

Provider Manual 2020

Revised and Effective, as of: February 10, 2020; August 26, 2019; June 21, 2019



Provider Manual – Contents

Section 1	Introduction	Page 3
Section 2	Member Services	Page 8
Section 3	Billing and Reimbursement	Page 18
Section 4	Benefits	Page 35
Section 5	Authorization Process and Medical Management	Page 40
Section 6	Case and Disease Management	Page 51
Section 7	Pharmacy	Page 64
Section 8	Practitioner Information	Page 69
Section 9	Credentialing and Standards of Care	Page 75
Section 10	Compliance and Fraud, Waste and Abuse	Page 86
Section 11	Quality Improvement	Page 93
Section 12	Commercial Plans	Page 99
Section 13	INTEGRITY /Medicare Medicaid Plan (MMP)	Page 103

Section 1: Introduction to Neighborhood Health Plan of Rhode Island (Neighborhood)

Welcome

Company Profile

Our Members

Who Works at Neighborhood

Confidentiality

Member /Patient Information

Essential Telephone and Fax Number

Publications

Website

Welcome

Neighborhood Health Plan of Rhode Island (Neighborhood) is 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. The Provider Manual is updated annually, at minimum, but may also be updated ad hoc.

As an organization, Neighborhood continually strives to embody the following Mission, Vision, and Values in our employee's 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 health care 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 attract

Company Profile

Neighborhood is a not-for-profit 501c3 health maintenance organization (HMO) insurance company with a consistent record of earning “Excellent” accreditation by the [National Committee for Quality Assurance \(NCQA\)](#). Founded in partnership with Rhode Island’s Community Health Centers in December 1993, we are governed by a [17-person board](#).

We served our first 1,490 members in 1994, and by 2000, we grew to 50,000 members. Starting in November 2013 through the introduction of the Affordable Care Act and state leadership’s decision to extend coverage to more Rhode Islanders, Neighborhood has since doubled its membership, revenue, and staff. In 2019, Neighborhood celebrates 25 years of service.

Today, Neighborhood—with 500 employees and \$1.4 billion in revenue—serves one out of every five Rhode Islanders with approximately [195,000 members](#).*

Our Members

Neighborhood insures about 60 percent of the vulnerable populations—with low income, disabilities or other special needs—in Rhode Island. We are committed to a culture of caring and ensuring our members have access to the medical treatment and community services necessary within a culturally and linguistically appropriate setting to achieve health and wellbeing.

We also provide health coverage for about 25,000 individuals* through Rhode Island’s health insurance exchange, [HealthSourceRI](#). Neighborhood’s eleven plans are the lowest cost plans available through Rhode Island’s health insurance exchange.

Who Works at Neighborhood

Neighborhood employs staff that 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 delivers excellent service to our members and providers alike, working daily to make care more equitable and cost-effective.

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 and its members, providers, employees and 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 1-401-427-6799 or the Compliance Hotline at 1-888-579-1551.

Essential Telephone and Fax Numbers

Behavioral Health - Optum	Phone and/or Fax
Medicaid	Phone: 1-401-443-5997
Commercial	Phone: 1-833-470-0578
INTEGRITY	Phone: 1-401-443-5995
Neighborhood Member Services	
Medicaid Managed Care Plans ACCESS / RIt Care, TRUST / Rhody Health Partners (RHP) and RHP Expansion	Phone: 1-800-459-6019 (TDD/TTY 711) Fax: 1-401-459-6021
Commercial Plans for Individuals and Families and Small Employers	Phone: 1-855-321-9244 (TDD/TTY 711)
INTEGRITY (Medicare-Medicaid Plan)	1-844-812-6896 (TDD/TTY 711)
Neighborhood Provider Services	
Eligibility Claim/Billing Issues Credentialing Provider Relations	1-800-963-1001
UM/ Prior Authorization	Phone: 1-401-459-6060 Fax: 1-401-459-6023
Pharmacy	Medicaid & Exchange Fax: 1-866-423-0945 MMP Fax: 1-855-829-2875 Medically Administered Requests (Buy & Bill all LOB) Fax: 1-844-639-7906 1-401-427-8200 Fax: 1-866-423-0945
EOHHS Medicaid Provider Help Desk	1-401-784-8100

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.

