TMA™
Tennessee Medical Association

GUIDE TO THE 2015 CREDENTIALING LAW

For several years, the Tennessee Medical Association (TMA) advocated for passage of legislation that would permit physicians going through the credentialing process with health plans to be reimbursed for services provided to those health plan members during the credentialing process. 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 that they would gladly risk having to reimburse the plan if their physician was not eventually credentialed. Finally, in 2015 legislation passed to address this situation thanks to a bill sponsored by Senator Richard Briggs and Representative Bryan Terry.

The new law has some nuances of which TMA members need to be aware in order to take advantage of the benefits the law brings to medical practices and physicians. This is TMA's guide to the law for members.

The salient point of the law, found at TCA 56-7-1001, and effective on **January 1, 2016,** is that Tennessee commercial health plans are required to provide any medical group practice with which the plan has an existing contract, a list of all information and supporting documentation required for a credentialing application to be considered complete. There is a timetable for doing so. It also allows for a process by which a provider/practice may be paid for claims for dates of service provided by the applicant during his/her pending credentialing application.

SCOPE OF THE LAW

The scope of the law is Tennessee commercial health plan credentialing and it applies to physicians and other health care professionals providing services in medical group practices. The law has no applicability to hospital or other facility credentialing.

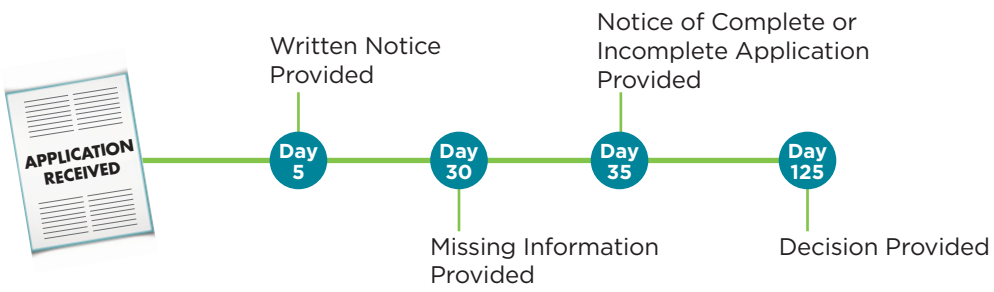
The **law does not** apply to the TennCare program, CoverKids, Access Tennessee, or any other plan managed by the state department of finance and administration. The law does not apply to federal programs such as Medicare, Medicare Advantage, or TriCare.

TIMETABLE

The timetable starts when the new provider applicant submits his/her credentialing application to the health plan.

Within five (5) business days of receipt of the application, the health plan is required to provide written notice of the status of the application to the medical group practice. The notice must indicate whether the health plan considers the application complete or incomplete.

TIMETABLE OF A CREDENTIALING APPLICATION



If the application is considered incomplete, the health plan must include a list of all of the information that is missing in the written notice to the medical group practice.

Once the medical group practice receives the written notice that the new provider applicant's credentialing application is incomplete, the practice must provide the missing information within thirty (30) calendar days of the notice. Otherwise, credentialing is discontinued. If credentialing is discontinued, the applicant must start the process over.

In addition, if a new provider applicant fails to submit a complete network participation enrollment form, including signature evidencing intent to participate with the group, and any other required documentation within thirty (30) calendar days of the notice of an incomplete application, then the new provider applicant may not be eligible to receive retroactive payment for services rendered once the credentialing application is complete.

If the missing information is provided to the plan within thirty (30) calendar days of the notice of the incomplete application, then the plan has five (5) business days to notify the medical group practice in writing whether the application is considered complete or incomplete, and if incomplete, what information is still needed to make it complete.

Once the application is deemed by the plan to be complete, the plan has ninety (90) calendar days in which to notify the provider applicant of the plan's decision on the credentialing application.

CLAIMS SUBMISSION TO THE HEALTH PLAN

No claims for covered services during the pendency of the credentialing application should be submitted to the health plan until the application is complete and accepted. If this provision is violated, the plan can deny the claims.

Once you receive written notice from the plan that the credentialing application is complete, hold all claims for covered services until you receive notice from the plan that the credentialing application has been approved. Then submit the claims for covered services between the date the application is considered by the plan to be complete and notification that the application is approved. Reimbursement for those services shall be at the contracted in-network rate.

Only submit claims for services provided on behalf of the group. If the new provider's start date is after notification that the credentialing application is complete, then that is the date of reference for payment of claims. Submission of claims from a former practice or another practice setting 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/contract with all providers who submit complete credentialing applications.

Health plans can recoup claims from the practice if credentialing approval was obtained by fraud.

Amounts not paid for claims for dates of services during pendency of the credentialing application cannot then be billed to the plan's member. In other words, no balance billing.

CREDENTIALING CERTAINTY

The law's applicability to re-credentialing is unclear. The use of the term "new provider applicant" would lead one to believe that the law does not apply to the re-credentialing process. However, some plans might not interpret the law that way. Members experiencing problems with re-credentialing or reports of plans taking the position that the law does not apply to re-credentialing should contact the TMA legal department.

START THE CLOCK

Be careful. The law does not specify as to 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. TMA recommends that providers assume it is the date listed on the notice unless the notice specifies otherwise. This is because the health plan will have no way to know when the notice is received by the new provider applicant unless the plan sends the notice via registered mail.

Likewise, TMA recommends that the new provider applicant and medical group practice assume that the 90 day clock in which to make a decision on the credentialing application starts on the date listed in the notice that the application is complete unless otherwise stated in the notice.

NOTICE DELIVERY

The law does not specify the mode by which notices must be sent by the health plans to medical group practices. It just requires that such notices be "in writing". If credentialing application instructions do not tell the applicant how the notices will be sent to the practice, the practice should contact the plan to find out so it can be looking for a letter, email, etc.

WHO GETS THE NOTICE?

The law requires direction of the notices to the "medical group practice"; not the "new provider applicant." Plans may inadvertently direct notices to the new provider applicant. If the new provider applicant is at a different address than the medical group practice, this could cause problems, not to mention be a technical violation of the law. Medical group practices should request that new provider applicants immediately share notices received with the practice. The TMA legal affairs department should be notified if a health plan directs notice correspondence required by this law to the new provider applicant rather than the practice.

CHECK THE DATE

Health plans have been known to play fast and loose with dates on correspondence. This can be especially egregious when matters of payment are at stake. For example, contract amendments dated November 1, which gave practices thirty days to accept or reject an amendment, have sometimes been received by practices within only a few days of the deadline. Be cognizant of this practice and pay close attention to dates on the notices. Report abuses to the TMA legal affairs department.

HOLD CLAIMS

It is critical that claims for services provided to health plan members during the pendency of the credentialing application not be submitted until the plan provides notice that credentialing has been approved. If a practice slips up on this, it may risk not getting paid for any service provided during dates of service during the pendency of the credentialing application.

LAW EFFECTIVE DATE

Be aware of the effective date, January 1, 2016. The law applies to credentialing applications submitted on or after that date. So, medical practices might want to be strategic as to when new provider credentialing applications are submitted for physicians starting with the group in early 2016.

REPORT VIOLATIONS

There is no penalty built into the law to address health plans which violate this law. However, consistent or habitual violation by health plans could justify amending the law to add one. TMA members who believe that a health plan violated this law should contact the TMA legal department, legal@tnmed.org.