Section 1
Introduction to Neighborhood Health Plan of Rhode Island (Neighborhood)
■ Welcome to Neighborhood
■ Who We Are
■ Essential Telephone Number Directory
■ Confidentiality

Section 2
Customer Service
■ Neighborhood Member Card
■ How to Verify Member Eligibility
■ Member Co-payments
■ Member Rights and Responsibilities
■ Member Complaint and Appeal Process

Section 3
Billing and Reimbursement
■ Neighborhood Required CMS 1500 Claims Information
■ Neighborhood Required UB04 Claims Information
■ How to Submit Claims Electronically to Neighborhood
■ EDI Reports
■ Remittance Advice
■ Claims Submission Standards
■ Complete Claims
■ Non-Complete Claims
■ Professional and Facility Procedural Coding Requirement
■ Time Limitations for Claim Submissions
■ Coordination of Benefits
■ Claims Editing Software Overview
■ Claims Auditing Overview
■ Reconsideration Process
■ Administrative Appeals
■ Fraud and Abuse
■ Contact Us

Section 4
Benefits
■ Benefits Information
■ Behavioral Health Services
■ Interpreter Services
■ Transportation Benefits
■ Member Education Services
Section 5
Authorization Process/Medical Management
- Medical Management
- Prior Authorization Process
- Emergency and Urgent Care Services
- Post-Stabilization
- Late or Retroactive Authorizations
- Requesting Services from a Non-Participating Provider
- Coordination of Benefits
- Medical Necessity Review
- Medical Necessity Decision Criteria
- Adverse Determination (Denial) and Appeals
- Case and Disease Management
- Breathe Easy Asthma Program
- Control for Life Diabetes Program
- Take a Breath for Members COPD
- Don’t Skip a Beat Program
- Bright Start Program
- Healthy Heart Program

Section 6
Pharmacy
- Formulary
- How to Use the Drug Formulary
- Coverage Limitations
- OTC Medications
- Pharmacy and Therapeutics Committee
- Generic Substitution
- Experimental Drugs
- Benefit Exception Process
- Prior Authorization
- Adverse Determination
- Pharmacist and Prescriber Communications

Section 7
Practitioner Information
- Primary Care
- The Role of the Primary Care Practitioner
- The Role of the Specialty Care Practitioner
- On-Call Protocol
- Closing Your Practice to New Members
- Practitioner Termination
- Continuity of Care
- Practitioner Information Changes

Section 8
Quality Management
- Quality Improvement Program
- Neighborhood’s Quality Improvement Activities
- Quality Improvement Methodology
Section 9
Standards of Care
- Medical Record Keeping and Documentation Standards
- Access to Care Standards
- Credentialing and Recredentialing Process
- Office Site Assessment
- Remedial Action, Disciplinary Action, and Appeal Process

Section 10
Customer Service Request Forms
- Member Site Change Request Form
- Member Education Request Form
- Rite Care Interpreter Services Fax Request Form
- Rite Care Taxi/Van Transportation Authorization Form

Provider Services Request Forms
- New Practitioner Notification Form
- On-Call Provider Group Notification Form
- Practitioner Termination Notification Form
- Changes to Billing Address/Tax Identification Number Notification Form

Behavioral Health Request Form
- Primary Care Provider Behavioral Health Communications Form

Claims Review Process and Submission Form
Section 1

Introduction to Neighborhood Health Plan of Rhode Island (Neighborhood)

- Welcome to Neighborhood
- Who We Are
- Essential Telephone Number Directory
- Confidentiality
Welcome to Neighborhood

We at Neighborhood Health Plan of Rhode Island (Neighborhood) are very pleased you and your staff have chosen to be part of our provider network. We look forward to developing a strong relationship and partnering with you to provide high quality health care to our members. This Provider Manual is designed to guide you in working with us and supplements your Agreement with Neighborhood. The manual includes valuable information specific to the benefits of our members, the services provided by Neighborhood, and the policies and procedures that have been put in place to ensure satisfaction for both our members and providers. Please call or fax Neighborhood Customer Service with any questions you may have at 1-401-459-6020 (phone) or 1-401-459-6021 (fax).

As an organization, Neighborhood continually strives to embody the following Mission, Vision, and Values in our employees’ day-to-day work and interactions with external customers:

Mission

Neighborhood Health Plan of Rhode Island, an innovative health plan in partnership with the Community Health Centers, secures access to high quality, cost-effective health care for Rhode Island’s at-risk populations.

Vision

To advance its mission, Neighborhood is working to create a world where:

- Everyone in Rhode Island has comprehensive healthcare coverage and access to high-quality health care.
- Community Health Centers are models for the delivery of high-quality, cost-effective primary care and the building blocks of community health in their respective communities.
- Neighborhood helps transform health care delivery as an essential partner in the State’s Medicaid program.
- Neighborhood members are actively engaged in their health and health care.

Values

Ardently Advocate for Members: Neighborhood treats members with dignity and respect and strives to create access to needed services and social supports.

Foster Partnerships: Only by working collaboratively at all levels of Neighborhood’s internal organization and by strengthening our external partnerships can we accomplish our mission.

Innovate to Improve the Health Care System: Neighborhood is dedicated to innovating in order to improve the way we work and to transform the health care system.

Demonstrate Value: Neighborhood must use our health care financing position to improve health outcomes, lower costs and ensure access to care.

Passionately Promote Health Equity: Neighborhood cares about those who are disenfranchised from the health care system and works to ensure that access to care and improved health outcomes become more equitable.

Create an Exceptional Workplace: Neighborhood is an employer of choice and works to advance its workforce.
Who We Are

Neighborhood is a health plan committed to serving its members and providers and contributing to effective change in the Rhode Island health care system. Working collaboratively with key community partners like the Community Health Centers (CHC) and our colleagues throughout the state, we continue to sustain and improve our provider network and health plan benefits in order to deliver high quality health care to our members in a cost-effective manner.

Who we serve

The members we serve represent the diverse populations that call Rhode Island home. The majority of our members are mothers and children, working families, and children and adults with disabilities.

Who works at Neighborhood

Neighborhood employs staff who live in the cities, towns and neighborhoods we serve. Our diverse and talented employees live in the communities we serve and are committed to the mission of providing everyone with access to high quality care. Accordingly, Neighborhood staff deliver excellent service to our members and providers alike, working daily to make care more equitable and cost-effective.

Who we work with

Neighborhood was founded in 1993 by the Rhode Island Community Health Centers (www.rihca.org) and is proud of its community-based heritage. Like the CHCs, we seek to become integrally connected to the local community and the partners with whom we collaborate. Our current network of providers includes the CHCs and other private practices and specialists.

Neighborhood works with the State of Rhode Island to serve four Medicaid populations:

1) Low and moderate income families;
2) Children with special care needs (CSN);
3) All children in the Rhode Island foster care system; and
4) Medicaid-only adults

How we do it

Neighborhood is committed to delivering the highest quality services. We have been rated “Excellent” by the National Committee for Quality Assurance (NCQA) since 2001 and work with our provider sites to achieve the highest standards of care. We have a record of innovation that includes unprecedented service to children with special health care needs, children in the state foster care system and members requiring medical interpretation services. At the same time, we are mindful stewards of precious resources and funds.
Essential Telephone Number Directory

<table>
<thead>
<tr>
<th>If You Have a Question About</th>
<th>Please Call and Ask For</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Behavioral Health /Substance Abuse</strong></td>
<td>Beacon Health Strategies, LLC</td>
</tr>
<tr>
<td>Clinical Information</td>
<td>1-800-215-0058 or 1-800-963-1001</td>
</tr>
<tr>
<td>Claims Inquiry</td>
<td>Fax 1-781-994-7633</td>
</tr>
<tr>
<td>Outpatient Clinical Review</td>
<td></td>
</tr>
<tr>
<td>Credentialing/Provider Relations</td>
<td>1-781-995-7556</td>
</tr>
<tr>
<td>Claims Inquiry</td>
<td>Fax 1-781-994-7639</td>
</tr>
<tr>
<td><strong>Medical Management / Authorizations</strong></td>
<td>Clinical Administrative Support</td>
</tr>
<tr>
<td>Ancillary Services, Clinical Issues, Clinical Quality, Hospitalizations, Requests for Authorizations</td>
<td>1-401-459-6060</td>
</tr>
<tr>
<td></td>
<td>Fax: 1-401-459-6023</td>
</tr>
<tr>
<td><strong>Claims</strong></td>
<td>Neighborhood Customer Service</td>
</tr>
<tr>
<td>Billing Questions</td>
<td>1-401-459-6020</td>
</tr>
<tr>
<td>Claims Issues</td>
<td></td>
</tr>
<tr>
<td><strong>Marketing</strong></td>
<td></td>
</tr>
<tr>
<td>Member Recruitment</td>
<td></td>
</tr>
<tr>
<td><strong>Member Services</strong></td>
<td></td>
</tr>
<tr>
<td>Member Education/Inquiries</td>
<td></td>
</tr>
<tr>
<td>Member Eligibility/Site Changes</td>
<td></td>
</tr>
<tr>
<td>Interpreter and Transportation Services</td>
<td></td>
</tr>
<tr>
<td><strong>Pharmacy</strong></td>
<td>Pharmacy Fax: 1- 866-423-0945</td>
</tr>
<tr>
<td>Complete drug formulary online: <a href="http://www.nhpri.org">www.nhpri.org</a></td>
<td></td>
</tr>
<tr>
<td>General Questions</td>
<td></td>
</tr>
<tr>
<td>Prior Authorization</td>
<td></td>
</tr>
<tr>
<td><strong>Provider Services</strong></td>
<td></td>
</tr>
<tr>
<td>Provider Support</td>
<td></td>
</tr>
<tr>
<td>Provider Recruitment</td>
<td></td>
</tr>
<tr>
<td>Practice Changes</td>
<td></td>
</tr>
<tr>
<td><strong>Credentialing</strong></td>
<td></td>
</tr>
<tr>
<td>Quality Management</td>
<td>1-401-459-6000</td>
</tr>
<tr>
<td>Case &amp; Disease Management</td>
<td>1-401-459-6750</td>
</tr>
<tr>
<td>RItc Care Infoline</td>
<td>1-401-462-5300 (for all languages)</td>
</tr>
<tr>
<td>Adults in Managed Care Help Line</td>
<td>1-401-784-8877</td>
</tr>
<tr>
<td>EDS Infoline</td>
<td>1-401-784-8100</td>
</tr>
</tbody>
</table>
Confidentiality

Neighborhood and its employees are in possession of a broad range of confidential information. The improper use or disclosure of this information could be harmful to Neighborhood or its members, providers, employees or business partners. Therefore, each Neighborhood employee has an obligation to protect and properly use all confidential information ethically and in accordance with the law and/or our contractual obligations. To that end:

All employees, including temporary staff, consultants, students and interns, receive Privacy Training and are required to read and sign Neighborhood’s Confidentiality Policy.

Neighborhood requires that its subcontractors and business partners agree to protect the confidentiality of the information we disclose to them and sign a Business Associate Agreement that outlines their responsibilities relative to protected health information.

Neighborhood includes a clause on confidentiality in all of its contractual agreements with its participating providers.

In order to ensure appropriate oversight of all aspects of confidentiality, Neighborhood has an internal Security Review Team charged with the responsibility for ensuring that policies and processes are in place to safeguard confidential information and are implemented and followed throughout the organization, and with those entities with whom we have agreements.

Member/Patient Information

Neighborhood employees are required to protect and maintain the confidentiality of all member information in accordance with the law. Confidential information regarding Neighborhood members is not used, discussed or disclosed unless supported by a legitimate business purpose. Questions regarding the appropriateness of releasing confidential information are addressed to the Neighborhood Chief Privacy Officer. The Chief Privacy Officer can be reached at 1-401-459-6000.

Proprietary Information

Practitioner information, as well as information pertaining to Neighborhood’s competitive position, business strategies, payment and reimbursement is considered proprietary and is shared only with staff that have a need to know such information in order to perform the functions of their job. Neighborhood employees are instructed to seek guidance from their supervisor or the Chief Privacy Officer regarding whether information is proprietary or whether proprietary information can be shared.
Section 2
Customer Service

- Neighborhood Member Card
- How to Verify Member Eligibility
- Member Co-payments
- Member Rights and Responsibilities
- Member Complaint and Appeal Process
Neighborhood Member Identification Card

Upon enrollment every Neighborhood member is issued a Neighborhood identification (ID) card. Neighborhood will have two card formats in use by our members. Members enrolled prior to conversion of new system will have an ID card that includes member name, member nine digit ID number, member date of birth, group number, assigned participating provider group name and phone number. A sample of this Neighborhood member ID card is shown below.

Member identification cards issued after conversion of new system will also include individual primary care physician name. In addition, group numbers will be replaced with alphabetical benefit plan IDs on these cards.
This crosswalk shows how the group numbers will map to the new benefit plan ID numbers. Please note that remittance advices will use these alphabetical plan ID numbers after conversion of new system.

<table>
<thead>
<tr>
<th>Current Neighborhood Group Number</th>
<th>New Benefit Plan ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>1100</td>
<td>MED Plan</td>
</tr>
<tr>
<td>1400</td>
<td>EFP Plan (State Bill)</td>
</tr>
<tr>
<td>1450</td>
<td>EFP Plan (Direct Bill)</td>
</tr>
<tr>
<td>1550</td>
<td>SOBRA Plan</td>
</tr>
<tr>
<td>5100</td>
<td>SUB</td>
</tr>
<tr>
<td>5210</td>
<td>CSN (SSI)</td>
</tr>
<tr>
<td>5211</td>
<td>CSN (Katie Beckett)</td>
</tr>
<tr>
<td>5220</td>
<td>CSN (Subsidized Adoption)</td>
</tr>
<tr>
<td>5230</td>
<td>CSN (Subsidized Adoption)</td>
</tr>
<tr>
<td>6110</td>
<td>RHP Plan (SPMI No Waiver)</td>
</tr>
<tr>
<td>6111</td>
<td>RHP Plan (SPMI With Waiver)</td>
</tr>
<tr>
<td>6121</td>
<td>RHP Plan (MRDD With Waiver)</td>
</tr>
<tr>
<td>6130</td>
<td>RHP Plan (Other Disabled No Waiver)</td>
</tr>
<tr>
<td>6131</td>
<td>RHP Plan (Other Disabled With Waiver)</td>
</tr>
<tr>
<td>6140</td>
<td>RHP Plan (Other Disabled No Waiver)</td>
</tr>
<tr>
<td>6141</td>
<td>RHP Plan (Other Disabled With Waiver)</td>
</tr>
</tbody>
</table>

Members are advised and expected to carry their Neighborhood member ID card at all times and to call their primary care practitioner (PCP) before seeking services, except in cases on life-threatening emergencies.
How to Verify Member Eligibility

All providers should verify a member’s eligibility when providing services to a member(s) who presents a Neighborhood identification card. Primary care practitioners must also verify that the member is assigned to the provider group and one of the group’s participating primary care practitioners in order to receive reimbursement for services rendered. Neighborhood encourages our primary care providers to verify member site assignment even if your practice is listed on the member’s identification card. Please review medical coverage policies posted on www.nhpri.org for information on services that are only payable to the members’ PCP or his/her covering provider.

How to Verify Member Eligibility

Neighborhood has contracted with Navinet to provide real time eligibility, PCP assignment and claims status information.

Log into Navinet at https://connect.navinet.net and look for Neighborhood Health Plan of Rhode Island in the health plan list.

Information is available on Navinet when you need it — 5:00am to 3:00am Monday through Saturday, 5:00am to 5:00pm Sunday.

If you have questions regarding Navinet please call them at 1-888-482-8057.

Participating providers without internet access may also contact Neighborhood Customer Service to verify member eligibility at 1-401-459-6020 or 1-800-459-6019, 8:30AM to 5:00PM Monday through Friday.

Member Site Change Requests

If upon verifying member eligibility and site assignment, your office learns that an eligible member is assigned to another primary care site, please have the member contact Neighborhood Customer Service at 1-800-459-6019 or 1-401-459-6020 or complete and sign the Member Site Change Request Form in Section 10.

Providers have five (5) business days from the date of service to fax the Member Site Change Request Form to Neighborhood at 1-401-459-6021. Site changes for newborns will be accepted for up to 30 days from date of birth. Site changes faxed beyond five (5) business days will be effective on the date the information was faxed. Please note: this form must be signed by the member or member’s parent/head of household in order to be processed.

**Important Note:** The member or member’s parent/head of household must sign this form in order for the site change to be processed. Please confirm and include the member’s correct home address and telephone number on the form; this will enable us to expedite the site change request in a more timely manner.
Member Co-Payments

A small portion of Neighborhood members have limited benefit packages and/or may be required to pay a co-payment for certain services. When applicable, co-payment information is indicated on the front of the member’s Neighborhood ID card directly on the front of the member ID card. There are several types of possible co-payments that may be shown on the Neighborhood ID card:

1. Office Visit (OV)
2. Pharmacy (RX)
3. Emergency Room (ER)

Co-payments should be collected from Neighborhood members at the time of service.

<table>
<thead>
<tr>
<th>HEALTH EDGE GROUP # DESCRIPTION</th>
<th>GROUP #</th>
<th>COMMENTS</th>
<th>SERVICES WITH COPAYS</th>
<th>COPAY*</th>
</tr>
</thead>
<tbody>
<tr>
<td>EFP</td>
<td>1400 &amp; 1450</td>
<td>Extended Family Planning Package (a limited benefit package)</td>
<td>Health Care Provider Visits</td>
<td>$2.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Voluntary Sterilization Procedures</td>
<td>$15.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>30 day supply of contraceptives</td>
<td>$1.00</td>
</tr>
<tr>
<td>SOBRA</td>
<td>1550</td>
<td>Rite Care SOBRA Members (a full Rite Care benefit package with copays)</td>
<td>Office Visits</td>
<td>$5.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ambulatory Surgical Procedure</td>
<td>$15.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Prescriptions</td>
<td>$2.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Inpatient Hospital Admission</td>
<td>$25.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Non-Emergency Use of Emergency Transportation</td>
<td>$35.00</td>
</tr>
</tbody>
</table>
Member Rights and Responsibilities

Provided below is the Neighborhood Member Rights and Responsibilities Statement. Members can find the statement in Neighborhood’s Member Handbook.

Neighborhood promises to work with our primary care practitioners and other health care professionals to provide our members with the highest quality health care services.

Rights of a Member

- You have a right to receive information about Neighborhood, its services, practitioners and providers, and members’ rights and responsibilities.
- You have a right to be treated with respect and recognition of your dignity and right to privacy.
- You have the right to participate with your practitioners in decision-making regarding your health care.
- You have the right to privacy of all records and communications to the extent required by law. (Neighborhood employees follow a strict confidentiality policy regarding all member information.)
- You have the right to respectful, personal attention without regard to your race, national origin, gender, age, sexual orientation, religious affiliation, or preexisting conditions.
- You have the right to obtain a second medical opinion from an in-network provider without prior authorization.
- You have the right to a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- You have the right to voice complaints or appeals about Neighborhood or the care provided by its practitioners.
- You have the right to make recommendations about Neighborhood’s Member Rights and Responsibilities policies.

Responsibilities of a Member

- Choose a Primary Care Practitioner (PCP) and Primary Care Site. Your PCP will coordinate all of your medical care. You may change your PCP at any time by calling Neighborhood Customer Service at 1-800-459-6019 or 1-401-459-6020.
- Have all of your medical care provided by or arranged by a Neighborhood participating doctor.
- Carry your Neighborhood Identification Card with you and show it whenever you seek medical care.
- Provide, to the extent possible, information that Neighborhood and its practitioners and providers need to care for you.
- Learn about your health problems and help plan treatment you and your PCP agree on.
- Follow the plans and instructions for care that you have agreed on with your practitioners.
- Talk with your PCP about all specialty care. If you need a specialist, your PCP will work with you to make sure you get quality care.
- Call your PCP first for help if you have an urgent medical condition. If an emergency is life threatening, go immediately to the nearest Emergency Room or call 911. You (or a friend or relative) should contact your PCP the next day.
- Let Neighborhood know about changes to your name, home address, telephone number, marital status, number of dependents or if you have other insurance coverage.
Member Complaint and Appeal Process

Neighborhood is committed to working with our members to provide quality health care services that meet their needs and are delivered in a timely and respectful manner. To better serve members, Neighborhood has a process to resolve our members’ complaints and appeals about claims received, benefit coverage, medical services that were denied or determined not to be medically necessary, adverse medical services, access to appointments, quality issues or concerns, breaches of confidentiality, or other issues that cause our members dissatisfaction.

What is a Complaint?

A complaint is an expression of dissatisfaction about the care or services received as a Neighborhood member. Complaints may be submitted in writing or over the telephone by Neighborhood members or their authorized representative. We encourage members to communicate with us if they have a complaint about access, quality of care, or coverage decisions (including non-payment of a claim).

If members need help filing a written complaint, they can call Neighborhood Customer Service at 1-800-459-6019 or 1-401-459-6020. We can assist them in completing the appropriate paperwork on their behalf. Copies of Neighborhood’s Complaint and Appeals Resolution Procedures are also available by contacting Neighborhood Customer Service Department at 1-401-459-6020.

Written complaints should be sent to:

Customer Service: Complaints/Appeals
Neighborhood Health Plan of Rhode Island
299 Promenade Street
Providence, RI 02908

What Happens When a Complaint is Submitted?

Neighborhood Customer Service will investigate each complaint and contact the member within 30 calendar days from when we received the request. Sometimes Neighborhood Customer Service staff might need to contact a member or a provider to get more information about a complaint. Neighborhood Customer Service staff will provide the member with an update on the outcome or resolution of the complaint. Quality of care complaints are resolved within 60 days of all information being received.

More Options for Rite Care Members

A member who is not satisfied with Neighborhood’s initial response to a complaint may file a formal grievance with Neighborhood Customer Service. Neighborhood Customer Service will evaluate the grievance and will notify the member of Neighborhood’s decision within 30 calendar days of receiving the written or verbal grievance.

