

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), Duals CONNECT (CO-DSNP), INTEGRITY for Duals (FIDE)
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

Covered benefits 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 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.

For FIDE members: Continuity of care requirements are separate and distinct from the Period of Deemed Continued Eligibility requirements.

Authorization Not Required	<ol style="list-style-type: none"> 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	<ol style="list-style-type: none"> 1. Requests for <u>non-emergency care</u>, including second opinions, from non-participating practitioners or providers. 2. Services requested to preserve continuity of care, namely an <u>on-going clinical relationship</u> (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 the following criteria are met:
 - The service being requested is medically necessary and NOT available within the NHP network.
 - The member is being referred by an IN-Network provider with the same specialty as the Out-of-Network provider who is being referred to due to clinical complexity or inability to provide adequate service AND services are not available within the current provider network.

- OR Member is temporarily outside the service area and the service cannot be delayed.
 - OR The member is actively undergoing treatment that 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: 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 member's care, OR
 - b. A plan physician assumes responsibility for the member's care through transfer, OR
 - c. A Neighborhood representative and the treating physician reach an agreement concerning the member's care, OR
 - d. The member is discharged from the facility.
 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 an in-network 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), or Rhody Health Partners (RHP) 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 Duals CONNECT (CO-DSNP) and Health Benefits Exchange, Individual Market only, lines of business who have an existing relationship with a non-participating practitioner/provider have three (3) months from the date of enrollment to transition services to a Neighborhood participating practitioner/provider under certain circumstances.

7. Members transitioning from the MMP-INTEGRITY line of business to the INTEGRITY for Duals (FIDE) line of business are allowed to receive medically necessary covered services from Out-of-Network Providers:

- a. Pregnant Members past the twenty-fourth (24th) week of pregnancy can remain under their current obstetrician's/gynecologist's care through the post-partum checkup.
- b. Members diagnosed with and receiving treatment for a terminal illness can remain with established providers for up to nine (9) months.
- c. Members with chronic or acute medical, behavioral health, or substance abuse conditions whose providers leave Neighborhood's network can remain with these providers for up to six (6) months.

8. Members newly enrolled (New to Neighborhood) in the INTEGRITY for Duals (FIDE) line of business who have an existing relationship with a non-participating practitioner/provider can continue seeing Out-of-Network Providers and Neighborhood will honor existing Prior Authorizations for Medically Necessary Covered Services until the shorter of:

- a. Six (6) months after enrollment,
- b. Expiration of the Prior Authorization period
- c. Additionally:
 - i. Members who are permanent residents of nursing facilities or assisted living facilities may remain in that nursing facility or assisted living facility regardless of whether that nursing facility or assisted living facility is in Neighborhood's Provider Network.
 - ii. In the event of member pregnancy and is actively receiving medical necessary covered prenatal care services at time of enrollment, Neighborhood is responsible for the costs of continuation of such medically necessary prenatal care services, including prenatal care, delivery, and post-natal, without any form of authorization needed and without regard to whether such services are being provided by a network or non-Network Provider until:
 1. Members in First Trimester at the time of enrollment: Neighborhood can reasonably transfer the Member to a Network Provider without impeding service delivery that might be harmful to the Member's health.
 2. Members in Second and Third Trimester at the time of enrollment: for sixty (60) calendar days postpartum, provided the Member remains covered through Neighborhood, or referral to a safety net provider if the Member's eligibility terminates before the end of the postpartum period.
 3. Members actively receiving medically necessary covered services other than prenatal services at the time of enrollment: Neighborhood shall provide continuation of such services up to ninety (90) calendar days or until the member may be reasonably transferred to an in-Network Provider without disruption, whichever is less. Prior Authorization may be required for continuation of the services beyond thirty (30)

- calendar days; however, denying authorization solely on the basis that the provider is a non-contract provider is prohibited.
- iii. When a new member with Special Health Care Needs is actively receiving medically necessary services at the time of enrollment, Neighborhood will provide continuation/coordination of such services up to ninety (90) Calendar Days or until the member may be reasonably transferred to a Network Provider without disruption, whichever is less.
 1. Member with Special Health Care Needs are defined as individuals who have or are at risk for chronic physical, developmental, behavioral, or emotional conditions and also requires health and related services of a type or amount beyond that required by another similarly aged individual.
 - iv. In the event a member who is newly enrolled with Neighborhood is actively receiving Medicaid covered durable medical equipment, prosthetics, orthotics, and certain supplies services at the time of enrollment, Neighborhood will provide continuation for the lesser of:
 1. Up to ninety (90) Calendar Days; or
 2. Until the member may be reasonably transferred to a Network Provider without disruption.
8. Female members enrolled in RItCare, Children with Special Health Care Needs (CSN), Substitute Care (SUB), Rhody Health Expansion (RHE), the Rhody Health Partners (RHP), Duals CONNECT (CO-DSNP), and INTEGRITY for Duals (FIDE) 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.
9. 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.

Limitations and Exclusions

- Commercial members enrolled in Small Group Point of Service (SGPOS) and Individual Point of Service (IDPOS) plans do not have out-of-network benefits for:
 - Durable Medical Equipment
 - Diabetic Shoes
 - Other DME Services
 - Wigs
 - Home Health Care – including Private Duty Nursing and Home Infusion
 - Telemedicine

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, 8/20/25, 12/10/25
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, 8/20/25, 12/10/25
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, 8/20/25 , 12/10/25
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, 8/20/25 , 12/10/25
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, 8/20/25, 12/10/25

Neighborhood reviews clinical medical policies on an annual basis.

Disclaimer:

**Out of Network/Out of
Area- # 027**

Last reviewed: 12/10/25

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.