SECTION 2: NETWORK PARTICIPATION

of the Member Provider Policy & Procedure Manual

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This section provides information about network participation. If Blue Cross and Blue Shield of Louisiana (Louisiana Blue) makes 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 *Member Provider Policy & Procedure 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.lablue.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.lablue.com/providers.

This manual is provided for informational purposes only and is an extension of your Member 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 our policies. Louisiana Blue retains the right to add to, delete from and otherwise modify the *Member Provider Policy & Procedure Manual* as needed. This manual and other information and materials provided are proprietary and confidential and may constitute trade secrets.

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 Louisiana Blue or Plan). As a participating provider in our networks, you join other providers linked together through a business relationship with Louisiana Blue.

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

- Facilitate providers and Louisiana Blue working together to voluntarily respond to public concern over costs.
- Continue to give 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 costs 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, the 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 agreements. 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 professional services if applicable. To ensure prompt and accurate payment, it is important that you provide all patient information on the required claim form, including appropriate HCPCS, CPT® codes and ICD-10-CM diagnosis and procedure codes. Also, remember to include your national provider identifier (NPI) on the claim form.

  The Claims Submission section of this manual will give you specific information about completing the claim form as well as HCPCS, CPT and ICD-10-CM coding information.

- **Accepting Louisiana Blue payment plus the member's deductible, coinsurance and/or copayment, if applicable, as payment in full for covered services.**
  Louisiana Blue's payment for covered services is based on your charge not to exceed the 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 Louisiana Blue 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 Louisiana Blue's 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 members **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 Louisiana Blue of your possible involvement in a concierge or membership program.** Such involvement must be communicated in writing to your Provider Contracting Representative before our members are contacted about this new process. Louisiana Blue will discuss with you your intentions and plans for the concierge or membership program and how it will affect our members.

- **Providing financial and medical information necessary to carry out the terms of the Member Provider Agreement.**

  Louisiana Blue may require this information in a format designated by the Plan, at no charge to the Plan or its members, including but not limited to:

  1. Financial statements, ledgers, billings, itemized statements, price lists and patient ledgers.
  2. Medical records and medical record abstract information. When requested, the Member Provider shall make available complete medical records or medical record abstracts in a format that Plan personnel can utilize.
  3. Notify Louisiana Blue of advance notice changes and updates to hospital's services charge master.

AMENDMENTS TO PROVIDER AGREEMENTS

Louisiana Blue 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.

MEMBER PROVIDER BENEFITS

Member Providers are those hospitals and affiliated units that have entered into a Member Provider Agreement with Louisiana Blue. As a Member Provider, a hospital enjoys a close working relationship with the largest health insurer in Louisiana. As a result, the hospital shares in many advantages:

- All Member Providers receive recognition in our marketing programs. Louisiana Blue members have benefit incentives in the member contracts/certificates to choose Member Providers over non-member providers.
- For Member Providers, the member's benefits are paid directly to the hospital.
- Louisiana Blue provides coverage for large groups, small groups and individuals. Consequently, a higher percentage of premium receipts are paid in benefits as compared to other health insurers in Louisiana. Both of these factors reduce hospitals' uncompensated care levels. As a Member Provider, a hospital works with Louisiana Blue to benefit the overall healthcare industry in Louisiana.

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 Louisiana Blue.

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

PROVIDER GROUP PARTICIPATION STATUS REQUIREMENT

A provider group operating under a single Tax Identification Number (TIN) must maintain the same participation status for all practitioners affiliated with that TIN. Provider groups cannot contract with the Plan with both participating and nonparticipating providers under the same TIN.

If a provider group elects to participate in the Plan's network under a specific TIN, all providers billing under that TIN will be subject to the same participation status, contractual terms, reimbursement methodologies and administrative requirements.

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, Louisiana Blue 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 Louisiana Blue providers.

Louisiana Blue 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.

Louisiana Blue follows the U.S. Centers for Medicare & Medicaid Services (CMS) reciprocal billing arrangement or fee-for-time compensation arrangement billing requirements, which can be found at www.cms.gov.

NONPARTICIPATING PROVIDERS

Nonparticipating providers do not have a contract with Louisiana Blue, 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 nonparticipating provider.

Members usually pay significant costs when using nonparticipating 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 nonparticipating 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 Louisiana Blue or HMO Louisiana.

Note: The member's policy is an agreement between the member and Louisiana Blue 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 nonparticipating hospital, the benefits that Louisiana Blue 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, coinsurance and deductibles when receiving services from nonparticipating providers.