If members are not satisfied with Neighborhood’s decision, they may register a formal grievance and/or notify the Department of Health (DOH). After they have exhausted all internal avenues, they may request a fair hearing from the Office of Health and Human Services (OHHS) at 1-401-462-5300 or 1-401-462-3363 (TTY).
Section 3

Billing and Reimbursement

- Neighborhood Required CMS 1500 Claims Information
- Neighborhood Required UB 04 Claims Information
- How to Submit Claims Electronically to Neighborhood
- EDI Reports
- Additional Links and Resources
- Remittance Advice
- Claims Submission Standards
- Complete Claims
- Non-Complete Claims
- Industry Standard Coding Requirements
- Time Limitations for Claims Submission
- Coordination of Benefits
- Claims Editing Software Overview
- Claims Auditing Overview
- Reconsideration Process
- Administrative Appeals
- Fraud and Abuse
- Contact Us
Neighborhood Required CMS 1500 Claims Information

The following is a listing of the claims information that is required by Neighborhood in order for your claims to be reviewed for potential payment. If any of the required information is omitted or invalid, your claim(s) may be returned for correction and resubmission. The “Instruction” column indicates whether a particular field is Required (mandatory) or Optional:

<table>
<thead>
<tr>
<th>Box</th>
<th>Box Heading</th>
<th>Instruction</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Carrier Type</td>
<td>Optional</td>
</tr>
<tr>
<td>1a</td>
<td>Insured’s ID Number</td>
<td>Required</td>
</tr>
<tr>
<td>2</td>
<td>Patient’s Name</td>
<td>Required</td>
</tr>
<tr>
<td>3</td>
<td>Patient’s Date of Birth</td>
<td>Required</td>
</tr>
<tr>
<td>4</td>
<td>Insured’s Name</td>
<td>Required</td>
</tr>
<tr>
<td>5</td>
<td>Patient’s Address</td>
<td>Required</td>
</tr>
<tr>
<td>6</td>
<td>Patient’s Relationship to Insured</td>
<td>Optional</td>
</tr>
<tr>
<td>7</td>
<td>Insured Address</td>
<td>Optional</td>
</tr>
<tr>
<td>8</td>
<td>Patient Status</td>
<td>Required</td>
</tr>
<tr>
<td>9</td>
<td>Other Insured’s Name</td>
<td>If Applicable</td>
</tr>
<tr>
<td>9a</td>
<td>Other Insured’s Policy or Group Number</td>
<td>If Applicable</td>
</tr>
<tr>
<td>9b</td>
<td>Other Insured’s Date of Birth</td>
<td>If Applicable</td>
</tr>
<tr>
<td>9c</td>
<td>Employer’s Name or School Name</td>
<td>If Applicable</td>
</tr>
<tr>
<td>9d</td>
<td>Insurance Plan Name or Program Name If Applicable</td>
<td>If Applicable</td>
</tr>
<tr>
<td>10</td>
<td>Is Patient’s Condition Related to:</td>
<td></td>
</tr>
<tr>
<td>10a</td>
<td>Employment</td>
<td>Required</td>
</tr>
<tr>
<td>10b</td>
<td>Auto Accident</td>
<td>Required</td>
</tr>
<tr>
<td>10c</td>
<td>Other Accident</td>
<td>Optional</td>
</tr>
<tr>
<td>10d</td>
<td>Reserve for Local Use</td>
<td>Optional</td>
</tr>
<tr>
<td>11</td>
<td>Insured’s Policy Group or FECA Number</td>
<td>Optional</td>
</tr>
<tr>
<td>11a</td>
<td>Insured’s Date of Birth</td>
<td>Optional</td>
</tr>
<tr>
<td>11b</td>
<td>Employer’s Name or School Name</td>
<td>Optional</td>
</tr>
<tr>
<td>11c</td>
<td>Insurance Plan Name or Program Name</td>
<td>Optional</td>
</tr>
<tr>
<td>11d</td>
<td>Is There Another Health Benefit Plan?</td>
<td>Optional</td>
</tr>
<tr>
<td>12</td>
<td>Patient’s or Authorized Person’s Signature</td>
<td>Required</td>
</tr>
<tr>
<td>13</td>
<td>Insured’s or Authorized Person’s Signature (Assignment of Benefits)</td>
<td>Required</td>
</tr>
<tr>
<td>14</td>
<td>Date of Current Illness, Injury, Pregnancy</td>
<td>Optional</td>
</tr>
<tr>
<td>15</td>
<td>First Date of Onset of Same/Similar Illness</td>
<td>Optional</td>
</tr>
<tr>
<td>16</td>
<td>Dates Unable to Work in Current Occupation</td>
<td>Optional</td>
</tr>
<tr>
<td>17</td>
<td>Name of Referring Physician</td>
<td>If Applicable</td>
</tr>
<tr>
<td>Box</td>
<td>Box Heading</td>
<td>Instruction</td>
</tr>
<tr>
<td>-----</td>
<td>-----------------------------------------------------------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>17a</td>
<td>Legacy Referring</td>
<td>Optional</td>
</tr>
<tr>
<td>17b</td>
<td>Referring Physician NPI#</td>
<td>Optional</td>
</tr>
<tr>
<td>18</td>
<td>Hospitalization Dates Related to Current Services</td>
<td>If Applicable</td>
</tr>
<tr>
<td>19</td>
<td>Reserved for local use</td>
<td>Optional</td>
</tr>
<tr>
<td>20</td>
<td>Outside Laboratory?</td>
<td>Optional</td>
</tr>
<tr>
<td>21</td>
<td>Diagnosis or Nature of Illness or Injury</td>
<td>Required</td>
</tr>
<tr>
<td>22</td>
<td>Medicaid Resubmission Code</td>
<td>Optional</td>
</tr>
<tr>
<td>23</td>
<td>Prior Authorization Number</td>
<td>Required, If Applicable</td>
</tr>
<tr>
<td>24a</td>
<td>Date of Service, From and To</td>
<td>Both Required</td>
</tr>
<tr>
<td>24b</td>
<td>Place of Service (Valid codes only, outdated codes are not accepted).</td>
<td>Required</td>
</tr>
<tr>
<td>24c</td>
<td>Emergency Service</td>
<td>Optional</td>
</tr>
<tr>
<td>24d</td>
<td>Procedures, Services or Supply Code (modifiers), including NDC numbers</td>
<td>Required</td>
</tr>
<tr>
<td>24e</td>
<td>Diagnosis Pointer</td>
<td>Required</td>
</tr>
<tr>
<td>24f</td>
<td>Charges</td>
<td>Required</td>
</tr>
<tr>
<td>24g</td>
<td>Days or Units</td>
<td>Required</td>
</tr>
<tr>
<td>24h</td>
<td>EPSDT Family Plan</td>
<td>Optional</td>
</tr>
<tr>
<td>24i</td>
<td>ID Qualifier</td>
<td>Optional</td>
</tr>
<tr>
<td>24j</td>
<td>Provider ID Number Taxonomy</td>
<td>If Applicable</td>
</tr>
<tr>
<td>24j</td>
<td>Rendering Provider NPI Number</td>
<td>Required (in non-shaded area)</td>
</tr>
<tr>
<td>25</td>
<td>Federal Tax ID Number</td>
<td>Required</td>
</tr>
<tr>
<td>26</td>
<td>Patient’s Account Number</td>
<td>Required</td>
</tr>
<tr>
<td>27</td>
<td>Accept Assignment</td>
<td>Required</td>
</tr>
<tr>
<td>28</td>
<td>Total Charge</td>
<td>Required</td>
</tr>
<tr>
<td>29</td>
<td>Amount Paid</td>
<td>If Applicable</td>
</tr>
<tr>
<td>30</td>
<td>Balance Due</td>
<td>If Applicable</td>
</tr>
<tr>
<td>31</td>
<td>Signature of Practitioner or Supplier</td>
<td>Required</td>
</tr>
<tr>
<td>32</td>
<td>Name/Address of Facility Where Services Rendered</td>
<td>Required</td>
</tr>
<tr>
<td>33</td>
<td>Practitioner/Supplier’s Billing Name/Address Telephone Number. For Participating Providers the Neighborhood Provider and Vendor Number which is assigned by Neighborhood. For Non-Participating Providers submit your PIN#.</td>
<td>Required</td>
</tr>
</tbody>
</table>
CMS-1500 Required Fields

<table>
<thead>
<tr>
<th>Field Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medicare/Medicaid/Tricare/Champus/GROUP HEALTH PLAN/FECA/OTHER</td>
</tr>
<tr>
<td>2. Patient's Name (Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>3. Patient's Birth Date (MM DD YY)</td>
</tr>
<tr>
<td>4. Insured's Name (Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>5. Patient's Relationship to Insured (Self, Spouse, Child, Other)</td>
</tr>
<tr>
<td>6. Patient Status (Single, Married, Other)</td>
</tr>
<tr>
<td>7. Insured's Address (No., Street)</td>
</tr>
<tr>
<td>8. ZIP Code</td>
</tr>
<tr>
<td>9. Telephone (Include Area Code)</td>
</tr>
<tr>
<td>10. Other Insured's Name (Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>11. Insured's Policy Group or FECA Number</td>
</tr>
<tr>
<td>12. Is Patient's Condition Related To: (Other)</td>
</tr>
<tr>
<td>13. Insured's Date of Birth (MM DD YY)</td>
</tr>
<tr>
<td>14. Insured's Date of Admission (MM DD YY)</td>
</tr>
<tr>
<td>15. Diagnosis or Nature of Illness or Injury (Relate Name 1, 2, or 3 to Item 24E) by Line</td>
</tr>
<tr>
<td>16. Dates Patient Unable to Work in Current Occupation (MM DD YY)</td>
</tr>
<tr>
<td>17. Hospitalization Dates Related to Current Services (MM DD YY)</td>
</tr>
<tr>
<td>18. Date of Service (MM DD YY)</td>
</tr>
<tr>
<td>19. Place of Service (E.M.S. CPCPCS MODIFIER)</td>
</tr>
<tr>
<td>20. Procedure, Services, or Supplies (Explain Unusual Circumstances)</td>
</tr>
<tr>
<td>21. Diagnosis Code (CPT CODE)</td>
</tr>
<tr>
<td>22. Prior Authorization Number</td>
</tr>
<tr>
<td>23. Dates of Service (MM DD YY)</td>
</tr>
<tr>
<td>24. Place of Service (E.M.S. CPCPCS MODIFIER)</td>
</tr>
<tr>
<td>25. Federal Tax ID Number</td>
</tr>
<tr>
<td>27. Accept Assignment (YES, NO)</td>
</tr>
<tr>
<td>28. Total Charge</td>
</tr>
<tr>
<td>29. Amount Paid</td>
</tr>
<tr>
<td>30. Balance Due</td>
</tr>
<tr>
<td>31. Signature of Physician or Supplier (Including Degrees or Credentials)</td>
</tr>
<tr>
<td>32. Service Facility Location Information</td>
</tr>
<tr>
<td>33. Billing Provider Info &amp; Ph #</td>
</tr>
</tbody>
</table>
# Neighborhood Required UB-04 Claims Information

The following is a listing of the claims information that is required by Neighborhood in order that your claims be reviewed for potential payment. If any of the required information is omitted or invalid your claim(s) may be returned for correction and resubmission. The “Instruction” column indicates whether a particular field is Required (mandatory) or Optional:

<table>
<thead>
<tr>
<th>Box</th>
<th>Box Heading</th>
<th>Instruction</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Provider Name, Address and Phone</td>
<td>Required</td>
</tr>
<tr>
<td>2</td>
<td>Pay-to Name, address and Secondary Identification Fields</td>
<td>Required</td>
</tr>
<tr>
<td>3a</td>
<td>Patient Control Number</td>
<td>Required</td>
</tr>
<tr>
<td>3b</td>
<td>Medical/Health Record Number</td>
<td>Required</td>
</tr>
<tr>
<td>4</td>
<td>Type of Bill</td>
<td>Required</td>
</tr>
<tr>
<td>5</td>
<td>Federal Tax Number</td>
<td>Required</td>
</tr>
<tr>
<td>6</td>
<td>Statement Covers Period (From-Through)</td>
<td>Required</td>
</tr>
<tr>
<td>7</td>
<td>Not Used</td>
<td>Optional</td>
</tr>
<tr>
<td>8</td>
<td>Patient’s Name</td>
<td>Required</td>
</tr>
<tr>
<td>9</td>
<td>Patient’s Address</td>
<td>Required</td>
</tr>
<tr>
<td>10</td>
<td>Patient’s Birth Date</td>
<td>Required</td>
</tr>
<tr>
<td>11</td>
<td>Patient’s Sex</td>
<td>Required</td>
</tr>
<tr>
<td>12</td>
<td>Admission Date</td>
<td>Required</td>
</tr>
<tr>
<td>13</td>
<td>Admission Hour</td>
<td>Required</td>
</tr>
<tr>
<td>14</td>
<td>Type of Admission</td>
<td>Required</td>
</tr>
<tr>
<td>15</td>
<td>Source of Admission</td>
<td>Required</td>
</tr>
<tr>
<td>16</td>
<td>Discharge Hour</td>
<td>Required</td>
</tr>
<tr>
<td>17</td>
<td>Patient Status</td>
<td>Required</td>
</tr>
<tr>
<td>18-28</td>
<td>Condition Codes If Applicable Type of Admission</td>
<td>If Applicable</td>
</tr>
<tr>
<td>29</td>
<td>Accident State</td>
<td>Not Used</td>
</tr>
<tr>
<td>30</td>
<td>Not Used</td>
<td></td>
</tr>
<tr>
<td>31-34</td>
<td>Occurrence Codes and Dates If Applicable</td>
<td>If Applicable</td>
</tr>
<tr>
<td>35-36</td>
<td>Occurrence Span Codes and Dates If Applicable</td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>Not Used</td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>Responsible Party Name and Address</td>
<td>Required</td>
</tr>
<tr>
<td>39-41</td>
<td>Value Codes and Amounts If Applicable</td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>Revenue Code</td>
<td>Required</td>
</tr>
<tr>
<td>43</td>
<td>Revenue Description</td>
<td>Optional</td>
</tr>
<tr>
<td>44</td>
<td>HCPCS/Rates/HIPPS Rate Codes</td>
<td>Optional</td>
</tr>
<tr>
<td>45</td>
<td>Service Dates</td>
<td>Required</td>
</tr>
<tr>
<td>46</td>
<td>Units of Service</td>
<td>Required</td>
</tr>
<tr>
<td>47</td>
<td>Total Charges</td>
<td>Required</td>
</tr>
<tr>
<td>Box</td>
<td>Box Heading</td>
<td>Instruction</td>
</tr>
<tr>
<td>------</td>
<td>-------------------------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>48</td>
<td>Non-covered Charges</td>
<td>Optional</td>
</tr>
<tr>
<td>49</td>
<td>Not Used</td>
<td></td>
</tr>
<tr>
<td>50A</td>
<td>Payer Identification</td>
<td>Required</td>
</tr>
<tr>
<td>51A</td>
<td>National Health Plan Identifier</td>
<td>Required</td>
</tr>
<tr>
<td>51</td>
<td>National Health Plan Identifier</td>
<td>If Applicable</td>
</tr>
<tr>
<td>51C</td>
<td>National Health Plan Identifier</td>
<td>If Applicable</td>
</tr>
<tr>
<td>52A</td>
<td>Release of Information Certification Indicator</td>
<td>Required</td>
</tr>
<tr>
<td>53A</td>
<td>Assignment of Benefits Certification Indicator</td>
<td>Required</td>
</tr>
<tr>
<td>54A</td>
<td>Prior Payments</td>
<td>Required</td>
</tr>
<tr>
<td>55A-C</td>
<td>Estimated Amount Due From Patient</td>
<td>Optional</td>
</tr>
<tr>
<td>56</td>
<td>National Provider ID (NPI)</td>
<td>Required</td>
</tr>
<tr>
<td>57</td>
<td>Other Provider ID</td>
<td></td>
</tr>
<tr>
<td>58A</td>
<td>Insured’s Name1</td>
<td>Required</td>
</tr>
<tr>
<td>59A</td>
<td>Patient’s Relationship to Insured</td>
<td>Required</td>
</tr>
<tr>
<td>60A</td>
<td>Insured’s Unique ID</td>
<td>Required</td>
</tr>
<tr>
<td>61A</td>
<td>Insurance Group Name</td>
<td>Required</td>
</tr>
<tr>
<td>62A</td>
<td>Insurance Group Number</td>
<td>Required</td>
</tr>
<tr>
<td>63</td>
<td>Treatment Authorization Code</td>
<td>Required, If Applicable</td>
</tr>
<tr>
<td>64</td>
<td>Document Control Number (DCN)</td>
<td>If Applicable</td>
</tr>
<tr>
<td>65</td>
<td>Employer Name</td>
<td>Required</td>
</tr>
<tr>
<td>66</td>
<td>Diagnosis and Procedure Code Qualifier</td>
<td>Required</td>
</tr>
<tr>
<td>67</td>
<td>Principle Diagnosis Code</td>
<td>Required</td>
</tr>
<tr>
<td>67A-Q</td>
<td>Other Diagnosis Code (including POA Codes)</td>
<td>Required</td>
</tr>
<tr>
<td>68</td>
<td>Not Used</td>
<td></td>
</tr>
<tr>
<td>69</td>
<td>Admitting Diagnosis</td>
<td>Required</td>
</tr>
<tr>
<td>70A-C</td>
<td>Patient’s Reason for Visit</td>
<td>If Applicable</td>
</tr>
<tr>
<td>71</td>
<td>Prospective Payment System (PPS) Code</td>
<td>Not Used</td>
</tr>
<tr>
<td>72</td>
<td>External Cause of Injury (ECI) Code</td>
<td>Not Used</td>
</tr>
<tr>
<td>73</td>
<td>Not Used</td>
<td></td>
</tr>
<tr>
<td>74</td>
<td>Principle Procedure Codes and Date</td>
<td>Required (Inpt)</td>
</tr>
<tr>
<td>75A-E</td>
<td>Other Procedure Codes and Dates</td>
<td>If Applicable</td>
</tr>
<tr>
<td>76</td>
<td>Attending Provider Name and Identifiers (including NPI)</td>
<td></td>
</tr>
<tr>
<td>77</td>
<td>Operating Provider Name and Identifiers (including NPI)</td>
<td>If Applicable</td>
</tr>
<tr>
<td>78-79</td>
<td>Other Provider Name and Identifiers (including NPI)</td>
<td>If Applicable</td>
</tr>
<tr>
<td>80</td>
<td>Remarks</td>
<td></td>
</tr>
<tr>
<td>81CC</td>
<td>Code-Code Field</td>
<td>If Applicable</td>
</tr>
<tr>
<td>a-d</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Field</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>Patient Name</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Patient Address</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Admission Date</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Admission Time</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Condition Codes</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Occurrence Code</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Occurrence Date</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Occurrence Time</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Occurrence Span From</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Occurrence Span To</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Self pay Code</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Hospital/Physician Code</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Sign Date</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Sign Code</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Total Charges</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Non-covered Charges</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Payer Name</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Health Plan ID</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Prior Payments</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Est. Amount Due</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Group Name</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Insurer's Group No</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Treatment Authorization Codes</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Document Control Number</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Employer Name</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Code</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Date</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Time</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Site</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Code</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Date</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Time</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Site</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Code</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Date</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Time</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Site</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Code</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Date</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Time</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Site</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Code</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Date</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Time</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Site</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Code</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Date</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Time</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Site</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Code</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Date</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Time</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Site</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Code</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Date</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Time</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Site</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Code</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Date</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Time</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Site</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Code</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Date</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Time</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Site</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Code</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Date</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Time</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Site</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Code</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Date</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Time</td>
<td>Required</td>
<td></td>
</tr>
<tr>
<td>Procedure Site</td>
<td>Required</td>
<td></td>
</tr>
</tbody>
</table>
How to Submit Claims Electronically to Neighborhood

Neighborhood currently accepts electronic claims submission of CMS-1500 and UB-04 forms using the federally required ANSI 837 Version 004010 format. Neighborhood is able to accept direct submission of files via FTP or Secure FTP. All claims submission files and any response files transmitted using legacy FTP protocol will require encryption. You may find it necessary to purchase encryption software compatible with the one that Neighborhood is currently using. This will ensure the proper level of security and confidentiality of the data being transmitted. The use of Secure FTP protocol, which natively has an encryption algorithm included, will not require the use of an additional 3rd party encryption methodology. Upon approval of your request to submit electronic claims directly to Neighborhood, we will contact you with your FTP user name and password.

To submit claims electronically to Neighborhood:

1. Please refer to Neighborhood’s 837 Companion Guide available from your Provider Services Specialist.

2. Please confirm your intent to send a test file with Neighborhood’s Provider Services Specialists at 1-401-459-6000. Please include the following information with your confirmation:
   - Name of designated contact/technician/programmer
   - Contact phone number and e-mail address
   - Method of delivery
   - Timeframe when Neighborhood should expect to receive the test file

3. Program your billing system to export a text file in ANSI 837 format per the Companion Guide.

You will hear from Neighborhood within fourteen (14) business days from the date of submission. If the testing was unsuccessful, you will be asked to resubmit the file. For technical questions regarding proper submission, please contact your Provider Services Specialist who will work internally to resolve the issue.

If the testing was successful, the Neighborhood Provider Services’ Staff will provide you with notification of Neighborhood’s approval to submit claims electronically.

All claims submitted electronically are subject to contractual timely filing limits. Please refer to your Neighborhood agreement for specific filing limits.

Reconciliation

For each file submitted, Neighborhood will generate electronic confirmation reports to be sent to you. The report will indicate all claims submitted in the batch in total, those claims accepted, and those claims that rejected. An error report reflecting all rejections will allow you to analyze any claims that were not accepted into our claims processing system (e.g., due to invalid member information).

If you have any questions about this information, please contact Provider Services at 1-401-459-6000.
EDI Reports

In addition to the Neighborhood Remittance Advices, practitioners who submit electronically also receive the following reports on paper or electronically, depending on how they are set-up. These reports verify information received via the EDI process.

1. EDI Import Report - Verifies that claims sent electronically correspond with claims received, services sent match up with services received and dollars sent match up with dollars received.

2. EDI Import Detailed Report - The Member Name, DOB, Sex, Member ID, Provider ID, Account #, TX ID, Procedure Code, Diagnosis Code, Vendor Number and Dollar Amount on all claims on the file.

3. Professional Error Summary Report - A list of total number of claims submitted, the total errors on the claims and the error messages.

4. Professional Errors Detail Report - A listing of claims that have been rejected due to error in a file that has been submitted. Using the Neighborhood EDI Pre-processor Error Listing, Neighborhood claims staff corrects errors that can be corrected.

5. Provider Error Summary - The Claims department uses this report to match the Professional Error Summary and Detail Reports to ensure that they correspond with each other.

6. Claim Error Report – A list of errors that the claims department cannot correct, sorted by provider.

7. Batch Control and Reconciliation Report - Confirms the total number of claims accepted vs. total number of claims rejected.

8. Change Log - Generated so the practice/billing company can view the actual corrections made: old value (how claim was submitted) vs. new value (corrections which were made by the Claims Department). This information should be used to update your billing system for future claims submission.

Paper Claim Reports

Most claims submitted to Neighborhood on paper are converted to electronic files. Paper submitters will receive an electronic Batch Detail Statistic Report which will list any submissions that are rejected due to an error in the information on the claim.
Remittance Advice

Practitioners receive the Neighborhood Remittance Advice (RA) as notification of claims adjudication completion. The Remittance Advice details all claims processed for that period along with a bulk payment, if applicable. Payments are made via Electronics Funds Transfer and Remittance Advice are sent to providers secure e-mail address or fax. To update your information, please contact your provider services representative.

The RA details the following information for each claim:

- Provider ID number
- Group ID number
- Date of Service
- Date of Receipt
- Claim Number
- Procedure Code
- Modifier
- Billed Amount
- Adjustment Reason
- Allowed Amount and Reason
- Not Covered Amount and Reason
- COB Amount and Reason
- Co-pay Amount and Reason
- Net Paid and/or Hold Reason
Claims Submission Standards

Neighborhood accepts professional charges submitted on a CMS 1500 billing form and institutional charges on a UB-04 form. Claims must be submitted with appropriate and valid coding for the date and type of service rendered.

Paper claims should be submitted to:

Neighborhood Health Plan of Rhode Island
299 Promenade Street
Providence, RI 02908
Claims Submission Fax: 1-401-459-6146

If you have any questions, please call Customer Service at 1-401-459-6020 between the hours of 10:00 a.m. and 3:00 p.m., Monday through Friday.

Complete Claims

Neighborhood defines a complete (clean) claim as a claim or invoice for payment of healthcare services that are submitted via acceptable claim forms or electronic formats with all required fields completed with accurate and complete information in accordance with the insurer’s requirements.

A claim is considered “complete” if ALL of the following conditions are met:

1. The services must be eligible, provided by an eligible provider, and provided to a person covered by the insurer.
2. The claim has no material defect or impropriety, including, but not limited to any lack of required substantiating documentation or incorrect coding.
3. There is no dispute regarding the amount claimed.
4. The payer has no reason to believe that the claim was submitted fraudulently or there is no material representation.
5. The claim does not require special treatment or review that would prevent the timely payment of the claim (be sent outside the corporation for external review)
6. The claim does not require coordination of benefits, subrogation or other third-party liability.
7. Full patient name
8. Patient’s date of birth
9. Valid and properly formatted member identification number
10. Complete service level information
   - Date of service
   - Industry standard diagnosis codes
   - Place of service
   - Industry standard procedure codes
   - Charge information and units
   - Service provider’s name, address and valid NPI number
   - Provider Federal tax identification number
   - Billing Provider’s name, address and valid NPI number
11. Only one provider per claim
Non-Complete Claims

Non-complete claims are standard claim forms that do not meet the criteria above and/or may require further investigation beyond the information contained on the claim. Neighborhood may require additional information to process and/or adjudicate the claim including but not limited to, medical necessity review, pricing review, an invoice or operative notes to substantiate payment.

Timely Filing and Non-Complete Claims

Submissions that are rejected back to the provider from Neighborhood are not considered to be clean. The notice of rejection will not serve as proof of timely filing. This applies to all methods of claims submission, including paper and electronic submissions. Any corrected claims must be resubmitted within contractually determined timely filing terms.

Professional and Facility Procedural Coding

Valid procedural coding is required to process professional and facility services. Failure to furnish valid coding may result in payment delays or claim rejection. Codes must be in effect for the date of service.

Professional Coding

CPT Codes
All professional services require valid CPT coding for the date and nature of service.

HCPCS Level II Codes
All pharmacy, DME, and ambulance services require a valid HCPC code for the date and nature of service.

Facility Coding

Revenue Codes
All facility services require a valid four digit revenue code for the date and nature of service.

CPT Codes
All outpatient facility services require a corresponding valid CPT code or HCPC code for reimbursement.

HCPCS Level II Codes
All pharmacy, DME, nursing, home therapy and other applicable charges require a valid HCPC code for the date and nature of service.

