SECTION 2: NETWORK PARTICIPATION

of the Professional Provider Office Manual

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This section provides information about network participation. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this section and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.bcbsla.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.bcbsla.com/providers.

This manual is provided for informational purposes only and is an extension of your Professional Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Member Contract/Certificate contains information on benefits, limitations and exclusions, and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed.

As stated in your agreement: This manual is intended to set forth in detail Blue Cross policies. Blue Cross retains the right to add to, delete from and otherwise modify the *Professional Provider Office Manual* as needed. This manual and other information and materials provided by Blue Cross are proprietary and confidential and may constitute trade secrets of Blue Cross.

Section 2: NETWORK PARTICIPATION

Participating providers are those physicians, allied health providers and facilities who have entered into a provider agreement with Blue Cross and Blue Shield of Louisiana, including HMO Louisiana, Inc., (herein referred to as Blue Cross or Plan). As a participating provider in our networks, you join other providers linked together through a business relationship with Blue Cross.

Our networks emphasize the primary roles of the participating provider and Blue Cross. They are designed to create a more effective business relationship among providers, consumers and Blue Cross. Our participating provider networks:

- Facilitate providers and Blue Cross working together to voluntarily respond to public concern over costs.
- Continue to give Blue Cross members freedom to choose their own providers.
- Demonstrate providers' support of realistic cost-containment initiatives.
- Limit out-of-pocket expenses for patients to predictable levels and reduce their anxiety over the cost of medical treatment.

As applicable, providers are encouraged to comply with Interoperability Standards and to demonstrate meaningful use of health information technology in accordance with the HITECH Act.

As applicable, provider agrees to maintain a notice of HIPAA privacy practices, as required by HIPAA, at the point where a Plan member would enter provider's website or web portal.

PARTICIPATING PROVIDER AGREEMENTS

Your responsibilities and agreements as a participating provider are defined in your provider agreement(s). You should always refer to your agreement when you have a question about your network participation. As a participating provider, you also have the following responsibilities to our members—your patients:

- **Submitting claims for members.**
  This includes claims for inpatient, outpatient and office services. To ensure prompt and accurate payment, it is important that you provide all patient information on the CMS-1500 claim form (or the UB-04 claim form for certain allied providers) including appropriate Physicians' Current Procedural Terminology (CPT®) codes and ICD-10-CM diagnosis codes. National Provider Identifiers (NPIs) are required on all claims (Blue Cross-assigned provider numbers are no longer used). The Claims Submission section of this manual gives specific information about completing the claim form as well as CPT and ICD-10-CM coding information. The Allied Health Providers section gives specific information about completing the CMS-1500 and UB-04 claim forms.

- **Accepting Blue Cross payment plus the member deductible, coinsurance and/or copayment, if applicable, as payment in full for covered services.**
  Blue Cross' payment for covered services is based on your charge not to exceed the Blue Cross allowable charge. You may bill the member for any deductible, coinsurance, copayment and/or non-covered service. However, you agree not to collect from the member any amount over the Blue Cross allowable charge.

  The Provider Payment Register/Remittance Advice summarizes each claim and itemizes patient liability, the amount above the allowable charge and other payment information. Additional information concerning the Payment Register/Remittance Advice is included in the Reimbursement section of this manual.

- **Cooperating in Blue Cross' cost-containment programs where specified in the member contract/certificate and not billing the member or Plan for any services determined to be not medically necessary or investigational, unless the provider has notified the member in advance in writing that certain not medically necessary or investigational services will be the member's responsibility.** Generic or all-encompassing notifications to member will not meet the specific notification requirement mentioned here.

  Certain Plan member contracts/certificates include cost-containment programs such as prior authorization, concurrent review and case management. The member ID card will contain telephone numbers for prior authorization. Also, the member should inform you if his/her benefit program includes cost-containment provisions or incentives.

- **Informing Blue Cross of your possible involvement in a concierge or membership program.** Such involvement must be communicated in writing to your Network Representative before our members are contacted about this new process. Blue Cross will discuss with you your intentions and plans for the concierge or membership program and how it will impact our members.

AMENDMENTS TO PROVIDER AGREEMENTS

Blue Cross has the right to amend provider agreements by making a good faith effort to notify the provider at least 60 days prior to the effective date of the change.

ALLIED HEALTH PROVIDERS

Allied health providers are licensed and/or certified healthcare providers other than a physician, or hospital, and may include a clinical laboratory, urgent care center, managed mental healthcare provider, optometrist, chiropractor, podiatrist, psychologist, therapist, durable medical equipment supplier, ambulatory surgical center, diagnostic center and any other healthcare provider, organization, institution or such other arrangement as recognized by Blue Cross.

