Application

Application of this Medical Policy applies to:
RIte Care (MED), Rhody Health Partners (RHP), Rhody Health Expansion (RHE), Children with Special Health Care Needs (CSN), Substitute Care (SUB), Commercial (HBE), INTEGRITY for Duals (FIDE), Duals CONNECT (CO-DSNP)
Application Excluded for:
Extended Family Planning

Medicare Distinction

For INTEGRITY for Duals (FIDE) and Duals CONNECT (CO-DSNP) 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 Medicare guidelines, then Neighborhood will apply coverage guidance from other widely used treatment guidelines with peer-reviewed scientific evidence, such as InterQual® and/or internal Clinical Medical Policies.

Description

Neighborhood Health Plan of Rhode Island (Neighborhood) covers medically necessary care delivered in multiple settings, including hospitals, outpatient surgery centers, skilled nursing facilities, both inpatient and outpatient physical/occupational/speech therapy settings, and in physician office or health centers.

Inpatient services covered in this policy:

Medical	Behavioral Health (BH)/Psychiatric
Acute Hospital (including procedures, hospital readmissions and less than 24-hour stays)	Acute Hospital
Skilled Nursing Facility (SNF)	Substance Use Disorder (SUD) Services
Acute Rehabilitation	Acute Residential Treatment
Subacute Care (SAC)	Non-Hospital/Community Based Detox
Long Term Acute Care (LTAC)	Substance Use Residential Treatment
Custodial Nursing Facility Care	Partial Hospitalization Programs (BH and SUD)

Coverage Determination

Medically necessary services are defined as those services needed for the prevention, diagnosis, cure, or treatment of a health-related condition including those necessary to prevent a detrimental change in the member's medical or mental health status. Medically necessary services must be provided in the most cost effective and appropriate setting and shall not be provided solely for the convenience of the member or service provider.

Discharge planning is expected to be started at the onset of each level of care. Extended service for the purpose of discharge planning will also be evaluated by Neighborhood's AMD or Physician Reviewer for a final determination.

Rhode Island Medicaid covers an array of Long-Term Services and Supports (LTSS) for adults. To be eligible for LTSS, an individual must meet Medicaid LTSS eligibility requirements for Nursing Facility Level of Care by requiring the highest level of care needs. For INTEGRITY for Duals members, an approved LTSS Nursing Facility Level of Care waiver from EOHHS is required to receive custodial care at a nursing facility for more than 30 consecutive days. Eligibility is determined by EOHHS, not Neighborhood.

Inpatient Levels of Care

Criteria

Neighborhood's Medical Management Department contracts with Change Healthcare to utilize InterQual®, the leading evidence-based clinical criteria and utilization management technology. InterQual®'s medical decision support system assists payers and providers with delivering the highest quality and most appropriate care while eliminating unnecessary costs. InterQual®'s highly trained clinical development team performs a systematic review and critical appraisal of evidence to help ensure criteria are based on the best available evidence. Change Healthcare uses a rigorous evidence-based development process to develop the objective criteria and utilizes multidisciplinary experts to provide multi-level peer review that includes review of clinical trials, the latest standards of care, and best practices. It is the standard criteria applied for inpatient facility review.

Neighborhood utilizes Change Health Care InterQual® criteria in reviewing medical necessity for prospective, concurrent, and retrospective assessment of inpatient medical and behavioral health facility reviews using the below InterQual® criteria modules and subset(s). A review of the medical documentation is compared to InterQual® criteria to determine if the level of care or the services being requested are appropriate, given the clinical intervention and the member's status.

In addition to the medical necessity review, a level of care or intensity of service will also be determined for Sub-Acute Care/Skilled Nursing Facility authorizations based on the clinical condition of the member and the ordered skilled services with the guidance of InterQual® LOC: Subacute/SNF.

Custodial Level of Care	**Level I SNF Skilled**	**Level II SNF Skilled**	**Level III SNF Skilled**	**Level IV SNF Skilled**
Non-skilled service **OR** Less than 5 days a week or less than an hour per day of skilled services **OR** Long term care trach vent dependent	Skilled nursing at least daily **OR** Skilled therapy 1-2 hours per day at least 5 days per week	Skilled nursing at least 4 hours daily **OR** Skilled therapy 2-3 hours per day at least 5 days per week	Skilled nursing at least 4 hours daily **AND** Skilled therapy 2-3 hours per day at least 5 days per week	Direct skilled care at least 6 or more hours per day

