Neighborhood Health Plan OF RHODE ISLAND™

910 Douglas Pike, Smithfield, RI 02917

Post-Service Prior Authorizations No Longer Accepted for MMP Line of Business

Neighborhood News – October 2024

Effective **October 7, 2024**, post-service prior authorizations, also known as retro authorizations, will no longer be accepted for the INTEGRITY (MMP) line of business. All providers seeking authorization must obtain approval prior to services being rendered. This update aligns Neighborhood Health Plan of Rhode Island (Neighborhood) with standards set by the Centers for Medicare and Medicaid Services (CMS). **Please note this update applies to the MMP line of business only**.

Members in need of urgent medical care will not be impacted.

CMS guidelines state:

> "Prior authorization is designed to ensure that certain health care services, items, and medications are medically necessary and covered by the member's benefit before they are provided. This helps to manage health care costs and improve the quality of care. The health care provider submits a prior authorization request on behalf of the member before the service is provided."

When submitting a prior authorization request, providers should:

- Submit the prior authorization request in advance of the planned service date to ensure timely review and decision-making.
- Ensure that all required clinical documentation is included with the request to support medical necessity.
- Maintain open communication with Neighborhood and respond promptly to request for additional information.

If a prior authorization request is submitted after the care is provided, Neighborhood will issue a denial notice advising the provider to submit a claim for processing. Should the claim deny, the provider will need to follow the provider administrative appeal process.

Submitting a Provider Administrative Appeal Online

To facilitate a provider appeal, providers should follow these steps:

1. Fill out the Provider Appeal E-Form on nhpri.org (Providers > Provider Resources > Forms).
2. Attach a copy of the denied claim or a clear reference to the denied claim and/or remittance advice.
3. Include specific supporting documentation that justifies why the denial should be waived or reconsidered.

Other Ways to Submit Provider Administrative Appeals

- **Email**: Appeals can be securely emailed to GAUMailbox@nhpri.org.
- **Fax**: Appeals can also be faxed to 401-709-7005.

Note: Neighborhood will only approve appeals regarding authorizations submitted after a service is provided in one of the following extenuating circumstances:

- Unable to Know Situation - The provider and/or facility is unable to identify from which health plan to request an authorization. The patient was not able to tell the provider about their insurance coverage, or the provider verified different insurance coverage prior to rendering services. Provider must submit the verification that was done.
- Not Enough Time Situation - The patient requires immediate medical services and the provider was unable to anticipate the need for a pre-authorization immediately before or while performing a service.
- An enrollee is discharged from a facility and there was insufficient time for institutional or home health care services to seek approval prior to the delivery of the service.

Adhering to these processes and requirements facilitates a smoother authorization process while ensuring members receive appropriate and effective treatment.

If you have questions about this notification, please contact our Provider Services team at 1- 800-963-1001. Thank you for your continued partnership and commitment to providing quality care to our members.

Note: This notice was mailed via USPS to all contracted providers and sent via email on August 7, 2024 to all providers registered for Neighborhood's News and Updates. If you would like to be added to the distribution list, please click here to sign up.