A separate provider contract should be signed for allied health providers to participate in our networks.

RECIPROCAL BILLING AND FEE-FOR-TIME COMPENSATION ARRANGEMENTS (*formerly referred to as locum tenens*)

In the instance a regular provider (physician or physical therapist who has a professional practice) is unable to provide services to members, Blue Cross allows the provider to **temporarily** hire a "like" provider (physician of the same specialty and/or licensure or physical therapist) as a replacement for the regular provider. The regular provider may be absent for reasons such as illness, pregnancy, vacation or continuing medical education.

These services should be furnished under an arrangement that is either:

- reciprocal billing
  or
- fee-for-time compensation

Both providers entering into the reciprocal billing arrangement or the fee-for-time compensation arrangement must already be credentialed Blue Cross and Blue Shield of Louisiana providers.

Blue Cross recognizes reciprocal billing arrangement or fee-for-time compensation arrangement services for the following provider types:

- doctor of medicine
- doctor of osteopathic medicine
- doctor of dental medicine
- doctor of dental surgery
- doctor of podiatric medicine
- doctor of optometry
- chiropractor
- physical therapist – only available for outpatient physical therapy services in a health professional shortage area (HPSA), a medically underserved area (MUA) or in a rural area.

A **reciprocal billing arrangement** can be used when a "like" provider enters into the **temporary** agreement to have services furnished to regular patients on an "occasional reciprocal basis" during an absence. The provider identifies the reported services by applying Modifier Q5 on the CMS-1500 claim form. These can be informal arrangements.

A **fee-for-time compensation arrangement** can be used when a "like" provider enters into the **temporary** agreement to have services furnished to regular patients. This involves a formal arrangement that is for a continuous specified time period, not to exceed 60 continuous days. The provider identifies the reported services by applying Modifier Q6 on the CMS-1500 claim form.

Reciprocal billing and fee-for-time compensation arrangements are not allowed to extend beyond a 60-day continuous time period unless the physician or physical therapist is called to active duty as a member of a reserve component of the Armed Forces.

Blue Cross follows the CMS reciprocal billing arrangement or fee-for-time compensation arrangement billing requirements, which can be found at www.cms.gov.

NON-PARTICIPATING PROVIDERS

Non-participating providers do not have a contract with Blue Cross and Blue Shield of Louisiana, HMO Louisiana network or any other Blue Cross and Blue Shield plan. These providers are not in our networks. We have no fee arrangements with them. We establish an allowable charge for covered services rendered by non-participating providers. We use this allowable charge to determine what to pay for a member's covered services when a member receives care from a non-participating provider.

Members usually pay significant costs when using non-participating providers. This is because the amounts that providers charge for covered services are usually higher than the fees that are accepted by participating and HMO Louisiana providers. In addition, participating and HMO Louisiana providers waive the difference between the actual billed charge for covered services and the allowable charge, while non-participating providers do not. The member will pay the amounts shown in the "Non-Network" column on their schedule of benefits, and the provider may balance bill the member for all amounts not paid by Blue Cross or HMO Louisiana.

Please Note: The member's policy is an agreement between the member and Blue Cross or HMO Louisiana only. The member will receive a lower level of benefits because care was not received from a participating provider. Providers cannot waive the member's cost sharing obligations, such as deductibles, coinsurance (including out-of-network coinsurance differentials), penalties or the balance of the bill except for services covered under the No Surprises Act. A claim that is filed that includes any amounts the provider waives may be a fraudulent claim because it includes amounts that the member is not being charged, and will be reduced by the total amount waived.

PPO and HMO Point of Service Members

When a member receives covered services from a non-participating hospital, the benefits that Blue Cross will pay under the member's benefit plan will be reduced by 30%, except for services covered under the No Surprises Act. This penalty is the member's responsibility.

The member may also be responsible for higher copayments, coinsurances and deductibles when receiving services from non-participating providers.

HMO Louisiana Members

HMO Louisiana members enrolled in an HMO product have no benefits for services provided by non-participating providers without obtaining prior approval. Our authorization department will (1) determine if the services are medically necessary, and (2) approve a member to receive the medically necessary covered services from a non-participating provider, benefits will be at the highest level possible to limit the member's out-of-pocket expenses. There is no guarantee of benefits.

HMO-HMO and HMO-POS members do not have to obtain prior authorization to receive emergency medical services. A member should seek emergency care at the nearest facility.