Publications

Neighborhood Health Plan of Rhode Island is committed to providing clear, accurate and timely communications to our provider network. Neighborhood publishes Neighborhood News, a quarterly provider e-newsletter, as well as a Provider Manual. Both are available online at <http://www.nhpri.org/Providers/ProviderManualNewsletter>.

Website

Neighborhood's website, www.nhpri.org, offers the most current provider-focused information and resources including, but not limited to:

- Pharmacy - Comprehensive information and resources for each product's formulary, preauthorization, benefits and the network.
- Claims Submission - Includes coverage summaries and billing guidelines as well as coding and reference tools.
- Provider Directory - Web based search function to find a network provider.
- Medical Management – Quick reference for authorization requirements and request forms.
- Durable Medical Equipment – Information about our partner, DMEnsions, along with their network and preauthorization listing.
- Behavioral Health – Information about our partner, Optum, along with their contact information.
- For your patient – Patient education and support material.
- Eligibility & Claim Status – Link to NaviNet, which provides online eligibility, benefits and claims status look up.
- For INTEGRITY, our new Medicare-Medicaid Plan, we have a dedicated web page, www.nhpri.org/INTEGRITY.

Section 2: Member Services

Neighborhood Member Identification Card

How to Verify Member Eligibility

How to Request Member Site Changes Member Co-payments

Member Rights and Responsibilities

Member Complaints and Appeals Process

- Complaints & Grievances
- Member Appeals
 - Standard Appeals
 - Expedited Appeals
 - Clinical Appeal
 - Administrative Appeal
 - Appeals for Members covered with a Medicaid plan
 - Appeals for Members covered with a Neighborhood Commercial (Marketplace) plan
 - Appeals for INTEGRITY Members

Neighborhood Member Identification Card

Every Neighborhood member is issued a Neighborhood identification (ID) card upon enrollment. 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 of life-threatening emergencies. Cards issued prior to 11/01/2013 are still active.

Our Offerings

As of January 1, 2020



Medicaid Plans

Plans for individuals and families who qualify for Medicaid.

Plan Name	Line of Business	Serves	Member Services
ACCESS	Rite Care • Medicaid (MED)	Children and Families • Children up to age 19, income up to 261% FPL (including lawfully present immigrants here <5 yr); Parents up to 141% FPL (lawfully present > or = 5 yr)	1-800-459-6019 (TTY 711)
	• Extended Family Planning (EFP) • Substitute Care (SUB) • Children with Special Health Care Needs (CSN)	• Pregnant women up to 253% FPL, 60 days postpartum or 60 days post loss of pregnancy • Youth in DCYF care up to age 26 who were enrolled in DCYF at age 18 • Children with special health care needs (up to 21 yr)	
TRUST	Rhody Health Partners (RHP)	Adults • 21 yr or older, receive SSI or income up to 100% FPL, not enrolled in Medicare, no long-term services and supports (LTSS)	
	Rhody Health Partners Expansion (RHE)	• 19-64 yrs, no dependents, not pregnant at time of enrollment, income up to 133% FPL, not eligible for Medicaid or Medicare Part A and Part B (RI resident, lawfully present >5 yr)	

Medicare-Medicaid Plan

A plan for individuals who are eligible for full benefit Medicare and Medicaid (dual eligibles).

Plan Name	Line of Business	Serves	Member Services
INTEGRITY Medicare-Medicaid Plan (MMP)	Medicare-Medicaid Plan (MMP)	Adults • 21 yr or older, permanent Rhode Island resident; entitled to Medicare Part A, enrolled in Medicare Part B, and eligible to enroll in Medicare Part D; and are receiving full Medicaid benefits	1-844-812-6896 (TTY 711)

Commercial Plans: Individual Market

Plans with comprehensive coverage for individuals without access to employer-sponsored insurance.

Plan Name	Line of Business	Cost	Member Services
ECONOMY	Bronze HSA	Lowest monthly cost, highest monthly cost sharing	1-855-321-9244 (TTY 711)
INNOVATION	Bronze	Lower monthly cost, higher cost sharing	
COMMUNITY	Silver HSA – Base only	Low monthly cost, high cost sharing	
PLUS	Gold	High monthly cost, lower cost sharing	
ESSENTIAL	Gold	Higher monthly cost, lower cost sharing	
VALUE	Silver	Highest monthly cost, low cost sharing	

Commercial Plans: Small Business Health Options Program (SHOP)

Plans with comprehensive coverage for small businesses with up to 50 employees.