InterQual® LOC Module	**Subsets**			
Acute Adult And Acute Pediatric	Acetaminophen Overdose	Electrolyte or Mineral Imbalance	Hypoglycemia	Infections: Sepsis
	Acute Kidney Injury	Epilepsy	Infections: Cellulitis	Infections: Skin
	Anemia	Extended Stay	Infections: CNS	Labor and Delivery
	Antepartum	Gastrointestinal (GI) Bleeding	Infections: Covid-19	Non-Traumatic Bleeding
	Asthma	General Medical	Infections: Endocarditis	Pancreatitis
	Bowel Obstruction	General Surgical	Infections: General	Postpartum Complication after Discharge

	Carbon Monoxide Poisoning	General Trauma	Infections: GI/GYN	Pulmonary Embolism
	Cystic Fibrosis	Hematology/Oncology:Hemolytic Uremic Syndrome	Infections: Musculoskeletal	Rhabdomyolysis or Crush Syndrome
	Dehydration or Gastroenteritis	Hypertension	Infections: Pneumonia	Sickle Cell Disease
	Diabetes Mellitus	Hypertensive Disorder of Pregnancy	Infections: Pyelonephritis or Complex UTI	Withdrawal Syndrome
	Diabetic Ketoacidosis			
Acute Adult Only	Acute Coronary Syndrome (ACS)	COPD	Hematology/Oncology: Complications or Disease Progression	Stroke
	Arrhythmia, Atrial	Deep Vein Thrombosis	Hematology/Oncology: Treatments	Syncope
	Arrhythmia, Blocks	Gallbladder Disorders	Hyperglycemic Hyperosmolar State	TIA
	Arrhythmia, Ventricular or Abnormal ECG Finding	Heart Failure	Inflammatory Bowel Disease	
Acute Pediatric Only	Bone Marrow Transplant/Stem Cell Transplant (BMT/SCT)	Failure to Thrive	Hematology/Oncology: Chemotherapy	Hyperbilirubinema
	Brief Resolved Unexplained Event (BRUE)	Hematology/Oncology: Acute Leukemia or Lymphoma	Hematology/Oncology: Malignant Disease	Infections: Meningitis
	Croup	Hematology/Oncology: Brain Malignancy or Metastasis	Hematology/Oncology: Tumor Lysis Syndrome	Nursery
Long Term Acute Care	Medically Complex	Respiratory Complex	Ventilator Weaning	Wound/Skin
Inpatient Rehabilitation	Burns	CNS/TBI	Medically Intensive Rehabilitation	Orthopedic/ Amputation
	Pediatric Rehabilitation	Spinal Cord Injury	Subacute Rehabilitation	

Subacute/ SNF	Acute Infections (SAC/SNF)	Cardiovascular & Coagulation Disorders (SAC-SNF)	Medical Management (SAC-SNF)	Pediatric (SNF)
	Acute Neurologic (SNF)	General Surgery (SAC-SNF)	Orthopedic Surgery (SNF)	Pulmonary (SAC-SNF)
	Cancer (SAC-SNF)	Major Joint Replacement or Spinal Surgery (SAC-SNF)	Orthopedic/ Musculoskeletal (SNF)	
Behavioral Health	Adult and Geriatric Psychiatry	Child and Adolescent Psychiatry		
The ASAM Criteria Navigator	ASAM 3rd Edition Level 4 Medically Managed Intensive Inpatient Services, Adolescent	ASAM 4th Edition Level 3.7: Medically Managed Residential Treatment, Adult	ASAM 3rd Edition Level 3.3 Clinically Managed Population-Specific High-Intensity Residential Services, Adult	ASAM 3rd Edition Level 2.5 Partial Hospitalization Services, Adolescent
	ASAM 4th Edition Level 4: Medically Managed Inpatient Treatment, Adult	ASAM 3rd Edition Level 3.5 Clinically Managed Medium-Intensity Residential Services, Adolescent	ASAM 3rd Edition Level 3.1 Clinically Managed Low-Intensity Residential Services, Adolescent	ASAM 4th Edition Level 2.5: High-Intensity Outpatient Treatment, Adult
	ASAM 3rd Edition Level 3.7 Medically Monitored High-Intensity Inpatient Services, Adolescent	ASAM 4th Edition Level 3.5: Clinically Managed High-Intensity Residential Treatment, Adult	ASAM 4th Edition Level 3.1: Clinically Managed Low-Intensity Residential Treatment, Adult	