DRG Codes
When contractually reimbursed

Revenue codes must crosswalk with any corresponding CPT or HCPC code billed. Neighborhood Health Plan of RI will accept pharmacy, supply, and device charges billed by revenue code only. An invoice may be required; please refer to any individual contractual language.
Diagnosis Coding

Claims submitted to Neighborhood Health Plan of RI will not be processed without a diagnosis code. The following guidelines from CMS bulletin B-03-046 should be followed by all providers in assigning an ICD-9-CM code:

- Assign an ICD-9-CM code that provides the highest degree of accuracy and completeness. In the context of ICD-9-CM coding, the “highest degree of specificity” refers to assigning the most precise ICD-9-CM code that most fully explains the narrative description of the symptom or diagnosis. Concerning the level of specificity, ICD-9-CM codes contain 3, 4, or 5 digits. If a 3-digit code has a 4-digit code that further describes it, then the 3-digit code is not acceptable for claim submission. If a 4-digit code has a 5-digit code that further describes it, then the 4-digit code is not acceptable for claim submission.

- All services billed require a supportive diagnosis on the claim form.

- Diagnoses documented as “probable,” “suspected,” “questionable,” and “rule-out” or “working diagnosis” should not be coded as though they exist in the outpatient or office setting. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit such as signs, symptoms, abnormal test results, exposure to communicable disease, or other reason for the visit. In an inpatient setting, these diagnosis codes may be indicated as the reason for admission.

- Information for laboratories includes the following “Include the ICD-9-CM diagnosis code, as furnished by the physician/practitioner”. And “If a diagnosis or narrative diagnosis is not submitted by the physician/practitioner, laboratories must request this information from the physician/practitioner who ordered the service.”

On the CMS form 1500, providers shall enter the diagnosis code reference number (1, 2, 3, or 4) from the item 21 to relate the date of service and procedures performed to the primary diagnosis listed. Only reference one diagnosis indicator in item 24E, per line of service from the valid diagnosis codes in item 21.

Providers who are submitting claims with improper diagnosis codes may be subject to internal audit. Coders must use the ICD-9-CM coding book that is effective for the date the service was provided. The updated codes are published in the Federal Register in the spring of each year.

Common Facility Bill Types

Valid bill types are required to process facility claims. Failure to furnish a valid bill type for the submission may result in processing delays or claim rejection. Some common bill types are listed below:

Inpatient Bill Types

- 111 Inpatient Hospital
- 112 Interim Inpatient Bill (Initial Claim)
- 113 Interim Inpatient Bill (Continuing Claim)
- 114 Interim Inpatient Bill (Last Claim)
- 115 Inpatient Late Charges
- 117 Replacement Inpatient Claim (corrected claim)
Outpatient Bill Types

- 131 Outpatient Hospital
- 135 Outpatient Late Charge
- 137 Replacement Outpatient Claim (corrected claim)
- 141 Outpatient Hospital- same as 131

Home Health Care Bill Types

- 331 Outpatient Home Health Care
- 332 Outpatient Home Health Care- Interim (Initial Claim)
- 333 Outpatient Home Health Care- Interim (Continuing Claim)
- 334 Outpatient Home Health Care- Interim (Last Claim)
- 337 Outpatient Home Health Care- (Corrected Claim)

Ambulatory Surgical Center Bill Types

- 831 Outpatient Ambulatory Surgical Center
- 835 Outpatient Ambulatory Surgical Center Late Charges
- 837 Outpatient Ambulatory Surgical Center (replacement/corrected claim)
Time Limitations for Claims Submission

Claims must be submitted in accordance with each practitioner’s contract, usually ninety (90) days from the date of service. Each submission must meet the definition of a clean claim. Only clean claims are eligible for timely filing reconsideration.

Behavioral Health Claims

Claims for mental health care / substance abuse services should be submitted to our behavioral health partner – Beacon Health Strategies, LLC at the following address:

Beacon Health Strategies, LLC
Attn: Claims Department
500 Unicorn Park Drive, Suite 401
Woburn, MA 01801-3393
www.beaconhealthstrategies.com

Claims must be received by Beacon within 90 days from the date of service as determined by the date received at Beacon. Electronic claims can be submitted.

Billing Member and Hold Harmless Provisions

In their contract with Neighborhood, practitioners accept the Neighborhood fee schedule and therefore, cannot bill or balance bill members for covered services. Other than allowable co-payments or deductibles, in no event can the practitioner bill, charge or have any recourse against Neighborhood members for services provided by the practitioner under their agreement with Neighborhood.
**Coordination of Benefits**

Coordination of benefits (COB) occurs when a member is covered by more than one health insurance carrier (including medical, dental and vision coverage). Under the Rite Care and Rhody Health Partners Programs, Neighborhood is the payer of last resort. If any member is known to have other insurance coverage, all claims will be denied and reconsidered for payment upon receipt of an Explanation of Benefit (EOB) from the primary insurance carrier. When submitting to Neighborhood for secondary payments, please be aware of the following:

- Claims must be submitted on a valid claim form with the other carrier’s EOB attached.
- The EOB must be legible and all charges and member information must match the claim form.
- Neighborhood will only pay for dollar amounts that the member is deemed liable for on the EOB, up to our allowed fee schedule.
- Neighborhood will only pay as secondary for services that are covered benefits under the plan.

Effective July 1, 2010, contracted providers have ninety (90) days from the date on a primary carrier’s EOB to submit for any secondary balances, unless otherwise dictated by provider contract.

**Third Party Liability**

Third party liability is defined as an injury that may result from the fault or negligence of another party. This may include auto accidents, workman’s compensation, slip and fall injuries, product liability and malpractice. Neighborhood will accept billing for any related medical bills (all benefit plan and contractual coverage provisions apply) and pursue recovery of any charges post payment. Any provider of service who has received reimbursement from a third party (i.e. any liability insurance carrier or attorney) and Neighborhood must reimburse Neighborhood for any payment made on behalf of the member.
Claims Editing Software Overview

Neighborhood Health Plan of RI employs various methods of claims reimbursement editing and auditing of all services billed to ensure appropriate claims adjudication. This includes meeting contractual obligations and compliance with national standards such as the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA). Below is a list of different editing and auditing methods, including, but not limited to:

Claims Reimbursement- Prospective (Pre-Payment) Adjudication

Claims screening software consistently screens for the following (but is not limited to):

- Valid CPT/HCPC coding
- Valid/Missing modifier coding
- Valid age and gender for procedure or diagnosis billed
- Valid diagnosis for procedure billed
- Diagnosis coding to 4th or 5th digit
- Supportive diagnosis coding
- Utilization of non-specified coding
- Unbundling
- Re-bundling of laboratory services
- NCCI edits
- Global, inclusive, mutually exclusive, or fragmented procedures
- Multiple Radiological Procedures, Same Day
- Multiple Visits, Same Day
- Duplicate procedures
- Up-coding
- Potential Fraud and Abuse activity

Unbundling is defined by the Centers for Medicare and Medicaid Services (CMS) as billing separate procedures individually when one more comprehensive code should be reported. Neighborhood Health Plan of RI will deny up-coding of unbundled procedures and replace with a more comprehensive procedure.

Mutually Exclusive Procedures are defined by CMS as services that cannot be performed during the same session due to conflicting descriptor language or medical improbability or impossibility. These edits are based on either the CPT code definition or standards of medical/surgical practice. Code pairs that are billed together and considered mutually exclusive will be reviewed. Generally only the procedure with the lower allowance in the code pair will be paid.
National Correct Coding Initiative Edits (CCI) were developed by CMS in an effort to promote national correct coding methodologies and develop coding practices that avoid inappropriate payment of services. The edits are updated on a quarterly basis based on changes to the procedure codes, changes in technology, and in the standards of medical and surgical practice.

Medically Unlikely Edits (MUEs) were implemented by CMS as of January 1, 2007 and are effective as of October 1, 2008. These edits are based on codes that would not likely be performed in more than certain quantities as defined by CMS.

Separate Procedures are CPT® procedure codes that include a designation “separate procedure”. The codes that are deemed “separate procedures” will not be considered for payment when billed with a code for the total procedure of which it is considered a component. The inclusion of “separate procedure” within the procedure code description is used to describe a procedure that should not be reported in addition to a total procedure or service. If a procedure that is described as a “separate procedure” is performed independently and not related to another procedure or service, such as in a separate session, separate site, or different organ system, it may be considered for payment. The addition of appropriate modifiers, diagnosis codes, and operative reports may indicate that the “separate procedure” has been performed as an independent procedure. If the information included with the claim is not sufficient to make a determination, a request for complete notes will be made.

Examples of services screened and adjudicated per the standards above include, but are not limited to, the following in combinations:

- Evaluation and management services billed with dialysis, audiology, allergy and immunology services
- Denial of payment for other procedures which are included in Evaluation and Management procedures as defined by AMA billing standards and/or CMS guidelines
- Exploratory surgery billed with more extensive surgical procedures
- Separate components of surgical services when a more comprehensive code is available
- Evaluation and management services billed with injections or immunizations
- Pathology Services
- Radiological Services
- Respiratory Services
- Urological Services
- Consultation Services

Notes and an appended modifier are required to consider denied charges for separate payment consideration. Please see the “Reconsiderations” section of this manual for further instruction on how to submit documentation for further review.
Services denied based on NCCI edits or MUE edits cannot be billed to Neighborhood Health Plan of RI members. These denials are based on incorrect coding and cannot be billed to the member.

For detailed information regarding any of the above edits, please contact Customer Service at 401-459-6020. Please have your Remittance Advice in hand so we may assist you with claim specific denials.
**Claims Auditing Overview**

Neighborhood employs various review methods to audit and verify provider compliance including but not limited to, industry standard coding, adequate medical note documentation, contractual provisions and authentication of charges billed. Audits may be performed pre or post payment. These audits are conducted by Neighborhood staff members who are professionally certified with various designations earned through the American Academy of Professional Coders (AAPC) and other industry training and certification forums. All medical information will be kept in the strictest of confidence. A separate patient authorization will only be required or obtained when required by law.

**Requests for Medical Records for Payment Review or Audit**

- Requests for medical records and/or audits may be performed on site or requested via regular mail and/or a Remittance Advice (explanation of benefits)
- The frequency of audits vary from pre payment, post payment, quarterly, semi-annually to annually
- For retrospective audits, a pre-determined sample size based on claims submission volume will be requested and reviewed
- Any on site audit will be scheduled at least thirty days prior to the review
- Results will be communicated, in writing, within thirty days post review

Generally, retrospective claims audits will not exceed one year from the original payment date. Some exceptions include:

- Fraud and Abuse Investigations – there is no time limitation for retrospective review
- Retroactive Membership and/or Termination
- Coordination of Benefits exceptions
- Third party liability activity
- Any claims activity resulting from legal activity not otherwise defined.

*Neighborhood Health Plan of RI uses the 1997 Documentation Guidelines for Evaluation and Management Services standards when performing reviews on professional services.*

**Provider Audits (On Site or Otherwise)**

A written request for the audit will be sent to the business office manager or designated hospital representative thirty days (30) prior to the audit date. The audit will be scheduled at a mutually convenient time for all parties. The provider/hospital agrees not to cancel previously scheduled audits without fifteen (15) days advance notice in writing to the Claims Quality and Audit Manager.
The number of medical records to be reviewed will be determined by Neighborhood based on standard audit sampling calculation. Neighborhood may choose to supply a predetermined list of records to be reviewed or a random sampling at the time of the site visit. The provider/hospital will not restrict the number of records to be made available for audit. Any medical records and corresponding documentation will be furnished to the auditor. Neighborhood has the right to review and copy audit related records upon request. Neighborhood will not reimburse for any fees related to audit or record review activity.

Unless otherwise stipulated by contract, Neighborhood will provide written audit findings (and corrective action required, if applicable) to the provider/hospital within 30 days of the record review. Providers/hospitals have the right to discuss or dispute these findings within 30 days of receipt of Neighborhood’s findings. Audit discrepancies will be retracted via the provider’s remittance advice if no contrary supporting documentation is received within 30 days of Neighborhood’s audit findings.
Reconsideration Process

• A review of claims payment decision as a result of a provider/practitioner request.

Policy:

• A provider may resubmit the claim, with any applicable revisions (including appended modifiers) and complete notes attached, if applicable, for reconsideration. Providers have 180 to 365 days from the date of service (depending on individual contractual terms) from the date of the original denial to resubmit for further consideration.

• Please allow 30 days for a reconsideration to be processed.

• Provider will be notified in writing of any upheld denial.

• If a reconsidered claim denial is upheld, the provider may pursue the matter through Neighborhood’s appeals process. All providers have one year from the original remittance advice to appeal a claim.

Please submit all reconsideration requests, with supporting documentation to:

Neighborhood Health Plan of RI
Attention: Claims Quality and Audit
299 Promenade Street
Providence, RI 02908
Fax: 401-459-6188
E-Fax: 401-709-7110
Administrative Appeals

Administrative appeals are defined as a request to appeal the decision outcome of your reconsideration request, denial of authorization, and denial of late claims.

To qualify as an appeal, appeals directed to Neighborhood must include a cover letter on practice letterhead, the Claims Review Process and Submission Form, with a hard copy of the denied claim, remittance advice, or any other supporting documentation attached. All administrative appeals for retroactive authorizations must be submitted with a copy of the medical record in order to be processed. As of appeal receipt date 7/1/2010, any request for retroactive authorizations greater than 3 business days from date service rendered will be denied.

Please direct formal appeals in writing to:

Appeals Coordinator
Neighborhood Health Plan of Rhode Island
299 Promenade Street
Providence, RI 02908

Practitioners are entitled to two levels of internal appeal. If the practitioner is not satisfied with the decision of the first level appeal (Level I Appeal), the practitioner may appeal again (Level II Appeal). Level II Appeals should include any additional documentation not supplied in the Level I Appeal for consideration. Decisions are made according to the following timelines:

• Written acknowledgement of your appeal will be sent within five (5) days.
• The outcome of the appeal will be determined within thirty (30) days of receipt of the initial request.
• Practitioners will be notified in advance if a determination will require more than thirty (30) days, requiring an extension. The extension for a determination will not exceed fifteen (15) days.
• A notification letter which includes the appeal determination and the rights of the provider for further appeal will be sent within one day of the determination.
• All claim appeals must be received within 365 days of the initial remittance advice. Any request received over 365 days from the date of the initial remittance advice will be denied.

An appeal may require additional time for processing in the event additional documentation is needed. The timelines above do not apply until all required documentation is received.
NEIGHBORHOOD HEALTH PLAN OF RHODE ISLAND
Claims Post Payment or Denial Review Process and Submission Form

To inquire about the outcome of a claim, please submit a Post Payment or Denial Review Request. To dispute the outcome of a claim, please file an Administrative Appeal with any supportive documentation. An Administrative Appeal should not be filed without submitting a Post Payment or Denial Review Request first.

THIS FORM AND ACCOMPANYING DOCUMENTATION SHOULD BE MAILED TO:

NHPRI, ATTN: CLAIMS QUALITY AND AUDIT, 299 PROMENADE STREET, PROVIDENCE RI 02980

Check the box below that applies to this request- see reference grid below for assistance:

Post Payment or Denial Review: _
Administrative Appeal*: _

Please complete the required information below.

Provider Name: _______________________
Provider Address: _______________________
Contact Name: _______________________
Contact Phone: _______________________
Contact Email (optional): _______________________

Claim Information:
Date of Service: _______________________
Member Name: _______________________
Member ID Number: _______________________
Claim Number: _______________________

Description of request:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Important Footnotes:

*If medical notes are required and not included, provider correspondence will be returned. Any subsequent resubmission with additional required information does not extend any applicable filing limit terms. Please note: If a medical necessity denial was rendered by a Physician Reviewer, please refer to the Provider Manual, Authorization Process/Medical Management – Adverse Determination (Denials) and Appeals for direction.
Please use this grid as a guide in determining the correct category for your request. A service must be processed and denied on a remittance advice by NHPI to be considered an appeal (with the exception of retroactive authorization requests). An Administrative Appeal should not be filed without submitting a Post Payment or Denial Review Request first.

<table>
<thead>
<tr>
<th>Denial Reason</th>
<th>Request Type</th>
<th>Required Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Reimbursement for Service Performed</td>
<td>Post Payment or Denial Review</td>
<td>Medical notes supporting reimbursement and appropriate modifier are required for reconsideration.</td>
</tr>
<tr>
<td>Authorization Denials/Retroactive Authorization Requests</td>
<td>Administrative Appeal</td>
<td>For requests over three (3) business days from date of service, must meet qualifying exception criteria for retrospective review and must include medical notes.</td>
</tr>
<tr>
<td>Bundled Procedure Denials</td>
<td>Post Payment or Denial Review</td>
<td>Medical notes supporting reimbursement and appropriate modifier are required for reconsideration.</td>
</tr>
<tr>
<td>CCI Denials</td>
<td>Post Payment or Denial Review</td>
<td>Medical notes supporting reimbursement and appropriate modifier are required for reconsideration.</td>
</tr>
<tr>
<td>Gender/Age Denials</td>
<td>Post Payment or Denial Review</td>
<td>Corrected claim or medical notes are required for reconsideration.</td>
</tr>
<tr>
<td>Incorrect Payment or Denial Per Contract (Overpayments or Underpayments)</td>
<td>Post Payment or Denial Review</td>
<td>Request form with description of issue required for review.</td>
</tr>
<tr>
<td>Invalid/Medically Unlikely Units</td>
<td>Post Payment or Denial Review</td>
<td>Medical notes are required for reconsideration.</td>
</tr>
<tr>
<td>Late Claim Denials</td>
<td>Administrative Appeal</td>
<td>Claim form and proof of timely clean claim submission within contracted time frame is required (i.e., copy of NHPI EDI claim acceptance report) as well as any other supportive documentation.</td>
</tr>
<tr>
<td>Obstetrical Global Denials</td>
<td>Post Payment or Denial Review</td>
<td>Medical notes supporting reimbursement and appropriate modifier are required for reconsideration.</td>
</tr>
<tr>
<td>Procedure/ Diagnosis Denials</td>
<td>Post Payment or Denial Review</td>
<td>Corrected claim or medical notes are required for reconsideration.</td>
</tr>
<tr>
<td>NOCP Denials</td>
<td>Post Payment or Denial Review</td>
<td>Copy of site change request form for date of service rendered.</td>
</tr>
<tr>
<td>Rejected Claims</td>
<td>Corrected Claim</td>
<td>Corrected claim form and proof of timely clean claim submission within contracted time frame is required (i.e., copy of NHPI EDI claim acceptance report).</td>
</tr>
<tr>
<td>Surgical Global Denials</td>
<td>Post Payment or Denial Review</td>
<td>Medical notes supporting reimbursement and appropriate modifier are required for reconsideration.</td>
</tr>
<tr>
<td>Unlisted Procedure Denial</td>
<td>Post Payment or Denial Review</td>
<td>Medical notes are required for reconsideration.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Claim and Additional Documentation/Review Request Submission Guidelines</th>
<th>Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Clean Claim Submission</td>
<td>Within timely filing terms defined per contract (i.e., 90 days unless otherwise noted in contract)</td>
</tr>
<tr>
<td>Rejected claim submission (claim denied for missing, invalid or incomplete information required to successfully process claim in our transactional system)</td>
<td>Practitioners should make every effort to submit within 365 days of NHPI’s rejection</td>
</tr>
<tr>
<td>Post Payment or Denial Review Request (i.e., provider submission of notes to request additional reimbursement, over or underpayment of claim, corrected claims resulting from claim edit denials)</td>
<td><strong>Within 365 days of initial remittance advice date</strong></td>
</tr>
<tr>
<td>Requests for patient record or additional information requested by NHPI for claim adjudication</td>
<td>Practitioners should make every effort to submit within 365 days of NHPI’s request for additional information</td>
</tr>
<tr>
<td>Appeal of accurately adjudicated claim</td>
<td>Within 365 days of initial remittance advice date</td>
</tr>
</tbody>
</table>
Fraud and Abuse

Neighborhood recognizes that fraud and abuse has a high impact upon the health care industry. In our efforts to combat fraud and abuse as a partner in health care, we are committed to building and maintaining a proactive program that detects and prevents fraud and abuse while complying with our obligations under federal and state laws, as well as our Medicaid contractual responsibilities.

How do we define “Fraud and Abuse”?  

Fraud: Fraud is defined an intentional deception or misrepresentation done by an individual with the knowledge that it will result in an unauthorized benefit to themselves or others.

Abuse: Abuse is defined as a practice that is inconsistent with sound fiscal, business, or medical practices that result in an unnecessary cost to the Medicaid program, or in reimbursement from services that are not medically necessary or fail to meet professionally recognized standards for health care.

The following are common examples we recognize as fraud and abuse by providers:

- Billing for services that were not rendered
- Misrepresenting the diagnosis to justify the services
- Altering claims forms to receive a higher level of payment or circumvent a denial
- Soliciting, offering, or receiving a kickback for referral of patients in exchange for other services
- Concealing ownership of related companies (i.e., the physician also owns the radiological service)
- Deliberate duplicate billing to more than one payor source
- Unbundled or exploded charges in which the provider bills for components of a procedure instead of using a comprehensive code
- Providing Certificates of Medical Necessity for members ineligible
- Falsifying plans of treatment or medical records
- Misrepresenting the services provided or the person receiving the care
- Billing for non-covered benefits by using a different diagnoses
- Billing services provided on one date over a period of
- Gang visit billing at a skilled nursing facility or other group domicile for members that did not receive any care
- Excessive charges for services or supplies
- Claims for services that are not medically necessary
- Over-utilization of medical or health care services
- Underutilization of services
- Solicitation for payment for covered services outside of co-payment amounts
- Duplicate billing defined as repetitive billing less than 30 days from original submission date and/or after a claim has already been adjudicated and finalized
The following are common examples we recognize as fraud and abuse by members:

- Excessive use or overuse of benefits
- Using another individual’s benefits card or information
- Lending, altering or duplicating a benefit card or information
- Altering or forging prescriptions
- Providing incorrect eligibility information to obtain services
- Simultaneously receiving benefits in Rhode Island and other states
- Knowingly assisting providers in furnishing services to defraud Medicaid

If you suspect fraud and abuse, you can report it several ways, including anonymously if you want on our 24 hour hotline, 1-800-826-6762, or you can contact your provider services representative or our Managed Care Regulation Manager at 1-401-459-6000. Remember, we need your help to put a stop to fraud and abuse.

Neighborhood reserves the right to perform any retroactive claim dollar retractions resulting from fraud and abuse as dictated by the False Claims Act. There is no statute of limitations to recovering funds associated with fraudulent billing.
Contact Us

Claims Inquiries by Telephone:

Customer Service 401-459-6020

Claims Inquiries by the Web:

Navinet www.NaviNet.net

Claims Corrections and Resubmissions via Fax:

Claims Production Department 401-459-6146 or 401-709-7028 (e-fax)

Claims Adjustments and Appeals requests via Fax:

Claims Quality and Audit 401-459-6188 or 401-709-7111 (e-fax)

Claims Reconsiderations (Review of medical notes) via Fax:

Claims Quality and Audit 401-459-6188 or 401-709-7110 (e-fax)

Claims and Correspondence Via regular mail at:

Neighborhood Health Plan of Rhode Island
299 Promenade Street
Providence, RI 02908
Section 4

Benefits

- Benefits Information
- Behavioral Health Services
- Transportation Benefits
- Interpreter Services
- Member Education Services
# Benefits Information

The following are covered services available to Neighborhood members. For additional detail, please refer to the medical coverage policies at nhpri.org/administrative/resources.

