Clinical Medical Policy

Primary Care Prior Authorization Policy for Commercial Lines of Business - # PA-002

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 the legislation (H5120A) passed during the 2025 session of the R.I. General Assembly. This legislation pertains to SECTION 2. Section 27-18.9-2 of the General Laws. This policy pertains to all Commercial Lines of Business which are covered by this 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.

Guidelines for Providers:

In alignment with the legislative language, when services/products are ordered or rendered by the PCP within the normal course of providing primary care, they will not require Prior Authorization within the following guidelines. **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 (referral circle) 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. 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.**

6. 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 HHS No Surprises Act.

7. 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.

8. 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.

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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"