No Surprises Act Open Negotiation

One regulatory provision of the Consolidated Appropriations Act (CAA) 2021 is the No Surprises Act Open Negotiation process.

The No Surprises Act protects consumers from surprise bills or balance billing when a non-participating provider bills a member for more than what Blue Cross pays plus the member cost-share.

Non-participating providers cannot charge members an unexpected bill when the member is not able to choose who treats them. Non-participating providers who render services to members in a true health emergency cannot balance bill members for more than the Blue Cross allowable charge.

When balance billing is not allowed, the member also has the following protections. The member is only responsible for paying any copayments, coinsurance or deductible that they would pay if the provider was in their network. Blue Cross will process claims for non-participating providers and facilities as follows:

- Cover emergency services without requiring the member to get approval for services in advance (prior authorization).
- Cover emergency services by non-participating providers.
- Count any amount the member pays for emergency services or non-participating provider services at in-network facilities toward the member's in-network deductible and out-of-pocket limit.

Members are protected from balance billing for:

- Emergency services: If a member must get care in a true emergency from a non-participating provider, the most the provider may bill that member is the member's copayment, coinsurance or deductible for in-network care. The member cannot be balance billed for these emergency services. This includes care the member may get after they are in stable condition unless that member gives written consent and gives up their protections not to be balanced billed.
- Certain services at a network hospital or ambulatory surgical center: When a member gets services from an in-network hospital or ambulatory surgical center, certain providers there may be non-participating. In most cases, non-participating providers who see the member in a network hospital cannot send that member a surprise bill unless they obtained consent from the member.

Those non-participating providers rendering services covered by the No Suprises Act may negotiate with Blue Cross for more than the allowable charges for services. The 30-day open negotiation period is available within 30 business days of the date of receipt of the initial claim payment.

To start the open negotiation period, the non-participating provider must complete and submit the No Surprises Act Open Negotiation Notice form. It is available online at www.bcbsla.com/providers >Resources >Forms. Send completed forms to providerdisputesCAA@bcbsla.com.

For more information about the federal law, visit www.cms.gov/nosurprises.

Notice for Patient Consent Requirements

If a member gets other care at in-network facilities, non-participating providers cannot balance bill the member unless the member gives written consent and gives up these protections. Our members are not required to get care from non-participating providers, and the CAA's No Surprises Act protects members from surprise bills in the situations outlined above.

Eligible non-participating providers must include written notice to the patient within the timeframes defined by applicable law. The Centers for Medicare and Medicaid Services (CMS) has published a consent waiver form that non-participating providers can use. The federal Standard Notice and Consent Documents Under the No Surprises Act (consent form) is available at www.cms.gov/nosurprises >Policies and Resources >Overview of Rules & Fact Sheets >Guidance & Technical Resources. The patient must sign and date the consent and acknowledge receipt of written notice about the payment and how it may affect cost sharing.

The following non-participating providers cannot ask the member to give up their balance-billing protections:

- Anesthesiologists
- Emergency room physicians
- Neonatologists
- Pathologists
- Radiologists
- And other providers of ancillary services as defined by applicable law

Submitting Patient Notice & Consent

Providers can submit claims electronically or hardcopy. Providers must also submit a copy of the consent waiver to Blue Cross as documentation that the patient is waiving their protective rights for balance billing. When billing electronically, there is not an option to include attachments. To ensure that Blue Cross properly receives the consent documentation, please follow the claims filing guidelines below:

For Electronic Claims:

- Submit the claim electronically.
- Submit a copy of the signed consent waiver by mail, fax or email at the same time.
- Complete and include the Blue Cross CAA Consent Submission Form as a cover sheet. It is available at www.bcbsla.com/providers >Resources >Forms. Submission instructions are included on the form.

  Please Note: The Blue Cross CAA Consent Submission Form is not a patient consent waiver. Our form simply allows Blue Cross to obtain additional information to match the patient consent waiver to your electronic claim.

For Paper Claims:

- Submit the signed consent waiver as an attachment to your hardcopy claim form.

Servicing Facility Claim Requirements

To ensure that Blue Cross can identify claims involving members who receive non-emergency out-of-network services in connection with an in-network facility visit, professional providers must include the servicing facility on all submitted claims. The claim will deny if it does not include the name, address and NPI number of the servicing facility.

Please enter the servicing facility information for paper and electronic claims as indicated below.

Paper Claims:

- CMS-1500 Health Insurance Claim Form: Block 32

Electronic 837P, Professional Claims:

- Servicing Facility – Claim Level: 2310C loop

CREDENTIALING PROGRAM OVERVIEW

Blue Cross fully credentials providers who apply for network participation. Our credentialing program is accredited by the Utilization Review Accreditation Commission (URAC). All provider information obtained during the credentialing process is considered highly confidential.