<table>
<thead>
<tr>
<th>Service Category Name</th>
<th>Service Type</th>
<th>Rite Care</th>
<th>Sub Care</th>
<th>CSN</th>
<th>RHP</th>
<th>Extended Family Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Services Inpatient</td>
<td>Behavioral Health Services Inpatient</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>Inpatient behavioral health hospital care, day treatment, partial hospitalization, some residential treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Residential Treatment (ARTS) BH</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>Behavioral Health Inpatient</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>Crisis Stabilization</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>Day Treatment</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>Substance Abuse Treatment Inpatient</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>Outpatient Behavioral Health Services</td>
<td>Behavioral Health Services Outpatient</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>Outpatient behavioral health care services with mental health providers</td>
<td>Behavioral Health Care Outpatient</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>Diversionsary Outpatient</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>Enhanced Outpatient Services (inclusive of CAITS)</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>Methadone Maintenance Treatment Outpatient</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>Substance Abuse Treatment Outpatient</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>Cancer Treatment Experimental</td>
<td>Cancer Treatment Experimental</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>Experimental cancer treatment for members when medical necessary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childrens Care</td>
<td>Childrens Care</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Routine and medically necessary care for children from birth up to age 21</td>
<td>Early Intervention Program (EIP)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Follow Up Care-speciality visits, assessments and therapy (EPSDT)</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Psychological Testing Children</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Routine Doctor Visits for children (&lt;21) (EPSDT)</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Fluoride Varnish</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Prenatal Pediatrician Visit</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Newborn Services</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Childrens Preventive Care</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Pediatric Development and Autism Screening</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Circumcision Newborn in Hospital</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>School Based Clinics</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Consultation Services</td>
<td>Consultation Services</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>A physician’s formal opinion for another physician’s patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dialysis (Outpatient)</td>
<td>Dialysis Services</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>Services for end stage renal failure</td>
<td>Outpatient Dialysis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>DME</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>Durable medical equipment and supplies that are medically necessary and may be rented or purchased</td>
<td>Medical and Surgical Supplies</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>Medical and Surgical Supplies Auth Required</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>Diabetic Shoes</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>Wigs</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>Other DME Services</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>Emergency Services</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>Emergency services in and out of state</td>
<td>Emergency Room Care</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>Transportation</td>
<td>Transportation</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>Ambulance Stretcher Emergency Transportation</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>Ambulance Stretcher Non Emergency Transportation-Auth Required</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>Ambulance Non Emvency Transportation (Wheelchair Van) Auth Required</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Family Planning</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Women’s Care for family planning and reproductive health; women can choose any in-network provider for family planning services.</td>
<td>Gyn annual exam (comprehensive) EFP annually</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>X</td>
</tr>
<tr>
<td>Gyn annual exam (comprehensive) annually</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>Gyn family planning visits-5 per year</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>Gyn family planning visits-EFP 5 per year</td>
<td></td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>X</td>
</tr>
<tr>
<td>Sterilization</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>Sterilization-EFP</td>
<td></td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>X</td>
</tr>
<tr>
<td>Service Category Name</td>
<td>Service Type</td>
<td>Rite Care</td>
<td>Sub Care</td>
<td>CSN</td>
<td>RHP</td>
<td>Extended Family Planning</td>
</tr>
<tr>
<td>----------------------------------------------------------------</td>
<td>----------------------------</td>
<td>-----------</td>
<td>----------</td>
<td>-----</td>
<td>-----</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Home Health Care Services</td>
<td>Home Health Care</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td><strong>Home health care services, including skilled nursing</strong></td>
<td><strong>services, personal care services and rehab when medically necessary</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Care Social Work Services</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Home Health Care IV Infusions</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Services</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Personal Care Services</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Rehab Services Through HHC</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Maternity care services (Early Maternity Discharge)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Hospice Services</td>
<td>Hospice Services</td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Health care services for the members who are end stage or</td>
<td><strong>terminally ill</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice Care-Inpatient</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Hospice Care-Outpatient</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Hospital Services Inpatient</td>
<td>Hospital Services Inpatient</td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Dialysis (Inpatient)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td><strong>Initial hospital care; subsequent hospital care; inpatient</strong></td>
<td><strong>consultations; critical care; room &amp; board</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity Services Inpatient</td>
<td>Hospital Services Inpatient</td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>- Vaginal Delivery</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>- Cesarean Delivery</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>- Nursery Room</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>- Medical Services Inpatient</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>- NICU</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>- ECMO (Extracorporeal Membrane Oxygenation)</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Critical Care</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Surgical Services Inpatient</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Gastric Bypass Surgery</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Hospital Services Outpatient</td>
<td>Hospital Services Outpatient</td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Hospital Outpatient diagnostic, therapeutic and surgical</td>
<td><strong>services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Outpatient Diagnostic</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>- Amniocentesis</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Hospital Outpatient Surgical Service</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Abortion Conditionally Covered</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Hospital Outpatient Therapeutic</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>- Chemotherapy</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>- Wound Care Centers</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Interpreter services</td>
<td>Interpretation</td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Interpretation services when medically necessary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory &amp; Pathology</td>
<td>Laboratory Services</td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Laboratory testing inpatient or outpatient</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory Tests</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Laboratory Tests-EFP</td>
<td></td>
<td>O</td>
<td>O</td>
<td></td>
<td>O</td>
<td>X</td>
</tr>
<tr>
<td>Genetic Testing</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Home Blood Draws</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Laboratory Tests-EFP</td>
<td></td>
<td>O</td>
<td>O</td>
<td></td>
<td>O</td>
<td>X</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>Oral Surgery</td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Oral Surgery limited per contract</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Pain Management</td>
<td>Pain Management Services</td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Pain Management services medically necessary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Education Services</td>
<td>Patient Education Services</td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Patient education for health or health-related issues</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma Education</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Diabetic Education Classes</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Nutritional Classes</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Childbirth Education</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Parenting Classes</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Smoking Cessation Services</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Weight Management Programs</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td></td>
</tr>
<tr>
<td>Physician Services</td>
<td>Physician Services</td>
<td>X</td>
<td>X</td>
<td></td>
<td>O</td>
<td>X</td>
</tr>
<tr>
<td>Service Category Name</td>
<td>Service Type</td>
<td>RLte Care</td>
<td>Sub Care</td>
<td>CSN</td>
<td>RHP</td>
<td>Extended Family Planning</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>-----------</td>
<td>----------</td>
<td>-----</td>
<td>-----</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Office visits (office or clinic) to a doctor or health care practitioner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visits Primary Care</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Immunizations and Vaccines</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Office Visits EFP</td>
<td></td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Office Visits Specialty Care</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Psychological Testing Adult</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Office Visits Prenatal and Post Partum</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prescriptions</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Medications prescribed by a health plan physician or health care practitioner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs (Contraceptives)</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Drugs (Contraceptives) EFP</td>
<td></td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Drugs Injectable &amp; Infusion No Auth</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Drugs Auth Required</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Drugs Other Oral Inhalant &amp; Topical</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Chemotherapy</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Immune Globulins</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Pharmaceutical Miscellaneous (NDC Required)</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td><strong>Radiology Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Radiology services inpatient or outpatient</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiology No Auth Required</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Radiology Services Auth Required</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Bone Density Scans</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Screening Mammography-1 per 11 rolling months, female member, age 35 or older</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Stereotactic Radiation Surgery &amp; Therapy-Gamma Knife Cyber Knife</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Radiology Oncology Therapy</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Radiology Interventional</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td><strong>Rehabilitative Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Rehab services inpatient and outpatient</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rehabilitation Services Inpatient</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Rehabilitative Services-Occupational Therapy</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Rehabilitative Services-Physical Therapy</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Rehabilitative Services-Speech Therapy</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Rehabilitative Services-Cardiac</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Rehabilitative Services-Pulmonary Home</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Facility Care</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Care rendered at a skilled nursing home or in a skilled nursing bed when medically necessary and ordered by a health plan physician</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transplant Services</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Most organ transplant services covered when ordered by a health plan physician</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision Care</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td><strong>Vision Care (optometry) services, eyeglasses and frames</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye Exam Routine</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Eye Exam Diabetic</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Eye Exam Medically Necessary</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Eyewear (Routine Fitting)</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Eyewear (Fitting of Contact Lenses)</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Lenses Routine</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Lenses Medically Necessary</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Contact Lenses Auth Required</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Frames</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Ophthalmological Services Special</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

**LEGEND:**

X: LOB has the benefit
O: Not a benefit for the LOB
Behavioral Health Services

Neighborhood Health Plan of Rhode Island (Neighborhood) partners with Beacon Health Strategies, LLC (Beacon) to improve the behavioral health and wellbeing of our members. Beacon shares Neighborhood’s mission to work collaboratively with providers to ensure our members receive the right behavioral health care, at the right time, in the right place.

Neighborhood and Beacon share an expertise in serving at risk populations. Beacon’s experience allows for tailored behavioral health services to meet the clinical, demographic, and cultural needs of our members and behavioral health providers. As a fully accredited managed behavioral health care organization, Beacon meets the rigorous standards of Utilization Review Accreditation Commission (URAC) and the National Committee for Quality Assurance (NCQA).

Many of Beacon’s clinical and administrative staff are on-site at the Neighborhood office on 299 Promenade Street. This includes behavioral health care managers. Beacon’s case management program is a voluntary program to assist members and/or their families with behavioral health needs. This unique integrated model allows for efficiency in serving the medical and behavioral health provider community as well as meeting both the clinical and behavioral health needs of our membership. Beacon’s clinical staff works closely with Neighborhood’s to collaborate and coordinate member care.

Neighborhood and Beacon make every effort to create a system of care which eliminates barriers for providers and members. Prior authorization for outpatient behavioral health visits is not needed for a member’s first 12 visits. Members can self refer to a behavioral health provider. Primary Care Physicians and Specialists can also refer Neighborhood members to a behavioral health provider without obtaining prior authorization. Local Beacon representatives can provide assistance to members, Primary Care Physicians and Specialists in obtaining referrals if needed. All members have access to urgent, inpatient, diversionary and outpatient behavioral health care.

Neighborhood will reimburse for some behavioral health services when rendered by a Primary Care Physician.

To promote clinical integration of medical and behavioral health, Neighborhood and Beacon support both integrated and co-located practice models. Co-located and integrated practice models provide our members better access to treatment. Both models also enable more effective coordination of care and communication between medical and behavioral health providers. In addition, Neighborhood and Beacon worked collaboratively with the other insurers in the state to develop a PCP/BH communication sheet which is available on the Beacon website (www.beaconhealthstrategies.com), and in Section 10 of this manual.

If you are a provider interested in co-locating a behavioral health provider at your practice or want to explore opportunities in creating an integrated medical/behavioral health practice model, please call 1-401 459-6697. If you are a provider and need assistance in making a behavioral health referral or you wish to speak with a behavioral health case manager, please call Beacon at 1-800-215-0058.
Interpreter Services

Neighborhood offers on-site interpreter services to assist RIte Care members who speak languages other than English. To use this service, we request that our practitioners/practices or members contact us at least seventy-two (72) hours prior to the date of service when interpreter services are required to ensure that an interpreter is available. Please contact us two (2) weeks prior to the date of service for sign language services.

Required information necessary when requesting services includes:

- Member ID number, member name, date of birth, home address, and contact number.
- Name of the practitioner/practice requesting services and the practice phone number.
- Place of service where interpreter services will be required, including provider name, phone number, and address (with suite, floor number, or special directions as necessary)
- Preferred gender of the interpreter
- Requested language
- Correct date and time of service

For your convenience, a copy of the RIte Care Interpreter Services Fax Request Form is available in Section 10. This form may be completed and faxed to Neighborhood Customer Service at 1-401-459-6021. Practitioners may also request interpreter services by contacting Neighborhood Customer Service at 1-401-459-6020 or 1-800-459-6019.

Important Reminder
If a member cancels an appointment with your office during which an interpreter had been scheduled to attend, Neighborhood encourages you to contact us so that we may cancel and/or reschedule interpreter services as necessary. Please contact Neighborhood Customer Service at 1-401-459-6020 or 1-800-459-6019.
RIte Care Transportation for Medical Appointments

Both RIte Care and RHP members are eligible for transportation to and from their medical appointments. Many members have bus passes provided to them, but in some instances transportation by bus would either not be feasible or convenient. In these situations, Neighborhood Customer Service will arrange for taxi or van transportation. To qualify for this type of transportation, the following criteria must be met:

- A member cannot ride the bus because of a medical condition
- The member lives more than one-half mile away from a bus stop or the doctor’s office and the member does not have any other way of getting to their medical appointment.

RIPTA Bus Transportation:

Bus transportation is a benefit available to RIte Care members. Neighborhood members are eligible to receive a free RIPTA bus pass for themselves and each of their children.

**Steps to receive and use RIPTA monthly bus pass:**

1. Visit the Customer Service Desk of any Rhode Island Stop & Shop or Shaw’s supermarket.
2. Show your Rhode Island Medical Assistance card. This is the card with the white anchor on it.
3. Show your children’s Rhode Island Medical Assistance card(s).
4. Present your RIPTA bus pass and your children’s bus passes when boarding a RIPTA bus.
5. Return to Stop & Shop or Shaw’s supermarket on or near the 25th of each month to receive your bus pass for the next month.

Most RIte Care and RIte Share members who need non-emergency medical transportation will be eligible to receive a “Rhody Ten” ride pass. This will provide each eligible member up to 10 one-way bus rides per month to meet their non-emergency medical transportation needs. These passes will be available at Stop and Shop and Shaw’s supermarkets throughout the state.

Families who receive cash assistance (FIP) or have recently transitioned off of cash assistance will continue to be eligible for an unlimited monthly bus pass to be used for work, training, school or medical appointments. Families must present each member’s white Medical Assistance card at the supermarket customer service desk in order to receive the Rhody Ten ride pass or the unlimited monthly RIPTA bus pass.

**Taxi/Van Transportation:**

Neighborhood will provide taxi/van transportation to medical appointments scheduled at a doctor’s office or health center when:

- A member cannot ride the bus because of a medical condition
- The member lives more than one-half mile away from a bus stop or the doctor’s office and the member does not have any other way of getting to their medical appointment.
Transportation for Scheduled Doctor Appointments:

To arrange taxi or van transportation for appointments scheduled in advance, members must contact Neighborhood Customer Service at 1-800-459-6019 or 1-401-459-6020 at least twenty-four (24) to forty-eight (48) hours before their doctor’s appointment. Neighborhood offers taxi transportation only for certain types of appointments, only when a doctor submits an authorization form which identifies a medical condition, or if they live one-half mile away from a bus stop and the doctor’s office. Members should contact Neighborhood Customer Service to understand whether the transportation they need will be covered.

Transportation for Emergency or Urgent Doctor Appointments:

Neighborhood can assist members schedule same day transportation to a doctor’s office only for urgent or emergency visits. If a member requires urgent transportation to their doctor’s office, they should contact Neighborhood Customer Service at 1-800-459-6019 or 1-401-459-6020 immediately for assistance in getting a ride.

Important Reminder
Members are required to contact Neighborhood at 1-800-459-6019 or 1-401-459-6020 if there are any changes in their appointment that will impact a transportation that has been arranged.
Member Education Services

Neighborhood Customer Service is readily available to assist with member education and outreach to ensure that both our members’ and providers’ needs are being met.

Following are some of the instances where member education may benefit our members and your practice:

- Assisting and explaining member site changes and PCP assignment
- Appropriate use of the Emergency Room and/or specialty practitioners
- Review of Neighborhood benefits
- Assistance with transportation requests
- Failure to keep scheduled appointments

Providers should contact Neighborhood Customer Service in the event a member appears to require re-education on Neighborhood benefits, policies, and procedures. Representatives from Neighborhood Customer Service will attempt to contact the member via telephone or mail in the effort to re-educate and assist them. Providers may also fax the Member Education Request Form, found in Section 10, to Neighborhood Customer Service at 1-401-459-6021.
Section 5

Authorization Process/Medical Management

- Medical Management
- Prior Authorization Process
- Emergency and Urgent Care Services
- Post Stabilization
- Late or Retroactive Authorizations
- Requesting Services from a Non-Participating Provider
- Coordination of Benefits
- Medical Necessity Review
- Medical Necessity Decision Criteria
- Adverse Determination (Denial) and Appeals
- Case and Disease Management
- Breathe Easy Asthma Program
- Control for Life Diabetes Program
- Take a Breath for Members COPD
- Don't Skip a Beat Program
- Bright Start Program
- Healthy Heart Program
Medical Management

Purpose
The goal of Neighborhood’s Medical Management Department is to ensure positive patient outcomes by addressing and supporting members’ medical and social needs in the most cost effective and efficient way. The department is designed into three functional arms.

The Utilization and Clinical Policy area is designed to ensure timely, accessible, coordinated care for members. This area ensures that medically necessary utilization occurs in the most appropriate care setting within the benefit plan through the use of approved clinical protocols and guidelines.

The Case Management area offers programs that focus on assessment and coordination of members’ care along the health care continuum to maximize positive outcomes and to provide quality, member-focused, cost effective care. The case management program is a comprehensive, collaborative design that supports the unique needs of our members by encouraging self management, working with providers and collaborating with other members of the clinical team, such as behavioral health and pharmacy.

The Clinical Programs area drives the Disease Management programs and Health & Wellness activities to enable and empower members with chronic conditions to live active, healthy lives, confident in their abilities to manage their condition(s). These programs apply a multi-disciplinary, continuum-based approach to health care delivery that focuses on the identification of populations with established medical conditions. Built on evidence-based practice guidelines, the Disease Management programs are designed to reinforce and support practitioners’ care treatment plans through member outreach and education focused on self-management, ongoing monitoring, continuous evaluation, and management.

Utilization and Clinical Medical Policy
A Neighborhood team comprised of physicians, nurses, clinical coordinators and other clinical staff works in collaboration with the member’s practitioner(s) to ensure that the services requested are medically necessary and also not over- or under-utilized. On an annual basis, the physicians and nurses evaluate clinical criteria used for decision making, and through training and consultation with external clinical specialists, ensure the clinical criteria available is appropriate and specific for our membership. The Neighborhood team also works with the member’s practitioners to facilitate coordination of services and identifies “high risk” members that may benefit from case management. The team members are not compensated for denying covered services.
Prior Authorization Process

How to Reach Medical Management

- A telephone answering system and fax line are available to members and practitioners both during and outside of normal business hours for inbound communications and access to Neighborhood’s Medical Management Department twenty-four (24) hours a day, seven (7) days a week.
- Department staff are physically available from 8:30am – 5:00pm during normal business hours to receive inbound communication and conduct outbound communication via telephone, 1-401-459-6060; e-mail; and fax, 1-401-459-6023.
- A phone messaging system is in place for requests/inquiries outside of business hours. These requests are processed the next business day. The telephone number is 1-401-459-6060 or 1-800-264-3955.
- Medical Management Department staff communicates with members and practitioners about the following utilization topics:
  - Inquiries about utilization management policies and procedures
  - Requests for prior authorization
  - Inquiries about the status of an existing authorization
  - Requests for additional information needed for medical review decision-making
  - Requests for copies of the clinical criteria used to make a decision
  - Notification of inpatient admissions or other services requiring prior authorization
  - Other utilization management inquiries or requests.

How to Obtain Authorization

Neighborhood will issue authorization tracking numbers to the requesting practitioner/provider. This may be the referring practitioner or the treating practitioner/provider. The “authorization” is contingent upon the member’s eligibility and benefits in Neighborhood at the time services are rendered, and, if applicable, medical review determination regarding level of care.

- The following information is required for Neighborhood to issue an authorization for services:
  - Member’s identification number, and/or other identifiers
  - Ordering practitioner
  - Practitioner, hospital clinic, or ancillary provider who is to provide the service
  - Dates of Services
  - Principle diagnosis
  - Services or level of care requested
  - Is there a third party liability or COB (e.g. other insurance, workers compensation, MVA)
• Requests for authorization numbers may be faxed directly to Medical Management (MM). The fax number is 1-401-459-6023.

• Requests for authorization may also be mailed to Neighborhood:
  Neighborhood Health Plan of Rhode Island
  Medical Management Department
  Attn: Utilization and Clinical Medical Policy
  299 Promenade Street
  Providence, RI 02908

NOTE: Forms that you need can be found on the website location
Providers -> Administrative Resources -> Provider Forms -> MM Request Forms

A Word about Prior Authorization Requirements
Neighborhood’s “Authorization Quick Reference Guide,” which summarizes which services require authorization, is available on our website at www.nhpri.org at For Providers > Administrative Resources > Prior Authorization Information.

Authorizations are to be obtained prior to the date of service or admission. In order to allow sufficient time for a thorough medical review of the request, the expectation is that authorization requests for scheduled services will be received at least 3 business days prior to scheduled date of service, and include required medical necessity documentation.

Authorizations for unscheduled, emergent services that cannot be requested in advance or during normal business hours should be requested within 1 business day of the initiation of the service.

Neighborhood will only accept retroactive requests up to three business days after the date the service is rendered or the date of admission (i.e. by the end of the third business day following).

Any service requested greater than three business days after the date the service is rendered will not be considered and claims for those services will be administratively denied for lack of authorization.

Provider Notification of Decisions
Neighborhood’s average turnaround time for decisions is 3-4 days. The authorization is communicated via fax. Any adverse decisions will be communicated by phone with a letter to follow which includes our member’s appeal rights.
Emergency and Urgent Care Services

Neighborhood does not require prior authorization for emergency services rendered to eligible members.

**Emergency services** means covered inpatient and outpatient services that are as follows:

- Furnished by a provider that is qualified to furnish these services under this title, and
- Necessary to evaluate or stabilize an emergency medical condition.

**An emergency medical condition** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

**Urgent care services are covered in-network.**

**Out of network services for urgent medical conditions are covered when the services are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition:**

- A member is temporarily out of the plan's service area, or
- The plan's provider network is temporarily unavailable or inaccessible, or
- It was not reasonable given the circumstances to obtain the services through the members primary physician

**An urgent medical condition** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of medical attention within twenty-four (24) hours could reasonably be expected to result in

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.
Post-Stabilization

Post-Stabilization Care Services means services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition.

The attending emergency physician, or the provider actually treating the member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge.
**Late or Retroactive Authorizations**

Retroactive Authorization Policy has been modified, effective July 1, 2010. Authorizations are to be obtained prior to the date of service or admission. However, authorizations for unscheduled, emergent services that cannot be requested in advance or during normal business hours can be retroactively requested up to three business days after the date the service is rendered or the date of admission (i.e. by the end of the third business day following).

Any service requested greater than three business days after the date the service is rendered will not be considered and claims for those services will be administratively denied for lack of authorization.

The following circumstances ONLY will be considered as exceptions to this policy:

- Medicare/Medicaid retractions
- Coordination of Benefits
- Retroactive eligibility as determined by DHS

The list of services requiring authorizations can be found at [http://www.nhpri.org](http://www.nhpri.org) under Providers –> Administrative Resources

Please note that our radiology vendor, MedSolutions, and our DME vendor, DMEnsions, will also follow this three day retro policy.
Requesting Services from a Non-Participating Provider

When determined to be medically necessary, Neighborhood authorizes covered services provided by a non-participating provider. In order for the member to receive these services, prior authorization from Neighborhood’s Medical Management Department must be obtained by calling 1-401-459-6060, or faxing to 1-401-459-6023. Prior authorization from Neighborhood is also required for consultations, second opinions and follow-up services provided by a non-participating provider.

Authorizations to a non-participating provider may be issued by the Medical Management Department for reasons including, but not limited to:

- Services not available within the participating provider network including a second opinion
- Services cannot be delayed for member temporarily outside the service area who cannot reach a network provider
- Services to preserve continuity of care for members including but not limited to, those receiving treatment for an acute medical condition or an acute episode of a chronic illness, or members in their second or third trimester of pregnancy
- Ongoing treatment for an acute medical condition, or if member undergoing active treatment for a chronic condition at the time the member’s practitioner terminates his/her contract with the Health Plan.
- Follow up care from emergency services
- Ancillary services required during a transition period for new members, until such practitioner/provider becomes contracted or member can be redirected to an in-network practitioner/provider.

Members who see a specialist who is not in Neighborhood’s provider network could be responsible for a co-pay or pay for the services provided by that specialist, if prior authorization is not obtained. Also refer to Neighborhood’s Clinical Medical Policy for Out-of-Network/Out-of-Area care.
Coordination of Benefits

Under the RIte Care and Rhody Health Programs, Neighborhood is considered to be the payor of last resort. If the primary insurance authorizes services, Neighborhood will pay deductibles and copays. If primary insurance denies services, Neighborhood will deny unless the service requires an authorization and one has been obtained from Neighborhood Medical Management department. See Section 3 of Provider Manual for further information.

The following services require prior authorization when Neighborhood is the secondary payor:

- Inpatient admissions

The following services do not require authorization when Neighborhood is the secondary payor unless the provider has written documentation that primary insurance has denied the service:

- Home Care [Exception: If Medicare prime, home infusion requires prior authorization from Neighborhood. No written denial from Medicare necessary.]
- Outpatient rehab therapies
- DME
Medical Necessity Review

The Medical Management program includes utilization review for medical necessity for inpatient services and some specialty services. Utilization review activities for Mental Health and Behavioral Health are delegated to Beacon Health Strategies, LLC. The Director of Pharmacy Programs and his staff are responsible for benefit coverage and medical necessity decisions. Below is a brief description of each of the different types of reviews:

- A review before service is provided is a prospective or pre-service review. An example is custom equipment requested for the member.

- Review during the same time as the service is given is concurrent review. An example is an inpatient stay in a facility.

- When the request for authorization occurs after the service has been given, a retrospective or post-service review is required.

The Neighborhood team works with our providers to determine medical necessity and coverage of services. Services are not denied based on cost although members may be directed to alternative cost-efficient services, providers or settings of care. (Refer to Medical Review Process and Adverse Determination and Appeals.)
Medical Necessity Decision Criteria

Neighborhood utilizes Managed Care Appropriateness Protocol (MCAP) as the review criteria for services. Clinical Medical Policies (CMP) are the review criteria utilized for conditional benefit determinations.

