OVERVIEW AND HISTORY:

For several years, the Tennessee Medical Association (TMA) advocated for passage of legislation that would permit physicians undergoing the credentialing process with health plans to be reimbursed for services provided to enrollees while the process was ongoing. The rationale was that at least 99% of physicians are eventually credentialed with health plans but the process can take several weeks, even months, to complete. Practices overwhelmingly expressed a willingness to reimburse the plan if their physician was not eventually credentialed. Finally, in 2015 legislation was passed to address this situation thanks to a bill sponsored by Sen. Richard Briggs and Rep. Bryan Terry.

The new law had some nuances of which TMA members need to be aware in order to take advantage of its benefits. The salient point of the law is that Tennessee commercial health plans are required to provide any medical group practice, with which the plan has existing contract, a list of all information and supporting documentation required for a credentialing application to be considered complete. The law also establishes a process by which a provider or practice may be reimbursed for dates of service provided by the applicant during his or her pending credentialing application.

SCOPE OF THE LAW:

Tennessee’s commercial health plan credentialing law applies to physicians and other healthcare professionals providing services in medical group practices. The law has no applicability to hospital or other facility credentialing.

The law does not apply to the TennCare program, CoverKids, Access Tennessee, or any other plan managed by the Tennessee Department of Finance & Administration. The law does not apply to federal programs such as Medicare, Medicare Advantage, or TriCare.

TIMETABLE:

The timetable starts when the new provider applicant submits his or her credentialing applications to the health plan. Within five days of receipt of the application, the health plan is required to provide written notice of the status of the application to the medical practice. The notice must indicate whether the health plan considers the application complete or incomplete. If the application is considered incomplete, the health plan must include a list of all the missing information via written notice to the medical practice.
Once the medical practice receives written notice of the incomplete status, the practice must provide missing information within 30 calendar days. Otherwise, credentialing is discontinued. If credentialing is discontinued, the applicant must start the process over.

In addition, if the new applicant fails to submit a complete network participation enrollment form, including signature evidencing intent to participate in the group, and any other required documentation within 30 calendar days, then the new provider application may not be eligible to receive retroactive payment for services rendered.

If the missing information is provided to the plan within 30 calendar days, then the plan has five business days to notify the practice in writing whether the application is considered complete or incomplete. If incomplete, the plan must specify what information is still needed to deem it complete.

Once the application is deemed complete, the plan has 90 calendar days to notify the applicant of the plan’s decision on the credentialing application.

**CLAIM SUBMISSIONS:**

No claims should be submitted during the pending credentialing application. If this provision is violated, the plan can deny retroactive payment for dates of service.

Once the credentialing application is complete, hold all claims for covered services until receiving notice that the application is approved. At this time, claims may be submitted between the date the application is deemed completed and the date it is deemed approved. Reimbursement for such services shall be at the contracted in-network rate.

If the new provider’s start date is after notification of the application’s completion, then that is the date of reference for payment of claims. Submission of claims from a former practice are not covered by this law.

If the health plan denies the credentialing application or does not wish to contract with the provider, retroactive claims will not be paid. The law does not require a health plan to credential or contract with all providers who submit completed credentialing applications.
Health plans can recoup claims from the practice if credentialing approval was obtained by fraud. Amounts not paid for claims during the pending credentialing application cannot then be billed to the plan’s members. In other words, no balance billing.

**THINGS TO REMEMBER:**

**Credentialing Certainty:** The law’s applicability to re-credentialing is unclear. The use of the term “new provider applicant” suggests it does not apply to re-credentialing; however, some plans may not interpret it this way. Members experiencing problems with this process should contact TMA’s legal department.

**Start the Clock:** Be careful. The law does not specify whether the 30 days begins on the date listed in the notice document or whether it begins on the date the provider actually receives the notice. The TMA recommends that providers assume it is the date listed on the notice unless specified otherwise. This is because health plans have no way of knowing when a notice is received unless it is sent via registered mail.

**Notice Delivery:** The law does not specify the mode by which health plans must send notices to medical group practices, it simply requires that they be in writing. If credentialing instructions do not specify, the practice should contact the plan to discern what format correspondence will be received (i.e. letter, email, etc.).

**Who Gets the Notice:** The law requires notices to be sent to the medical group practice, not the new provider applicant. If the new applicant is at a different address than the medical group practice, this could cause problems. To resolve this potential issue, medical group practices should request that new provider applicants immediately share notices received with the practice. TMA’s legal department should be notified if a health plan directs correspondence to the new provider applicant rather than to the practice.

**Check the Date:** Health plans have been known to play fast and loose with dates of correspondence. This can be especially egregious when matters of payment are at stake. For example, contract amendments dated November 1 which give practices 30 days to accept or reject the terms can sometimes be received only a few days before the deadline. Be cognizant of this practice and pay close attention to dates on the notice. Report abuses to TMA’s legal department.

**Report Violations:** There is no penalty built into the law to address health plan violations. However, consistent or habitual violation could justify amending the law to add one. TMA members who believe a health plan violated this law should contact the legal department at legal@tnmed.org.