Plan Name	Line of Business	Cost	Member Services
STANDARD	Bronze HSA	Lowest monthly cost, highest cost sharing	1-855-321-9244 (TTY 711)
CHOICE	Silver	Low monthly cost, low cost sharing	
EDGE	Gold	High monthly cost, low cost sharing	
PREMIER	Gold	Higher monthly cost, lower cost sharing	
PRIME	Platinum	Highest monthly cost, lowest cost sharing	

Neighborhood Health Plan of Rhode Island #0200
19-NHPR-0253 REV1219

How to Verify Member Eligibility

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

No PCP will be identified on the ID card if Neighborhood is not the primary payer (i.e., for INTEGRITY / MMP members who are in their initial transition period). There are two ways to verify member eligibility:

1. NaviNet: 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 – 24 hours a day, seven days a week, and is current up to the prior business day. If you have questions regarding NaviNet, please call 1-888-482-8057 for Customer Support.
2. Call Neighborhood: Participating providers without internet access may also call Neighborhood to verify member eligibility at 1-800-963-1001, 8:00 a.m. to 6:00p.m. Monday through Friday.

How to Request Member Site Changes

If a member requires a change to the assigned primary care facility, please have the member call Neighborhood Member Services at the number listed on their ID card.

The provider's office can also request this change by completing the Member Site Change Request Form found in the Forms section of this manual and faxing it to Neighborhood at 401-709-7093. Providers have five (5) business days from the date of service to fax this form for services to be considered for payment.

Site changes for newborns will be accepted for up to thirty (30) days from date of birth. Site changes faxed after five business days 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. 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 timely manner.

Member Co-Payments

In some plans, Neighborhood members may 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. Co-payments should be collected from Neighborhood members at the time of service.

There are several types of co-payments that may be shown on the Neighborhood ID card:

- Office Visit (OV)
- Pharmacy (RX)
- Emergency Room (ER)

Member Rights and Responsibilities

Members can find a copy of their rights and responsibilities in their Member Handbook or on www.nhpri.org in the Current Members section.

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.

Member Rights

Neighborhood members have the following rights:

- To receive information about Neighborhood, its services, practitioners, and providers, and members' rights and responsibilities.
- To be treated with respect and recognition of your dignity and right to privacy.
- To participate with their practitioners in decision-making regarding your health care.
- To privacy of all records and communications as required by law. (Neighborhood employees follow a strict confidentiality policy regarding all member information.)
- To be treated respectfully and receive personal attention without regard to race, national origin, gender, age, sexual orientation, religious affiliation, or preexisting conditions, medical conditions, claims, medical history, genetic information or disability.
- To an open discussion of appropriate home and community services or medically necessary treatment options or the members conditions, regardless of cost or benefit coverage.
- To get a second medical opinion for medical and surgical concerns.
- To voice complaints or appeals about Neighborhood or the care provided by its practitioners and/or agencies.
- To make recommendations about Neighborhood's Member Rights and Responsibilities policies.
- To refuse treatment, and if so, it will not affect future treatment.
- To receive information on available treatment options and alternatives.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- To request and receive a copy of their medical records, and request that they be amended or corrected.
- To be given health care services and reasonable accommodations.
- To receive health care services covered by Neighborhood with no balance billing by one of our providers or practitioners.
- To understand the requirements and benefits of the plan.
- To receive member materials in a manner that can easily be understood, including formats that take into consideration members with special needs.
- To include length of stay following childbirth for mothers and newborns.

Member Rights specific to the plan they are enrolled in with Neighborhood can be found within the member handbooks and evidence of coverage. This information is accessible through www.nhpri.org or by calling Member Services.

Member Responsibilities

As a Neighborhood member, members have the following responsibilities:

To choose a Primary Care Practitioner (PCP) and primary care site. Their PCP will coordinate all of your medical care. They may change their PCP at any time by calling Neighborhood Member Services.