HMO Louisiana Members

HMO Louisiana members enrolled in an HMO product have no benefits for services provided by nonparticipating 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 nonparticipating 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 nonparticipating provider bills a member for more than what Louisiana Blue reimbursed plus the member's cost share.

Nonparticipating providers cannot charge members an unexpected bill when the member is not able to choose who treats them. Nonparticipating providers who render services to members in a true health emergency cannot balance bill members for more than the 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. Louisiana Blue will process claims for nonparticipating 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 nonparticipating providers.
- Count any amount the member pays for emergency services or nonparticipating 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 nonparticipating 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 nonparticipating. In most cases, nonparticipating providers who see the member in a network hospital cannot send that member a surprise bill unless they obtained consent from the member.

Those nonparticipating providers rendering services covered by the No Surprises Act may negotiate 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 nonparticipating provider must complete and submit the No Surprises Act Open Negotiation Notice form. It is available online at www.lablue.com/providers >Resources >Forms. Send completed forms to providerdisputesCAA@lablue.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, nonparticipating 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 nonparticipating providers, and the CAA's No Surprises Act protects members from surprise bills in the situations outlined above.

Eligible nonparticipating providers must include written notice to the patient within the timeframes defined by applicable law. CMS has published a consent waiver form that nonparticipating 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 nonparticipating 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 hard-copy. Providers must also submit a copy of the consent waiver as documentation that the patient is waiving their protective rights for balance billing. When billing electronically, there is no option to include attachments. To ensure that Louisiana Blue 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 CAA Consent Submission Form as a cover sheet. It is available at www.lablue.com/providers >Resources >Forms. Submission instructions are included on the form.

  Note: The CAA Consent Submission Form is not a patient consent waiver. Our form simply allows Louisiana Blue 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 hard-copy claim form.

Servicing Facility Claim Requirements

To ensure that Louisiana Blue 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 National Provider Identifier (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

Louisiana Blue 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.lablue.com/providers, choose "Network Enrollment," then "Join Our Networks" and select "Professional Providers" or "Facilities and Hospitals."

Credentialing Packets

Credentialing packets and criteria are available on our Provider page at www.lablue.com/providers. Choose "Network Enrollment," then "Join Our Networks," then select "Professional Providers" or "Facilities and Hospitals" to find the applicable credentialing packets. All packets to create a new provider record include an application for iLinkBlue and Electronic Funds Transfer. iLinkBlue is our secure online tool for professional and facility healthcare providers.

When a request or application is received that is incomplete or missing information, a notification will be sent to the provider of the incorrect or missing information. A new request/application will need to be submitted through DocuSign. The processing time will begin again when the new completed request or application is 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 nonparticipating in our network(s) until the credentialing packet has been approved by our Credentialing Committee. Once approved by the Credentialing Committee, providers will remain nonparticipating until they sign and execute an agreement through our Provider Contracting Department for participation. If the provider is joining a group with an existing agreement, they will become a participating provider after credentialing is completed.

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

If the provider's request to become credentialed is denied by the Credentialing Committee, the provider may request participation in the Plan's networks again no earlier than one year from the Credentialing Committee's final decision date.

Recredentialing

After the initial credentialing process, all network providers must undergo recredentialing within 36 months from the date of the last approval. Louisiana Blue reserves the right to initiate the recredentialing process at any point during the 36-month credentialing cycle. The recredentialing process is conducted in the same manner as the initial credentialing process. Network providers are considered to be approved by our 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

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

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 Louisiana Blue 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 programs.
- No disciplinary actions.
- No convictions of a felony or instances where a provider committed acts of moral turpitude.
- No current drug or alcohol abuse.

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, Birthing Center, Hospital, IOP/PHP, CDU, Psychiatric, Home Health, Hospice, Skilled Nursing Facility, Long Term Acute Care or 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

Facility Rights

Facilities have a right to review information obtained from outside sources (e.g., occupational or state licensing boards) to support their credentialing application. Louisiana Blue is not required to make available any references, recommendations or peer-reviewed protected information.

Facility CLIA Certification

Facilities that perform laboratory testing procedures on-site are required to submit a copy of their Clinical Laboratory Improvement Act (CLIA) certification when applying for credentialing or undergoing the recredentialing process.

Freestanding Diagnostic Imaging Facilities

Louisiana Blue 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 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).

