REFERENCE TITLE: health insurers; provider credentialing

State of Arizona
House of Representatives
Fifty-third Legislature
Second Regular Session
2018

HB 2322

Introduced by
Representative Carter

AN ACT

AMENDING TITLE 20, ARIZONA REVISED STATUTES, BY ADDING CHAPTER 26; RELATING TO HEALTH INSURERS.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Title 20, Arizona Revised Statutes, is amended by adding chapter 26, to read:

CHAPTER 26

PROVIDER CREDENTIALING

ARTICLE 1. GENERAL PROVISIONS

20-3401. Definitions

IN THIS CHAPTER, UNLESS THE CONTEXT OTHERWISE REQUIRES:

1. "APPLICANT" MEANS A PROVIDER THAT SUBMITS A CREDENTIALING OR RECREDENTIALING APPLICATION TO A HEALTH INSURER TO BECOME A PARTICIPATING PROVIDER IN THE HEALTH INSURER'S NETWORK.

2. "APPLICATION" MEANS EITHER:

(a) AN APPLICANT'S INITIAL APPLICATION TO BE CREDENTIALED AS A PARTICIPATING PROVIDER.

(b) AN APPLICANT'S APPLICATION TO BE RECREDENTIALED AS A PARTICIPATING PROVIDER.

3. "CREDENTIALING" MEANS TO COLLECT, VERIFY AND ASSESS WHETHER A PROVIDER MEETS RELEVANT LICENSING, EDUCATION AND TRAINING REQUIREMENTS TO BECOME OR REMAIN A PARTICIPATING PROVIDER.

4. "DESIGNEE" MEANS A THIRD PARTY TO WHOM THE HEALTH INSURER HAS DELEGATED CREDENTIALING ACTIVITIES OR RESPONSIBILITIES.

5. "HEALTH INSURER" MEANS A DISABILITY INSURER, GROUP DISABILITY INSURER, BLANKET DISABILITY INSURER, HEALTH CARE SERVICES ORGANIZATION, HOSPITAL SERVICE CORPORATION, MEDICAL SERVICE CORPORATION OR A HOSPITAL, MEDICAL, DENTAL AND OPTOMETRIC SERVICE CORPORATION AND INCLUDES THE HEALTH INSURER'S DESIGNEE.

6. "LOADING" MEANS TO INPUT A PARTICIPATING PROVIDER'S INFORMATION INTO A HEALTH INSURER'S BILLING SYSTEM FOR THE PURPOSE OF PROCESSING CLAIMS AND SUBMITTING REIMBURSEMENT FOR COVERED SERVICES.

7. "PARTICIPATING PROVIDER" MEANS A PROVIDER THAT HAS BEEN CREDENTIALED OR RECREDENTIALED BY A HEALTH INSURER OR ITS DESIGNEE TO PROVIDE HEALTH CARE ITEMS OR SERVICES TO SUBSCRIBERS IN AT LEAST ONE OF THE HEALTH INSURER'S PROVIDER NETWORKS.

8. "PROVIDER" MEANS A PHYSICIAN, HOSPITAL OR OTHER PERSON THAT IS LICENSED IN THIS STATE OR OR THAT IS OTHERWISE AUTHORIZED TO FURNISH HEALTH CARE SERVICES IN THIS STATE.

9. "SUBSCRIBER" MEANS A PERSON WHO IS ELIGIBLE TO RECEIVE HEALTH CARE BENEFITS PURSUANT TO A HEALTH INSURANCE POLICY OR COVERAGE ISSUED OR PROVIDED BY A HEALTH INSURER.

20-3402. Requirements for electronic application submission

A. A HEALTH INSURER SHALL ESTABLISH A PROCESS FOR THE ELECTRONIC SUBMISSION OF A CREDENTIALING OR RECREDENTIALING APPLICATION.

B. A HEALTH INSURER SHALL ESTABLISH AN ELECTRONIC PROCESS TO SUBMIT SUPPORTING DOCUMENTATION FOR A CREDENTIALING OR RECREDENTIALING APPLICATION AND FOR UPDATING CHANGES TO A PARTICIPATING PROVIDER'S TAX

IDENTIFICATION NUMBER, ADDRESS AND CONTACT INFORMATION IN THE INSURER'S BILLING SYSTEM.

20-3403. Credentialing committee

A CREDENTIALING COMMITTEE CONSISTING OF AT LEAST TWO PERSONS MUST REVIEW CREDENTIALING APPLICATIONS. AT LEAST ONE OF THE COMMITTEE MEMBERS REVIEWING A SPECIFIC APPLICATION MUST BE A PROVIDER WITH KNOWLEDGE OF THE APPLICANT'S SCOPE OF PROFESSIONAL PRACTICE.

20-3404. Credentialing timelines

A. THE HEALTH INSURER SHALL CONCLUDE THE CREDENTIALING PROCESS, INCLUDING THE PROCESSING OF A CHANGE OF ADDRESS OR TAX IDENTIFICATION NUMBER OR ANY OTHER MODIFICATION OF INFORMATION FOR AN APPLICANT, WITHIN SIXTY CALENDAR DAYS AFTER THE DATE THE HEALTH INSURER RECEIVES A COMPLETE APPLICATION.

B. A HEALTH INSURER SHALL PROVIDE WRITTEN OR ELECTRONIC NOTICE OF THE APPROVAL OR DENIAL OF A CREDENTIALING OR RECREDENTIALING APPLICATION TO AN APPLICANT WITHIN SEVEN CALENDAR DAYS AFTER THE CONCLUSION OF THE CREDENTIALING PROCESS.