Neighborhood uses American Society of Addiction Medicine (ASAM) criteria for treatment of substance use disorders as clinical guides to improve assessment and outcomes-driven treatment and recovery services for members. ASAM criteria are a collection of objective guidelines that give providers and clinicians a way to standardize treatment planning and patient placement for

treatment, as well as how to provide continuing, integrated care and ongoing service planning. ASAM Criteria use "multidimensional" assessments and guide treatment professionals, and intensity of treatment "levels" of cares that connect to each other to act as benchmarks. Members can move through levels, depending on unique needs. ASAM Criteria use separate criteria and levels of care benchmarks for adults and adolescents. ASAM criteria is accessed through The ASAM Criteria Navigator in InterQual®.

Neighborhood recognizes that the criteria can never address all the issues; criteria cannot apply to every patient in every situation. Use of the criteria never replaces clinical judgment. Whether inpatient facility services are reasonable and necessary must be based on an assessment of each patient's individual care needs. Therefore, denial of services based on numerical utilization screens, diagnostic screens, diagnosis, or specific treatment norms is not appropriate.

Additional Elements Utilized for Medical Necessity Decisions:
When a review is required for medical necessity determination, the following elements, as applicable, are requested by the Utilization Management Nurse (UMN) and/or Associate Medical Director (AMD) or Neighborhood Physician Reviewer:

- Medical Records
- Progress Notes describing the history of the current problem, status, and current treatment plan.
- Diagnostic testing results pertinent to the requested service
- Patient psych-social history as appropriate and related to the current problem.
- Consultant's summaries/notes
- Operative and pathological reports
- Rehabilitation evaluations, progress, attendance, and adherence

In addition to the following information requested and considered in or to determine if there are other factors which may impact the plan of care and attribute to the medical necessity of the request.

Hospital Readmissions (Medical)

Neighborhood shall conduct unplanned hospital readmission reviews to determine if the readmission was considered clinically related to the previous admission. Unplanned readmissions determined to be related to the previous admission will not be reimbursed. This applies to all types of acute care admissions as well as contracted and non-contracted facilities.

Neighborhood shall conduct a medical records review to determine if the subsequent hospital admission is related to the previous hospital admission. By definition, a readmission generally means an acute care hospital with unplanned admission within 30 days of discharge, for the treatment of the same diagnosis, and from the same or other acute care facility in the same healthcare system.

Criteria

Medical records shall be reviewed to determine if the readmission was clinically related to the previous admission based on one of the following criteria:

- A medical readmission for a continuation or recurrence from the previous admission for the same/similar condition or related condition (e.g., readmission for diabetes following an initial admission for diabetes).
- A medical complication related to care during the previous admission (e.g., patient discharged with urinary catheter readmitted for treatment of a urinary tract infection).
- An unplanned readmission for surgical procedure to address a continuation or a recurrence of a problem causing the previous admission (e.g., readmitted for appendectomy following a previous admission for abdominal pain and fever)
- An unplanned readmission for a surgical procedure to address a complication resulting from the previous admission (e.g., readmission for drainage of a post-operative wound abscess following an admission for a bowel resection)

Note: *Medical record review is to determine if the admission is related and not an assessment of medical necessity or appropriateness of the setting.*

Excluded from readmission review are:

- Readmissions that are planned for repetitive treatments such as cancer chemotherapy, transfusions for chronic anemia, or other similar repetitive treatments or scheduled elective surgery.
- Readmissions due to malignancies (limited to those who are in an active chemotherapy regimen), burns, or cystic fibrosis
- Readmissions due to organ or bone marrow transplants
- Obstetrical admissions
- Readmissions with a documented discharge status of left against medical advice
- Readmissions greater than 30 calendar days from the last discharge
- Readmissions when the previous admissions for transient ischemia attack (TIA) had all of the following:
    1. ABCD score of 3 or greater
    2. Brain, carotid and cardiac imaging was completed
    3. Started on anti-platelets during the first admission
    4. Had CVA within 30 days

Inpatient Only Procedures

Neighborhood Health Plan will follow CMS guidance for inpatient only procedures. Medicare has established a list of procedures that it believes can only be safely performed in the inpatient setting. These services have OPPS status indicator "C" in OPPS Addendum B and are listed together in

Addendum E of each year's OPPS/ASC final rule.
https://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/OCEQtrReleaseSpecs.html

Exclusions and Limitations:

INTEGRITY for Duals, Duals CONNECT, and Commercial (HBE) Members:

- Outpatient and pre-diagnostic services provided up to three (3) days prior to an inpatient episode of care, including the day of member admission, are considered part of the MS-DRG payment.
- Neighborhood currently uses the Medicare MS-DRG as established by CMS to assign an MS-DRG to an inpatient claim. Refer to the CMS website for additional information.
- Eligibility changes during an Inpatient Hospital Stay: If a member has another insurer at the time of admission and becomes eligible with Neighborhood during the stay, then the other insurer would be responsible for the entirety of the members stay.