Neighborhood uses the above-established criteria as a guideline when reviewing medical service necessity, but clinical judgment is always used when determining the appropriate level of care. Neighborhood considers its’ ultimate goal to be the provision of clinically necessary services at the appropriate level of care for the appropriate duration. Medical Review criteria may not be appropriately applicable to all members in all circumstances. Neighborhood’s clinical staff ensures that individual consideration is given when necessary.

The Medical Directors of each of the sixteen (16) Rhode Island hospitals review the MCAP criteria annually and are provided with an opportunity to comment. All comments are recorded and included in revisions of the criteria. A copy of the criteria is available at the Rhode Island Medical Society Office.

The use of the MCAP criteria is reviewed and approved annually by Neighborhood’s Clinical Management Committee (CMC).

Neighborhood’s Clinical Medical Policies are developed and/or revised following thorough review of current medical literature and standards of practice. To the extent possible, Neighborhood’s CMPs are developed according to evidence-based outcomes, and are presented to CMC annually for further review and recommendations. Neighborhood’s Chief Medical officer gives final approval. Please refer to the Neighborhood website to view current CMPs at the following location: Providers -> Clinical Resources -> Clinical Medical Policies.

Procedure for Requesting MCAP Criteria

All Neighborhood practitioners have the right to view the criteria utilized to render decisions. When MCAP is used, practitioners may request a copy of the MCAP criteria fact sheet by contacting the Medical Management Department Staff at 1-800-264-3955. The MCAP criteria is proprietary and copyrighted and therefore, cannot be distributed in their entirety. Practitioners are welcome to view the complete criteria at Neighborhood Health Plan of Rhode Island, 299 Promenade Street, Providence, RI 02908. Practitioners may also request excerpts from the criteria which can be mailed or faxed to the practitioner’s office. If upon review, you have any questions about MCAP criteria, one of Neighborhood’s certified Clinical Management Nurses or Associate Medical Director will be happy to assist you.

All clinical medical policies are available on Neighborhood’s website, or a copy can be obtained by contacting Medical Management.

Medical Review Process

Medical review is conducted to confirm the medical necessity of treatments or services rendered, as well as the appropriateness of the care setting. Medical review requires evaluation of specific clinical information on-site, over the telephone, or via written communication. Clinical Management Nurses compile all pertinent clinical information gathered from the treating practitioners/staff, review against the Neighborhood medical necessity decision criteria and consider individual patient needs. Once complete, the Clinical Management Nurse confirms medical necessity, the appropriateness of the care setting, and authorizes the requested service. When the Medical Review Nurse is not able to confirm the medical necessity and appropriateness of care setting, the case is referred to a Neighborhood physician reviewer for a final decision.
Adverse Determination (Denial) and Appeals

Adverse Determination (Denials)
Medical necessity denials are decisions not to certify or authorize a covered medical benefit. Decisions regarding level of care or services are not medically necessary are made only by one of Neighborhood’s Associate Medical Directors or physician reviewers who is a similarly licensed practitioner as the ordering practitioner.

In order to accommodate the clinical urgency of each medical situation, medical review decisions are determined in a timely manner once all medical information is collected. Written notification of the adverse decision is communicated to the practitioner and the member and includes the total number of days or services denied, the denial reason, the medical necessity decision criteria utilized, the availability of physician reviewers to further discuss the decision with the ordering practitioner, and the availability of the criteria used. The notification also includes a description of the appeal rights.

Decisions are made according to the following timelines:

- Pre-service requests (non-urgent) are made within 15 calendar days from the receipt of the request, and prior to the date of service.
- Pre-service requests (urgent) are made within 72 hours of receipt of the request and prior to the date of service.
- Concurrent (hospital inpatient) requests are made prior to the end of the certified period, or within 24 hours of request, whichever comes first.
- Post-service requests are made within thirty (30) calendar days from receipt of the request.

The ordering practitioners may contact a physician or pharmacist reviewer to discuss denial decisions.

Medical Management: 1-401-459-6060 or 1-800-264-3955
Pharmacy: 1-800-963-1001

Appeals
Member and providers have the right to file an appeal to change or reconsider an adverse medical necessity decision previously made by Neighborhood. A written description of the member’s rights and the appeal process is included in both the written denial notification and the Neighborhood Member Handbook. A Neighborhood representative is available to assist in the initiation of the appeal request. An expedited appeal process exists for members requiring a review determination for urgent situations.

All members and providers are entitled to two levels of internal appeal. A licensed practitioner with the same licensure status as the ordering physician reviews first and second level clinical appeals; additionally, a licensed practitioner with the same specialty as the ordering physician reviews second level appeals. No reviewer involved in prior reviews/direct care may participate in subsequent reviews.

Please direct formal appeals in writing to:

Appeals Coordinator
Neighborhood Health Plan of Rhode Island
299 Promenade Street
Providence, RI 02908
An external appeal process is also available to members who disagree with Neighborhood’s final Level II decision. This level of appeal is reviewed by an external appeals agency with which Neighborhood holds a Memorandum of Understanding (MOU). A document entitled “Instructions for Members who Wish to Request an External Appeal” is included when a member receives a Level II denial decision letter.

Rite Care and Rhode Health members who are not satisfied with the outcome of an appeal may initiate a fair hearing with the department of Human Services (DHS). Members must exhaust Neighborhood’s internal appeal process before requesting a DHS Fair Hearing. The member or their representative must contact DHS directly at (English or Spanish) 1-401-462-5300 or 1-401-462-3363 (TTY). Members may also file a complaint with the Department of Health (DOH) at any time during the appeal process at 1-401-222-2231. Members may also contact Rhode Island Legal Services at 1-401-274-2652 at any point to help with an appeal.

Practitioners or members who have received notification from Neighborhood’s Medical Management Department of an adverse determination may appeal in writing to the Appeals Coordinator within ninety (90) days from receipt of notification of a denial decision and within sixty (60) days of a Level I appeal decision. A different practitioner of the same or similar specialty as typically treats this type of condition will make the decision.

- Pre-service requests (services not yet rendered) are processed within fifteen (15) calendar days from receipt of the request
- Post-service requests (after services rendered) are processed within fifteen (15) calendar days from receipt of the request
Case and Disease Management

In the effort to not only improve our members’ quality of care, but also their quality of life, Neighborhood has developed comprehensive Case Management and Disease Management Programs to benefit eligible members.

What is Case Management?
Neighborhood’s Case Management Program design focuses on evaluation and assistance in the coordination of members’ care along the health care continuum. Members are identified and refereed in a variety of ways including self referrals, referrals from family members, providers, Medical Review Nurses, Customer Service Staff, Disease Management staff and external agencies.

Individualized care coordination programs focus on wellness education, the removal of barriers that have been identified as preventing access to medically necessary health care services and the delivery of continuous and coordinated medically appropriate care. The Medical Management Department has multiple care coordination programs.

Individualized case management programs focus on assisting members at risk or with complex needs in achieving and maintaining wellness, providing educational support, and improving quality of life including the coordination of service and supports. Each case management program has established policies and procedures, outcome measures, and program admission criteria that identify those members who may benefit from case management intervention in order to maximize positive outcomes and to provide quality, member-focused, cost effective care. Neighborhood Case Managers utilize the Case Management Society of America (CMSA) standards of practice along with the nursing process of assessment, planning, intervention and evaluation in conducting activities. Each program has defined practices and standards for member care planning and documentation as well as case closure criteria. The Medical Management Department has the following case management programs: Pre-natal Case Management, Neonatal Case Management, Pediatric Case Management, Adult Case Management, and Complex Case Management.

To determine whether a member is eligible for one of Neighborhood’s Case Management programs, providers are encouraged to contact Customer Service at 1-401-459-6020, Monday through Friday 8:30am – 5:00pm.

What is Disease Management?
Disease Management is a multi-disciplinary, continuum-based approach to health care delivery that focuses on the identification of populations with established medical conditions. Neighborhood recognizes the importance of Disease Management Programs to:

- Support the relationship between practitioners and their patients and reinforce the established plan of care.
- Emphasize the prevention of exacerbations and complications utilizing cost-effective evidence-based practice guidelines and patient empowerment strategies such as self-management.
- Continuously evaluate clinical, humanistic, and economic outcomes with the goal of improving overall health.
Who are Neighborhood’s Case and Disease Managers?

The Case Managers at Neighborhood are nurses, community outreach specialists and other health care professionals with experience and skills in related clinical areas. Neighborhood’s Case Managers will work with our providers to:

- Support and reinforce members in their efforts to adhere to treatment interventions recommended by their health care providers.
- Advocate for members to obtain the most appropriate health care services available, through education, referral and negotiation.
- Act as a liaison between all providers to enhance communication and coordination of care.
- Educate members, families and health care providers regarding benefits, availability of services, community resources, entitlement programs, and health care alternatives.
- Reduce barriers relating to transportation, language, pharmacy and keeping followup appointments.

Disease management programs that are currently offered at Neighborhood include Asthma, Coronary Artery Disease (CAD), Chronic Obstructive Pulmonary Disease, Diabetes and Heart Failure. Disease management resides within the Medical Management Department at Neighborhood. Please contact the Clinical Programs Department at 1-401-459-6750 for further information or questions about Neighborhood’s Disease Management Programs.
Breathe Easy Asthma Program

The goal of Neighborhood Health Plan of Rhode Island’s (Neighborhood’s) Breathe Easy Asthma Program is to enable and empower members with persistent asthma to live normal, healthy lives, confident in their abilities to manage asthma. Built on evidence-based clinical practice guidelines, the Breathe Easy Program is designed to reinforce the practitioner’s care and treatment plan through member outreach, education, monitoring and self-management.

Evidence Based Clinical Practice Guidelines

Neighborhood develops and/or adopts clinical practice guidelines for asthma, they reference guidelines by the National Asthma Education and Prevention Program (NAEPP) Expert Panel Report (EPR-3) Guidelines for the Diagnosis and Management of Asthma - Full Report 2007 (US Department of Health and Human Services, National Institutes of Health, National Heart, Lung and Blood Institute). NIH publication No. 08-4051, August 2007. Full report can be found on http://www.nhlbi.nih.gov/guidelines/asthma/. Copies of the guidelines are available upon request or may be obtained by visiting our website. Please contact our Customer Service Department at 1-401-459-6750 or visit: http://www.nhpri.org. From our home page click on “Providers” then click on “Clinical Resources” from the drop down menu. The interventions and member education offered by the Breathe Easy Program have been developed to align with the recommendations detailed in the guidelines.

Population Identification

A member is considered to have persistent asthma if he/she is two years of age or older and has the following (using CPT and NDC codes provided by HEDIS/NCQA and updated annually) during the measurement year and the year prior to the measurement year. Criteria need not be the same across both years.

- At least four asthma medication dispensing events (excluding leukotriene receptor antagonists if that is the only asthma dispensed
- At least one emergency department visit with primary diagnosis of asthma
- At least one acute inpatient stay with primary diagnosis of asthma
- At least four outpatient visits with any diagnosis of asthma and at least two asthma medication dispensing events.

Program Participation

Neighborhood members identified as having asthma do not need to enroll in the Breath Easy Program; they are automatically enrolled upon identification. Participation and membership in the program is voluntary and members may opt not to participate at any time by calling Neighborhood. All members receive a welcome letter introducing the Breathe Easy Program and informing them of the services, benefits, and educational materials they can expect to receive. Participation in the program can also result from referrals made by Neighborhood’s Customer Service or Case Management Departments, our network providers, or member self referrals.
Patient Education and Outreach

Members in the Breathe Easy Program receive periodic mailings that contain educational resources and recommendations to assist them in better managing their condition. Topics covered include:

- Use of anti-inflammatory medications for persistent asthma
- Importance of establishing a written asthma action plan
- Environmental triggers that may exacerbate a members condition
- Need for regular physician visits (at least two times per year)

Most of the letters sent to members accompany educational materials, brochures, or guides that have been adopted for use by Neighborhood. To request a copy of those materials or mailings, please call us at 1-401-459-6750.

Members identified as being at the highest risk receive telephonic outreach from a Disease Case Manager who will conduct an assessment to determine problems, identify interventions and develop treatment plan that will assist the member in regaining control of their asthma condition, discuss self management strategies, evaluate their status, and monitor their condition and adherence to treatment goals.

Additional Benefits/ Services Available to Members with Asthma

Asthma education programs (RItc Care only); Neighborhood recognizes the import role that education plays in asthma control and treatment. Enrolled RItc Care members can seek one-on-one or group educational opportunities to learn about their asthma. Children with asthma and their parent(s) may be eligible to participate in the Draw A Breath Program at Hasbro Children’s Hospital in Providence; Classes are available in both English and Spanish.

Asthma Medications and Supplies

Formulary medications are limited to a maximum 30-day. Spacers and peak flow meters are available through the pharmacy. Microchamber is the formulary spacer for members age 7 and older. For those ages 6 and under, Aerochamber, with mask if necessary, is formulary. Members are limited to one spacer and/or peak flow meter per 365 day period. Nebulizers, available through our participating DME vendors, do not require prior authorization.
Coordination of Care-Working with Our Providers

Neighborhood provides our physicians with actionable information derived from health plan claims and pharmacy data to support improved patient outcomes. Quarterly reports are sent to selected primary care sites to inform them of the asthma care milestones that Neighborhood monitors, and whether or not each was achieved by the member. Report detail includes whether the practice’s members with asthma have filled their controller medication prescriptions, recently visited the ED for an acute exacerbation, or had a visit with their primary care physician. If you would like to see a sample copy of the report that you might receive, call us at 1-401-459-6750. Members who have opted out of the Breathe Easy Program, but do have asthma, will still be included in the quarterly asthma report sent to providers.

Outcome Measurement and Effectiveness of the Breathe Easy Programs

We want to make sure that our Breathe Easy Program is effective in achieving improved health outcomes for our members with asthma and its delivery of services to our members and providers. Some of the key measures that Neighborhood pays attention to assess the program include:

- HEDIS measure: Use of Appropriate Asthma Medications
- Utilization metrics (ER visits/ inpatient utilization)
- Member satisfaction with Neighborhood’s disease management services (annual survey/complaints data)

For More Information

Please call us at 1-401-459-6750 if you have questions about Neighborhood’s Breathe Easy Program for members with asthma, how we work with your patients, or about the services available to your members with asthma.
Control for Life Diabetes Program

The goal of Neighborhood Health Plan of Rhode Island’s (Neighborhood’s) Control for Life Diabetes Program is to enable and empower members with diabetes to live normal, healthy lives, confident in their abilities to manage diabetes. Built on evidence-based practice guidelines, the Control for Life Program is designed to reinforce the physician's care and treatment plan through member outreach/education, monitoring and management.

Evidence Based Practice Guidelines

Neighborhood has adopted as a primary source, the clinical practice guideline based on nationally recognized clinical guidelines such as those of the American Diabetes Association. Copies of the guidelines are available upon request or may be obtained by visiting our website. Please contact our Clinical Programs Department at 1-401-459-6750 or visit : http://www.nhpri.org. From the top of our home page click on “Providers” and then click on “Clinical Resources” from the drop down menu and then click on “Clinical Practice Guidelines” under “Additional Resources”. The interventions and member education offered by the Control for Life Program have been developed to align with the recommendations detailed in the guidelines.

Population Identification

Neighborhood identifies members age 18 years and older for participation in the Control for Life Program. Members are considered to have diabetes if claims data meets one or more of the following criteria:

- The member was dispensed insulin and/or oral hypoglycemics and/or antihyperglycemics (excluding glucophage/ metformin) During the past two years on an ambulatory basis and/or
- The member had two face-to-face encounters in an ambulatory or non-acute inpatient setting with a diagnosis of diabetes and/or
- The member had one face-to-face encounter in an acute inpatient or emergency room setting during the past two years with a diagnosis of diabetes

Note: Members with diagnosis of gestational diabetes, polycystic ovary syndrome, and steroid-induced diabetes are excluded from the population.

Program Participation

Neighborhood members identified as having diabetes do not need to enroll in the Control for Life Program; they are automatically enrolled upon identification. Participation and membership in this program is voluntary and members may opt not to participate at any time by calling Neighborhood. All members receive a welcome letter introducing the Control for Life Program and informing them of the services, benefits, and educational materials they can expect to receive. Participation in the program can also result from referrals made by Neighborhood Customer Service or Case Management Departments or network providers, or member, or self referrals.
Patient Education and Outreach
Member of the Control for Life Program receive periodic mailings that contain educational resources and recommendations to assist them in better managing their condition. Topics covered include:

- Importance of controlling blood sugar, through nutrition exercise and weight management.
- Importance of obtaining recommended diabetic milestone screenings/tests
- Need for regular physician visits (at least two a year) for their condition
- Importance of medication adherence

Educational materials, brochures, or guides that have been adopted for use by Neighborhood accompany most of the letters sent to members. To request a copy of those materials or mailings, please call us at 1-401-459-6750.

Members identified as being high risk receive telephonic outreach from a Disease Case Manager. An assessment will be conducted to determine problems, identify interventions and develop a treatment plan that will assist the member in regaining control of their diabetes condition. The Disease Case Manager will discuss lifestyle issues which may exacerbate their condition, discuss self-management strategies, evaluate their status and in general, monitor their condition and adherence to treatment goals.

Additional Benefits/ Services Available to Members with Diabetes
Diabetes Education (RIte Care only); RIte Care members may be referred to a Certified Diabetes Educator to learn more about diabetes and improve their self management skills. No prior authorization is required. To obtain a list of Neighborhood’s contracted diabetes educators and/or education site, please contact the Provider Services Staff at 1-401-459-6020.

Diabetes Medications and Supplies
Syringes, oral and injectable diabetes medications listed in the Neighborhood Formulary are covered by prescription at no cost to most members or when applicable, with a co-payment. Visit our website for more information http://www.nhpri.org/matriach/default.asp. From the top of our home page, click on “Providers” and then click on “Pharmacy Resources”. Diabetes supplies are covered as durable medical equipment (DME) and require a practitioner’s order or prescription. Routine office visits to the member’s selected primary care practitioner and laboratory tests needed to manage diabetes care are encouraged and covered by Neighborhood. Routine podiatry care is covered for members with diabetes. An annual dilated eye exam for the detection of diabetic eye disease, preformed by a participating ophthalmologist and/or optometrist, is also a covered benefit.
Coordination of Care - Working with our Providers

Neighborhood provides our physicians with actionable information derived from health plan claims and pharmacy data to support improved patient outcomes. Quarterly reports are sent to selected primary care sites to inform them of diabetes care milestones that Neighborhood monitors, and whether or not each was achieved by the member. Report details include whether the practice’s members with diabetes are have received specific lab tests, screenings or exams such as A1c, LDL-C, dilated retinal eye exams, nephro screen, flu vaccine or have had a visit with their primary care physician. If you would like to see a sample copy of the report that you might receive, call us at 1-401-459-6631. Members who have opted out of the Control for Life Program, but do not have diabetes, will still be included in the quarterly diabetes reports sent to providers.
Take a Breath Program for Members COPD

The goal of the Neighborhood Health Plan of Rhode Island’s (Neighborhood’s) Take a breath Program for members with COPD, is to enable and empower members with COPD to live normal, healthy lives, confident in their abilities to manage their condition. Built on evidence-based practice guidelines, the Take a Breath COPD Program is designed to reinforce the physician’s care and treatment plan through member outreach/education, monitoring and management.

Evidence Based Practice Guidelines

Neighborhood has adopted the COPD guidelines developed through the Global Initiative for the Diagnosis Management and Prevention of Chronic Obstructive Lung Disease, World Health Organization, National Heart, Lung and Blood Institute; 2006. Copies of the guidelines are available upon request or may be obtained by visiting our website. Please contact our Clinical Programs Department at 1-401-459-6750 or visit: http://www.nhpri.org. From the top of our home page, click “Providers” and then click “Clinical Resources” from the drop down menu. The interventions and member education offered by the Take a Breath Program have been developed to align with the recommendations detailed in the guidelines.

Population Identification

Neighborhood identifies members ages 40 years and older for participation in the Take a Breath Program. Members are considered to have COPD if claims data meet one or more of the following criteria:

- Claims evidence of at least one inpatient or one emergency room visit with a primary diagnosis of COPD in the last 12 months OR
- Claims evidence of at least two physicians or specialists office visits with primary diagnosis of COPD within the last 12 months

Program Participation

Neighborhood members identified as having COPD do not need to enroll in the Take a Breath Program; they are automatically enrolled upon identification. Participation and membership in the program is voluntary and members may opt not to participate at any time by calling Neighborhood. All members receive a welcome letter introducing the Take a Breath Program informing them of services, benefits, and educational materials they can expect to receive. Participation in the program can also result from referrals made by Neighborhood Customer Service or Case Management Department, our network providers, or member self-referrals.
Patient Education and Outreach

Members in the Take a Breath Program receive periodic mailings that contain educational resources and recommendations to assist them in better managing this condition. Topics covered include:

- Tobacco cessation
- Breathing exercises
- Preventing lung infections
- Energy conservation
- Importance of regular doctor visits

Educational materials, brochures, or guidelines that have been adopted for use by Neighborhood accompany most of the letters sent to members. To request a copy of those materials or mailings, please call us at 1-401-6750.

Additional Benefits/ Services Available to Members with COPD

Medications and supplies

Medications listed in the Neighborhood Formulary are covered by prescription at no cost to most Neighborhood Members or when applicable, with a co-payment.

Visit our website for more information http://www.nhpri.org/matriach/default.asp. From the top of our home page click “Providers” then click “Pharmacy Resources” from the drop down menu.

Routine office visits to the members selected primary care practitioner and laboratory tests needed to manage COPD are encouraged and covered by Neighborhood.

Outcome Measurement and Effectiveness of the Take a Breath Program

We want to make sure that our Take a Breath Program is effective in achieving improved health outcomes for our members with COPD and in its delivery of services to our members and providers. Some of the key measures that Neighborhood pays attention to assess the program include:

- HEDIS measure: Use of Spirometry in Diagnosis and Assessment of COPD
- Utilization metrics (ER visits/ inpatient utilization)
- Member satisfaction with Neighborhood’s disease management services (annual survey/ complaints data)

For more information

Please call us at 1-401-459-6750 if you have any questions about Neighborhood’s Take a Breath Program for members with COPD or how we work with your patients with COPD.
Don’t Skip a Beat Program for members with coronary artery disease (CAD).

The goal of Neighborhood Health Plan of Rhode Island’s (Neighborhood’s) Don’t Skip a Beat Program is to enable and empower members with heart disease to live normal and healthy lives, confident in their abilities to manage their heart condition. Built on evidence-based practice guidelines, the Don’t Skip a Beat Program is designed to reinforce the physician’s care and treatment plan though member outreach, education, monitoring and management.

Evidence Based Practice Guidelines
Neighborhood has adopted as a primary source, the clinical practice guideline based on nationally recognized clinical guidelines such as those of the American Heart Association (ACC/ AHA). Copies of the guidelines are available upon request or may be obtained by visiting our website. Please contact our Clinical Programs Department at 1-401-459-6750 or visit http://www.nhpri.org. From the top of our home page click “Providers” then click on “Clinical Resources” from the drop down menu. The interventions and member education offered by the Don’t Skip a Beat Program have been developed to align with the recommendations detailed in the guidelines.

Population Identification
Neighborhood identifies members ages 18 years or older for participating in the Don’t Skip a Beat Program. Members are considered to have CAD if claims data meets the following criteria:

- Claims evidence of having a heart disease diagnosis in the last 12 months

Program Participation
Neighborhood members identified as having CAD do not need to enroll in the Don’t Skip a Beat Program; they are automatically enrolled upon identification. Participation and membership in the program is voluntary and members may opt at any time by calling Neighborhood. All members receive a welcome letter introducing the Don’t Skip a Beat Program informing them of services, benefits and educational materials they can expect to receive. Participation in the program can also result in referrals made by Neighborhood Customer Service or Case Manager Department, our network providers, or member self referrals.

Patient Education and Outreach
Members in the Don’t Skip a Beat Program receive periodic mailings that contain educational resources and recommendations to assist them in better managing their condition. Topics covered include:

- Importance of diet and exercise
- Blood pressure control
- Recognizing a heart attack or angina
• Controlling stress
• Cholesterol management
• Need for regular physician visits for their CAD

Educational materials, brochures, or guidelines have been adopted for use by Neighborhood accompany most of the letters sent to members. To request a copy of those materials or mailings, please call us at 1-401-459-6750.