Participating providers are expected to cooperate with quality-of-care policies and procedures. An integral component of quality of care is the credentialing of participating providers. Participation is available for professional providers and facilities.

The credentialing program includes initial credentialing as well as recredentialing every three years.

For more information on our credentialing and data management process, including frequently asked questions, visit www.bcbsla.com/providers >Network Enrollment >Join Our Networks >Professional Providers.

Credentialing Applications

The credentialing packets and criteria are available on our Blue Cross Provider page at www.bcbsla.com/providers >Network Enrollment >Join Our Network >Professional Providers >Join Our Network. All packets include an application for iLinkBlue and Electronic Funds Transfer. iLinkBlue is our secure online tool for professional and facility healthcare providers.

We return incomplete or incorrect credentialing applications and stop the application process. The process starts over once all completed documents are received.

Initial Credentialing

If a provider applies for participation in any of our networks, initial credentialing is required before being approved for participation. When a fully completed credentialing packet and required supporting documentation are received, the credentialing process can take up to 90 days. Our credentialing staff verify the provider's credentials including, but not limited to, state license, professional malpractice liability insurance, State CDS Certificate, etc., according to our policies and procedures and URAC standards.

Providers will remain non-participating in our network(s) until the application has been approved by the Blue Cross Credentialing Committee. Once approved by the Blue Cross Credentialing Committee, providers will remain non-participating until they sign and execute an agreement through our Provider Contracting Department for participation.

After 90 days, providers may inquire about their credentialing status by contacting the Provider Credentialing & Data Management Department at PCDMstatus@bcbsla.com.

Recredentialing

After the initial credentialing process, all network providers must undergo recredentialing within 36 months from the date of the last approval. The recredentialing process is conducted in the same manner as the initial credentialing process. Network providers are considered to be approved by the Blue Cross Credentialing Committee and recredentialed for another three-year cycle unless otherwise notified.

If a provider's network participation has been terminated, that provider will be required to reapply and complete the initial credentialing process before being reinstated as a participating provider in our networks.

Credentialing Committee

The Blue Cross Credentialing Committee meets to review credentialing twice per month. Based upon compliance with the criteria below, the Blue Cross Credentialing Committee reviews the provider's credentials to ascertain compliance with the following criteria. The Blue Cross Credentialing Committee, comprised of network practitioners, makes a final recommendation of approval or denial of a provider's application.

All participating providers must maintain these criteria (as applicable for provider type) on an ongoing basis:

- Unrestricted license to practice medicine in Louisiana as required by state law.
- Agreement to participate in the Blue Cross networks.
- Professional/malpractice liability insurance that meets required amounts.
- Malpractice claims history that is not suggestive of a significant quality of care problem.
- Appropriate coverage/access provided when unavailable on holidays, nights, weekends and other off hours.
- Absence of patterns of behavior to suggest quality of care concerns.
- Utilization review pattern consistent with peers and congruent with needs of managed care.
- No sanctions by either Medicaid or Medicare.
- No disciplinary actions.
- No convictions of a felony or instances where a provider committed acts of moral turpitude.
- No current drug or alcohol abuse.

Professional Credentialing

Professional providers requesting Blue Cross network participation must complete the initial professional credentialing application packet, which includes a checklist of required documents as well as the Louisiana Standardized Credentialing Application (LSCA). All providers, regardless of network participation, must include their NPI(s) on the application.

Reimbursement During Credentialing (for professional providers only)

Professional healthcare providers can be reimbursed for claims at network allowable charges and member benefit options during the credentialing process, and the claims are paid directly to the provider. Blue Cross sets up qualifying providers for this reimbursement when they meet the following criteria:

- This provision does not apply for solo practitioners.
- Provider must be applying for network participation to join a provider group that already has an executed group agreement on file with Blue Cross for the same provider type. For Example: A nurse practitioner (NP) applying for network participation must be joining a provider group that already has an executed allied health agreement on file with Blue Cross.
- NPs must submit a copy of the collaborating agreement with a physician. Collaborating physician must participate in the same networks as the NP.
- Physician assistants (PAs) must submit a copy of intent to practice agreement with a physician that participates in the same networks as the PA.
- If reimbursement during credentialing criteria is met, reimbursement during credentialing is backdated up to one month prior to the date of application receipt.