- To have all of their medical care provided by, or arranged by, a provider in the Neighborhood network.
- To carry their Neighborhood member ID and if applicable, their Rhode Island Medical Assistance card.
- To provide, to the extent possible, information that Neighborhood and its practitioners and providers need to care for them.
- To learn about their health problems and help coordinate treatment that they and you as the provider agree to.
- To follow the plans and instructions for care that they agreed upon with providers.
- To talk with their PCP about all specialty care. If they need a specialist, we encourage members to work with their PCP to make sure they get quality care.
- To call their PCP first for help if they have an urgent medical condition. If an emergency is life threatening, call 911 right away or go to the nearest emergency room.
- To let Neighborhood know about changes to their name, home address, telephone number, or if they have other insurance coverage.
- To call Neighborhood Member Services if they have any questions about their rights and responsibilities.

Provider Complaints

Neighborhood is committed to Provider satisfaction and improving the Provider experience. If, at any time, a provider's office or facility needs assistance, Neighborhood's Provider Services Department can assist and, if they are unable to resolve the issue for you on the telephone or via their internal escalation process, they may accept a provider-initiated complaint.

Neighborhood Grievances and Appeals Unit logs each provider complaint and acknowledges the complaint either verbally or in writing. The complaint will be resolved via written notification within 30 calendar days from receipt unless additional time is needed.

Member Complaints and Appeals Processes

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 member complaints, grievances and appeals about claims received, benefit coverage, medical services that were denied or determined not to be medically necessary, adverse medical services, access to medical care, quality issues or concerns, breaches of confidentiality, or other issues that cause member dissatisfaction, including allegations of discrimination.

Member Complaints & Grievances – All Lines of Business

Member satisfaction is our number one priority at Neighborhood. When a member is dissatisfied, they may file a complaint or a grievance verbally or in writing directly with Neighborhood or through an authorized representative, such as their provider, family member, or friend, as long as this person has been appointed in writing to speak for the member. Complaints and grievances submitted by someone other than a member without written consent will be dismissed by Neighborhood until written consent is received from the member or his/her Legal Representative.

Written complaints and grievances should be sent to:

Neighborhood Health Plan of Rhode Island
Attn: Grievance and Appeals Unit
910 Douglas Pike
Smithfield, RI 02917

A complaint or grievance is an oral or written expression of dissatisfaction from a member or his/her authorized representative. Neighborhood will review an actual or alleged circumstance that gives the member cause for protest, causes a disruption of care, creates a level of anxiety, or leads to dissatisfaction with the plan or treatment received from a contracted plan provider.

If a provider receives an inquiry from Neighborhood requesting information to aid in the investigation and resolution of a member complaint or grievance, the provider is required to comply with Neighborhood's request as soon as possible and within fourteen (14) calendar days.

Neighborhood's Grievance and Appeals Unit and Quality Assurance Committee logs each complaint and/or grievance and contacts the member or their authorized representative with a resolution within thirty (30) or ninety (90) calendar days from the date the request was received in accordance with applicable regulations.

If members are not satisfied with Neighborhood's complaint or grievance response, the Rhode Island Office of the Health Insurance Commissioner Rhode Island Insurance Resource, Education and Assistance Consumer Helpline (RIREACH) can also assist members with any complaints or concerns. They can be reached at 1-855-747-3224 (1-855-RIREACH) or rireach@ripin.org

Additional information pertaining to Members covered under Neighborhood INTEGRITY MMP:

For members enrolled in the Neighborhood INTEGRITY (Medicare-Medicaid Plan), any expression of dissatisfaction with the manner in which health care services have been provided, regardless of whether remedial action can be taken by the plan, is considered a Grievance. Grievances could include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievances may also include complaints that a covered health care service procedure or item during the course of treatment did not meet accepted standards for delivery or health care. Grievances submitted by someone other than a member without written consent will be dismissed by Neighborhood until written consent is received from the member or his/her Legal Representative.

INTEGRITY grievances may be filed verbally with Neighborhood Member Services or in writing. Written grievances should be sent to:

Neighborhood Health Plan of Rhode Island
Attn: Grievance and Appeals Unit
910 Douglas Pike
Smithfield, RI 02917

When Neighborhood receives a complaint from a member against a contracted plan provider, the Grievance and Appeals Unit or Quality Assurance Committee will outreach to the office in question to allow the provider the opportunity to review the member's concerns and provide a response. Neighborhood appreciates your full cooperation in responding to these requests, as they are a beneficial way to provide additional member education and support.

Neighborhood's Grievance and Appeals Unit and Quality Assurance Committee logs each grievance and contacts the member or their authorized representative with a resolution within thirty (30) calendar days from the date the request was received. If additional time is needed to obtain a sufficient response to a member grievance and it is in the best interest of the member to take the extra time, we may take an extension of up to 14 days.

