LOUISIANA DEPARTMENT OF INSURANCE
JAMES J. DONELON
COMMISSIONER

ADVISORY LETTER 2018-04

TO: **ALL HEALTH INSURANCE ISSUERS AND HEALTH MAINENANCE ORGANIZATIONS**

FROM: **JAMES J. DONELON, COMMISSIONER OF INSURANCE**

RE: **NETWORK PROVIDER DIRECTORY ACCESSIBILITY AND ACCURACY**

DATE: **SEPTEMBER 20, 2018**

Act 290 of the 2018 Regular Legislative Session amended and reenacted La. R.S. 22:1873(B)(4) and 1879(B)(3) and enacted La. R.S. 1020.1 through 1020.6, relative to the Accessibility and Accuracy of Network Provider Directories, effective January 1, 2019.

It has been brought to my attention that confusion exists in the marketplace relative to certain provisions of Act 290. This advisory letter seeks to address four specific questions that have been presented to this Department.

1. **When must the provider directory be updated if credentialing is completed before the effective date of the provider contract?**

   La. R.S. 22:1020.3(B) states:

   > B. The health insurance issuer shall update the directory to list a healthcare provider not later than ten business days after the effective date of the provider's credentialing with the health insurance issuer.

Credentialing is not truly effective until both the credentialing and the provider contract are effective. Therefore, the directory must be updated no later than the contract effective date or ten business days after credentialing completion, whichever occurs later.

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La. R.S. 22:1020.3(C) states:

> C. The health insurance issuer shall update the directory to remove a healthcare provider not later than ten business days after the effective date of the termination of the provider's credentialing with the health insurance issuer.

In the event of termination, the directory must be updated no later than the contract expiration date or ten business days after the termination of the provider's credentialing, whichever occurs earlier.

2. Is the timeline, within which provider directory updates must be completed, triggered by the receipt of any report of inaccuracy from any person?

La. R.S. 22:1020.4(B) states:

> B. If the health insurance issuer receives a report from any person that specifically identified directory information may be inaccurate, the issuer shall investigate the report and correct the information, as necessary, in accordance with the following schedule:
>
> (1) Not later than the second business day after the date the report is received if the report concerns the health insurance issuer's representation of the network participation status of a healthcare provider.
>
> (2) Not later than the fifth business day after the date the report is received if the report concerns any other type of information in the directory.

La.R.S. 22:1020.4(A) provides:

> A. A health insurance issuer shall conspicuously display in the issuer's provider directory an email address, a toll-free telephone number, or another mechanism that is easily accessible to any individual by which the individual may report any inaccuracy in the directory.

The operative phrase in section A is "by which the individual may report." Any notification of a directory inaccuracy submitted via the mechanism provided under La. R.S. 22:1020.4(A) is a "report" and triggers the two or five business day update requirement under La. R.S. 22:1020.4(B). Any notification received outside of this mechanism is not a "report" for purposes of this statute and does not trigger this timeline.

3. When does the provider directory update timeline begin to run?

The requirement to update a provider directory runs upon receipt of a report of an inaccuracy. This timeline is linked to the receipt of the report, regardless of any difficulties verifying the information or updating company systems to reflect the accurate information. The incorrect information must be corrected within two business days when the inaccuracy concerns a provider's participation status or within five business days when the inaccuracy concerns any other type of information in the directory.

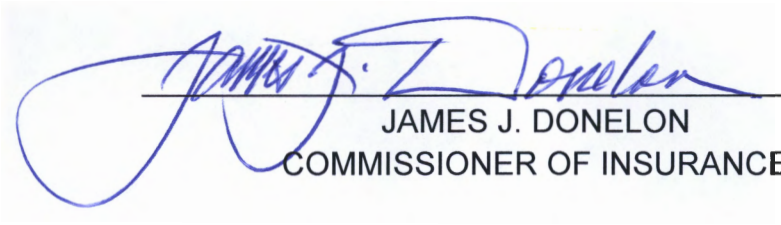
4. Does the requirement to report to the Commissioner three or more reports of inaccurate provider directory information concern three reports of any directory inaccuracies or must the three reports concern the same provider's information?

La. R.S. 22:1020.5(A) provides:

> A. If, in any thirty-day period, a health insurance issuer receives three or more reports that allege the issuer's directory inaccurately represents a healthcare provider's network participation status and that are confirmed by the issuer's investigation, the health insurance issuer shall immediately report that occurrence to the commissioner.

Use of the singular possessive word "provider's" indicates an intent to limit this reporting requirement to instances of three or more inaccuracies concerning the same provider. Further, the inaccuracies must relate to the provider's network participation status, not merely any directory information. Therefore, issuers must report to the Commissioner anytime they receive three or more reports, within a thirty day period, concerning the inaccurate network participation status of a single provider.

Baton Rouge, Louisiana, this 20 day of September, 2018.



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