Neighborhood Health Plan OF RHODE ISLAND™

Clinical Medical Policy

Primary Care Prior Authorization Policy for Medicaid Lines of Business- # PA-001

Last reviewed: 10/14/26

Purpose:

The purpose of this policy is to provide guidance and clarity to the actions that Neighborhood is taking surrounding prior authorization to meet the requirements spelled out in Article 8 of the SFY 2026 Enacted budget, H5076 Sub A as Amended during the 2025 session of the R.I. General Assembly. This change is in effect for three years, beginning October 1, 2025, and sunsetting on October 1, 2028. This policy pertains to the Medicaid Line of Business which is covered by this legislation**. Medicare service benefits are excluded from this R.I. state legislation.**

Policy Statement:

A significant change regarding prior authorizations for primary care providers (PCPs) was approved in Rhode Island during the 2025 session of the General Assembly. A new three-year pilot program, passed as part of the state budget, prohibits insurers from requiring prior authorization for most medically necessary services ordered by PCPs (in-scope of their daily practice). This applies to a range of primary care providers, including general internists, family physicians, pediatricians, geriatricians, OB-GYNs, nurse practitioners, and physician assistants credentialed as PCPs by the insurer. The main goal of this initiative is to reduce the administrative burden on primary care providers and streamline patient care. Providers have identified prior authorization as a significant source of frustration for both providers and patients, leading to delays and potentially hindering access to necessary care, according to the American Medical Association. Neighborhood Health Plan of Rhode Island (Neighborhood) is committed to meeting the requirements of this legislation with the following interpretations and guidelines.

EOHHS Guidance for compliance with State law for Medicaid Lines of Business:

The Executive Office of Health and Human Services (EOHHS) provided the following guidance language for Medicaid MCOs implementing this pilot program to allow for compliance with the new RI State law.

In alignment with legislative language, services must meet two primary criteria to be included in the pilot:

1. The service must be ordered in the normal course of providing primary care treatment.
2. A PCP must be responsible for submitting the PA request for this service.

In the case that a service is billed by a PCP, under their PCP NPI, there is a strong presumption that the service is both being provided in the normal course of primary care treatment, and that the PCP would be responsible for submitting the PA request. Therefore, all services billed by PCPs participating in the pilot and ordered under their PCP NPI will be exempt from prior authorization requirements.

For services ordered by a PCP but provided and billed by a different provider, EOHHS has identified a set of codes that are appropriate to include in the pilot. The criteria EOHHS used for inclusion in the pilot under these circumstances are:

- Codes for which at least 10% of prior authorization requests are currently made by PCPs, for at least one MCO.
- Of the above, codes for which PCPs have made at least 10 requests in the most recent 12- month period, for at least one MCO and for which at least two-thirds (66%) of PCP PA requests are approved.

The following codes are therefore proposed for inclusion in the pilot: Note that this will require submissions to include the PCP identification as the ordering provider.

17999 43235 43249 43251 43255 45378 45380 45384 45385
70486 70487 70488 76380 70496 70498 70544 70545 70546 70551 70552 70553 71275 71550 71551 71552
72195 72196 72197 74176 74177 74178 74181 74182 74183 S8037 77046 77047 77048 77049
81229 81415 95810 95811 A4239 B4035 B4150 B4152 B4160 B4161
E0637 E1161 E1232 E1234 E2510 S9127

- When a PCP is listed as the ordering provider on one of these codes, prior authorization will not be required.
- Additional codes may be added at provider request and following Executive Office of Health and Human Services (EOHHS) approval

In alignment with the final guidance from EOHHS, the following Guidelines are clarified for Neighborhood Providers: **Claims submissions must include the "ordering/referring provider" as well as modifier 'V1' to allow for payment, when the billed service is not rendered by a PCP.**

1. Prior authorizations will be waived for eligible primary care providers who order a qualifying service for a qualifying member.

2. An eligible primary care is enrolled, credentialed, and contracted with Neighborhood.

3. The Provider must be the member's assigned PCP or at the same site as the member's assigned PCP and the ordering provider must have engaged in clinical decision making for the ordered service.

4. Pharmacy products (example: Diabetic Testing Supplies, OTC products, etc.) and prescription medications, as outlined in Section 27-18.9-2 of the General Laws, are not included in the legislation or this process. Prior authorization of these products will continue to be required.

5. Based upon Home Care Regulations 210-RICR-20-05-1.7 For Medicaid members "Prior Authorization is required for all home care services." This extends to LTSS as well as Adult Day and Assisted Living.

6. Services that are not covered: If a service or treatment is ordered by a PCP which is not included within a member's benefits or is excluded from coverage based on regulations, it would trigger a denial of payment. This includes quantity limits on services or products.

7. Only in-network services are eligible for a prior authorization waiver. Out-of-network services require prior authorization. When services are to be provided by an out-of-network provider or facility, prior authorization will still be necessary to assess coverage and patient financial responsibility, according to the State of Rhode Island's balance billing protection disclosure model notice.

8. Services that require EOHHS criteria: Some services may have specific criteria set by the Executive Office of Health and Human Services (EOHHS) that require prior authorization to ensure medical

necessity and appropriateness, particularly within the Medicaid program. These include various DME products in the Medicaid line of business. Prior authorization will remain in place for these items except as detailed above for the selected codes.

9. Individual providers with a documented history of fraud, waste, or abuse may be an exception and still be required to submit prior authorization requests, according to the Rhode Island Attorney General's Office.

10. The right to audit a practice's compliance with this policy is reserved.

Note: When Q reporting codes or codes for contrast products are billed with codes that are allowed to be submitted without Prior Authorization, they will be paid likewise without prior authorization being required.

Exclusions:

Home care, home health, adult day, and private duty nursing codes are excluded because of long-standing state policy that requires PA for these services and because PA requests for these services are properly made by the furnishing and billing provider.

CMP Number: **CMP Cross Reference:**	**CMP# PA-001** **CMP# PA-002**
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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.

References:

HB5120A from General Assembly: SECTION 2. Section 27-18.9-2 of the General Laws in Chapter 27-18.9 entitled "Benefit 4 Determination and Utilization Review Act"