Expedited Processing

Expedited processing applies to a limited group of professional providers only. In most cases, this applies to practitioners with admitting privileges or admitting arrangements.

Louisiana law allows professional providers a 30-day expedited application processing. To be eligible for expedited processing, providers must meet the following criteria:

- Providers who are:
  - Already credentialed with Blue Cross and are joining a new group, or
  - Are not yet credentialed but are joining a provider group that already has an executed group agreement on file with Blue Cross for the same provider type. For Example: An NP applying for network participation must be joining a provider group that already has an executed allied health agreement on file with Blue Cross.
- Provider must have admitting privileges to a network hospital or an approved exception. The following specialties are viewed as an exception: hospital-based anesthesiology, hospital-based pathology, hospital-based radiology, podiatric medicine, dermatology, allergy and immunology,

psychiatry, addiction psychiatry, sleep medicine, physical medicine and rehabilitation (physiatry), medical genetics and radiology providers that "read films" only on patients that are directed to a diagnostic facility by another provider, all pediatric subspecialties for the above specialties, physical therapy, occupational therapy and speech language pathology. Consulting privileges are required for infectious disease.

- When applicable, provider must list their admitting privileges information in the hospital affiliations section on the appropriate credentialing application.
- Blue Cross credentialing policy allows certain eligible providers to have an arrangement with a hospitalist group to admit their patients in lieu of their own hospital privileges. A copy of the arrangement must be submitted with the credentialing application.
- Agree to hold our members harmless for payments above the allowable amount.

To request expedited processing, include the following with the initial credentialing application:

- Letter asking Blue Cross to invoke the expedited process. The letter must:
  1. Include your agreement to hold our members harmless for payments above the allowable amount.
  2. Identify the provider group name.
  3. Be on company letterhead and signed by the provider or an authorized representative. An electronic signature is acceptable.
- When applicable, signed admitting privileges agreement to a network hospital.

Write the letter requesting expedited processing similar to the sample below:

> {Date}
>
> Dear Blue Cross and Blue Shield of Louisiana:
>
> In accordance with the Louisiana law extending certain requirements for credentialing of healthcare providers, please accept this written request for expedited processing for {provider's name} as a new provider at {provider's group name} at our group contract rate and with in-network benefits. {Provider's group name} agrees that all contract provisions, including holding covered members harmless for charges beyond the Blue Cross allowable amount and the member's cost share amount (deductible, coinsurance and/or copayment, as applicable) will apply to the new provider.
>
> {Signature of the provider}

CLIA Certification Required

Professional providers who perform laboratory testing procedures in the office, are required to submit a copy of their Clinical Laboratory Improvement Act (CLIA) certification when applying for credentialing or undergoing the recredentialing process.

Credentialing Process and Provider Specialty Network Provider Directory

As a network provider, you may only participate in the Blue Cross networks and be listed in the network provider directory as the primary specialty you identified to Blue Cross on your credentialing application. For example, providers may not participate in our networks as one of the following specialties of general practice, family practice, internal medicine or pediatrics unless they practice in a full primary care provider (PCP) capacity. For more information on our credentialing process, visit our Provider page. For more information on our network provider directory, see the Provider Directories section of this manual.

Facility Credentialing

Facilities requesting network participation must complete the initial facility credentialing application packet, which includes a checklist of required documents as well as the Facility Credentialing Application. Select facility types must also complete a Facility Information Form:

- Facility Information Form A: Ambulance Company
- Facility Information Form B: DME Supplier or Pharmacy
- Facility Information Form C: Ambulatory Surgical Center, Hospital, IOP/PHP Psych/CDU, Skilled Nursing Facility, Long Term Acute Care, Rehabilitation Center
- Facility Information Form D: Urgent Care Clinic/Walk-in Clinic
- Facility Information Form E: Diagnostic Radiology (Free Standing)
- Facility Information Form F: Retail Health Clinics
- Facility Information Form G: Laboratory
- Facility Information Form H: Outpatient Cath Lab

Freestanding Diagnostic Imaging Facilities

Blue Cross requires that all freestanding diagnostic imaging facilities and the equipment used for the modalities listed below be accredited by either the American College of Radiology (ACR) and/or the Intersocietal Accreditation Commission (IAC) as a condition for network participation. If a facility performs any or all of the modalities below and is not accredited or fails to remain accredited, they will be removed from all Blue Cross networks in which they participate.