Additional Benefits / Services Available to Members with heart disease

Medications and Supplies
Medications listed in the Neighborhood Formulary are covered by prescription at no cost to most Neighborhood members or when applicable, with a co-payment. Visit our website for more information http://www.nhpri.org/matriarch/default.asp. From the top of our home page, click on “Providers” and then click on “Pharmacy Resources” from the drop down menu.

Routine office visits to the member’s selected primary care practitioner and laboratory tests needed to manage heart disease are encouraged and covered by Neighborhood.

Outcome Measurement and Effectiveness of the Don’t Skip a Beat Program
We want to make sure that our Don’t Skip a Beat Program is affective in achieving improved health outcomes for our members with CAD and in its delivery of services to our members and providers. Some of the key measures that Neighborhood pays attention to assess the program include:

• Utilization metrics (ER visits / impatient utilization)
• Member satisfaction with Neighborhood’s disease management services (annual survey / complaints data)

For More Information
Please call us at 1-401-459-6750 if you have any questions about Neighborhood’s Healthy Heart program for members with CAD or how we work with your patients with CAD.
Bright Start Program

The goal of Neighborhood’s Bright Start Program is to improve birth outcomes for the children born to Neighborhood members. Built on evidence-based guidelines, the Bright Start Program is designed to reinforce the practitioner’s care and treatment plan through members outreach / education, monitoring and management.

Neighborhood works with members and providers participating in the Bright Start Program to facilitate:

- Appropriate prenatal care
- Adequate prenatal nutrition
- Access to needed services for behavioral health problems and substance abuse (tobacco, alcohol, and / or drugs in the prenatal period)
- Case management services and community support referrals as needed
- Education about breastfeeding for optimal infant / child development
- Education about optimal birth spacing
- Education about birth control
- Adequate postpartum care

Evidence Based Practice Guidelines

Neighborhood has established clinical guidelines for pre-natal care based on national clinical guidelines such as those of the American College of Obstetricians and Gynecologists. Copies of the guidelines are available upon request or may be obtained by visiting our website. Please contact our Customer Service Department at 1-401-459-6020 or visit: http://www.nhpri.org. From our home page, click on “Providers” at the top of the page and then click on “Clinical Resources” from the drop down menu.

Population Identification

Neighborhood identifies pregnant women for participation in the Bright Start Program based on the practitioners submission of pre-authorization for maternal services, and / or through hospital admissions.

Program Participation

Neighborhood members identified as being pregnant do not need to enroll in the Bright Start Program, they are automatically enrolled upon identification. Participation in the program are voluntary and members may opt not to participate at any time by calling Neighborhood. All members receive a Welcome Kit introducing the Bright Start Program and informing them of the services, benefits and educational materials they can expect to receive. Participation can also result from the referrals made by Neighborhood’s Customer Service or Case Management Department, our network providers or member self referrals.
Patient Education and Outreach

Once notified of the pregnancy, Neighborhood mails educational information about topics such as, the importance of prenatal care, nutrition, avoiding substance abuse, breastfeeding, and birth control. After delivery, members are sent additional educational information about the need for a postpartum visit, the importance of childhood immunizations, birth control, and postpartum depression.

Case Management / Care Coordination

Members with a moderate or high-risk pregnancy, as determined by a health risk assessment or due to a recent hospital admission, may be eligible to receive care coordination or case management services, (depending on the risk factor identified) throughout their prenatal and postpartum period. Behavioral health and smoking cessation services are available, and members are referred to the appropriate community resources as needed.

Additional Benefits / Services Available to Pregnant Members

Member Education Programs for Pregnant Women

Neighborhood encourages education for all members who are pregnant and reimburses for prenatal classes. Members may self-refer or be referred by their health care practitioners. No prior authorization is required. Classes are offered in Spanish and English at certain locations. To obtain a list of classes, please contact the Providers Relations Staff at 1-401-459-6020.

Pregnancy Medications

Formulary pre-natal vitamins are covered at 100%

Obstetrical Services

All medical care related to pregnancy, childbirth or miscarriage is covered. Services include: prenatal examinations, tests, (e.g. metabolic screening, amniocentesis, CVS, etc.) diet regulation, child birth education, post partum care, delivery and hospital care for childbirth, miscarriage, complications of pregnancy and new born care rendered by any participating practitioner, including nurse midwife.

Coordination of Care-Working with Our Providers

Individual case management / care coordination encounter reports are sent to the pregnant member’s provider that may include the risk level of the member contacted, educated, referrals, plan of care and other services provided by the case manager.

For More Information

Please call us at 1-401-459-6750 if you have questions about neighborhood’s Bright Start Program for pregnant members, how we work with your patients, or about the services available to your pregnant neighborhood members. If you would like to refer someone to the Neighborhood Bright Start Program, please call 1-401-459-6675.
Healthy Heart Program for Members With Heart Failure

The goal of Neighborhood Health Plan of Rhode Island’s (Neighborhood’s) Healthy Heart Program for members with heart failure (HF), is to enable and empower members with HF to live normal, healthy lives, confident in their abilities to manage their heart condition. Built on evidence-based practice guidelines, the Healthy Heart Program is designed to reinforce the physicians care and treatment plan through member outreach / education, monitoring and management.

Evidence Based Practice Guidelines

Neighborhood has adopted as primary sources, the clinical practice guideline based on nationally recognize clinical guidelines such as those of the American College of Cardiology and the American Heart Association (ACC/AHA). Copies of the guidelines are available upon request or may be obtained by visiting our website. Please contact our Clinical Programs Department at 1-401-459-6750 or visit: http://www.nhpri.org. From the top of our home page, click on “Providers” and then click on “Clinical Resources” from the drop down menu. The interventions and member education offered by the Healthy Heart Program have been developed to align with the recommendations detailed in the guidelines.

Population Identification

Neighborhood identifies members ages 21 years and older for participation in the Healthy Heart Program. Members are considered to have HF if claims data meets one or more of the following criteria:

- Claims evidence of at least 2 face to face encounters in an ambulatory, non acute impatient settings, or emergency room setting with a diagnosis of HF within the previous 12 months and/or
- Claims evidence of at least 1 face to face encounter in an acute impatient setting, with a diagnose of HF within the previous 12 months.

Program Participation

Neighborhood members identified as having HF do not need to enroll in the Healthy Heart Program; they are automatically enrolled upon identification. Participation and membership in the program is voluntary and members may opt at any time by calling Neighborhood. All members receive a welcome letter introducing the Healthy Heart Program informing them of the services, benefits, and educational materials they can expect to receive. Participation in the program can also result from referrals made by Neighborhood Customer Service or Case Management Department, or network providers, or member self referrals.

Patient Education Outreach

Members in the Healthy Heart Program receive periodic mailings that contain educational resources and recommendations to assist them in better managing their condition. Topics covered include:

- Importance of dietary changes
- Tracking weight
• Warning signs of a flare up
• Types of medication used
• Need for regular physician visit

Educational materials, brochures, or guides that have been adopted for use by Neighborhood accompany most of the letters sent to members. To request a copy of those materials or mailings, please call us at 1-401-459-6020.

Additional Benefits / Services Available to Members with Heart failure

Medications and Supplies
Medications listed in the Neighborhood Formulary are covered by prescription at no cost to most Neighborhood members or when applicable, with a co-payment.

Visit our website for more information http://www.nhpri.org/matriarch/default.asp. From the top of our home page, click on “Providers” and then click on “Pharmacy Resources” from the drop down menu.

Routine office visits to the member’s selected primary care practitioner and laboratory tests needed to manage HF are encouraged and covered by Neighborhood.

Outcome Measurement and Effectiveness of the Healthy Heart Program

We want to make sure that our Healthy Heart Program is effective in achieving improved health outcomes for our members with HF and in its delivery of services to our members and providers. Some of the key measures that Neighborhood pays attention to assess the program include:

• Utilization metrics (ER visits / impatient utilization)
• Member satisfaction with Neighborhood’s disease management services (annual survey / complaints data)

For More Information

Please call us at 1-401-459-6020 if you have any questions about Neighborhood’s Healthy Heart Program for members with HF or how we work with your patients with HF.
Section 6
Pharmacy

- Formulary
- How to Use the Drug Formulary
- Coverage Limitations
- OTC Medications
- Pharmacy and Therapeutics Committee
- Generic Substitution
- Experimental Drugs
- Benefit Exception Process
- Prior Authorization
- Adverse Determination
- Pharmacist and Prescriber Communications
Formulary

A Formulary is a list of medications covered under a specific pharmacy benefit. Below are the rationale and process used in defining the Formulary, other details of the pharmacy benefit, and avenues for discussion and appeal when Non-Formulary and restricted medications are requested.

How to Use the Drug Formulary

The Formulary is a list of covered and preferred drug agents for Neighborhood members. The formulary is available on Neighborhood’s website, www.nhpri.org. Drugs are listed by their drug class. Drugs are also listed alphabetically. All products are listed by their generic names, and a common proprietary (branded) name. The Formulary also includes the names of some drugs that are not covered for Neighborhood members. Drugs are identified as being either “covered” or “non covered” in the column labeled “DRUG TIER”. Drugs identified as “FG” or “FB” are covered. Drugs identified as “NF” are not covered. Drugs identified as “GA” are brand name drugs that have generic equivalents available. Drugs identified as “GA” are not covered but, in most cases, the generic equivalent of these drugs are covered.
Coverage Limitations

The Formulary does not provide information regarding all coverage and limitations associated with an individual member’s prescription drug plan. Many members have specific exclusions, co-payments, or a lack of coverage, which are not reflected in the Formulary.

The Formulary applies only to outpatient drugs provided to members, and does not apply to medications used in inpatient settings. If a member has any specific questions regarding their coverage, they should contact Neighborhood Customer Service at 1-800-459-6019 or 1-401-459-6020.

The following general provisions pertain to all covered individuals:

A) Some Over the Counter products are covered for members. A written prescription is required for OTC products.

B) Drug products not listed in the Formulary at www.nhpri.org, or specifically listed as covered, are not covered.

C) Any drug products used for cosmetic purposes are not covered.

D) Experimental drug products, or any drug product used in an experimental manner are not covered (except as required by law or regulation).

E) Replacement of lost or stolen medications will be covered on a case by case basis.

F) Infertility treatment is not covered for members.

G) Unless otherwise stated, dispensed quantities are limited to one month’s supply.

H) Drug products failing industry-standard patient safety screens will not be dispensed at the pharmacy without further information from the prescriber.
OTC Medications

Written prescription required

The following therapeutic classes of OTC products listed in bold are covered for Neighborhood members ONLY. Examples of drugs included in each category are listed below the therapeutic class. This is not an all-inclusive list. Generics, if available, are mandatory.

**OTC Analgesics/Salicylates/Non-Salicylates/NSAIDs**
- Acetaminophen
- Arthritis Pain Formula
- Ascriptin
- Aspirin
- Bufferin
- Children’s Advil
- Children’s Motrin
- Excedrin
- Ibuprofen
- Naproxen Sodium

**OTC Acid Relief**
- Alka-Seltzer
- Gaviscon
- Gelusil
- Maalox
- Mylanta
- Rolaid
- Zantac 75
- Zantac 150 Maximum Strength

**OTC Antidiarrheals/Intestinal Adsorbents and Protectants**
- Bismuth
- Imodium A-D
- Kapectate
- Loperamide
- Pepto-Bismol

**OTC Antiemetic/Antivertigo Agents**
- Dramamine
- Emetrol
- Meclizine

**OTC Antiflatulents**
- Mylanta Gas Relief
- Mylicon
- Phazyme
- Simethicone Drops

**OTC Antihistamines**
- Alavert Products
- Benadryl
- Chlor-Trimeton
- Claritin Products
- Unisom
- Zyrtec

**OTC Antitussives/Non-Narcotic Cough and Cold Agents/ Sympathomimetics/Expectorants**
- Actifed
- Alka-Seltzer Plus Cold
- Benadryl Allergy Decongestant
- Children’s Sudafed Cold/Cough
- Contac
- Dimetapp
- Guaifenesin
- Infant Tylenol Cold
- Organidin NR
- Pediacare Products
- Pseudoephedrine
- Robitussin
- Robitussin Cough, Cold and Flu
- Robitussin D
- Robitussin CF
- Robitussin PE
- Scot-Tussin Products
- Theraflu
- Tramaminic
- Tylenol Cold
- Vick’s 44E Cough & Chest

**OTC Calcium Replacement**
- Calcium Carbonate
- Calcium Citrate
- Calcium Lactate
- Calcium with Vitamin D
- Oyster Shell Calcium

**OTC Condoms**
**OTC Contraceptives, (Intravaginal)**
Encare
Gynol II

**OTC Ear Preparations**
Debrox
Gly-Oxide
Murine Ear Wax Removal System

**OTC Electrolyte Maintenance**
Oralyte
Pedialyte Freezer Pops
Pediatric Electrolyte

**OTC Artificial Tears/Lubricants**
Artificial Tears
Dry Eyes
Lacri-Lube S.O.P.
Murine

**OTC Eye Vasoconstrictors**
Naphazoline
Neo-Synephrine
Visine

**OTC Eye Allergy**
Alaway (Ketotifen)
Opcon-A
Vasocon-A
Visine-A

**OTC General Inhalation Agents**
Sodium Chloride for Inhalation

**OTC Hemorrhoidal Preparations/Rectal Preparations**
Anusol
Anusol HC
Nupercainal
Preparation H

**OTC Iron Replacements**
Carbonyl Iron
Feosol
Ferrous Fumarate
Ferrous Gluconate
Ferrous Sulfate

**OTC Laxatives/Cathartics/Intestinal Adsorbents and Protectants**
Bisacodyl
Citrucel
Docusate Sodium
Fiber Laxative
Fleet Products
Glycerin Suppositories
Konsyl
Magnesium Citrate
Metamucil
Milk of Magnesia
Mineral Oil
Miralax
Senokot

**OTC Magnesium Salt Replacements**
Slo-Mag

**OTC Multivitamin/Mineral Preparations**
Aquasol A Drops
Dialvyte 800
Drisdol Drops
Folic Acid
Multivitamin (Pediatric and Geriatric)
Multivitamin w/Iron
Niacin
One-Tablet-Daily
Slo-Niacin
Vitamin A Preparations
Vitamin B Preparations
Vitamin B1, B12, B2, B6 Preparations
Vitamin C Preparations
Vitamin D Preparations
Vitamin E Preparations
Zinc Replacements (Zinc Gluconate, Zinc Sulfate, Zinc Chelate)
**OTC Nasal Preparations/ Sympathomimetics**
- Afrin
- Nasalcrom
- Ocean (Sodium Chloride)

**OTC Nutrient Supplements** *(Secondary to WIC benefits, PA Req)*
- Boost *(Secondary to WIC benefits, PA Req)*

**OTC Smoking Deterrent Agents**
- Nicoderm CQ Patches
- Nicorette Gum

**OTC Topical Antifungals/Antibiotics**
- Bacitracin
- Clotrimazole
- Lotrimin AF
- Lotrimin Ultra Cream 1% *(Butenafine 1%)*
- Miconazole
- Neosporin
- Nizoral A-D
- Polysporin
- Tinactin
- Tolnaftate
- Triple Antibiotic

**OTC Topical Steroids**
- Hydrocortisone

**OTC Miscellaneous Topicals**
- Abreva
- Aquaphor
- Aveeno
- Calamine Lotion
- Compound W
- Desitin
- Domeboro
- Duofilm
- Eucerin
- Oatmeal, Colloidal
- Orajel
- Povidone Iodine
- Vick's Vapor Rub
- Vitamin A and D Ointment

**OTC Pediculicides**
- Nix
- RID

**OTC Vaginal Antifungals**
- Gyne-Lotrimin Products
- Monistat Products
- Mycelex Products
- Vagistat Products

**OTC Diagnostics**
- Acetest
- Chemstrip UG
- Clinistix
- Clinistix Reagent
- Combistix
- DiaHr
- Ketostix
- Multistix
- Uristix

**OTC Miscellaneous**
- Asthma Peak Flow Meters
- Asthma Spacers
- Diabetic Lancets
- Ipecac
- Tablet Splitters
- Zostrix
- Zostrix HP
Pharmacy and Therapeutics Committee

The development and maintenance of the Neighborhood Formulary is dynamic and requires constant attention. Expert advice is provided to Neighborhood by its Pharmacy and Therapeutics (P&T) Committee. The P&T Committee meets quarterly to consider addition of new pharmaceuticals, and to review the adequacy of the current Formulary. The Formulary is updated and posted on the Neighborhood website (www.nhpri.org) after each P&T meeting. Providers are encouraged to review the Formulary and provide input and comments to the Neighborhood P&T Committee.

Drugs considered for inclusion on the Neighborhood Formulary are evaluated relative to available alternate therapies (both pharmaceutical and non-pharmaceutical) use to treat specific disease states and/or physical conditions. The Neighborhood P&T Committee uses the criteria listed below in the evaluation of drugs considered for inclusion on the Neighborhood Formulary.

1) Safety: the potential for adverse reactions, side effects and drug interactions.
2) Efficacy: the potential effects of treatment under optimal conditions.
3) Effectiveness: the actual effects of treatment under real life conditions.
4) Relevant benefits of current formulary agents of similar use.
5) Cost and outcome modeling: potential health outcomes and resulting total cost of drug and medical care; potential savings available. The context of plan demographics, alternate agents, and cost-effectiveness are pieces of the decision-making process.
6) Condition of potential duplication of similar drugs currently on the formulary
7) Any restrictions that should be delineated to assure safe, effective, or proper use of the drug.
8) Requirements and restrictions set forth in the Medicaid Managed Care Services Pharmacy Benefit Plan Protocols established (and amended) by the RI Department of Human Services.
Generic Substitution

When available, FDA approved generic drugs are to be used in all situations. The brand names listed are for reference use only, and do not denote coverage, unless specifically noted. Greater economy is realized through the use of generic equivalents. This policy is consistent with Rhode Island law, and is not meant to preclude or supplant any state statutes that may exist. All drugs, which are or become available generically, are subject to review by Neighborhood’s Pharmacy and Therapeutics Committee.

- As permitted by Rhode Island pharmacy statutes, generic substitution using all forms of A-rated generics is allowed if, pursuant to pharmacist’s judgment, there is sufficient evidence that the generic product will produce the same therapeutic effect as the brand comparator.

- Certain drug products with complex pharmacokinetics, dosage forms, narrow therapeutic efficacy, or where blood level maintenance is crucial will not be subject to substitution. These products are:
  - Dilantin
  - Premarin

This list is reviewed and updated periodically based on the clinical literature and available pharmacokinetic principals of the drug products.

Experimental Drugs

The experimental nature or use of drug products will be determined by the P&T Committee using current medical literature. Any drug product or use of an existing product which is determined to be experimental, will be excluded from coverage.
Benefit Exception Process

Coverage for non-Formulary, not covered or restricted drugs may be applied for by prescribers. Requests for non-Formulary, not covered or restricted medications are addressed by Neighborhood pharmacy and medical staff. When a member gives a prescription order for a non-Formulary, not covered or restricted drug to a pharmacist, the pharmacist will evaluate the patient’s drug history and contacts the prescriber to confirm the medical necessity for the drug. The prescriber will then call the Neighborhood pharmacist, to obtain approval. The prescriber will provide information to address the following:

a) The use of Formulary products in contraindicated in the patient.

b) The patient has failed an appropriate trial of Formulary or related agents.

c) The choices available in the Drug Formulary are not suited for the present patient care need, and the drug selected is required for patient safety.

d) The use of a Formulary Drug may provoke an underlying condition, which would be detrimental to patient care.

Application of the above criteria will reflect patient safety screens, and P&T Committee approved Step Therapy protocols. There is no therapeutic substitution in management of the Neighborhood Formulary benefit.
Prior Authorization

Drug products, which are listed as Prior Authorization (PA) required, require approval when the member presents a prescription to a network pharmacy. To obtain coverage, a prescriber or pharmacist may:

a) Fax a completed Prior Authorization Request to the pharmacist at Neighborhood at 1-866-423-0945.

b) Contact the pharmacist at Neighborhood at 1-401-459-6020 and provide all necessary information requested.

Each request will be reviewed on individual patient need, and according to criteria approved by the Neighborhood P&T Committee. For information on the process for denials, see section on Adverse Determination below.
Adverse Determination

For requests that do not meet the criteria for a benefit exception:

a) The rationale and Formulary alternatives will be provided to the prescribing provider.

b) In instances where the prescriber feels the recommended alternatives do not meet the needs of the patient, the prescriber will be referred to the Neighborhood Medical Director or Physician Advisor for approval or denial of the request. After discussion with the prescriber, the Medical Director or Physician Advisor will assess the prescription’s medical necessity before making a determination.

c) In the event of a denial, the Medical Director or Physician Advisor will discuss with the prescribing practitioner the reason for the denial, and an explanation of the appeals process as outlined in Policy and Procedure for Clinical Appeals.

Please refer to Section 3 for information on the standard appeals process, which is to be adhered to in the event of an adverse determination.
Pharmacist and Prescriber Communications

The Formulary is a tool to promote cost-effective prescription drug use. The Neighborhood P&T Committee has made every attempt to create a document which meets all therapeutic needs; however, the art of medicine makes this a formidable task. Neighborhood welcomes the participation of prescribers, pharmacists, and ancillary medical providers, in this dynamic process. Prescribers and pharmacists are strongly encouraged to direct any suggestions or comments regarding the Formulary to Neighborhood at the following address:

Chair, Pharmacy and Therapeutics Committee
Neighborhood Health Plan of Rhode Island
299 Promenade Street
Providence, RI 02908
Section 7

Practitioner Information

- Primary Care
- The Role of the Primary Care Practitioner
- The Role of the Specialty Care Practitioner
- On-Call Protocol and Notification
- Closing Your Practice to New Members
- Practitioner Termination
- Continuity of Care
- Practitioner Information Changes
Primary Care

A primary care practitioner (PCP) is a practitioner who practices in the following areas of medicine: PED, OB/GYN, FP, or IM, inclusive of nurse practitioners; he/she is credentialed by the Plan and contracted as a PCP.
The Role of the Primary Care Practitioner

The Primary Care Practitioner (PCP) functions as the central access point for Neighborhood’s membership. In choosing to participate with Neighborhood, primary care practitioners have accepted the following responsibilities, also highlighted in the Participating Provider Group (PPG) Agreement:

- Coordinate all care for a Neighborhood member
- Furnish or arrange for the furnishing of covered services for each member and be responsible for the coordination of covered Services to members, including admissions to inpatient facilities, coordination between medical and behavioral health services, in compliance with Neighborhood policies and procedures.
- Establish and maintain medical records for each member that are consistent with current professional standards and medical requirements as set forth in applicable statutes and regulations of the State of Rhode Island.
- Make and maintain necessary and appropriate arrangements to ensure the availability of PCP consultation, at least by telephone, to members on a 24-hour-a-day, seven days-a-week basis, including arrangements to assure coverage of members after-hours or where the member’s PCP is otherwise absent. The covering PCP shall perform such services in the same manner in which the PCP provides services to his/her other patients.
- Establish and maintain written on-call arrangements. Such arrangements shall be forwarded to Neighborhood and shall include, but not be limited to: the practitioner’s name, tax identification number; and acceptance of the Neighborhood referral policies and procedures and the fee schedule.
- Maintain an appointment system, the goal of which is to ensure prompt access to medical care on-site. Prompt access is defined as thirty (30) days for routine care and twenty-four (24) hours for urgent medical conditions. For the purpose of this section, routine care shall include care for non-urgent symptomatic conditions and ongoing treatment of a chronic problem, and shall not include office procedures or routine physical exams.
- Be open for operations five (5) days per week per site, with a minimum appointment time of forty (40) hours per week per site, including one (1) additional evening until 8pm. Exceptions will be considered by Neighborhood’s Chief Medical Officer based on the site’s availability to provide documented continuity of care and access to services for urgent medical conditions.
- Designate as PCPs, eligible for accepting assignments of Neighborhood members, only those practitioners who are regularly scheduled for at least seventeen and one-half (17.5) hours of appointment time per week.
- Maintain policies and procedures regarding patient education. Patient education shall be an ongoing process which includes but is not limited to: orientation to provider services, self-management of medical problems and disease prevention, presentation of a written patient bill of rights, and assistance in reinforcing Neighborhood member orientation activities.
- PCP shall coordinate, if necessary, medically necessary emergency services on behalf of members as well as educate members on established Neighborhood policies and procedures for obtaining such services.
• Provide and administer care and services as set forth in the PPG Agreement in accordance with accepted medical practices and professional standards of behavior as set forth by the American Medical Association, the American Osteopathic Association, and the laws governing medical practice in the State of Rhode Island, as well as provide and administer care and services with the same standard of care, access, availability, skill and diligence customarily provided to all of his/her patients.