We review each provider's accreditation status during the provider's regularly scheduled recredentialing cycle. Providers are recredentialed by Louisiana Blue within 36 months in accordance with URAC standards. Providers who do not maintain their accreditation or do not abide by our 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, doctor of osteopathic medicine, certified registered nurse anesthetist, certified registered nurse first assistant, registered nurse first assistant, nurse practitioner, physician assistant 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 facility 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 Louisiana Blue 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 Louisiana Blue for that service. The other facility should not bill Louisiana Blue 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 Louisiana Blue for the hyperbaric oxygen therapy. XYZ Hospital should not bill Louisiana Blue or the member.

At least annually, Member Providers should furnish Louisiana Blue 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.

Note: Louisiana Blue 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 Louisiana Department of Health 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.

Professional Credentialing

Professional providers requesting network participation must complete the initial professional credentialing packet, which includes a checklist of required documents. Louisiana Blue only accepts the Council for Affordable Quality Healthcare (CAQH) credentialing application from professional providers requesting to participate in our networks. Submit your CAQH ID using the CAQH credentialing packets found on our Provider page at www.lablue.com/providers >Network Enrollment >Join Our Network >Professional Providers >Join Our Network. All providers, regardless of network participation, must include their NPI(s) on the credentialing packet.

Reimbursement During Credentialing (For Professional Providers Only)

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

- Provider is not a solo practitioner.
- Provider must be applying for network participation to join a provider group that already has an executed group agreement on file with Louisiana Blue for the same provider type. For example, a nurse practitioner applying for network participation must be joining a provider group that already has an executed allied health agreement on file.
- Nurse practitioners must submit a copy of the collaborating agreement with a physician. Collaborating physician must participate in the same networks as the nurse practitioner.
- Physician assistants must submit a copy of intent to practice agreement with a physician who participates in the same networks as the physician assistant.

If these criteria are met, reimbursement during credentialing will be granted if applicable to the network with an effective date up to one month prior to the receipt of a clean credentialing packet.

Practitioner Rights

Professional providers have a right to review information obtained from outside sources (e.g., malpractice insurance carriers, state licensing board) to support their credentialing application. Louisiana Blue is not required to make available any references, recommendations or peer-reviewed protected information.

Professional Provider CLIA Certification

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.

PCP Definition

Louisiana Blue recognizes the specialties of general practice, family practice, geriatrics, internal medicine or pediatrics as a primary care provider (PCP) when the provider practices in a full primary care provider capacity. Midlevels practicing in this capacity should indicate on the credentialing packet or Individual/ Group Provider Update Request Form that they are practicing as a PCP.

Credentialing Criteria Changes

A professional provider is required to report changes in their credentialing criteria 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 Enrollment Request Form and Electronic Funds Transfer Form are included in our credentialing packets. These documents are required to become a participating provider.

TELEHEALTH PROVIDERS

Louisiana Blue's provider record policy includes additional guidance for the provision of telehealth services to our members.

Qualifications

An individual provider must meet the following criteria to obtain a Louisiana Blue provider record as a telehealth provider.

1. Telehealth-only provider located within the state of Louisiana who is not considered a behavioral health provider:
   - Must be individually located within the state of Louisiana.
   - Must be affiliated with an approved physical practice or clinic location within the state of Louisiana.
   - Must meet Louisiana Blue's credentialing and contracting requirements.
2. Telehealth-only provider located within the state of Louisiana who is considered a behavioral health provider:
   - Must be individually located within the state of Louisiana.
   - Must meet Louisiana Blue's credentialing and contracting requirements.
3. Telehealth-only provider located outside the state of Louisiana with an in-state practice affiliation:
   - Must be licensed to practice within the state of Louisiana and have a telehealth permit when applicable.
   - Must be affiliated with a practice or group with an approved physical practice or clinic location within the state of Louisiana.
   - Must meet Louisiana Blue's credentialing and contracting requirements.
4. Telehealth-only provider located outside the state of Louisiana with no in-state affiliation:
   - Must contact the Blue Cross and Blue Shield Plan local to the practitioner to contract, credential and file claims.

Virtual Office or Shared Spaces for Practitioner Location

What is considered a virtual office or shared space?

- A virtual office is a service-based business solution that may provide such services as a professional, physical mailing address, mail handling or communication services without requiring a long-term traditional office lease. It presents to allow a credible presence while working from anywhere but the office location without the individual being required to be physically present at the location.
- Generally, it has a monthly fee to use the space that is a lower rate versus paying to lease a physical location to treat in person.
- It will sometimes offer the ability to purchase hours to physically use space within the location.
- The owner of the space generally identifies it as a "virtual office."

