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. A 30% penalty may apply when the non-participating provider is a hospital.

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 benefit because care was not received from a network 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. 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%. 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.

CREDENTIALING PROGRAM

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.

This process consists of two parts:

- Credentialing
- Recredentialing

If a provider applies for participation in any of our networks, initial credentialing is required before being approved for participation. Our credentialing program consists of a full initial review of a provider's credentials at the time of application to our networks.

The credentialing packets and criteria are available on our Provider page at www.BCBSLA.com/providers >Provider Networks >Join Our Network.

When a fully completed credentialing packet, agreement 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 Utilization Review Accreditation Committee (URAC) standards.

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

Providers will remain non-participating in our network(s) until the application has been approved by the Credentialing Committee.

Credentialing Committee

Blue Cross and the Credentialing Committee review the provider's credentials to ascertain compliance with the following criteria. 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

Based upon compliance with this criteria, Blue Cross will recommend to the Credentialing Committee that a provider be approved or denied participation in our network(s). The Credentialing Committee, comprised of network practitioners, makes a final recommendation of approval or denial of a provider's application. The Credentialing Committee meets to review credentialing twice per month.

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)

Louisiana law allows certain healthcare provider types the option to be reimbursed for claims at network allowable changes and member benefit options during the credentialing process and the claims are paid directly to the provider. To qualify for this provision, the professional provider must meet the following criteria:

- You must be applying for network participation to join a provider group that already has an executed group agreement on file with Blue Cross. This provision does not apply for solo practitioners.
- You must have admitting privileges to a network hospital. PCPs can have an arrangement with a hospitalist group to admit their patients.
- Your initial credentialing application for network participation must include a written letter of request asking Blue Cross to reimburse you at the group contract rate and an agreement to hold our members harmless for payments above the allowable amount.

View our *How to Request Reimbursement During Credentialing* guide for more information on the process. It is available on our Provider page at www.BCBSLA.com/providers >Provider Networks >Join Our Network.

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 Health Delivery Organization (HDO) Information Form. Select facility types must also complete an HDO attachment:

- HDO Attachment A: Ambulance Company
- HDO Attachment B: DME Supplier or Pharmacy
- HDO Attachment C: Hospital, Ambulatory Surgical Center or Free-standing Skilled Nursing Facility
- HDO Attachment D: Urgent Care Clinic/Walk-in Clinic
- HDO Attachment E: Diagnostic Radiology (Free-standing)
- HDO Attachment F: Retail Health
- HDO Attachment G: Laboratory
- HDO Attachment 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 an AIM Specialty Health 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), Nurse Practitioner (NP) 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.

Urgent Care Centers

For an urgent care center to participate in the Blue Cross networks, it must be open at least until 8 p.m., Monday through Friday and open for a minimum of eight hours on either Saturday or Sunday.

Note: Blue Cross also has additional specific credentialing requirements for certain facility types. Credentialing criteria are available on our Provider page at www.BCBSLA.com/providers >Provider Networks >Join Our Network.

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 Credentialing Committee and recredentialed for another three-year cycle unless otherwise notified.

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

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.

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.

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.

Type	Access Standard	Examples
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	Immediate access, 24 hours a day, 7 days a week	• Loss of consciousness • Seizures • Chest pain • Severe bleeding • Trauma
Urgent		
Medical conditions that could result in serious injury or disability if medical attention is not received	30 hours or less	• Severe or acute pain • High fever in relation to age and condition
Routine Primary Care		
Problems that could develop if untreated but do not substantially restrict a member's normal activity	5 to 14 days	• Backache • Suspicious mole
Preventive Care		
Routine exams	6 weeks or less	• Routine physical • Well baby exam • Annual Pap smear

Additional Availability Standards

- 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 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.

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 HDO Attachments)
- 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 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. **Please notify Provider Credentialing & Data Management if you have one of the following changes occur by using the Provider Update Request Form**:

Provider Demographic Change
Have a change in contact information, such as a new or updated email address
New providers join your practice
Obtain a new Tax ID number
Providers in your clinic retire or move
Close a practice
Merge a practice
Change or terminate your electronic funds transfer (EFT) payment information (commercial only)

Complete, sign and submit the Provider Update Request Form digitally with DocuSign. It is available on our Provider Page at www.BCBSLA.com/providers >Resources >Forms. A sample of this form is provided in Appendix II Forms at the end of this manual, but should be submitted through the DocuSign format only. The purpose of this form is to notify Blue Cross of changes or additions to provider demographic information, including what is displayed in our provider directories.

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 LOCATIONS POLICY

Beginning November 1, 2019, 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 16 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 (this is a new form). 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

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, 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.

Please Note: If a member is admitted as an inpatient and requires medically necessary diagnostic services not otherwise available at the inpatient facility and requires ground ambulance transport to receive additional services, the inpatient hospital lacking the needed services is responsible for the costs of all ambulance services. The ambulance service should not be billed to Blue Cross in this instance as it is included in the inpatient reimbursement of the hospital lacking the needed services

For example, a member, who is an inpatient at Main Street Hospital, needs hyperbaric oxygen therapy, but Main Street Hospital does not have the necessary equipment. Therefore, Main Street Hospital sends the member to Metropolitan Medical Center. Once the procedure is completed, the member returns to Main Street Hospital. In this case, Main Street Hospital should bill Blue Cross for the hyperbaric oxygen therapy and reimburse Metropolitan Medical Center accordingly. Metropolitan Medical Center 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.