C. THE HEALTH INSURER SHALL CONCLUDE THE PROCESS OF LOADING THE PROVIDER'S INFORMATION INTO THE HEALTH INSURER'S BILLING SYSTEM WITHIN TEN CALENDAR DAYS AFTER THE APPROVAL OF A CREDENTIALING APPLICATION.

20-3405. Acknowledgement of receipt of an application; notification of incomplete applications

A. A HEALTH INSURER SHALL PROVIDE WRITTEN OR ELECTRONIC ACKNOWLEDGEMENT TO AN APPLICANT WITHIN SEVEN CALENDAR DAYS AFTER THE HEALTH INSURER'S RECEIPT OF THE APPLICANT'S APPLICATION.

B. ON RECEIPT OF AN APPLICATION, A HEALTH INSURER SHALL PROMPTLY REVIEW THE APPLICATION TO DETERMINE IF THE APPLICATION IS COMPLETE.

C. IF THE HEALTH INSURER DETERMINES THAT THE APPLICATION IS INCOMPLETE, THE HEALTH INSURER SHALL NOTIFY THE APPLICANT IN WRITING OR BY ELECTRONIC MEANS THAT THE APPLICATION IS INCOMPLETE WITHIN SEVEN CALENDAR DAYS AFTER THE DATE THE HEALTH INSURER RECEIVED THE APPLICATION. THE NOTICE SHALL INCLUDE A DETAILED LIST OF ALL OF THE ITEMS REQUIRED TO COMPLETE THE APPLICATION.

D. IF THE HEALTH INSURER DOES NOT SEND THE NOTICE TO THE APPLICANT WITHIN THE REQUIRED TIME FRAME SPECIFIED IN THIS SECTION, THE APPLICATION IS DEEMED COMPLETE.

E. IF THE HEALTH INSURER NOTIFIES THE APPLICANT OF AN INCOMPLETE APPLICATION IN COMPLIANCE WITH SUBSECTION C OF THIS SECTION, THE TIME PERIODS SPECIFIED UNDER THIS SECTION ARE TOLLED, AND THE APPLICATION IS SUSPENDED FROM THE DATE THE NOTIFICATION WAS SENT TO THE APPLICANT UNTIL THE DATE ON WHICH THE HEALTH INSURER RECEIVES THE INFORMATION FROM THE APPLICANT TO COMPLETE THE APPLICATION.

F. ANY INFORMATION REQUESTED BY THE HEALTH INSURER TO COMPLETE THE APPLICATION SHALL BE NO MORE THAN NECESSARY FOR THE HEALTH INSURER TO FAIRLY AND RESPONSIBLY EVALUATE THE APPLICATION.

20-3406. Reported discrepancies; corrective action

A HEALTH INSURER SHALL TAKE REASONABLE STEPS TO CORRECT DISCREPANCIES IN THE PROVIDER OR NETWORK PLAN WITHIN THIRTY CALENDAR DAYS AFTER RECEIVING A WRITTEN OR ELECTRONIC REPORT OF THE DISCREPANCY FROM A PARTICIPATING PROVIDER.

20-3407. Covered services; claims

A HEALTH INSURER MAY NOT DENY A CLAIM FOR A COVERED SERVICE PROVIDED TO A SUBSCRIBER BY A PARTICIPATING PROVIDER WHO HAS BEEN APPROVED TO CONTRACT WITH A NETWORK PLAN IF THE COVERED SERVICES ARE PROVIDED AFTER THE EFFECTIVE DATE OF THE CONTRACT.

20-3408. Availability of credentialing information; policies

A. A HEALTH INSURER SHALL MAKE THE FOLLOWING INFORMATION AVAILABLE TO ALL APPLICANTS FOR CREDENTIALING AND RECREDENTIALING:

1. THE APPLICABLE CREDENTIALING POLICIES AND PROCEDURES.

2. A LIST OF ALL THE INFORMATION REQUIRED TO BE INCLUDED IN AN APPLICATION.

3. A CHECKLIST OF MATERIALS THAT MUST BE SUBMITTED IN THE CREDENTIALING PROCESS.

B. ON COMPLETION OF THE CREDENTIALING PROCESS, A HEALTH INSURER SHALL MAKE ALL INFORMATION PERTAINING TO A PROVIDER'S CREDENTIALING APPLICATION AND FINAL DECISION AVAILABLE TO THE APPLICANT ON REQUEST, IF ALLOWED BY LAW.

20-3409. Civil immunity; enforcement; civil penalty

A. A HEALTH INSURER THAT COMPLIES IN GOOD FAITH WITH THE REQUIREMENTS OF THIS CHAPTER IS IMMUNE FROM CIVIL LIABILITY FOR THE PURPOSES OF REVIEWING AND APPROVING A CREDENTIALING APPLICATION.

B. THE DIRECTOR OF INSURANCE SHALL ENFORCE THIS CHAPTER. A HEALTH INSURER THAT FAILS TO COMPLY WITH THIS CHAPTER OR WITH ANY RULES ADOPTED PURSUANT TO THIS CHAPTER IS SUBJECT TO A CIVIL PENALTY OF AT LEAST ONE THOUSAND DOLLARS AND NOT MORE THAN THREE THOUSAND DOLLARS PER DAY OF VIOLATION.

Sec. 2. Effective date

This act is effective from and after December 31, 2018.