• Ensure that Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services are provided to all eligible children and young adults up to the age of 21 in accordance with the Rhode Island EPSDT Periodicity Schedule and Neighborhood policies and procedures.*

• Ensure that all covered services shall be available and shall be provided at such times and places, including the member’s home or elsewhere, as necessary and practical as determined by PCP or as recommended by other participating practitioners subject to state regulatory requirements. The PPG shall assure open communication with members regarding medically necessary care or appropriate treatment alternatives, regardless of benefit coverage limitations.

• Ensure the member’s right to consent to or deny the release of identifiable medical or other information, except when such release is not required by law.

• Ensure the member’s right to refuse treatment without jeopardizing future treatment and the member’s right to ask for a second opinion in accordance with Neighborhood’s policies and procedures.

*Please contact Neighborhood Customer Service at 1-401-459-6020 prompt 3, or go to the Rhode Island Department of Health’s website at www.health.ri.gov for a copy of the Rhode Island EPSDT Periodicity Schedule.
The Role of the Specialty Care Practitioner

A specialty care practitioner is defined as a practitioner providing a consultation or ongoing specialty care, which is medically necessary, to a member. Neighborhood has an extensive network of participating (in network) specialty practitioners. Non-participating specialty care practitioners may also consult and/or provide care to Neighborhood members when medically necessary and with prior authorization from Neighborhood’s Case Management Program.

The specialty care practitioner is responsible for the provision of covered specialty care services working in collaboration with the member’s Primary Care Practitioner (PCP), and shall assure open communication with members regarding medically necessary care or appropriate treatment alternatives, regardless of benefit coverage limitations. The specialty care practitioner is expected to establish and maintain appropriate medical records for each member and to provide appropriate documentation of their findings to the member’s PCP within a reasonable timeframe.
On-Call Protocol and Notification

The Primary Care Site is responsible for member care twenty-four hours per day, seven days a week. Primary Care Sites shall arrange for after-hours coverage and accessibility to care outside of the on-site practitioners’ availability. During normal business hours, the Primary Care Site directs and manages member care and visits.

After Hours Coverage

Neighborhood will reimburse on-call primary care sites that render services and hands-on treatment to an eligible member in the event that the member’s PCP is unavailable. Telephone triage will not be reimbursed by Neighborhood.

Primary Care Sites should notify Neighborhood Customer Service at 1-401-459-6020 or their Provider Services Specialist of their on-call coverage group(s). Primary Care Sites may also complete the On-Call Provider Group Notification Form found in Section 10.
**Closing Your Practice to New Members**

In order to best meet the needs of his/her current patient population, Neighborhood recognizes that it may be necessary for a Primary Care Practitioner (PCP) or Primary Care Site to temporarily limit the number of Neighborhood members assigned to the PCP/Site by implementing one or more of the following strategies:

- Closing the site to Neighborhood membership with the exception of newborn patients
- Closing the site to Neighborhood membership with the exception of siblings of current patients
- Closing the site to Neighborhood membership entirely.

Notification of the PCP/Site’s decision to temporarily close the practice must be forwarded in writing to Neighborhood in advance. When a practitioner notifies Neighborhood in writing that the practice would like to be re-opened to new membership, Neighborhood will reopen the practice as indicated, provided the practice is compliant with the established Access to Care Standards outlined in Section 10. Please contact Neighborhood Customer Service at 1-401-459-6020, or your Provider Services Specialist with questions.
**Practitioner Termination**

Neighborhood practitioners are contractually obligated to inform Neighborhood sixty (60) days prior to their effective termination date with a participating primary care site, provider group or the Network to ensure coordination of care for their assigned members or members cared for by them. Following are Neighborhood's Policies and Procedures as they relate to the effective termination date of primary care and specialty practitioners, upon notification by the PPG:

**Primary Care Practitioners**

The provider shall notify Neighborhood members currently under a participating practitioner’s care prior to the effective date of termination. Neighborhood shall be responsible for notifying members of the PCP’s termination and the process by which those members shall continue to receive the covered services of a PCP.

**Specialty Practitioners**

The effective termination date for Specialty Practitioners is the date that he/she actually terminated with the respective PPG or the network. Specialty practitioners are responsible for notifying Neighborhood members currently under their care in advance of the date of termination.

Practitioner termination information should be communicated to the Provider Services department by using the Practitioner Termination Notification Form located in Section 10 for your convenience. The Practitioner Termination Notification Form may be faxed to Provider Services 1-401-709-7066 or contact your Provider Service Specialist.
Continuity of Care

Neighborhood recognizes the importance of our members’ established relationships with both participating and non-participating practitioners. Neighborhood will, on a case-by-case basis, authorize services to preserve an on-going clinical relationship with a non-participating practitioner or recently terminated practitioner to preserve continuity of care for reasons including but not limited to:

- Neighborhood members currently receiving active treatment for an acute medical condition or an acute episode of a chronic illness,
- Neighborhood members currently in their second or third trimester of pregnancy, and
- Children with special health care needs who are unable to be transitioned to a practitioner with comparable or greater expertise.

Please contact the Medical Management Department at 1-401-459-6060 to request authorization for the provision of services to Neighborhood members that you believe would qualify.

Practitioners who have terminated from the network should complete the “Continuity of Care Request Form” (Website → Providers → Administrative Resources → Prior Auth Info → MM Request Forms), and fax it to the Medical Management department at 1-401-459-6023. Authorization may be granted to extend the provision of services until the active treatment is concluded or, if earlier, one (1) year after termination. The Member Hold Harmless provisions of the Neighborhood contract shall continue in effect during the active treatment period.
Practitioner Information Changes

Participating practitioners and provider offices are required to notify Neighborhood of any important changes; including but not limited to changes in office hours, location, phone/fax number, the availability of practitioners, billing information, changes in board certification and/or hospital privileges, etc. Please contact Neighborhood Customer Service at 401-459-6020 or your Provider Services Specialist with this information. The following forms are located in Section 10 of this Provider Manual, and may be used to fax practitioner information changes to Neighborhood’s Provider Services Department.

- On-Call Provider Group Notification Form
- New Practitioner Notification Form
- Practitioner Termination Notification Form
- Changes to Billing/Tax Identification Number Notification Form
Section 8

Quality Management

- Quality Improvement Program
- Neighborhood’s Quality Improvement Activities
- Quality Improvement Methodology
Quality Improvement Program

Neighborhood Health Plan of Rhode Island’s (Neighborhood’s) Quality Improvement Program strives to ensure that enrolled members have access to high quality health care services that are safe, effective, responsive to their needs and result in positive health outcomes. Neighborhood monitors and evaluates the important aspects of care and service rendered to members, with particular emphasis and focus on accessibility to care, availability of services, member satisfaction, and health outcomes. This information is captured and evaluated through routine health plan reporting, annual HEDIS® and CAHPS® results, assessment of provider and member satisfaction, accessibility and availability standards, utilization trends, and specially designed quality improvement studies. Neighborhood assesses health plan performance against identified goals and objectives that are evidence-based and align with both state and national industry standards.

The overall goal of Neighborhood’s Quality Improvement Program is to ensure that members have access to high quality health care services that are safe, responsive to their needs and meet their expectations of satisfaction. The objectives of the Quality Improvement Program in support of this goal are to:

- Assure access to high quality medical and behavioral health care
- Implement intervention programs aimed at improving preventive care rates
- Apply the chronic care model to all disease management programs
- Provide support to members with acute health care needs
- Improve member and provider satisfaction
- Monitor and improve coordination of care across settings
- Ensure the safety of members in all health care settings
- Monitor physician adherence to established Clinical Practice Guidelines
- Develop action-oriented materials and communications to engage members in their care
- Improve HEDIS® and CAHPS® performance
- Maintain collaborative relationships with network providers and State agencies
- Improve operational efficiency in the work performed across the organization

To become involved or for more information about Neighborhood’s Quality Improvement Program, please contact Neighborhood’s Customer Service staff at 1-401-459-6020 or visit our website at www.nhpri.org.
Neighborhood’s Quality Improvement Activities

Provider Satisfaction
Neighborhood conducts an annual Provider Satisfaction survey to measure provider satisfaction with Neighborhood’s administrative and clinical processes. Neighborhood annually administers two separate surveys to physicians and office managers to better assess the needs of our external customers. These surveys assess respondents’ satisfaction with functional areas within Neighborhood and the Neighborhood network, as well as overall satisfaction and health plan loyalty. The information obtained is used to develop quality improvement initiatives across the organization to increase providers’ satisfaction with Neighborhood and to ensure high quality care for Neighborhood members.

Clinical Practice Guideline Development
Neighborhood’s Associate Medical Director’s Office develops clinical practice guidelines to ensure the delivery of age-appropriate, evidence-based care to enrolled members. Clinical practice guidelines for behavioral are developed by Neighborhood’s behavioral health vendor. Neighborhood annually assesses practitioner adherence to the guidelines to identify opportunities for performance improvement. The guidelines complement and reinforce the established medical philosophy and benefit coverage offered by the Plan. Clinical Practice Guidelines are updated no less than every two (2) years and are accessible to network practitioners via the Neighborhood website.

Disease Management Programs
Disease management is a multi-disciplinary, continuum-based approach to health care delivery that focuses on the identification of populations with, or at risk for, established medical conditions. Neighborhood’s disease management programs strive to: support the relationship between practitioners and their patients and reinforce the established plan of care; emphasize the prevention of exacerbations and complications utilizing cost-effective evidence-based practice guidelines and patient empowerment strategies such as self-management and patient education and outreach; and continuously evaluate clinical, humanistic, and economic outcomes with the goal of improving overall health. Neighborhood currently has disease management programs for asthma, diabetes, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), and heart failure (HF).
Peer Review Activity

Peer review is conducted according to the Rhode Island Board of Medical Licensure and Discipline Regulations. The CMO manages the peer review process and its delivery at the Clinical Affairs Committee. Cases requiring peer review are identified through member or provider complaints, and from any other source. The CMO may perform peer review directly, or arrange for review by an appropriate physician or committee of physicians, in accordance with Neighborhood’s policies and procedures. Remedial and disciplinary action shall be implemented in a timely manner in accordance with Neighborhood’s Professional Review Action policies and procedures.

Actions to Address Quality of Care Complaints

All complaints or issues received from members, providers, Neighborhood staff, state agencies, and other entities relative to the quality of care or services rendered to members are forwarded directly to the Quality Assurance Specialist for investigation, who coordinates the investigation and prepares the findings to be reviewed with the Associate Medical Director (AMD) assigned to the case. For complicated cases, the AMD may defer the case to the Quality Assurance Committee (QAC) for discussion prior to rendering a final decision. Complaints deemed to be issues of quality of care by the reviewing AMD and/or QAC are reported to the Clinical Affairs Committee on a regular basis. Simultaneously, member concerns specific to access for urgent or current conditions or illnesses are routed to a clinician in Neighborhood’s Associate Medical Director’s Office.
Quality Improvement Methodology

Neighborhood has chosen the Plan Do Study Act (PDSA) quality improvement methodology as the systematic approach employed across all departments to ensure continuous quality improvement in the Plan’s clinical and service performance and operational functions and efficiencies. For quality improvement opportunities that can benefit from the Project Management Office’s (PMO) governance structure, QI team leaders, in concert with their directors, collaborate with the PMO office.

The following are the steps applied to all quality improvement initiatives undertaken by Neighborhood:

**Plan**

Neighborhood monitors a variety of performance measures covering clinical care and service delivery to identify opportunities for improvement. Neighborhood uses HEDIS® and CAHPS® results, program evaluation results, member and provider satisfaction surveys, the Customer Service member call logs, claims, utilization data, disease and case management data, medical records, patient safety data, accessibility and availability surveys, member and provider focus groups, and other sources of data to guide and inform the quality improvement process. The available data are analyzed to assess performance over time, across providers, and among member sub-groups. Causal analysis is conducted, often in collaboration with network providers and/or member representatives, to better understand trends identified in the data and indicate opportunities for improvement.

Neighborhood’s standing QI committee, subcommittees, and ad-hoc QI workgroups are responsible for identifying potential quality improvement interventions and prioritizing the work and initiatives to be performed. Priorities are set, and interventions are designed based on the data analysis. Operational efficiency and the appropriate use of the resources within the organization are considered when prioritizing each activity/intervention. QI workgroups lead individual improvement activities through the PDSA cycle.

For each improvement activity selected, Neighborhood’s QI workgroups identify goals and objectives that are specific, measurable, achievable, relevant, and time-bound (SMART). The performance goals and objectives selected often align with local and national benchmark data, including but not limited to Quality Compass® and NCQA Accreditation benchmarks for Medicaid Managed Care organizations.

**Do**

The QI team leaders in collaboration with their improvement work groups carry out the interventions designed based on the analysis of the data.

**Study**

The improvement work group monitors the effectiveness of the interventions carried out based on the goals and measures previously identified. The data is collected, analyzed and the results are reported to the appropriate committee based on the targets established for each activity using the PDSA methodology including the identification of barriers and the interventions for overcoming the identified barriers.

**Act**

The QI team leaders in collaboration with their improvement work groups modify the interventions, as necessary, and identify the next steps. Successful interventions are monitored for sustainability and transferability.

To ensure that quality improvement is continuous and the identified goals and/or objectives are being met, each quality improvement activity is reviewed and discussed by the designated committee or subcommittee regularly. Modifications to the initiatives are implemented as necessary and incorporated into the QI Work Plan.
Section 9

Standards of Care

- Medical Record Keeping and Documentation Standards
- Access to Care Standards
- Credentialing & Recredentialing Process
- Office Site Assessment
- Remedial Action, Disciplinary Action & Appeal Process
Medical Record Keeping

It is the expectation of Neighborhood Health Plan of Rhode Island (Neighborhood) that comprehensive medical records detailing all aspects of our enrolled members’ care and treatment are maintained by our contracted providers to aid and inform other providers and/or the health plan of the members’ medical history and to assure coordinated care. Neighborhood shall have the right, upon request, with reasonable notice, to review any medical records maintained pertaining to covered services provided to members, and to copy the same. Neighborhood can release medical information to the Department of Human Services (DHS) for purposes directly related to the administration of the RIte Care or Rhody Health Partners programs. Reviews external to DHS are made in accordance with applicable state and federal regulations and laws.
Medical/Treatment Record Keeping, Availability and Confidentiality Standards

Neighborhood requires that the medical record keeping system and practices of all participating practitioners adhere to the following standards to assure that patient information and medical records are organized and maintained as confidential in accordance with applicable state and federal regulations; and are accessible to Neighborhood and / or other practitioners as necessary:

- There is an employee responsible for medical record keeping.
- Medical records are in a designated area accessible to staff only.
- There is one medical record for each patient labeled with patient’s name.
- There are written medical record policies and procedures that address security and confidentiality, retention of active and inactive files, release of information, including the availability of records for covering practitioners, and consent for or refusal of treatment.
- Patient name and ID number are noted on each sheet in the chart.
- Medical records are secured in folders and electronic medical records are password protected.
- Sections in the records are grouped by dividers or paper clips.
- There is a process for backing up electronic medical records, if electronic medical records are used.
- The record is legible.
- Medical/Treatment records keeping practice is reviewed during credentialing and recredentialing office site assessment.

Confidentiality

- A release of information policy must be in place to ensure patient confidentiality is consistent with federal and state regulations.
- Patient Information is maintained as confidential in accordance with applicable state and federal regulations.
- Neighborhood shall have the right, upon request, with reasonable notice, to review any medical records maintained pertaining to covered services provided to members, and to copy the same.
- Neighborhood can release medical information to DHS for purposes directly related to the administration of the RIté Care program. Reviews external to DHS are made in accordance with applicable state and federal regulations and laws.

Performance Measure/Quality Improvement

To assure compliance with established medical record standards, Neighborhood conducts review of medical/health records of their enrollees using standard performance HEDIS® measurement criteria as outlined in the HEDIS® Technical Specifications. HEDIS® development and maintenance is sponsored and supported by the National Committee for Quality Assurance (NCQA). HEDIS® is the most widely used set of standardized performance measures in the managed care industry.
Each HEDIS® measure is collected using one of three methodologies: administrative, hybrid or survey. The administrative method uses claims data to identify the denominator and numerator. In this case the denominator will include all members who meet the eligibility criteria based on the technical specifications defined under each measure. The hybrid method uses both administrative and medical record data to identify the denominator and numerator. The hybrid denominator consists of a systematic sample of members drawn from the eligible population. Each year, a provider mailing is sent to all provider sites with a list of member names and the measures to be reviewed by the medical record review team of registered nurses. Member satisfaction is assessed through the Customer Assessment of Healthcare Providers and Systems (CAHPS) survey. Careful sample requirements include continuous enrollment information. All measurement processes must pass an external audit by an NCQA-certified HEDIS® auditor. Neighborhood contracts with an NCQA-certified software vendor to calculate its HEDIS® measures. To comply with regulations, these rates are submitted both to NCQA and to the Department of Human Services every June. Neighborhood collects reports and uses HEDIS® results in the development of their quality work plans and in the development of continuous improvement processes.
Access to Care Standards

Neighborhood has developed guidelines to ensure our members’ accessibility to primary care services and their assigned Primary Care Practitioner (PCP).

Neighborhood will annually monitor primary care sites’ compliance with the access standards during and outside of the Participating Provider Group’s (PPG’s) established business hours. Neighborhood requires the hours of operation that providers offer must be the same for all patients regardless of payer. Evaluation of site-specific member complaints and grievances will be reviewed monthly.

Intervention and remedial action will be initiated whenever a PPG site cannot substantively meet the criteria outlined below, as determined by data obtained and reviewed from one of the sources referenced above. New or continued enrollment at the PPG site may be suspended should remedial action fail to bring the site into compliance. Decisions regarding the necessity of site closure will be made in consultation with the Rhode Island Department of Health (DOH) and the Center for Children and Family Health. PPGs may request new or continued enrollment once Neighborhood has confirmed that the “Access to Care” standards are met.

The standards are as follows:

- Urgent care is provided to patients within twenty-four (24) hours. Urgent care describes care that is necessary for a physical or mental medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of medical attention within twenty-four (24) hours could reasonably be expected to result in: a) placing the patient’s health in serious jeopardy, b) serious impairment to bodily function; or c) serious dysfunction of any bodily organ or part. Urgent care will be provided to members within twenty-four (24) hours, either by a practitioner located on site, by referral to a covering practitioner or through emergency instructions.

- Appointments for non-urgent, symptomatic visits will be available as clinically appropriate, or within thirty (30) days of either the member’s or practitioner’s request. Non-urgent, symptomatic visits describe visits during which medical care is provided for the acute onset of symptoms that are not considered urgent, or cannot be classified as life or limb-threatening. Examples include: cold symptoms, sore throat, or nasal congestion.

- Appointments for routine care will be available within thirty (30) days, or as determined clinically necessary by the practitioner. Includes the diagnosis/treatment of conditions in the effort to prevent the need for more complex treatment as well as to minimize the risk of developing chronic illness. Examples include: family planning, chronic pain, etc.

- New Plan members who do not have an existing relationship with the PPG will be able to obtain appointments within sixty (60) days of the date of request.

- Appointments for routine physical examinations will be available within 6 months.
• Practitioner coverage will be available twenty-four (24) hours per day, seven (7) days per week. To ensure twenty-four hour coverage, PCP’s must have one of the following mechanisms in place to handle incoming member phone calls outside of normal business hours:

1) Answering machine or service that directs the member to visit the closest Emergency Room.

2) Answering machine that directs the member to contact the PCP or the designated on-call practitioner; or an answering service that contacts the PCP or designated on-call practitioner on behalf of the member.

The linguistic capabilities of the answering service representatives with whom the PCP is contracted and/or the outgoing message on the PPG’s answering machine should represent the linguistic needs of the population served.

PCPs will exhibit compliance with the PCP:Member Ratio policy, highlighted in Section 2.08.02.06 of the Department of Human Services RIfte Care Contract with Neighborhood which states that no more than fifteen hundred (1500) RIfte Care members may be assigned to any single primary care practitioner in the Neighborhood network. For primary care teams and primary care sites, no more than one thousand (1000) members may be assigned per primary care practitioner within the same site or team; e.g., a primary care team with three (3) practitioners may be assigned a maximum of 3,000 RIfte Care members.
Credentialing and Recredentialing

To ensure that Neighborhood’s members have access to quality care, all practitioners who participate in Neighborhood network are credentialed prior to becoming effective in the network. To ensure that practitioners continue to meet Neighborhood’s standard for network participation practitioners are re-credentialed at least every 3 years. Neighborhood’s credentialing and recredentialing policies and procedures meet the requirements of recognized regulatory and accrediting organizations. The process of credentialing and recredentialing is conducted in a confidential, non-discriminatory manner and decisions are based on standard credentialing requirements in addition to established recruitment standards.

Before a practitioner’s contract can become effective, the Clinical Affairs Committee (CAC) must approve his/her application. The CAC is also responsible to approve all practitioners’ reappointment in the network. Neighborhood’s Chief Medical Officer (CMO) is responsible for overseeing the credentialing program.

The credentialing process takes up to 90 calendar days to complete. Practitioners have the right to:

- Check the status of their credentialing application by calling credentialing department at 401-459-6000.
- Review information submitted to support the credentialing application and correct erroneous information at any time by submitting a written request to credentialing department
- Be informed of the credentialing decision within 60 calendar days from the plan’s decision date
- Appeal the credentialing decision

Practitioners have the option of completing Neighborhood’s credentialing application or submit a copy of Center for Affordable Quality Healthcare (CAQH) application for credentialing and recredentialing.

Type of practitioner credentialed by Neighborhood

<table>
<thead>
<tr>
<th>Allopathic Physician (MD)</th>
<th>Physician Assistant (PA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Osteopathy Physician (DO)</td>
<td>Nutritionist</td>
</tr>
<tr>
<td>Doctor of Dental Surgery/Science (DDS) – Oral Surgeons Only</td>
<td>Certified Diabetic Outpatient Educator (CDOE)</td>
</tr>
<tr>
<td>Doctor of Medical Dentistry (DMD) – Oral Surgeons Only</td>
<td>Certified Asthma Educator (AE_C)</td>
</tr>
<tr>
<td>Doctor of Podiatric Surgery (DPM)</td>
<td>Tobacco Treatment Specialist (TTS)</td>
</tr>
<tr>
<td>Doctor of Optometry (OD)</td>
<td>Physical Therapist (PT)</td>
</tr>
<tr>
<td>Nurse Practitioner (NP)</td>
<td>Occupational Therapist (OT)</td>
</tr>
<tr>
<td>Certified Nurse Midwife (CNM)</td>
<td>Speech Pathologist (SP)</td>
</tr>
</tbody>
</table>

Neighborhood delegates the credentialing and recredentialing of behavioral health practitioners to Beacon Health Strategies, LLC. Contact Beacon at 1-781-995-7556 to request credentialing and recredentialing.
**Process:**

Credentialing and recredentialing of practitioners includes primary source verification of information provided on the application and information collected from monitoring other secondary source verifications.

Documentation needed for credentialing/recredentialing:

- Completed application (Neighborhood’s or complete hard copy of CAQH)
- Copy of current professional license in the state of practice
- Copy of current DEA certificate for each state of practice
- Copy of current Controlled Substance Registration certificate
- Copy of medical malpractice insurance face sheet with a minimum coverage of $1M per claim and $3M aggregate
- Copy of current Curriculum Vitae which include education/training information and work history for past 5 years (gaps in work history 6 months or greater must be explained)
- Copy of board certificate
- Copy of Education Commission for Foreign Medical Graduate (ECFMG) certificate (if applicable)
- Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate (if applicable)
**Office Site Assessment**

Neighborhood conducts site assessments to ensure that patient care sites meet Neighborhood’s standards for safety, cleanliness, medical record keeping, patient education, access to care and patient satisfaction. The assessment is conducted by trained Credentialing staff and the site assessment report serves as a mechanism for provider education and facilitation of continuous improvement in the provision of patient care and services.