Louisiana Blue does not support the use of virtual offices or shared spaces for any type of provider. The provider must apply to their local Blue Cross and Blue Shield Plan within the state of their residence to be credentialed, contracted and to file all claims.

The purchase of hours to treat in person at the office space is not recognized, as this does not guarantee the provider will be treating at the office on a regularly scheduled basis.

All requests that include a virtual office or shared space will be rejected upon receipt.

CONTINUOUS MONITORING

The Health Plan conducts ongoing monitoring of participating providers. Providers are continuously screened against the Office of Inspector General (OIG), Office of Foreign Assets Control (OFAC) and System for Award Management (SAM) exclusion databases. Providers identified on any of these lists are subject to denial or termination from the network.

State licenses and certifications are monitored on an ongoing basis. Practitioners who fail to renew a required license or certification before its expiration date will be immediately suspended from the network. Reinstatement may occur if the license or certification is renewed within 30 days of the lapse. Services rendered during periods of lapsed licensure or certification are not eligible for reimbursement.

The Health Plan also monitors the National Practitioner Data Bank (NPDB) during credentialing and continuously thereafter. Adverse actions identified through NPDB monitoring may be referred to the Credentialing Committee for review. Providers denied participation based on committee review will receive written notification of the decision.

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

To request network termination, use the Request for Termination Form. The form is available online at www.lablue.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

Louisiana Blue may terminate the participation of an individual provider or a facility for cause. Louisiana Blue shall give notice in accordance with the terms and conditions of the applicable Participation Agreement.

Louisiana Blue reserves the right to terminate an individual provider or a facility'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 Louisiana Blue unless otherwise stated in the notice.

Provider Termination Disputes

Any provider's participation that is terminated from a Louisiana Blue network for failure to adhere to applicable credentialing requirements will receive direct correspondence detailing the process by which an appeal to the determination may be submitted to Louisiana Blue.

PROVIDER AVAILABILITY STANDARDS

Louisiana Blue 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
Specialty Physician	
Routine	30-days
Urgent	15-days
Facilities	
Hospital/Emergency Room	Immediately
Non-Hospital Inpatient Facility	Same day
Urgent Care Center	Same day
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 ensuring 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 ensure 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 ensuring 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.
- 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, occupational/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 ongoing maintenance of chronic illnesses.
- Specialty Physician – A licensed physician holding a doctor of medicine or doctor of osteopathic medicine degree whose practice specialty is not classified as primary care.
- 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, with the purpose of diagnosing and treating illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

DIGITALLY SUBMITTING CREDENTIALING & DEMOGRAPHIC FORMS

Providers can complete, sign and submit many of our packets and forms digitally with DocuSign®. This replaces the need to print and submit hard copy documents. Through this enhancement, providers can electronically upload supporting documentation and even receive alerts (reminding them to complete packets) and confirm receipt.

The documents below are available in DocuSign format only.

- CAQH Professional Credentialing Packets (includes Attachment A - Location Hours)
- Facility Credentialing Packet (includes all Facility Information Forms)
- iLinkBlue Enrollment Request Form
- Electronic Funds Transfer (EFT) Enrollment Form
- Individual/Group Provider Update Request Form
- Facility Update Request Form
- Professional Tax Identification Number (TIN) Change Form
- Facility Tax Identification Number (TIN) Change Form
- Add Practice/Link to Group or Clinic Request Form
- Add Facility Location Form
- National Provider Identifier (NPI) Change Form
- Request for Termination Form
- Electronic Transactions Transfer (EFT) Change/Termination Form
- Electronic Remittance Advice (ERA) Enrollment Form
- Business Associate Profile (BAP) Form

Note: When submitting DocuSign documents, please do not also separately email them. 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 our PCDM Department, you may email PCDMstatus@lablue.com.

Facility Name and Tax Identification Changes

If a facility has undergone a change of ownership or any update that has resulted in a name or Tax Identification Number (TIN) change, then you need to submit the appropriate form and packet as indicated below.

To ensure the update is processed correctly, the forms must be submitted in the appropriate order, as this request requires the creation of a new provider record. In addition, the facility must complete the initial credentialing process so that all required documentation can be collected, reviewed and processed accordingly.

