Neighborhood Health Plan OF RHODE ISLAND™

Clinical Medical Policy

Out of Network/Out of Area- # 027

Last reviewed: 04/09/25

Benefit Coverage

Covered Benefit for lines of business including:
Health Benefits Exchange (HBE), Rite Care (MED), Children with Special Needs (CSN), Substitute Care (SUB), Rhody Health Partners (RHP), Rhody Health Expansion (RHE) Medicare Advantage Product
Excluded from Coverage:
Extended Family Planning (EFP)

Medicare Distinction

For Medicare Advantage Product members: Neighborhood Health Plan of Rhode Island (Neighborhood) uses guidance from the Centers for Medicare and Medicaid Services (CMS) for coverage determinations, including medical necessity. Coverage determinations are based on applicable payment policies, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs), and other available CMS published guidance.

In the absence of an applicable or incomplete NCD, LCD, or other CMS published guidance OR if available Medicare coverage guidance is not met, then Neighborhood will apply coverage guidance from the Rhode Island Executive Office of Health & Human Services (EOHHS), or other peer-reviewed scientific evidence, such as InterQual® and/or internal Clinical Medical Policies as a means of secondary coverage through the members' Medicaid benefit.

Description

Services considered to be "covered benefits" which are rendered to members by out-of-network (non-participating) practitioners/providers or when the member is located out-of-area are covered when - conditional criteria are met.

Out-of-network services are those services, treatments, and/or procedures provided to members by practitioners or providers who are not participating in the Neighborhood Health Plan of Rhode Island - (Neighborhood) network.

Out-of-area services include those services provided by practitioners and/or providers outside of Rhode Island and its border communities that do not hold a participating provider contract with Neighborhood.

Continuity of Care describes a relationship with a physician or other health care provider that is ongoing and - endures over time, during periods of illness and health; it is expected that the provider is familiar with the member's past medical and personal history. Neighborhood's expectation is that all clinicians involved in a member's health care communicate, collaborate to coordinate the member's care, and understand the goals for the member's health care.

Coverage Determination

Neighborhood has a broad network of practitioners and providers and will work with members and their practitioners/providers to evaluate the availability of necessary services within the local delivery system. Neighborhood evaluates the medical necessity of requests for services from out-of-network practitioners/ providers.

Authorization Not Required	1. Covered emergent and urgent care services rendered in emergency rooms and urgent care centers are authorized without review. 2. Out of Network/Area dialysis is covered with no authorization required for the Medicare Advantage Product population only. All other lines of business will require prior authorization.
Required Authorization	1. Requests for non-emergency care including second opinions from non-participating practitioners or providers. 2. Services requested to preserve continuity of care, namely an on-going clinical relationship *(see criteria below for specific details).*

Criteria

1. Requests for services for non-emergency care from out-of-network practitioners or providers are considered ONLY when all three of the following criteria are met:
   - the primary care practitioner and/or In-Network provider refers the member to the out of network provider, AND
   - the out of network provider agrees to communicate findings and treatment plan with the member's referring practitioner AND
   - one (1) of the following criteria are met:
     a. IF the referral to out of network specialist is being made by in-network specialist due to clinical complexity or inability to provide adequate service AND services are not available within the anticipating provider network.
     b. Member is temporarily outside the service area and the service cannot be delayed.
     c. Ongoing treatment is required for an acute medical condition, or if the member is undergoing active treatment for a chronic condition.

2. Post stabilization care
   - Please note: the organization's (Neighborhood's) financial responsibility for post-stabilization care services that have not been pre-approved ends when –
     a. a plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care, OR
     b. a plan physician assumes responsibility for the enrollee's care through transfer, OR
     c. a Neighborhood representative and the treating physician reach an agreement concerning the enrollee's care, OR
     d. the enrollee is discharged.

3. Services requested are to preserve continuity of care, namely an on-going clinical relationship with a non-participating specialty care practitioner, including but not limited to:
    a. Those receiving treatment for an acute medical or behavioral condition or an acute episode of a chronic illness,

    b. Members who are unable to be transitioned to a provider with comparable or greater expertise. It is expected that if the specialty is available in network, the transition will occur within six (6) months.