Accreditation is required to perform the following modalities:

- Magnetic resonance imaging (MRI)
- Computed tomography (CT)
- Positron emission tomography (PET)
- Nuclear Cardiology

An ***Opti****Net*® score of 80% or more for each modality is required. ***Opti****Net* is a Carelon online registration tool for gathering modality-specific data on imaging providers in areas such as facility qualifications, technologist and physician qualifications, accreditation and equipment. This information is used to determine conformance to industry-recognized standards, including those established by the American College of Radiology (ACR) and the Intersocietal Accreditation Commission (IAC).

Blue Cross reviews each provider's accreditation status during the provider's regularly scheduled recredentialing cycle. Providers are recredentialed by Blue Cross within 36 months in accordance with URAC standards. Providers who do not maintain their accreditation or do not abide by Blue Cross' credentialing guidelines will be subject to termination from any of our networks in which they participate. The only exception to this rule would be when a diagnostic imaging facility no longer performs a modality that requires accreditation or performs another modality that does not require accreditation.

This credentialing policy applies for freestanding (not hospital-based) diagnostic imaging facilities only.

Medical Staff

Only providers who are a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Certified Registered Nurse Anesthetist (CRNA), Certified Registered Nurse First Assistant (CRNFA), Registered Nurse First Assistant (RNFA), Nurse Practitioner (NP), Physician Assistant (PA) or Psychologist can be set up as a medical staff provider under the hospital agreement and file claims independently. All other providers are considered part of the hospital reimbursement and will not be set up independently under the hospital agreement.

Subcontracted Providers

Subcontracted services are those services furnished to patients by providers other than the Member Provider while the patient is inpatient or outpatient. These services include, but are not limited to: EKG services, CAT scans, MRI, PET imaging, DME, technical components of clinical and anatomical lab, technical component of diagnostic services, initial hearing screens for newborns, etc.

The reimbursement outlined in the Member Provider Agreement is intended to cover all hospital services rendered to a patient, including those services that are performed by subcontracted providers. Subcontracted providers should seek payment solely from the Member Provider. Subcontracted providers should not bill Blue Cross or the member for such services.

For those instances when Member Providers may need to send a member to another facility when the member is inpatient, the Member Provider should bill Blue Cross for that service. The other facility should not bill Blue Cross separately for the services rendered.

For example, a member, who is an inpatient at ABC Hospital, needs hyperbaric oxygen therapy, but ABC Hospital does not have the necessary equipment. Therefore, ABC Hospital sends the member to XYZ Hospital. Once the procedure is completed, the member returns to ABC Hospital. In this case, ABC Hospital should bill Blue Cross for the hyperbaric oxygen therapy XYZ Hospital should not bill Blue Cross or the member.

At least annually, Member Providers should furnish Blue Cross with a listing of any subcontracted providers with whom the Member Provider has contracted to perform the Member Provider's duties and obligations under the Member Provider Agreement.

Please Note: Blue Cross will not pay for initial hearing screens done on newborns when performed after discharge from the facility of birth. Initial hearing screens are inclusive of the hospital stay.

Statute: R.S. 46:2264(A) The office of public health in the Department of Health and Hospitals shall establish, in consultation with the advice of the Louisiana Commission for the Deaf and the advisory council created in R.S. 46:2265, a program for the early identification and follow-up of infants at risk, hearing impaired infants, and infants at risk of developing a progressive hearing impairment.

Source: Senate Bill No. 436.

Status Changes

A provider is required to report changes in their credentialing criteria to Blue Cross within 30 days from the date of occurrence. Failure to do so may result in immediate termination.

Examples of status changes providers are required to report include, but are not limited to:

- Change in Hospital Admitting Privileges
- Suspension/revocation of any license
- Change in Collaborative/Supervising Physician Agreement

iLinkBlue and Electronic Funds Transfer

iLinkBlue is our secure online tool for professional and facility healthcare providers. It is designed to help you quickly complete important functions such as eligibility and coverage verification, claims filing and review, payment queries and transactions. The iLinkBlue Application and Electronic Funds Transfer Form are included in our credentialing packets. These documents are required to become a participating provider.

TERMINATIONS

If a provider's network participation has been terminated, that provider will be required to reapply and complete the initial credentialing process before being reinstated as a participating provider in our networks.

Voluntary Termination

While Blue Cross makes reasonable efforts to resolve provider issues, contracted providers may voluntarily terminate their participation in our networks. **Providers must do so by providing at least 90 days advance written notice per notification in their network agreement.**

Upon receiving a contract termination notice for a PCP or a specialist, Blue Cross will close the PCP's panel to new members and notify affected members of the forthcoming contract termination. Blue Cross will provide assistance, as needed, to transition care to another participating PCP or specialist. The resigning provider is responsible for the continued care of Blue Cross patients during the 90-day notification period.