  When the member terminates during an inpatient admission, Neighborhood will reimburse until the management of the member's care is formally transferred to the care of another Health Plan, another program option, or fee-for-service Medicaid. Commercial will also follow this payment methodology.
    - If a member does not transition care, Neighborhood will reimburse through the end of the admission.

  If the member does not have coverage prior to becoming a Neighborhood Health Plan member, providers would need to bill with a statement from and through date according to when the member was enrolled. However, the admission date should reflect the actual date the member was admitted. Providers need to bill according to when the member was eligible.

Medicaid and Commercial members:

- For MEDICAL Admissions: Per the Rhode Island Executive Office of Health and Human Services (EOHHS) Inpatient Services guidelines, hospital inpatient stays must be at least 24 hours to be considered for inpatient level of care reimbursement. Any inpatient stay that is less than 24 hours is considered outpatient (observation) level of care. Observation is when a member has a condition that needs to be monitored in the hospital, potentially overnight, but not admitted. When medically necessary, Neighborhood may make exceptions to this EOHHS guideline in the following scenarios:
    - Member left against medical advice (AMA)
    - Member admitted to intensive care unit (ICU)
    - Member expired/deceased

- Member admitted for procedure on the CMS inpatient only procedure list
- Member had at least 1 observation day prior to upgrading to inpatient.
- Neighborhood does not pay the day of discharge unless upgrade to inpatient day is the same day as discharge AND meets one of the other listed exceptions which will be subject to medical necessity criteria review.

Medicaid Members:

- Eligibility changes during an Inpatient Hospital Stay: If the member has another insurer at the time of admission and becomes eligible with Neighborhood during the stay, then the other insurer would be responsible for the entirety of the members stay.

  When a member terminates during an inpatient admission, Neighborhood will reimburse until the management of the member's care is formally transferred to the care of another Health Plan, another program option, or fee-for-service Medicaid.
  - If a member does not transition care, Neighborhood will reimburse through the end of the admission.

  If a member does not have coverage prior to becoming a Neighborhood member, Neighborhood will compensate for covered days based on member eligibility at a per diem rate; subject to provider contractual agreements. Providers need to bill according to when the member was eligible.

- Skilled therapy services are not covered for members in custodial care.
- RHP & RHE Members:
  - May stay inpatient for up to 30 consecutive days in a skilled nursing facility or nursing facility at a skilled or custodial level of care. Members who have stays longer than 30 days are disenrolled from RHP/RHE by the Executive Office of Health and Human Services (EOHHS) and enrolled in Medical Assistance.
  - Neighborhood will cover the first thirty (30) days of hospice care for RHP and RHE members when delivered in a nursing home setting. Starting on the thirty-first day, Medical Assistance fee for service will reimburse the hospice care and the room and board.
- Skilled nursing facility services are non-covered for Extended Family Planning (EFP) members.

INTEGRITY for Duals and Duals CONNECT Members:

- Per CMS, only in rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours.
- Skilled therapy services will be reimbursed separately members in custodial care.

- Nursing facilities must meet all Federal and State pre-admission screening and resident review (PASRR) requirements for all Members seeking admission or re-admission to a nursing facility, subsequent to the provisions in 42 CFR § 483 Subpart C and 210-RICR-50-05-1. A copy of a completed PASRR is required with authorization requests for skilled and custodial nursing facility care.
- **INTEGRITY for Duals:** Members must have an approved Long Term Supports & Servies (LTSS) Nursing Facility Level of Care waiver from EOHHS to receive custodial care at a nursing facility for more than 30 consecutive days. Eligibility is determined by EOHHS, not Neighborhood.
- **Duals CONNECT:** Medicare-covered skilled nursing facility care is limited to 100 days per benefit period. To become eligible for a new 100-day Medicare covered benefit period of SNF care, the member must be out of a hospital or SNF for 60 days in a row.

Commercial and Duals CONNECT Members:

- Custodial care, rest care, day care, or non-skilled care in any facility is not covered. This includes care in convalescent homes, nursing homes, homes for the aged, halfway houses, or other residential facilities.

