Regular Session, 2013

HOUSE BILL NO. 392

BY REPRESENTATIVES STUART BISHOP AND ANDERS

Prefiled pursuant to Article III, Section 2(A)(4)(b)(i) of the Constitution of Louisiana.

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

AN ACT

To enact Part XI of Chapter 3 of Title 46 of the Louisiana Revised Statutes of 1950, to be comprised of R.S. 46:460.41 through 460.62, relative to the medical assistance program; to provide for managed care organizations which provide health care services to medical assistance program enrollees; to provide for standardized credentialing of providers; to provide for exemptions; to provide for standardized information to be provided with claims payment; to provide for payment for services rendered to newborns; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. Part XI of Chapter 3 of Title 46 of the Louisiana Revised Statutes of 1950, comprised of R.S. 46:460.41 through 460.62, is hereby enacted to read as follows:

PART XI. MEDICAID MANAGED CARE ADMINISTRATIVE SIMPLIFICATION

SUBPART A. DEFINITIONS AND EXEMPTIONS

§460.41. Definitions

As used in this Part, the following terms shall have the meaning ascribed to them in this Section unless the context clearly indicates otherwise:

(1) "Applicant" means a health care provider seeking to be approved or credentialed by a managed care organization to provide health care services to Medicaid enrollees.

(2) "Credentialing" or "recredentialing" means the process of assessing and validating the qualifications of health care providers applying to be approved by a managed care organization to provide health care services to Medicaid enrollees.

(3) "Department" means the Department of Health and Hospitals.

(4) "Enrollee" means a person who is enrolled in the Medicaid program.

(5) "Health care provider" or "provider" means a physician licensed to practice medicine by the Louisiana State Board of Medical Examiners or other individual health care practitioner licensed, certified, or registered to perform specified health care services consistent with state law.

(6) "Health care services" or "services" means services, items, supplies, or drugs for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(7) "Managed care organization" shall have the same meaning as provided for that term in 42 CFR 438.2 and shall also mean any entity providing primary care case management services to Medicaid recipients pursuant to a contract with the department.

(8) "Medicaid" and "medical assistance program" mean the medical assistance program provided for in Title XIX of the Social Security Act.

(9) "Primary care case management" means a system under which an entity contracts with the state to furnish case management services which include but are not limited to the location, coordination, and monitoring of primary health care services to Medicaid enrollees.

(10) "Secretary" means the secretary of the Department of Health and Hospitals.

(11) "Standardized information" means customary universal data concerning an applicant's identity, education, and professional experience relative to a managed care organization's credentialing process, including but not limited to name, address, telephone number, date of birth, social security number, educational background, state licensing board number, residency program, internship, specialty, subspecialty,

fellowship, or certification by a regional or national health care or medical specialty college, association or society, prior and current place of employment, an adverse medical review panel opinion, a pending professional liability lawsuit, final disposition of a professional liability settlement or judgment, and information mandated by health insurance issuer accrediting organizations.

(12) "Verification" or "verification supporting statement" means documentation confirming the information submitted by an applicant for a credentialing application from a specifically named entity or a regional, national, or general data depository providing primary source verification, including but not limited to a college, university, medical school, teaching hospital, health care facility or institution, state licensing board, federal agency or department, professional liability insurer, or the National Practitioner Data Bank.

§460.42. Exemptions

The provisions of this Part shall not apply to any entity that contracts with the department to provide fiscal intermediary services in processing claims of health care providers.

SUBPART B. PROVIDER CREDENTIALING

§460.51. Provider credentialing

A. 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 ninety days from the date on which the organization has received all of the information needed for credentialing, including the health care provider's correctly completed application and attestations and all verifications or verification supporting statements required by the organization to comply with accreditation requirements and generally accepted industry practices and provisions to obtain reasonable applicant-specific information relative to the particular or precise services proposed to be rendered by the applicant.

B.(1) Within thirty 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.

(2) A managed care organization shall inform the applicant in the event that any needed verification or a verification supporting statement has not been received within sixty days of the date of the managed care organization's request.

C. In order to establish uniformity in the submission of an applicant's standardized information to each managed care organization for which he may seek to provide health care services, 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 managed care 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.

§460.52. Interim credentialing requirements

A. Under certain circumstances and contingent upon the provisions of this Subsection being met, a managed care organization contracting with a group of physicians 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 group for covered health care services rendered by a new physician to the group, without health care provider credentialing as described in this Subpart. This provision 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 managed care 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.

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 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 has been credentialed by the managed care organization or that the managed care organization is required to list the physician in a directory of contracted physicians.

