Out of Network Provider Payment Policy

Policy Statement

This policy documents Neighborhood Health Plan of Rhode Island's (Neighborhood) coverage and reimbursement for services rendered by out-of-network providers.

Scope

This policy applies to:

☒**Medicaid** *excluding Extended Family Planning (EFP)*
☒**INTEGRITY**
☒**Commercial**

Prerequisites

All services must be medically necessary to qualify for reimbursement. Neighborhood may use the following criteria to determine medical necessity:

- National Coverage Determination (NCD)
- Local Coverage Determination (LCD)
- Industry accepted criteria such as Interqual
- Rhode Island Executive Office of Health and Human Services (EOHHS) recommendations
- Clinical Medical Policies (CMP)

It is the provider's responsibility to verify eligibility, coverage and authorization criteria prior to rendering services.

For more information please refer to:

- Neighborhood's plan specific Prior Authorization Reference page.
- Neighborhood's Clinical Medical Policies.

Please contact Provider Services at 1-800-963-1001 for questions related to this policy.

Definition

Active Treatment Period means a patient in active treatment for an acute medical condition at the time the provider terminates their Agreement with Neighborhood until the active treatment is concluded or, if earlier, one (1) year after termination.

Continuity of Care Period means the continued member access, for a limited period of time, not to exceed six months, for medically necessary care and services to prevent disruption in treatment during periods of transition.

Covered Services means those medically necessary inpatient, outpatient, professional, and ancillary health care services and supplies provided to members for whom Neighborhood has agreed to provide, arrange for or reimburse under the terms and conditions of the member's benefit plan.

Emergency Services 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.

Reimbursement Requirements

Medicaid

Emergency Services and Covered Services rendered to eligible and enrolled members during a Continuity of Care Period and/or by out-of-network providers will be reimbursed less any applicable cost-sharing, as follows:

- Neighborhood's usual and customary rate for out-of-network providers; or
- At a rate negotiated between Neighborhood and the out-of-network provider.
- If the provider's billed rate is less than Neighborhood's usual and customary rate, then the provider's billed rate will be paid.

Termination of the provider agreement shall not affect the method of payment or reduce the amount of reimbursement to the provider by Neighborhood for any patient during the Active Treatment Period. During the Active Treatment Period, provider shall be subject to all the terms and conditions of the terminated agreement, including, but not limited to, all reimbursement provisions that limit the member's liability (i.e., the member hold harmless provisions of the agreement shall continue in effect during the Active Treatment Period).

Commercial

In compliance with Section 102- Qualifying Payment Amount (QPA) of the No Surprises Act[1], services for out of network ER services, out of network air ambulatory services and services rendered by an out of network provider at an in network facility, will be reimbursed using the defined QPA methodology.

Termination of the provider agreement shall not affect the method of payment or reduce the amount of reimbursement to the provider by Neighborhood for any patient during the Active Treatment Period. During the Active Treatment Period, provider shall be subject to all the terms and conditions of the terminated agreement, including, but not limited to, all reimbursement provisions that limit the member's liability (e.g., the member hold harmless provisions of the agreement shall continue in effect during the Active Treatment Period).

[1] https://www.federalregister.gov/documents/2021/07/13/2021-14379/requirements-related-to-surprise-billing-part-i

INTEGRITY
Emergency Services and Covered Services rendered to eligible and enrolled members during the Continuity of Care Period and/or by out-of-network providers will be reimbursed less any applicable cost-sharing, as follows:

- Neighborhood's usual and customary rate for out-of-network providers; or
- At a rate negotiated between Neighborhood and the out-of-network provider.
- Rates will be inclusive of the Medicare Merit-Based Incentive Payment System (MIPS) adjustment.
- If the provider's billed rate is less than Neighborhood's usual and customary rate, then the providers billed rate will be paid.

Termination of the provider agreement shall not affect the method of payment or reduce the amount of reimbursement to the provider by Neighborhood for any patient during the Active Treatment Period. During the Active Treatment Period, provider shall be subject to all the terms and conditions of the terminated Agreement, including, but not limited to, all reimbursement provisions that limit the member's liability (i.e., the member hold harmless provisions of the Agreement shall continue in effect during the Active Treatment Period).

Claim Submission

Billable services are subject to contractual agreements, when applicable. Providers are required to submit complete claims for payment within contractually determined timely filing guidelines.

Coding must meet standards defined by the American Medical Association's Current Procedural Terminology Editorial Panel's (CPT®) codebook, the International Statistical Classification of Diseases and Related Health Problems, 10th revision, Clinical Modification (ICD-10-CM), and the Healthcare Common Procedure Coding System (HCPCS) Level II.

Documentation Requirements

Neighborhood reserves the right to request medical records for any service billed. Documentation in the medical record must support the service(s) billed as well as the medical necessity of the service(s). Neighborhood follows CMS standards for proper documentation requirements.

Member Responsibility

Commercial plans include cost sharing provisions for coinsurance, copays, and deductibles. Members may have out of pocket expenses based on individual plan selection and utilization. Please review cost sharing obligations or contact Member Services prior to finalizing member charges.

Disclaimer

This payment policy is informational only and is not intended to address every situation related to reimbursement for healthcare services; therefore, it is not a guarantee of reimbursement.

Claim payments are subject to the following, which include but are not limited to: Neighborhood Health Plan of Rhode Island benefit coverage, member eligibility, claims payment edit rules, coding and documentation guidelines, authorization policies, provider contract agreements, and state and federal regulations. References to CPT or other sources are for definitional purposes only.

This policy may not be implemented exactly the same way on the different electronic claims processing systems used by Neighborhood due to programming or other constraints; however, Neighborhood strives to minimize these variations.

The information in this policy is accurate and current as of the date of publication; however, medical practices, technology, and knowledge are constantly changing. Neighborhood reserves the right to update this payment policy at any time. All services billed to Neighborhood for reimbursement are subject to audit.

Document History

Date	Action
05/02/22	Policy Review Date
03/07/22	Updated format and added QPA language.
01/03/20	Disclaimer updated and format updated.
12/11/19	Effective Date.