MISSISSIPPI LEGISLATURE REGULAR SESSION 2016

By: Senator(s) Hill, Burton To: Medicaid

SENATE BILL NO. 2175

AN ACT TO CODIFY SECTION 83-41-419, MISSISSIPPI CODE OF 1972, TO PROVIDE FOR THE STANDARDIZED CREDENTIALING OF HEALTH CARE PROVIDERS PROVIDING HEALTH CARE SERVICES TO MEDICAID BENEFICIARIES IN A MANAGED CARE ORGANIZATION SETTING; TO PROVIDE FOR STANDARDIZED INFORMATION TO BE PROVIDED WITH CLAIM PAYMENTS FOR SUCH SERVICES; AND FOR RELATED PURPOSES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

SECTION 1. The following shall be codified as Section 83-41-419, Mississippi Code of 1972:

83-41-419. **Definitions.** (1) The following terms shall have the following meanings unless the context clearly indicates otherwise:

(a) "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.

(b) "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.

(c) "Department" means the Mississippi Department of Insurance.

(d) "Enrollee" means an individual who is enrolled in the Medicaid program.

(e) "Health care provider" or "provider" means (i) a physician or physician assistant (PA) licensed to practice medicine by the Mississippi State Board of Medical Licensure, or (ii) a nurse practitioner (NP) or advanced practice registered nurse (APRN) licensed, certified, or registered to perform specified health care services consistent with state law. This definition (e) shall not apply to any entity contracted with the Division of Medicaid to provide fiscal intermediary services in processing claims of the health care providers.

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

(g) "Managed care organization" shall have the same definition as the term is defined by Section 83-41-403 and 42 CFR 438.2 and shall include any entity providing primary care case management services to Medicaid recipients pursuant to a contract with the Division of Medicaid.

(h) "Primary care case management" means a system under which an entity contracts with the Division of Medicaid to furnish case management services that include, but are not limited to, the

location, coordination and monitoring of primary health care services to Medicaid beneficiaries.

(i) "Standardized information" means the 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.

(j) "Verification" or "verification supporting statement" means the 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.

(2) **Provider credentialing.** (a) Any managed care organization that requires a health care provider to be credentialed, recredentialed, or approved prior to rendering health care services to a Medicaid recipient shall complete a credentialing process within ninety (90) days from the date on which the managed care organization has received all the information needed for credentialing, including the health care provider's correctly and fully completed application and attestations and all verifications or verification supporting statements required by the managed care 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. If the provider already has a provider number with the Division of Medicaid or is currently credentialed by the State and School Employees' Health Insurance Plan, the process must be completed within thirty (30) days.

(b) (i) Within thirty (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 managed care organization in the event a submitted application is deemed to be not correctly and fully completed.

(ii) 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 (60) 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 paper format shall be 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 the current version of the Mississippi Standardized Credentialing Application Form, or its successor, as promulgated by the Department of Insurance.

(3) **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 health care providers that bills a managed care organization utilizing a group identification number, such as the group Federal Tax Identification Number (EIN) or the group National Provider Identifier as set forth in 45 CFR 162.402 et seq., shall pay the contracted reimbursement rate of the health care provider group for covered health care services rendered by a new provider to the group without health care provider credentialing as described in this subsection. This provision shall apply in either of the following circumstances:

(i) When the new health care provider has already been credentialed by the managed care organization, and the health care provider's credentialing is still active with the managed care organization.

(ii) 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 health care provider, and the managed care organization has not notified the health care provider group that credentialing of the new health care provider has been denied.

(b) A managed care organization shall comply with the provisions of paragraph (a) of this subsection no later than thirty (30) days after receipt of a written request from the health care provider group.

(c) Compliance by a managed care organization with the provisions of paragraph (a) of this subsection shall not be construed to mean that a health care provider has been credentialed by the managed care organization, or the managed care organization shall be required to list the health care provider in a directory of contracted health care providers.

(d) If, after compliance with paragraph (a) of this subsection, a managed care organization completes the credentialing process on the new health care provider and determines the health care provider does not meet the managed care

organization's credentialing requirements, the managed care organization may recover from the health care provider or the health care provider 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 health care provider of the adverse determination and provided that the prepaid entity has initiated action regarding such recovery within thirty (30) days of the adverse determination.

(4) **Claim payment information.** (a) Any claim payment to a health care 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 that are included in the payment. This itemization shall include, but shall not be limited to, all of the following items:

(i) The patient or enrollee's name.

(ii) The Medicaid health insurance claim number.

(iii) The date of each service.

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

(v) The Current Procedural Terminology code for each procedure, hereinafter referred to as "CPT code", including the amount allowed and any modifiers and units.

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

(vii) The payment amount of reimbursement.

(viii) 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 paragraph (a) of this subsection, acknowledgment of payment as a secondary payer, the primary payer's coordination of benefits information, and the third-party liability carrier code.

(c) (i) 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 paragraph (a) of this subsection, include a claim denial reason code specific to each CPT code listed that matches or is equivalent to a code used by the state or its fiscal intermediary in the fee-for-service Medicaid program.

(ii) 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 paragraph (a) of this subsection, include an American National Standards Institute compliant reason and remark code and shall make available to the health care provider of the service, a complimentary standard paper format remittance advice that contains a claim denial reason code specific to each CPT code listed that matches or is equivalent to a code used by the state or its fiscal intermediary in the fee-for-service Medicaid program.

(d) Each CPT code listed on the approved Medicaid fee-for-service fee schedule shall be considered payable by each Medicaid managed care organization or a fiscal agent or intermediary of the organization.

SECTION 2. This act shall take effect and be in force from and after July 1, 2016.