing process on a new physician and determined that the physician did 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 notified the applicant physician of the adverse determination and initiated the recovery within 30 days of the adverse determination.

New law retains prior law but expands the applicability to healthcare providers.

Prior law authorized 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 was not in excess of the amount owed by the insured or enrollee for out-of-network services.

New law retains prior law but expands the applicability to healthcare providers.

Effective August 1, 2018.

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