DIGEST

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Stuart Bishop HB No. 392

Abstract: Provides relative to credentialing and claims payment functions of managed care organizations participating in the La. Medicaid coordinated care network program.

Provisions relative to credentialing:

Proposed law provides that each managed care organization which requires a health care provider to be credentialed, recredentialed, or approved prior to rendering health care services to a Medicaid enrollee shall complete a credentialing process within 90 days from the date on which the organization received all of the information needed for credentialing.

Proposed law provides that within 30 days of the date of receipt of an application, a managed care organization shall inform the applicant of all defects and reasons known at the time by the organization in the event a submitted application is deemed to be not correctly completed.

Proposed law requires that managed care organizations inform an applicant in the event that any needed verification or a verification supporting statement has not been received within 60 days of the date of the organization's request.

Proposed law provides that until submission of an applicant's standardized information in a hard-copy (paper) format is superseded by a provider's required submission and a managed care organization's required acceptance by electronic submission, an applicant shall utilize and a managed care organization shall accept either of the following at the sole discretion of the organization:

(1) The current version of the Louisiana Standardized Credentialing Application Form, or its successor, as promulgated by the Department of Insurance.

(2) The current format utilized by the Council for Affordable Quality Healthcare, or its successor.

Proposed law provides that nothing in proposed law shall be construed to require a managed care organization credentialing or approval in determining inclusion or participation in the organization's contracted network.

Proposed law provides that a managed care organization contracting with a group of physicians that bills a managed care organization utilizing a group identification number shall pay the

contracted reimbursement rate of the physician group for covered health care services rendered by a new physician to the group, without health care provider credentialing as described in proposed law. Provides that such requirement shall apply in each of the following circumstances:

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

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

Proposed law provides that a managed care organization shall pay the contracted reimbursement rate of the physician group for covered health care services rendered by a new physician to the group no later than 30 days after receipt of a written request from the physician group. Provides that compliance by a managed care organization with these provisions of proposed law shall not be construed to mean that a physician has been credentialed by the organization or that the organization is required to list the physician in a directory of contracted physicians.

Proposed law provides that if a managed care organization completes the credentialing process for a physician new to a physician group and determines that the physician does not meet the organization's credentialing requirements, then the organization may 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, provided that the organization has notified the applicant physician of the adverse determination and further provided that the prepaid entity has initiated action regarding such recovery within 30 days of the adverse determination.

Provisions relative to claim payment:

Proposed law requires any claim payment to a provider by a managed care organization, or by a fiscal agent or intermediary of the managed care organization, be accompanied by an itemized accounting of the individual services represented on the claim which are included in the payment. Provides that this itemization shall include but not be limited to the following:

(1) The patient or enrollee's name.

(2) The Medicaid health insurance claim number.

(3) The date of each service.

(4) The patient account number assigned by the provider.

(5) The Current Procedural Terminology code (CPT code) for each procedure, including the amount allowed and any modifiers and units.

(6) The amount due from the patient which includes but is not limited to copayments and coinsurance or deductibles.

(7) The payment amount of reimbursement.

(8) Identification of the plan on whose behalf the payment is made.

In cases when a managed care organization is a secondary payer, proposed law requires the organization to send, in addition to all other information required by proposed law, acknowledgment of payment as a secondary payer, the primary payer's coordination of benefits information, and the third-party liability carrier code.

Proposed law provides the following requirements for cases in which a claim for payment is denied in whole or in part by the managed care organization, or by a fiscal agent or intermediary of the organization:

(1) If the denial is remitted in the standard paper format, then the organization shall, in addition to providing all other information required by proposed law, include a claim denial reason code specific to each CPT code listed which matches or is equivalent to a code used by the state or its fiscal intermediary in the fee-for-service Medicaid program.

(2) If the denial is remitted electronically, then the organization shall, in addition to providing all other information required by proposed law, include an ANSI compliant reason and remark code and shall make available to the provider of the service a complimentary standard paper format remittance advice which contains a claim denial reason code specific to each CPT code listed which matches or is equivalent to a code used by the state or its fiscal intermediary in the fee-for-service Medicaid program.

Proposed law requires each CPT code listed on the approved Medicaid fee-for-service fee schedule to be considered payable by each Medicaid managed care organization or a fiscal agent or intermediary of the organization.

Proposed law requires each managed care organization to compensate, at a minimum, the Medicaid fee-for-service rate in effect on the dates of service for all care rendered to a newborn Medicaid beneficiary by a nonparticipating Medicaid provider within the first 30 days of the beneficiary's birth.

Effective date:

Effective upon signature of governor or lapse of time for gubernatorial action.

(Adds R.S. 46:460.41-460.62)