4. Children who are in foster care and are members who are legitimately a Rhode Island resident but are not living in the State of Rhode Island at that time. Once the child in foster care/member is living in the State of Rhode Island, it would be expected that the transfer back to an in network or the original provider will be made within six (6) months.

5. Members newly enrolled (New to Neighborhood or changing lines of business) to the Children with Special Health Care Needs (CSN), Substitute Care (SUB), Rhody Health Expansion (RHE), Rite Care (MED), Rite Care (MED), Rhody Health Partners (RHP), or Medicare Advantage Product line of business who have an existing relationship with a non-participating practitioner/provider have six (6) months from the date of enrollment to transition services to a Neighborhood participating practitioner/provider.

6. Members newly enrolled (New to Neighborhood or changing lines of business) to the Health Benefits Exchange line of business, Individual Market only, lines of business who have an existing relationship with a non-participating practitioner/provider have (3) months from the date of enrollment to transition services to a Neighborhood participating practitioner/provider under certain circumstances.

7. Female members enrolled in RIteCare, Children with Special Health Care Needs (CSN), Substitute Care (SUB), Medicare Advantage Product. Rhody Health Expansion (RHE), or the Rhody Health Partners (RHP) lines of business are allowed access to an out of network women's health care specialist for routine and preventive services. A women's health care specialist may include obstetricians, gynecologists, certified nurse midwives, nurse practitioners, doulas, or another qualified health care professional specializing in women's health.

8. Ancillary services required during a transition period for new members, until such a practitioner/provider becomes contracted, or member can safely be redirected to an in-network practitioner/provider with comparable or greater expertise in treating the needs of the member.

Authorization Request Forms

Access prior authorization request forms by visiting Neighborhood's website at www.nhpri.org.

1. Click on Providers
2. Click on Provider Resources
3. Click on Forms
4. Click on "Click here for a list of prior authorization request forms" – forms are listed alphabetically.

A phone messaging system is in place for requests/inquiries both during and outside of business hours. Providers can call 1-800-963-1001 for assistance.

Covered Codes: For information on coding, please reference the Authorization Quick Reference Guide.

CMP Cross Reference:

Created:	September 2007
Annual Review Month	April
Review Dates	12/29/09, 10/23/12, 1/21/14, 09/05/14, 3/3/15, 2/18/16, 2/28/17, 2/27/18, 3/6/19, 3/4/20, 3/17/20, 3/10/21, 03/16/22, 3/8/23, 4/10/24, 04/9/25
Revisions Dates	11/03/10, 1/21/14, 09/05/14, 3/3/15, 2/18/16, 2/27/18, 3/6/19, 5/31/19, 3/17/20, 03/16/22, 3/8/23, 04/9/25
CMC Review Dates	12/06/11, 11/13/12, 1/21/14, 09/16/14, 3/3/15, 3/1/16, 3/14/17, 3/20/18, 3/6/19, 3/4/20, 3/10/21, 03/16/22, 3/8/23, 4/10/24, 04/9/25
Medical Director Approval Dates	2/12/08, 11/09/10, 12/28/11, 11/13/12, 1/28/14, 3/3/15, 3/1/16, 3/22/17, 4/12/18, 3/7/19, 3/4/20, 3/17/20, 3/10/21, 03/16/22, 3/8/23, 4/10/24, 04/9/25
Effective Dates	1/28/14, 3/3/15, 3/14/16, 3/23/17, 4/12/18, 3/7/19, 3/4/20, 3/24/20, 3/10/21, 03/16/22, 3/8/23, 4/10/24, 04/9/25

Neighborhood reviews clinical medical policies on an annual basis.

Disclaimer:

This medical policy is made available to you for informational purposes only. It is not a guarantee of payment or a substitute for your medical judgment in the treatment of your patients. Benefits and eligibility are determined by the member's coverage plan; a member's coverage plan will supersede the provisions of this medical policy. For information on member-specific benefits, call member services. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. Neighborhood reserves the right to review and revise this policy for any reason and at any time, with or without notice.