GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

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SENATE BILL 431

Short Title:	Provider Credentialing/Reimbursement.	(Public)
Sponsors:	Senators Perry and Krawiec (Primary Sponsors).	
Referred to:	Rules and Operations of the Senate	

April 1, 2019

A BILL TO BE ENTITLED

AN ACT TO MAKE AMENDMENTS RELATED TO HEALTH CARE PROVIDER CREDENTIALING BY INSURERS OFFERING HEALTH BENEFIT PLANS AND TO ENSURE REIMBURSEMENT FOR HEALTH CARE PROVIDERS WHILE PROVIDER CREDENTIALING APPLICATIONS ARE BEING PROCESSED.

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 58-3-230 is recodified as G.S. 58-50-271.

SECTION 1.(b) G.S. 58-3-245(c) reads as rewritten:

"(c) The directory listing shall include all of the types of participating providers. Upon a participating provider's written request, the insurer shall also list in the directory, as part of the participating provider's listing, the names of any allied health professionals who provide primary care services under the supervision of the participating provider and whose services are covered by virtue of the insurer's contract with the supervising participating provider and whose credentials have been verified by the supervising participating provider. These allied health professionals shall be listed as a part of the directory listing for the participating provider upon receipt of a certification by the supervising participating provider that the credentials of the allied health professional have been verified consistent with the requirements for the type of information required to be verified under ~~G.S. 58-3-230.~~G.S. 58-50-271."

SECTION 2. G.S. 58-50-271, as enacted by Section 1 of this act, reads as rewritten:

"**§ 58-50-271. ~~Uniform~~ Health care provider credentialing.**

(a) Credentialing for Health Care Providers Entering into New Insurer Contracts. – An insurer that provides a health benefit plan and that credentials providers for its networks shall maintain a process to assess and verify the qualifications of a licensed health care ~~practitioner~~ provider within 60 days of receipt of a completed provider credentialing application form approved by the Commissioner. If the insurer has not approved or denied the provider credentialing application form within 60 days of receipt of the completed application, upon receipt of a written request from the health care provider applicant and within five business days of its receipt, the insurer shall issue a temporary credential to the applicant if the applicant has a valid North Carolina professional or occupational license to provide the health care services to which the credential would apply. The insurer shall not issue a temporary credential if the applicant has reported on the application a history of medical malpractice claims, a history of substance abuse or mental health issues, or a history of ~~Medical Board~~ disciplinary ~~action.~~ action by any relevant professional licensing board. The temporary credential shall be effective upon issuance and shall remain in effect until the health care provider's credentialing application is approved or denied by the insurer.

An insurer that provides a health benefit plan and that credentials providers for its networks shall establish reasonable protocols and procedures for reimbursing health care provider applicants for covered health care services provided to insureds during the period in which the applicant's competed provider credentialing application is pending, including any health care services provided prior to the issuance of a temporary credential. These protocols and procedures shall apply only if the health care provider's credentialing application is approved by the insurer. At a minimum, the protocols and procedures shall do all of the following:

(1) Permit health care provider reimbursement for health care services rendered from the date the health care provider's completed provider credentialing application is received for consideration by the insurer.

(2) Require that any reimbursement be paid at the in-network rate that the health care provider would have received had the provider been, at the time the covered health care services were provided, a credentialed participating health care provider in the network for the applicable health benefit plan.

(3) Require that any reimbursement paid to the health care provider be retroactively recouped or rescinded if the provider's credentialing application is denied or the insurer is not willing to otherwise contract with the health care provider.

(b) Credentialing for Group Practices With Existing Insurer Contracts. – An insurer that has an existing contract with a group health care provider practice to participate in a health benefit plan network and that credentials providers for its networks shall maintain a process to assess and verify the qualifications of a new health care provider that joins the group practice within 60 days of receipt of a completed provider credentialing application form approved by the Commissioner. The insurer shall provide to the group practice a list of all information and supporting documentation required for credentialing a new health care provider that joins the practice. All of the following shall apply to the credentialing process for a new health care provider that joins a group practice that has an existing contract with an insurer to participate in a health benefit plan:

(1) An insurer shall notify a new health care provider applicant in writing of the status of a credentialing application no later than five business days after receipt of the application. The notice shall indicate if the application is complete or incomplete. If the application is incomplete, the notice shall indicate the information or documentation that is needed to complete the application.

