Neighborhood Health Plan OF RHODE ISLAND™

910 Douglas Pike, Smithfield, RI 02917

Update on Appeals for Post-Service Authorizations

Neighborhood News – January 2025

In our ongoing effort to streamline processes for the provider network, Neighborhood Health Plan of Rhode Island (Neighborhood) is sharing an important update regarding appeals related to post-service (retrospective) authorizations. **Effective immediately**, **all appeals** for post-service authorizations should be facilitated through the clinical appeal process **for all lines of business**.

To qualify as a post-service authorization request, the provider must have received either a dismissal letter issued by Utilization Management with appeal rights, or a claim remittance advice indicating claim denial due to missing/no authorization with appeal rights.

To facilitate an appeal, providers should use the Clinical Appeal Form available on our website.

INTEGRITY (MMP) Guidelines

As a reminder, **Effective October 7, 2024**, post-service authorizations are no longer accepted for the INTEGRITY (MMP) line of business except for the following exemptions:

- INTEGRITY (MMP) members who have been retroactively enrolled after receiving services;
- INTEGRITY (MMP) members within their continuity of care enrollment period;
- INTEGRITY (MMP) members in need of urgent or acute inpatient medical care.

Medicaid/Commercial Guidelines

Neighborhood will accept a request for post-service authorization for Medicaid or Commercial members if the request meets either of the following guidelines:

- The request precedes a bill for services (no claim received by Neighborhood) and is within seven (7) calendar days of the service; or
- The request precedes a bill for services (no claim received by Neighborhood) and one of the extenuating circumstances detailed below applies.
    - **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 to submit with authorization request the verification that was done.
    - **Not Enough Time Situation** – The patient requires immediate medical services, and the provider is unable to anticipate the need for a pre-authorization immediately before or while performing a service.
    - An enrollee is discharged from a facility and insufficient time exists for institutional or home health care services to receive approval prior to the delivery of the service.

Neighborhood is committed to ensuring a smooth and efficient process for all providers. We appreciate your attention to this update and your continued partnership in delivering quality care to our members.