Submit TIN changes in the following order:

- Facility Tax Identification Number (TIN) Change Form
- Facility Credentialing Packet (fill out with new TIN)

Submit name changes in the following order:

- Facility Update Request Form
- Facility Credentialing Packet (fill out with new name)

PROVIDER DIRECTORIES

As a network provider, you may only participate in our networks and be listed in the provider directory as the primary specialty you identified on your credentialing packet. As a participating provider, your name is included in the 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, excluding holidays. We make every effort to ensure the information in our provider directories is current and accurate.

You must notify the Provider Credentialing & Data Management Department if you have any changes within your practice. To do so, visit www.lablue.com/providers, choose "Resources," then "Forms." Select a link based on the type of change you are making to access the applicable update form. The forms are available in DocuSign® format, which allows you to complete, sign and digitally submit them directly to our Provider Credentialing & Data Management Department.

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

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 education and training, 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.

Professional Provider Verification

Louisiana Blue verifies professional provider information through CAQH. Practitioners can attest to their directory data and confirm practice locations in the CAQH Provider Data Portal. Every 90 days, CAQH will send a reminder asking you to attest your location information is up to date.

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

Note: All updates to provider records, whether for an individual practitioner or a group/clinic, must be submitted to Louisiana Blue through our DocuSign forms. The required forms are available online at www.lablue.com/providers >Resources >Forms.

This requirement applies to all record changes including but not limited to:

- Linking to a new clinic/group
- Addition or removal of practice locations
- Updates to mailing addresses or contact information
- Name changes for a practice
- Changes to banking information for a group/clinic record
- Termination of practitioner from Tax Identification Number

Submitting updates through DocuSign helps ensure that information is processed accurately and maintained in accordance with Louisiana Blue's provider record requirements.

If you are practicing at a new location, have a change to an existing location or are no longer at a location, you should also make those updates in the CAQH portal in order to ensure our system data is in agreement with CAQH.

Facility Verification

Louisiana Blue sends facilities a prepopulated Facility Provider Attestation Form via DocuSign to verify directory information. An authorized representative for the facility must attest that the information is correct/incorrect. If any of the data on the form is incorrect, the representative must complete the Facility Provider Attestation Appendix Form to report updated information.

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

Please ensure your facility correspondence email address is kept current in order to receive attestation-related emails from Louisiana Blue. To update your correspondence email address, complete the Correspondence Address Change section of the Facility Update Request form. Access this form at www.lablue.com/providers, click "Resources," then "Forms" and choose "I need to update my FACILITY demographic information."

PROVIDER DIRECTORY LOCATIONS POLICY

Louisiana Blue 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.
- A maximum of five locations per Tax ID, per professional provider will be displayed.

Each professional provider must report patient appointment availability for each location reported to Louisiana Blue. This information should be reported for new providers via the credentialing packet on Attachment A – Location Hours. Existing network providers must report this information on the recredentialing packet during the recredentialing process.

Additionally, professional providers are asked to report this information on the indicated form when making the following changes:

- Updating your physical address (Individual/Group Provider Update Request Form)
- Joining a new provider group or clinic (Add Practice/Link to Group or Clinic Request Form)
- Changing your Tax ID number (Professional Tax Identification Number TIN Change Form)
- Adding a new practice location (Add Practice/Link to Group or Clinic Request Form)

HEALTH CARE CONSUMER BILLING AND DISCLOSURE ACT

Louisiana law provides for notice requirements to inform members that certain providers performing services at a network facility may not necessarily be in their health plan network. The law requires that both facilities and health plans provide these notices in a variety of ways and also notify members of the potential for receiving a bill from these noncontracted providers. Facilities are also required to provide health plans with a listing of physicians or groups providing hospital-based services at the facility in the following specialties: anesthesiology, pathology, radiology, emergency medicine and neonatology. Based on this information, the health plan includes information on contracted, facility-based providers on its website. The law requires the facility to notify the health plan of any changes to this information within 30 days of the date of the change. When your facility has a change in this list of providers, please send the following information to us:

Facility

- Facility Name
- Physical Address
- Phone Number
- Facility Tax ID
- Facility NPI Number

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Hospital-Based Physicians at the Facility

- Physician or Group Name
- Physical Address
- Phone Number
- Physician or Group Tax ID
- Physician or Group NPI Number

To view our Hospital Based Physicians charts for each area, go to www.lablue.com >Find a Doctor or Drug >ER/OR Information.

View the complete text of the act: www.legis.la.gov/legis/ViewDocument.aspx?d=668373.