If the site scores below the established performance threshold (below 90%), the practitioner is required to develop and submit a corrective action plan within a specified time frame. Sites that require an improvement action plan will be re-evaluated at six months of initial visit. If after 12 months of the initial visit the site does not meet the established performance standards in the site assessment tool, and/or continues to meet Neighborhood’s established complaint threshold, the site is referred to the Associate Medical Director or his designee for review and is presented to CAC for disciplinary action. Site assessments are conducted:

- At primary care, obstetrics and gynecology offices and urgent care/walk in treatment centers which are not accredited by an accreditation organization approved by the Center for Medicare and Medicaid Services (CMS) for network entry, every three years for recredentialing when recredentialing criteria applies or if the site relocates or performs extensive renovation.
- At all practitioner offices in response to data analyses or medical record reviews that reveals opportunities for improvement.
- At all practitioner offices to address member complaints within 45 calendar days of meeting complaint threshold regarding:
  - Physical accessibility
  - Physical appearance
  - Adequacy of waiting and examining room space
  - Adequacy of medical/treatment record keeping

Credentialing staff assess the following during the visit:

- Physical accessibility and appearance
- Access to care
- Adequacy of supplies and equipment
- Adequacy of medical/treatment record keeping
- Policy and procedures
Remedial Action, Disciplinary Action and Appeal Process

Neighborhood exercises remedial and disciplinary action procedures and peer review processes to address substandard care and services provided by network practitioners to assure the safety of members and the delivery of high quality healthcare treatment and services, in accordance with established Rhode Island General Laws §5-37.3-7, the Health Care Quality Improvement Act, 42U.S.C.§ 11101 et seq., Neighborhood’s policies and procedures and the participating provider’s contract with Neighborhood. Neighborhood also maintains procedures for reporting disciplinary action and serious quality concerns to appropriate authorities.

Remedial Action

Remedial action is undertaken as a result of peer review activity conducted by the CMO, the CAC or Quality Assurance Committee (QAC) upon identification of a quality or care concern. Remedial Action may include one of the following activities with the practitioner under review:

- Telephone discussion
- Written Correspondence
- Request to appear before a committee of peers
- Request to participate in the development of a performance improvement plan and agree to subsequent monitoring.

Remedial action is warranted before disciplinary action occurs, except for those circumstances in which the Neighborhood Chief Medical Officer believes that failure to take such action may pose an imminent danger to the health of an individual.

Disciplinary Action

Neighborhood’s CMO is responsible for identifying circumstances requiring disciplinary action and forwarding the matter to CAC and the Board of Directors. Disciplinary action is warranted if the provider does not comply with Neighborhood’s remedial action request. At a minimum these circumstances include:

- A pattern of refusal to comply with Plan, local, state or federal requirement or regulations on clinical or administrative practice
- A pattern or clinical practice that falls below applicable standards and expectations
- Failure to maintain full and unrestricted license to practice
- Failure to comply with accepted ethical and professional standards and behavior

A provider under review receives written notification of the prospect of a disciplinary action and the reason therefore, the right to request a hearing, and his/her rights at such a hearing.
Disciplinary action which involves limitation or suspension of privileges with the plan shall be reported to the appropriate Board of Professional Licensure and/or Regulation, State Agencies as appropriate and to National Practitioner Data Bank/Health Integrity Data Bank (if applicable) immediately following the hearing with notification of due process to practitioner of provider.

**Appeal Process**

Neighborhood provides due process to all credentialed practitioners/providers against whom it takes actions for quality reasons and who face disciplinary action for quality of care or for failing to demonstrate improvement or corrective action following Neighborhood’s request for remedial action arising from ongoing performance monitoring or other mechanisms.

All practitioners/providers who are not approved for network participation, who lose contractual privileges or whose contractual privileges are altered as a result of disciplinary action, are notified within sixty (60) calendar days from the date of the decision or action taken. The notification includes the reason for the action and the practitioner/providers rights to appeal the decision or action.

To appeal a decision, practitioners/providers must submit a written request for a hearing within forty (40) calendar days from the date of the notice to:

Neighborhood Health Plan of Rhode Island  
Attn: Associate Medical Director  
299 Promenade Street  
Providence, RI 02908

For additional information on practitioner/provider appeal, please call the credentialing department at 401-459-6000.
Section 10

Customer Service Request Forms
- Member Site Change Request Form
- Member Education Request Form
- Rite Care Interpreter Services Fax Request Form
- Rite Care Taxi/Van Transportation Authorization Form

Provider Services Request Forms
- New Practitioner Education Form
- On-Call Provider Group Notification Form
- Practitioner Termination Notification Form
- Changes to Billing Address/Tax Identification Number Notification Form

Behavioral Health Request Form
- Primary Care Provider Behavioral Health Communications Form

Claims Review Process and Submission Form
**Member Site Change Request Form**

**Please Note:** This form authorizes Neighborhood Health Plan of Rhode Island (Neighborhood) to process PCP Site Changes at a Neighborhood member’s request. If the member prefers to speak with a Customer Service Specialist, please have them contact Neighborhood Customer Service at 1-800-459-6019.

Providers have five (5) business days from the date of service to fax this request to Neighborhood; otherwise site changes will be effective on the date the information was faxed. This form must be signed by the member or member’s parent/head of household in order to be processed.

<table>
<thead>
<tr>
<th>Date: __________</th>
<th>Number of pages (including this cover sheet): __________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Group Name: _________________________</td>
<td>Site Liaison/Contact Name: ____________________________</td>
</tr>
<tr>
<td>Phone Number: _______________________________</td>
<td>Fax Number: ________________________________________</td>
</tr>
</tbody>
</table>

When applicable, the information below must be completed by the member’s parent or head of household.

<table>
<thead>
<tr>
<th>Member Name/Head of Household Name: ____________________________</th>
<th>Member ID #: ____________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nombre del Pariente o Guardian</td>
<td>Numero de Inditificacion</td>
</tr>
<tr>
<td>Address: ______________________________________________________</td>
<td>State: __________________ Zip Code: __________</td>
</tr>
<tr>
<td>Direcciòn</td>
<td>Estado</td>
</tr>
<tr>
<td>Phone Number: _________________________________</td>
<td>Best time to reach: ______________________</td>
</tr>
<tr>
<td>Telefono</td>
<td>Mejor tiempo apropiado para llamar</td>
</tr>
<tr>
<td>Member Name/Head of Household Signature: __________________</td>
<td>Date: ____________________________</td>
</tr>
<tr>
<td>Firma del Pariente o Guardian</td>
<td>Fecha de hoy</td>
</tr>
</tbody>
</table>

**Important:**

Please be sure to specify the Member’s Primary Care Practitioner within the Provider Group if he/she has selected one; otherwise Neighborhood Customer Service will select a PCP within the group on behalf of the member.

<table>
<thead>
<tr>
<th>Neighborhood Member ID #</th>
<th>Member Name</th>
<th>Date of Birth</th>
<th>New Practitioner and Provider Group Name</th>
<th>Neighborhood Practitioner ID #</th>
<th>Today’s Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numero de Inditificacion</td>
<td>Nombre del Miembro</td>
<td>Fecha de Nacimiento</td>
<td>Nombre del Proveedor Nuevo</td>
<td>Numero del Proveedor</td>
<td>Fecha de hoy</td>
</tr>
</tbody>
</table>

For Neighborhood Use Only:

<table>
<thead>
<tr>
<th>Customer Service Specialist: ____________________________</th>
<th>Date: ____________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment Coordinator: _____________________________</td>
<td>Site Change Processed: ____________________________</td>
</tr>
<tr>
<td>Comments: __________________________________________</td>
<td></td>
</tr>
</tbody>
</table>
Member Education Request Form

Please complete this form and return via fax or mail to Neighborhood Customer Service. Address information above.

Date: __________ Number of pages (including this cover sheet): __________

Provider Group Name: _________________________ Site Liaison/Contact Name: ____________________________
Phone Number: _______________________________ Fax Number: ________________________________________

Member Information:

Member Name: __________ Member ID # or SSN#: __________
Nombre: __________ Numero de Inditificacion: __________

Parent/Head of Household Name: __________ Member ID # or SSN#: __________
Nombre del Pariente o Guardian: __________ Numero de Inditificacion: __________

Phone Number: __________ Best time to reach: __________
Telefono: __________ Mejor tiempo apropiado para llamar: __________

Education Request: Please check the type(s) of education to be provided:

____ Referral process (specify): __________
____ Proper use of the ER, Specialty Practitioners (specify): __________
____ Frequently misses appointments (please list DOS): __________
____ Benefit education (specify Dental, Pharmacy, Transportation, Vision, Substance Abuse, Mental Health, OB/GYN): __________
____ Follow-up care overdue (request that member contacts Neighborhood to schedule an appointment – please specify): __________
____ Other education (please describe): __________

Additional Comments – Please provide additional comments in the space below as needed:

For Neighborhood Use Only:

Resolution: __________
Completed by: __________ Date Completed: __________
RITE CARE Interpreter Services Fax Request Form

Fax no less than 72 business hours prior to the date of service.

<table>
<thead>
<tr>
<th>Member ID #</th>
<th>FAX THIS FORM TO 459-6021 NHPRI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member ID #</td>
<td>FAX THIS FORM TO 888-624-2748 UHP</td>
</tr>
</tbody>
</table>

TO BE COMPLETED BY PROVIDER REQUESTING SERVICE

**Requestors Information:**

Today's Date: ________________________________

Providers' Full Name: __________________________ Phone #: __________________________

Provider's Address: ____________________________

Individual Filling Out Form: ___________________

Member Name: ___________________________ D.O.B. __________________________

Member's Phone #: ____________________________

**Service Information:** (Date, Location, and Type of Interpreter Needed)

Date of Visit/Service: _______ / _______ / _______ Time: _______ am _______ pm

Length of Appointment: _______________________

Type of Appointment (medical, behavioral etc...): ____________________________

**Location:** (where interpreter services are to be provided I.e. office, clinic, department, or other)

__________________________________________________________

Language Needed: ______________________________

Sign Language Interpreter: ________________________________

(Preferable): _______ Male _______ Female _______ No Preference

Address: ____________________________________________

Special Instructions (apartment #, floor, parking, etc.): ________________________________
RIte Care Taxi/Van Transportation Authorization Form

The purpose of this form is to document a medical condition that restricts a member from meeting the Ride Program criteria of walking at least _ mile to and from a Bus Stop. (All rides beyond this distance are considered not to be on a bus route.) Please complete this form in its entirety to help ensure that appropriate transportation arrangements are made.

This form is to be completed by authorized provider staff. Please fax no less than 72 business hours prior to the date of service. Please print clearly.

<table>
<thead>
<tr>
<th>Member Name:</th>
<th>Member DOB:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Member Id:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Provider’s Fax Number:</th>
<th>Attn:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Dates of Authorization</th>
<th>From:</th>
<th>To:</th>
</tr>
</thead>
</table>

(Dates are subject to change based on members condition)

<table>
<thead>
<tr>
<th>Can this Member take public transportation (bus) to medical appointments?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

If answer above is “No” then please provide a diagnosis below:

Please provide an explanation associated with the diagnosis and the limitations as to why the member is not able to walk a _ mile to a bus stop or use public transportation.

<table>
<thead>
<tr>
<th>Form Completed By:</th>
<th>Today's Date:</th>
<th>Phone:</th>
</tr>
</thead>
</table>

Provider Signature:

Provider Name (Please print):

Note: Transportation authorizations need to be completed by the MD, NP, PA, PhD or Nurse Midwife who are aware of the member’s limitations.

To Be Completed By Neighborhood

<table>
<thead>
<tr>
<th>Issue Number</th>
<th>Approved By:</th>
</tr>
</thead>
</table>

Did Not Meet Requirements:

Neighborhood Needs Additional Information:
# New Practitioner Education Form

Please complete this form and return via fax or mail to Neighborhood Provider Services. Address information above.

<table>
<thead>
<tr>
<th>Date: __________</th>
<th>Number of pages (including this cover sheet): __________</th>
</tr>
</thead>
</table>

Provider Group Name: _________________________ Site Liaison/Contact Name: ____________________________

Phone Number: _______________________________ Fax Number: ________________________________________

## A. Practitioner Demographic Information

Practitioner Name: ____________________________________________

Title (MD, NP, etc.): _______ Specialty: __________________________ Sub-Specialty(s): __________________________

Start Date: _______________ Neighborhood ID # (if available): ______________________________________________

If the practitioner is not currently credentialed with Neighborhood, please complete Box D.

## B. Previous Practice Information (if available)

Provider Group Name: ________________________________________

Phone Number: _______________________________ Contact Name: _________________________________________

End Date: _________________________________

## C. Billing Information

Billing Name: ______________________________________________

Billing Address: _____________________________________________

Phone Number: ___________________________ Fax Number: _________________________________

Contact Name: _____________________________________________ Please attach a copy of the W-9 form.

## D. Credentialing Information

Please circle one:

- Has the incoming practitioner submitted an application to Neighborhood to date?  YES  NO
- Date submitted: ______________________________ 
- Would you like us to send you a Neighborhood Practitioner Application?  YES  NO
# On-Call Provider Group Notification Form

Please complete this form and return via fax or mail to Neighborhood Provider Services. Address information above.

Date: __________ Number of pages (including this cover sheet): __________

Provider Group Name: _________________________ Site Liaison/Contact Name: ____________________________
Phone Number: _______________________________ Fax Number: ________________________________________

<table>
<thead>
<tr>
<th>Provider</th>
<th>Group Name</th>
<th>Address</th>
<th>Phone</th>
<th>Contact Name</th>
<th>Tax ID #:</th>
<th>Does your office provide on-call coverage for this provider group?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes                      No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes                      No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes                      No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes                      No</td>
</tr>
</tbody>
</table>

Neighborhood Health Plan of Rhode Island  
www.nhpri.org

Attention: Provider Services  
299 Promenade Street  
Providence, RI 02908  
Phone: 1-401-459-6020 or 1-800-459-6019  
Fax: 1-401-709-7066
Practitioner Termination Notification Form

Please complete this form and return via fax or mail to Neighborhood Provider Services. Address information above.

Date: _________ Number of pages (including this cover sheet): _________

Provider Group Name: _________________________ Site Liaison/Contact Name: ____________________________
Phone Number: _______________________________ Fax Number: ________________________________________

A. Current Information

Practitioner Name: ________________________________________________________________
Neighborhood ID #: ________________________________
Termination Date: ____________________________

B. Network Participation

Please indicate the practitioner’s reason for leaving the provider group:

- ☐ Retirement  ☐ Moved out of state  ☐ Left the group*  ☐ Other: _______________________________________

*Does the practitioner wish to remain in the network:  ☐ Yes  ☐ No  ☐ Unknown

C. New Practice Information

Provider Group Name: _____________________________________________________________
Phone Number: _______________________________ Fax Number: _______________________________
Start Date: _______________________________ Contact Name: _________________________________

D. Member Information

Does this practitioner currently have a panel of Neighborhood members assigned to him/her?  ☐ Yes  ☐ No
If so, to whom should the members be reassigned? Please list practitioner name(s) and specifications as necessary:

Name: ________________________________________ Neighborhood Provider ID #: ________________________
Name: ________________________________________ Neighborhood Provider ID #: ________________________

Notes:

D. Authorized Signature

The information on this form is accurate and may be processed accordingly.

Signature: ____________________________ Date: ____________________________
# Changes to Billing Address/Tax Identification Number Notification Form

Please complete this form and return via fax or mail to Neighborhood Provider Services. Address information above.

Date: __________ Number of pages (including this cover sheet): __________

Provider Group Name: _________________________ Site Liaison/Contact Name: ____________________________

Phone Number: _______________________________ Fax Number: ________________________________________

Please complete the following section to update billing company and/or billing address information:

<table>
<thead>
<tr>
<th>A. Current Billing Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing Company Name: ________________________________</td>
</tr>
<tr>
<td>Billing Address: ____________________________ City, State &amp; Zip: ____________________________</td>
</tr>
<tr>
<td>Billing Contact Name: ____________________________ Billing Phone Number: ____________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Network Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing Company Name: ____________________________ Effective Date: ____________________________</td>
</tr>
<tr>
<td>Billing Address: ____________________________ City, State &amp; Zip: ____________________________</td>
</tr>
<tr>
<td>Billing Contact Name: ____________________________ Billing Phone Number: ____________________________</td>
</tr>
</tbody>
</table>

Please complete the following section to update Tax Identification Number information:

<table>
<thead>
<tr>
<th>A. Old Tax Identification Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Tax Identification Number: ____________________________ Date No Longer Utilized: ____________________________</td>
</tr>
<tr>
<td>Practitioner(s) Using this Tax Identification Number: ____________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. New Tax Identification Number (New W-9 form is required for all TIN # changes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Tax Identification Number: ____________________________ Effective Date: ____________ (Must attach W-9)</td>
</tr>
<tr>
<td>Practitioner(s) Using this Tax Identification Number: ____________________________</td>
</tr>
</tbody>
</table>

Authorized Signature

The information on this form is accurate and may be processed accordingly.

Signature: ____________________________ Date: ____________________________
### Primary Care Provider Behavioral Health Communication Form

Reviewed by PCP (signature): ___________________________  Date: ___________________________

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>NHPRI</th>
<th>UBH</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member’s Health Plan</td>
<td>NHPRI</td>
<td>UBH</td>
<td>Date</td>
</tr>
</tbody>
</table>

Attention Behavioral Health Provider: _________________. The patient listed below is currently receiving services and has consented to share the following medical information in Section B. Please complete the information in Section A.

Member Name: ________________  DOB: ________________  Insurance ID#: ________________

### SECTION A

1. Attached is a signed copy of the release of information (please one):  Y  N

2. The patient is being treated for the following behavioral health problem(s): LIST ALL DIAGNOSES

   ________________  ________________

3. The patient is taking the following prescribed psychotropic medication(s): (List ALL MEDICATIONS AND DOSAGE)

   ________________  ________________

4. The patient has the following Substance Abuse issue (if applicable):

   ____________________________________________________________________________

5. Please describe any special concerns:

   ____________________________________________________________________________

   ____________________________________________________________________________

   ____________________________________________________________________________

   ____________________________________________________________________________

   ____________________________________________________________________________

   ____________________________________________________________________________

   ____________________________________________________________________________

   ____________________________________________________________________________

   ____________________________________________________________________________

   ____________________________________________________________________________

   ____________________________________________________________________________

   ____________________________________________________________________________

Psychopharmacologist, is applicable: ________________

Behavioral Health Clinician: ________________

Behavioral Health Clinician Signature: ________________

### SECTION B

PCP: Please complete and return to the above behavioral health provider via mail or fax

1. Attached is a copy of patient’s last physical with date of last appointment (please circle):  Y  N

2. The patient is being treated for the following medical problem(s): (LIST ALL DIAGNOSES)

   ____________________________________________________________________________

   ____________________________________________________________________________

   ____________________________________________________________________________

   ____________________________________________________________________________

3. The patient is taking the following prescribed medication(s):

   ____________________________________________________________________________

   ____________________________________________________________________________

   ____________________________________________________________________________

4. The patient has the following Substance Abuse Issue (If applicable):

   ____________________________________________________________________________

   ____________________________________________________________________________

   ____________________________________________________________________________

   ____________________________________________________________________________

   ____________________________________________________________________________

5. Please describe any special concerns:

   ____________________________________________________________________________

   ____________________________________________________________________________

   ____________________________________________________________________________

   ____________________________________________________________________________

   ____________________________________________________________________________

   ____________________________________________________________________________

   ____________________________________________________________________________

   ____________________________________________________________________________

   ____________________________________________________________________________

   ____________________________________________________________________________

   ____________________________________________________________________________

   ____________________________________________________________________________

   ____________________________________________________________________________

   ____________________________________________________________________________

PCP Completing communication form:

Primary Care Physician
Signature: ________________

Address: ____________________________________________________________________________

Phone: ________________

Fax: ________________
NEIGHBORHOOD HEALTH PLAN OF RHODE ISLAND
Reconsideration/Appeals Request Form

A reconsideration request should be filed first. If this review outcome is not satisfactory you may submit an Administrative Appeal.

THIS FORM AND ACCOMPANYING DOCUMENTATION SHOULD BE MAILED TO:

NHPRI, ATTN: CLAIMS QUALITY AND AUDIT, 299 PROMENADE STREET, PROVIDENCE RI 02980

Check the box below that applies to this request- see reference grid below for assistance:

Reconsideration: _____
Administrative Appeal*:_____

Please complete the required information below.

Provider Name: _______________________
Provider Address: _______________________
Contact Name: _______________________
Contact Phone: _______________________
Contact Email (optional): _______________________

Claim Information:
Date of Service: _______________________
Member Name: _______________________
Member ID Number: _______________________
Claim Number: _______________________

Description of request:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Important Footnotes:

*If medical notes are required and not included, provider correspondence will be returned. Any subsequent resubmission with additional required information does not extend any applicable filing limit terms. Please note: If a medical necessity denial was rendered by a Physician Reviewer, please refer to the Provider Manual, Authorization Process/Medical Management – Adverse Determination (Denials) and Appeals for direction. This form should not be used for Clinical Appeals. For Level II Administrative Appeals, please reference the NHPRI provider manual, Section 3.
Please use this grid as a guide in determining the correct category for your request. A service must be processed and denied on a remittance advice by NHPRI to be considered an appeal (with the exception of retroactive authorization requests). An Administrative Appeal should not be filed without submitting reconsideration request first.

<table>
<thead>
<tr>
<th>Denial Reason</th>
<th>Request Type</th>
<th>Required Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Reimbursement for Service Performed</td>
<td>Reconsideration</td>
<td>Medical notes supporting reimbursement and appropriate modifier are required for reconsideration.</td>
</tr>
<tr>
<td>Authorization Denials/Retroactive Authorization Requests</td>
<td>Administrative Appeal</td>
<td>Requests over three (3) business days from date of service must meet qualifying exception criteria for retrospective review and must include medical notes.</td>
</tr>
<tr>
<td>Bundled Procedure Denials</td>
<td>Reconsideration</td>
<td>Medical notes supporting reimbursement, appropriate modifier (if applicable) and substantiating coding documentation are required for reconsideration.</td>
</tr>
<tr>
<td>CCI Denials</td>
<td>Reconsideration</td>
<td>Medical notes supporting reimbursement, appropriate modifier (if applicable) and substantiating coding documentation are required for reconsideration.</td>
</tr>
<tr>
<td>Gender/Age Denials</td>
<td>Reconsideration</td>
<td>Corrected claim is required for reconsideration.</td>
</tr>
<tr>
<td>Incorrect Payment or Denial Per Contract (Overpayments or Underpayments)</td>
<td>Reconsideration</td>
<td>Request form with description of issue required for review.</td>
</tr>
<tr>
<td>Invalid/Medically Unlikely Units</td>
<td>Reconsideration</td>
<td>Medical notes supporting reimbursement, appropriate modifier (if applicable) and substantiating coding documentation are required for reconsideration.</td>
</tr>
<tr>
<td>Late Claim Denials</td>
<td>Administrative Appeal</td>
<td>Claim form and proof of timely clean claim submission within contracted time frame is required (i.e., copy of NHPRI EDI claim acceptance report) as well as any other supportive documentation. A copy of a batch rejection report or an accounts receivable log is not considered proof of timely filing.</td>
</tr>
<tr>
<td>Obstetrical Global Denials</td>
<td>Reconsideration</td>
<td>Medical notes supporting reimbursement, appropriate modifier (if applicable) and substantiating coding documentation are required for reconsideration.</td>
</tr>
<tr>
<td>Procedure/Diagnosis Denials</td>
<td>Reconsideration</td>
<td>Corrected claim or medical notes are required for reconsideration.</td>
</tr>
<tr>
<td>NOPCP denials</td>
<td>Reconsideration</td>
<td>Copy of site change request form and confirmation of receipt by NHPRI for date of service rendered.</td>
</tr>
<tr>
<td>Surgical Global Denials</td>
<td>Reconsideration</td>
<td>Medical notes supporting reimbursement, appropriate modifier (if applicable) and substantiating coding documentation are required for reconsideration.</td>
</tr>
<tr>
<td>Unlisted Procedure Denial</td>
<td>Reconsideration</td>
<td>Medical notes are required for reconsideration.</td>
</tr>
</tbody>
</table>

### Claim and Additional Documentation/Review Request Submission Guidelines

<table>
<thead>
<tr>
<th>Term</th>
<th>Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Clean Claim Submission</td>
<td>Within 90 days of the date of service unless otherwise noted in contract</td>
</tr>
<tr>
<td>Rejected claim submission (claim denied for missing, invalid or incomplete information required to successfully process claim in our transactional system)</td>
<td>Within 90 days of the date of service unless otherwise noted in contract</td>
</tr>
<tr>
<td>Reconsideration Request (i.e., provider submission of notes to request additional reimbursement, over or underpayment of claim)</td>
<td>Within 365 days of initial remittance advice date</td>
</tr>
<tr>
<td>Requests for patient record or additional information requested by NHPRI for claim adjudication</td>
<td>Practitioners should make every effort to submit within 365 days of NHPRI’s request for additional information</td>
</tr>
<tr>
<td>Appeal of accurately adjudicated claim</td>
<td>Within 365 days of initial remittance advice date</td>
</tr>
</tbody>
</table>