D. If, after compliance with Subsection A of this Section, a managed care organization completes the credentialing process for the new physician and determines that the physician does not meet the managed care organization's credentialing requirements, then the managed care 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 managed care organization has notified the applicant physician of the adverse determination and further provided that the prepaid entity has initiated action regarding such recovery within thirty days of the adverse determination.

SUBPART C. CLAIM PAYMENT

§460.61. Claim payment information

A. Any claim payment to a provider by a managed care organization, or by a fiscal agent or intermediary of the managed care organization, shall be accompanied by an itemized accounting of the individual services represented on the

claim which is included in the payment. This itemization shall include, but shall not be limited to, all of the following items:

(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 for each procedure, hereinafter referred to as "CPT code", 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.

B. If a managed care organization is a secondary payer, then the organization shall send, in addition to all information required by Subsection A of this Section, acknowledgment of payment as a secondary payer, the primary payer's coordination of benefits information, and the third-party liability carrier code.

C.(1) If the 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, and the denial is remitted in the standard paper format, then the organization shall, in addition to providing all information required by Subsection A of this Section, 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 claim for payment is denied in whole or in part by the managed care organization, or by a fiscal agent or intermediary of the plan, and the denial is remitted electronically, then the organization shall, in addition to providing all information required by Subsection A of this Section, 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.

D. All managed care organizations shall recognize in their fee schedules all CPT codes which are included in the Medicaid fee-for-service fee schedule.

§460.62. Claims payment for care rendered to newborns; reporting

A. Each managed care organization shall compensate, at a minimum, the Medicaid fee-for-service rate in effect for the dates of service for all primary care services rendered to a newborn Medicaid beneficiary within thirty days of the beneficiary's birth regardless of whether the Medicaid provider rendering the services is contracted with the managed care organization.

B. On or before January 1, 2014, and annually thereafter, the department shall report to the House and Senate committees on health and welfare the incidence and causes of all re-hospitalizations of infants born premature at less than thirty-seven weeks gestational age and who are within the first six months of life.

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)]

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.

General provisions:

Proposed law stipulates that nothing in proposed law applies to any entity that contracts with DHH to provide fiscal intermediary services in processing claims of health care providers.

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 verifications 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 Dept. of Insurance.

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

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 is 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 all managed care organizations to recognize in their fee schedules all CPT codes which are included in the Medicaid fee-for-service fee schedule.

Proposed law requires each managed care organization to compensate, at a minimum, the Medicaid fee-for-service rate in effect for the dates of service for all primary care services rendered to a newborn Medicaid beneficiary within 30 days of the beneficiary's birth regardless of whether the Medicaid provider rendering the services is contracted with the managed care organization.

Proposed law requires that on or before Jan. 1, 2014, and annually thereafter, DHH report to the legislative committees on health and welfare the incidence and causes of all re-hospitalizations of infants born premature at less than 37 weeks gestational age and who are within the first six months of life.

Effective date:

August 1, 2013.

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

Summary of Amendments Adopted by House

Committee Amendments Proposed by House Committee on Health and Welfare to the original bill.

1. Added exemption from provisions of proposed law for any entity that contracts with DHH to provide fiscal intermediary services in processing claims of health care providers.

2. Deleted language providing that nothing in proposed law relative to provider credentialing shall be construed to require a managed care organization credentialing or approval in determining inclusion or participation in the organization's contracted network.

3. Deleted a requirement that each CPT code listed on the approved Medicaid fee-for-service fee schedule be considered payable by each Medicaid managed care organization or a fiscal agent or intermediary of the organization. Added in lieu thereof a requirement that all managed care organizations recognize in their fee schedules all CPT codes which are included in the Medicaid fee-for-service fee schedule.

4. Deleted a requirement that each managed care organization 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 30 days of the beneficiary's birth. Added in lieu thereof a requirement that each managed care organization compensate, at a minimum, the Medicaid fee-for-service rate in effect for the dates of service for all primary care services rendered to a newborn Medicaid beneficiary within 30 days of the beneficiary's birth regardless of whether the Medicaid provider rendering the services is contracted with the managed care organization.

5. Added a requirement that on or before Jan. 1, 2014, and annually thereafter, DHH report to the legislative committees on health and welfare the incidence and causes of all re-hospitalizations of infants born premature at less than 37 weeks gestational age and who are within the first six months of life.

6. Changed effective date of proposed law from date of signature by governor or lapse of time for gubernatorial action to August 1, 2013.

7. Made technical changes.