To request network termination, use the Provider Update Request Form and select the "Termination Request" option. The form is available online at www.bcbsla.com/providers >Resources >Forms. This form can be completed, signed and submitted digitally with DocuSign. We will advise you if additional information is necessary to process your request.

Involuntary Termination

Blue Cross may terminate the participation of an individual provider for cause. Blue Cross shall gives notice in accordance with the terms and conditions of the applicable Participation Agreement.

Blue Cross reserves the right to terminate an individual provider's network participation due to lack of claims activity over a given 24-month period by providing written or electronic notice to the provider at the appropriate correspondence address or email address, as provided in the applicable Participation Agreement, or as otherwise provided to Plan for correspondence purposes. The termination shall be effective upon the date written or electronic notice is sent by Blue Cross unless otherwise stated in the notice.

PROVIDER AVAILABILITY STANDARDS

Blue Cross is committed to providing high quality healthcare to all members, promoting healthier lifestyles and ensuring member satisfaction with the delivery of care. Within this context and with input and approval from various network providers who serve on our Medical Quality Management Committee, we developed the following Provider Availability Standards and Acute Care Hospital Availability Standards.

Access Standards

Service Type	Standard
Primary Care	
Routine	15-days
Urgent	7-days
Mental Health/Substance Use Disorder (MHSUD)	
Non-life-threatening Emergency	6-hours
Urgent	48-hours
Initial Visit Routine	10-business days
Follow-up Routine	30-days
High-impact Specialty Providers	
Routine	30-days
Urgent	15-days
High-volume Specialty Providers	
Routine	30-days
Urgent	15-days
Facilities	
Hospital/Emergency Room	Immediately
Non-hospital Inpatient Facility	30-hours
Urgent Care Center	30-hours
Outpatient Facility	15-days

Additional Availability Standards

- Routine care includes problems that could develop if untreated but do not substantially restrict a member's normal activity.
- Network physicians are responsible for assuring access to services 24 hours a day, 365 days a year other than in an emergency room for non-emergent conditions. This includes arrangements to assure patient awareness and access after hours to another participating physician.
- All network providers must offer services during normal working hours, typically between 9 a.m. and 5 p.m.
- Average office waiting times should be no more than 30 minutes for patients who arrive on time for a scheduled appointment.
- The physician's office should return a patient's call or portal message within four to six hours for an urgent/acute medical question and within 24 hours for a non-urgent issue.

Acute Care Hospital Availability Standards

- Acute care hospitals are responsible for assuring access to services 24 hours a day, 365 days a year.
- All contracted hospitals must maintain emergency room or urgent care services on a 24-hour basis and must offer outpatient services during regular business hours, if applicable.

Definitions

- Emergency – Medical situations in which a member would reasonably believe his/her life to be in danger, or that permanent disability might result if the condition is not treated.
- High-Impact Specialties and High-Volume Specialties – Blue Cross considers obstetrics and gynecology (OB/GYN) a high-volume specialty and oncology/hematology a high-impact specialty. Blue Cross may choose to monitor and analyze additional practitioner specialties if network changes, or other conditions warrant further review.
- Hospital – Inpatient acute care facilities.
- Mental Health/Substance Use Disorder (MHSUD) Practitioners – Includes the following specialties: psychiatrists, psychologists, addiction counselors, licensed clinical social workers, other licensed counselors, physician assistants and nurse practitioners.
- Non-life-threatening Emergency Room – A situation where clinical evidence shows that a person requires immediate care, but lack of care would not lead to death.
- Non-hospital Inpatient Facility – Includes but is not limited to inpatient alcohol/drug rehab centers, long-term acute care facilities, inpatient rehabilitation centers, inpatient residential treatment centers, skilled nursing facilities, and inpatient surgical hospitals.
- Outpatient Facility – Includes but is not limited to diagnostic radiology, occupation/physical therapy, outpatient infusion/chemotherapy, outpatient surgical services, speech language pathology, and urgent care facilities.
- Primary Care Provider (PCP) – May include but is not limited to the following specialties: general practice, family practice, internal medicine, nurse practitioners and physician assistants practicing within a PCP clinical office setting.
- Regular/Routine Physical Examinations and Routine MHSUD Office Visits – Services including well visits, health promotion, disease prevention, health maintenance, counseling, patient education, self-management support, care planning and the on-going maintenance of chronic illnesses.
- Urgent – Healthcare services that, if not provided timely to treat a condition or illness, including MHSUD conditions, presents a risk to the health of an individual.
- Urgent Care Center – Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

DIGITALLY SUBMITTING CREDENTIALING & DEMOGRAPHIC FORMS

Providers can complete, sign and submit many Blue Cross applications and forms digitally with DocuSign®. This replaces the need to print and submit hardcopy documents to the Provider Credentialing & Data Management (PCDM) Department. Through this enhancement, providers can electronically upload support documentation and even receive alerts (reminding them to complete applications) and confirm receipt.