Expedited grievances are resolved verbally within 24 hours of the time the grievance was received. Sometimes the Grievance and Appeals Coordinator will need to contact the member or provider to get more information about the complaint or grievance.

Clinical (Medical Necessity) Appeals

(Additional information pertaining to INTEGRITY MMP appeals is available in the INTEGRITY Section)

When to file the appeal:

- Medicaid appeals must be filed within 60 days of receiving the Initial Denial.
- Commercial/Exchange/Marketplace appeals must be filed within 180 days of receiving the Initial Denial.
- INTEGRITY appeals must be filed within 60 days of receiving the Initial Denial/Organization Determination.

Neighborhood's Grievance and Appeals Unit logs each appeal and sends a written acknowledgement to the appellant within five (5) calendar days of receipt of the appeal. The acknowledgment letter will note the anticipated date Neighborhood expects to complete review of the requested services or supplies. Due to the nature of expedited appeals, Neighborhood's Grievance and Appeals Unit may verbally acknowledge receipt of expedited appeals.

When the appeal will be resolved:

- All Lines of Business:
 - Expedited appeals are resolved within 72 hours of the date and time of receipt unless an extension is needed, and then an additional 14 days will be added to the turnaround timeframe.
 - Standard pre-service appeals are resolved within 30 calendar days of receipt unless an extension is needed, and then an additional 14 days will be added to the turnaround timeframe.
 - Post-service or payment appeals are resolved within 60 calendar days of receipt and are not eligible for expedited appeal timeframe or extensions.
- INTEGRITY-specific:
 - In addition to the timeframes above, effective January 1, 2020, INTEGRITY Part B Medication Appeals must be resolved within 72 hours (expedited) or seven (7) calendar days (standard) and are not eligible for extensions.
 - Additional information related to INTEGRITY appeals is available in the INTEGRITY Section below

Remember:

- Appeals for high-end radiology services must be filed directly with eviCore, following the instructions on the initial denial notification.
- Appeals for Part D drugs must be filed directly with CVS Caremark, following the instructions on the adverse coverage determination notification.

Clinical Appeals Description and Process

A clinical appeal is a request for reconsideration of an initial adverse clinical determination. Clinical appeals may be standard or expedited. Appeals submitted by someone other than a member without written consent will be dismissed in writing by Neighborhood until written consent is received from the member or his/her Legal Representative. A licensed practitioner with the same licensure status as the ordering physician reviews clinical appeals. No reviewer involved in prior reviews/direct care may participate in subsequent reviews.

When applying the standard appeal resolution timeline could seriously jeopardize the member's life, health, or ability to regain and/or maintain maximum function, an expedited appeal can be requested by the member, their authorized representative, or the member's treating provider.

Neighborhood reserves the right to have any request for expedited appeal status reviewed by a plan Medical Director to ensure that the request meets criteria for expedited status. If approved for expedited review status, expedited appeals are reviewed and determined no later than seventy-two (72) hours from time and date of receipt or as expeditiously as the member's condition dictates. If the request does not meet for expedited status, it will be transferred to the standard appeal timeframe. Expedited appeals submitted by someone other than a member or a member's treating provider, without written consent, will be dismissed by Neighborhood until written consent is received from the member or his/her Legal Representative.

Next Steps After Neighborhood Issues a Clinical Appeal Denial

- Medicaid members who are not satisfied with the outcome of a clinical appeal may request a State Fair Hearing with the Executive Office of Health and Human Services (EOHHS) within 120 days of Neighborhood's internal appeal denial. Members must exhaust Neighborhood's internal appeal process before requesting an EOHHS Fair Hearing. Members or their authorized representative must call EOHHS at 1-401-462-5300 or 1-401-462-3363 (TTY), (English or Spanish).
- Medicaid and Commercial/Exchange/Marketplace members or their treating providers who are not satisfied with the outcome of a clinical appeal may request an External Appeal in accordance with the Office of the Health Insurance Commissioner's (OHIC) requirements within four (4) months of Neighborhood's internal appeal denial. Please note that Commercial/ Exchange members may be responsible for paying \$25 per external appeal, up to \$75 in external appeal filing fees, per calendar year. No fee will be assessed for Medicaid members.