(2) If the application is incomplete and the new health care provider applicant submits additional information or documentation to complete the application, the insurer shall comply with the notice requirements of subdivision (1) of this subsection upon the receipt of the additional information or documentation.

(3) An insurer shall notify a new health care provider applicant of the results of the credentialing application within 60 days of receipt of a completed credentialing application.

(4) While a credentialing application for a new health care provider that joins a group practice that has an existing contract with the insurer is pending, an applicant shall hold, and shall not submit, any claims for reimbursement to the insurer for covered services provided by the applicant. If claims are submitted to the insurer for covered services provided by the applicant while the credentialing application is pending, the insurer may deny the claims. Upon notification of an approved credentialing application, all claims held under claims at the contracted in-network rate for any covered services provided on or after the date of the receipt of the complete credentialing application, subject to all the following:

a. In the event that the new health care provider applicant or the group practice has specified a network start date for the new provider that is later than the date of receipt of the complete credentialing application, the insurer shall pay claims at the contracted in-network rate for any covered services provided on or after the date specified.

b. An insurer's obligation to pay claims at the contracted in-network rate for any covered services provided applies only to services provided in the name of the group practice by a new health care provider applicant that is billing for services under the existing contract.

c. An insurer is not required to pay claims at the contracted in-network rate for any covered services provided by the new health care provider applicant if the new provider applicant's credentialing application is not approved or if the insurer is otherwise unwilling to contract with the new provider applicant.

d. A group practice may be required to refund any reimbursement paid by the insurer for services provided by a new health care provider applicant whose credentialing application approval was obtained by fraud.

e. If the new health care provider applicant's credentialing application is not approved or if any amount refunded to an insurer under sub-subdivision d. of this subdivision, then a group practice shall not collect from an insured any amount above the amount an insured would have been required to pay had the new health care provider applicant been in-network at the time the services were rendered.

~~(b)~~(c) The Commissioner shall by rule adopt a uniform provider credentialing application form that will provide ~~health benefit plan~~ insurers with the information necessary to adequately assess and verify the qualifications of an applicant. The Commissioner may update the uniform provider credentialing application ~~form, as necessary.~~ form. No insurer that provides a health benefit plan may require an applicant to submit information that is not required by the uniform provider credentialing application form.

~~(c) As used in this section, the terms "health benefit plan" and "insurer" shall have the meaning provided under G.S. 58-3-167.~~

(d) Nothing in this section shall require reimbursement of health care provider-rendered services that are not benefits or services covered by the insurer's health benefit plan."

SECTION 3.(a) The title of Article 41 of Chapter 90 of the General Statutes reads as rewritten:

"Article 41.

"~~Pathology Services~~ Health Care Services Billing."

SECTION 3.(b) Article 41 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-702. Billing for services after a credentialing application denial.**

(a) The following definitions apply in this section:

(1) Health benefit plan. – As defined in G.S. 58-3-167.

(2) Health care provider. – As defined in G.S. 90-410.

(b) If a health care provider is awaiting credentialing by a health benefit plan, does not hold a temporary credential under G.S. 58-50-217, and provides a covered health care service to a patient who is covered by the health benefit plan for which the provider is awaiting credentialing, and if that health care provider is later denied the credential or otherwise does not contract as part of the health benefit plan's provider network, then the health care provider shall not require that any reimbursement above the amount that would have been required to be paid

by the patient had the provider been in-network with the health benefit plan at the time the services were rendered."

SECTION 4. This act becomes effective October 1, 2019, and applies to provider credentialing applications received on or after that date.