Policy Title:	Out-of-Network Provider Reimbursement Policy
Effective Date:	11/13/2019
Review Date:	11/13/2019
Revision Date:	12/11/2019
Purpose: To define Neighborhood Health Plan of Rhode Island's (Neighborhood) coverage and reimbursement for services rendered by out-of-network providers.	
Scope: Medicaid, INTEGRITY, and Commercial	
Policy Statement: This policy covers Emergency Services, and Covered Services rendered by out-of-network providers, including within the Continuity of Care and Active Treatment Periods.	

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1. Definitions

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.

2. Prerequisites

All services must be medically necessary to qualify for reimbursement.

Service-specific criteria, benefit limitations and prior authorization requirements may apply. Prior authorization requirements vary by line of business and services provided. 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 Prior Authorization Reference Guide
- Neighborhood's Clinical Medical Policies. In the absence of a clinical medical policy, Neighborhood utilizes industry standard evidenced-based clinical review criteria.

Please contact Utilization Management at (401) 459-6060 for additional details.

3. Reimbursement Guidelines

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

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.
- If the provider's billed rate is less than Neighborhood's usual and customary rate, then the provider's billed rate will be paid.

Emergency Services rendered to eligible and enrolled members, by out-of-network providers, will be reimbursed less any applicable cost-sharing, as follows:

- According to State and Federal requirements.

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).

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).

4. Claim Submission

Billable services are subject to contractual agreements, when applicable. Providers are required to submit complete claims for payment within 90 days of the date services are provided to members.

Adjustments, corrections, and reconsiderations must include the required forms. All submissions must be in compliance with National Claims Standards.

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.

5. 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.

6. Disclaimer

This guideline is informational only, and not a guarantee of reimbursement.

Claim payments are subject 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. All services billed to Neighborhood for reimbursement are subject to audit.

Effective dates noted reflect the date the long standing policy was documented or updated to assist with provider education, unless otherwise noted. Neighborhood reserves the right to update this policy at any time.

7. Document History

Date	Action
12/11/2019	Effective Date