The documents below are available in DocuSign format only.

- Professional Credentialing Packet (includes LCSA Attachment A)
- Facility Credentialing Packet (includes all Facility Information Forms)
- iLinkBlue Agreement Packet
- Electronic Funds Transfer (EFT) Enrollment Form
- Provider Update Request Form

Please Note: When submitting DocuSign documents, please do not also separately email them to Blue Cross. Double submissions (submitting through DocuSign and sending an email of the completed form) could delay the processing time for your request.

If you have any questions on submitting DocuSign forms to Blue Cross, you may contact the PCDM Department at PCDMstatus@bcbsla.com.

DocuSign® is an independent company that Blue Cross and Blue Shield of Louisiana uses to enable providers to sign and submit provider credentialing and data management forms electronically.

PROVIDER DIRECTORIES

As a participating provider, your name is included in the Blue Cross product-specific provider directories featured on our website. Participating providers are listed in the directories by parish in alphabetical order under their specialty(ies).

Thousands of healthcare professionals and facilities across the state are in our networks. You can find the one you need quickly with our easily searchable directories online. Listings are updated daily. We make every effort to ensure the information in our provider directories is current and accurate.

You must notify Provider Credentialing & Data Management if you have any changes within your practice. To do so, use the Provider Update Request Form. It is available online at www.bcbsla.com/providers >Resources >Forms. It is a DocuSign® form, which allows you to complete, sign and digitally submit it directly to our Provider Credentialing & Data Management Department.

The form includes the following change request options:

- Demographic Information (i.e., new or updated email address, change of address, different operating hours, etc.)
- Electronic Funds Transfer (EFT)
- Existing Providers Joining a New Provider Group (includes solo providers creating a new provider group)
- Termination Request
- Tax ID Number Change
- Add New Practice Location (existing Tax ID)
- Remove Practice Location (existing Tax ID)

We will advise you if additional information is necessary to process your request.

Please Note: The Blue Cross and Blue Shield of Louisiana online provider directory is developed using information from network providers and facilities. Blue Cross does its best to post the most accurate, up-to-date information. However, because we continually add providers to our network, and providers occasionally decide to discontinue their participation, we cannot guarantee the accuracy or currency of our information at the time of your search. For the most current information, please contact the Customer Care Center.

PROVIDER DIRECTORY INFORMATION

A part of our commitment to serving our members is to provide them with current comprehensive information about our network providers.

Provider directory information includes demographic information such as medical school(s) attended and graduation year, gender, race/ethnic background (voluntarily reported), languages spoken and whether a physician's office is accepting new patients. Other information like providers' specialties, board certifications, hospitals where they admit and certain accreditation information is also available.

PROVIDER DIRECTORY VERIFICATION

Under the Consolidated Appropriations Act (CAA) 2021, providers are required to verify their demographic information in our online provider directories every 90 days. This ensures that the information published is accurate for member/patient use.

Blue Cross implemented a process to verify the information providers already have on file with us. Providers are sent a pre-populated Provider Attestation Form via DocuSign. Providers must attest that the information is correct/incorrect. If any of the data on the form is incorrect, the provider must complete the Provider Update Request Form to report updated information.

Should a provider fail to verify their information, they will be removed from Blue Cross' online provider directories. Network participation will not be affected, but a person searching our provider directories will not have access to your information.

PROVIDER DIRECTORY LOCATIONS POLICY

Blue Cross and Blue Shield of Louisiana limits the published practice locations of professional providers in our online provider directories as follows:

- Professional providers must be available to schedule patient appointments at a minimum of 8 hours per week at the location listed.
- A member must also be able to call and schedule a patient appointment at the location listed in the directory.

Each professional provider must report patient appointment availability for each location reported to Blue Cross. This information should be reported for new providers on the Louisiana Standardized Credentialing Application (LSCA) Attachment A – Location Hours. Existing network providers must report this information on the Recredentialing Application during the recredentialing process.

Additionally, professional providers are asked to report this information when completing the Provider Update Request Form to make the following changes:

- Updating your physical address
- Joining a new provider group or clinic
- Changing your Tax ID number
- Adding a new practice location