All covered lines of business:

- Neighborhood does not cover experimental procedures or treatments, except as otherwise required by law. Also refer to Neighborhood Clinical Medical Policy - Experimental Investigational #026.
- Admission to an in-network facility is required unless the network does not have the appropriate facility setting to meet the member's needs.
- Services must be ordered by a physician. All nursing facility admissions (skilled and/or custodial) must be ordered by an in-network physician.

References:

- Contract between State of Rhode Island Department of Health and Human Services and Neighborhood Health Plan of Rhode Island for Medicaid Managed Care Services, Section 1.19.
- Contract- Agreement between the State of Rhode Island Executive Office of Health and Human Services and Neighborhood Health Plan of Rhode Island Medicaid Managed Care Fully Integrated Dual Special Needs Plan, Effective January 1, 2026.
- Medicare Benefit Policy Manual Chapter 1: Inpatient Hospital Services Covered Under Part A.
- Change Healthcare InterQual®.

- Social Security Act Section 1889 (d)(1)(B)(iv).
- CMS Long-Term Care Hospital PPS.
- Centers for Medicare & Medicaid Services, Department of Health and Human Services, Title 42, Chapter IV, Subchapter B Part 412 Subpart O.
- CMS Medicare Managed Care Manual Chapter 4-Benefits and Beneficiary Protections.
- Centers for Medicare & Medicaid Services (CMS). Medicare Claims Processing Manual. Chapter 3: Inpatient Hospital Billing. §40.2.4: IPPS Transfers Between Hospitals. Part A: Transfers Between IPPS Prospective Payment Acute Care Hospitals; p.116. [CMS Web site]. Available at: http://www.cms.gov/manuals/downloads/clm104c03.pdf.
- Executive Office of Health and Human Services, Medicaid Provider Manual, Hospital Coverage Guidelines, Inpatient Services. Last updated on July 11th, 2023.
- Centers for Medicare & Medicaid Services (CMS). MS-DRG Classifications and Software, https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/ms-drg-classifications-and-software.
- Centers for Medicare & Medicaid Services (CMS). Pub 100-04 Medicare Claims Processing, https://www.cms.gov/files/document/r11842cp.pdf.

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:	CMP #026 Experimental Investigational
Created:	07/06/2010
Annual Review Month:	February

Review Dates:	3/13/12,2/26/13,03/18/14,3/3/15, 2/18/16,2/28/17,8/29/17, 2/27/18,9/4/19,6/21/20,8/18/21,8/17/22,8/16/23, 12/29/23, 2/14/24, 10/9/24, 2/12/25, 10/8/25, 2/11/26, 4/8/26, 10/14/26
Revision Dates:	3/02/11,7/01/11,3/13/12,02/18/16,6/30/16,8/29/17,2/27/18, 9/20/18,6/21/20,8/17/22, 12/29/23, 2/14/24, 10/8/25, 2/11/26 , 4/8/26
CMC Review Date:	7/13/10,3/08/11,3/13/12,3/12/13,03/18/14,3/3/15,3/01/16, 3/14/17,9/12/17,3/20/18,9/4/19,8/18/21,8/17/22,8/16/23, 2/14/24, 10/9/24, 2/12/25, 10/8/25, 2/11/26, 4/8/26, 10/14/26
Medical Director Approval Dates:	7/13/10,3/15/11,7/15/11,10/2/12,3/13/13,3/21/14,3/3/15, 3/01/16,3/22/17,11/7/17,4/12/18,9/16/19,8/18/21,8/17/22, 8/16/23, 2/14/24, 10/9/24, 2/12/25, 10/8/25, 2/11/26, 4/8/26, 10/14/26
Effective Dates:	3/21/14,3/3/15,3/14/16,7/1/16,3/23/17,11/7/17,4/12/18, 9/16/19,6/21/20,8/18/21,8/17/22,8/16/23, 12/29/23, 2/14/24, 10/9/24, 2/12/25, 10/8/25, 2/11/26, 4/8/26, 10/14/26

Neighborhood reviews clinical medical policies on an annual basis.

Disclaimer:

Neighborhood has developed medical policies to assist us in administering health benefits. This medical policy is made available to you for informational purposes only and does not constitute medical advice. It is not a guarantee of payment or a substitute for your medical judgment in the treatment of your patients. Members should always consult their physician before making any decisions about medical care. Treating providers are solely responsible for medical advice and treatment of members. 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.