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**GENERAL ASSEMBLY OF NORTH CAROLINA**
**SESSION 2017**

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**SENATE BILL DRS45273-MR-74 (03/15)**

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| Short Title: | Uniform Group Practice Provider Credentialing. | (Public) |
| Sponsors: | Senator Gunn (Primary Sponsor). | |
| Referred to: | | |

A BILL TO BE ENTITLED

AN ACT TO AMEND THE UNIFORM PROVIDER CREDENTIALING STATUTE TO THOROUGHLY ACCOUNT FOR THE CREDENTIALING OF HEALTH CARE PRACTITIONERS WHO JOIN A GROUP PRACTICE THAT HAS AN EXISTING CONTRACT WITH A HEALTH INSURER.

The General Assembly of North Carolina enacts:

**SECTION 1.** G.S. 58-3-230 reads as rewritten:

"**§ 58-3-230. Uniform provider credentialing.**

(a) Credentialing for New Providers. – 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 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 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. The temporary credential shall be effective upon issuance and shall remain in effect until the provider's credentialing application is approved or denied by the insurer. ~~When a health care practitioner joins a practice that is under contract with an insurer to participate in a health benefit plan, the effective date of the health care practitioner's participation in the health benefit plan network shall be the date the insurer approves the practitioner's credentialing application.~~

(a1) Credentialing for Group Practices With Existing Insurer Contracts. – An insurer that has an existing contract with a group 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 practitioner 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 practitioner that joins the practice. All of the following shall apply to the credentialing process for a new health care practitioner 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 practitioner 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 and that the applicant shall have 30 calendar days to supply the required information or documentation.

(2) If the application is incomplete and the new practitioner applicant submits additional information or documentation to complete the application within 30 calendar days, the insurer shall comply with the notice requirements of subdivision (1) of this subsection upon the receipt of the additional information or documentation.

(3) If a new practitioner applicant fails to submit a complete credentialing application to an insurer within 30 calendar days of notice of an incomplete application, then the application is deemed incomplete and shall be denied.

(4) An insurer shall notify a new practitioner applicant of the results of the credentialing application within 60 days of receipt of a completed credentialing application or a denial under subdivision (3) of this subsection.

(5) While a credentialing application for a new practitioner 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 this subdivision shall be submitted to the insurer and the insurer shall pay the 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 practitioner applicant or the group practice has specified a network start date for the new practitioner 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 practitioner 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 practitioner applicant if the new practitioner applicant's credentialing application is not approved or if the insurer is otherwise unwilling to contract with the new practitioner applicant.

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

e. A group practice may not collect from an insured any amount for services provided if the new practitioner applicant's credentialing application is not approved or any amount refunded to an insurer under sub-subdivision d. of this subdivision.

(b) The Commissioner shall by rule adopt a uniform provider credentialing application form that will provide health benefit plans 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. 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.~~The following definitions apply in this section:

(1) Existing contract. – A participating provider agreement between a group practice and an insurer under which practitioners bill for services provided to patients covered by a health benefit plan provided by the insurer.

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

(3) Insurer. – As defined in G.S. 58-3-167."

**SECTION 2.** This act becomes effective October 1, 2017, and applies to provider credentialing applications received on or after that date.