A member, a member's authorized representative, or a treating provider may ask for an External Appeal in writing, in person, or by calling Member Services at 1-800-459-6019, 711 (TDD/TTY).

Send written appeals to:

Neighborhood Health Plan of Rhode Island
Attention: Grievance and Appeals
910 Douglas Pike
Smithfield, RI 02917
or
Fax: 401-709-7005

Additionally, the Rhode Island Office of the Health Insurance Commissioner (OHIC) can assist members with any complaints or concerns by contacting them at:

Rhode Island Insurance Resource, Education, and Assistance Consumer Helpline

1210 Pontiac Avenue

Cranston, RI 02920

Telephone: (855) 747-3224 (855-RIREACH)

Web site: www.rireach.org

E-mail: rireach@ripin.org

- **INTEGRITY** clinical appeal denials for pre-service medical necessity decisions or post-service member payment appeals for services that *may* be considered for coverage under Medicare, will automatically be forwarded to MAXIMUS for second level appeal review in accordance with CMS requirements by Neighborhood's Grievances and Appeals Unit. If the service is not covered by Medicare or if the appeal is for a Provider Claim Payment Appeal, the appeal will not be forwarded to MAXIMUS for review as it does not qualify for MAXIMUS review. Any additional appeal rights, if applicable, will be communicated on the Neighborhood appeal denial notification letter.
(Additional information available in the INTEGRITY Section)

Administrative (non-clinical 'benefit') Appeals

An administrative appeal is a request by a member, a member's authorized representative, or a member's provider asking Neighborhood to reverse an administrative (non-clinical/non utilization management) benefit limitation or adverse determination. Appeals submitted by someone other than a member without written consent will be dismissed by Neighborhood until written consent is received from the member or his/her Legal Representative.

Next Steps After Neighborhood Issues an Administrative Appeal Denial

- **Medicaid** members who are not satisfied with the outcome of an administrative appeal may request a State Fair Hearing with the Executive Office of Health and Human Services (EOHHS) within 120 days of Neighborhood's internal appeal denial. Members must exhaust Neighborhood's internal appeal process before requesting an EOHHS Fair Hearing. Members or their authorized representative must call EOHHS at 1-401-462-5300 or 1-401-462-3363 (TTY), (English or Spanish). The external review process is not applicable for administrative appeals.

Additionally, the Rhode Island Office of the Health Insurance Commissioner (OHIC) can assist members with any complaints or concerns by contacting them at:

Rhode Island Insurance Resource, Education, and Assistance Consumer Helpline

1210 Pontiac Avenue

Cranston, RI 02920

Telephone: (855) 747-3224 (855-RIREACH)

Web site: www.rireach.org

E-mail: rireach@ripin.org

- **INTEGRITY** administrative appeal denials for pre-service decisions or post-service member payment appeals for services that *may* be considered for coverage under Medicare, will automatically be forwarded to MAXIMUS for second level appeal review in accordance with CMS requirements by Neighborhood's Grievances and Appeals Unit. If the service is not covered by Medicare or if the appeal is for a Provider Claim Payment Appeal, the appeal will not be forwarded to MAXIMUS for review. Any additional appeal rights, if applicable, will be communicated on the Neighborhood

appeal denial notification letter. (Additional information available in the INTEGRITY Section below)

Provider Claim Payment Appeals:

Appeals requesting that Neighborhood review and reverse a claim denial, Reconsideration Request decision, and/or Adjustment Request decision are known as Provider Claim Payment Appeals. These appeals must be filed 365 days from the denial date on the provider's Neighborhood Remittance Advice. Neighborhood's Grievances and Appeals Unit does not acknowledge these appeals in writing. Typically, these appeals are resolved within 60 calendar days from the date the appeal was received unless additional time is needed. Approvals may result in a claim adjustment and, in some cases, written notification. Denials will result in written notification. Duplicate and triplicate appeals will not be accepted or responded to as Neighborhood will use the first appeal submission as the official appeal request in these instances. For additional details on these appeals, please see the section below, entitled **Provider Claim Payment Appeals**.

Section 3: Billing and Reimbursement

Neighborhood Requirements for CMS-1500 Claim Submission

Neighborhood Requirements for UB-04 Claim Submission

Electronic Claim Submission

EDI Response Reports

Paper Claim Reports

Electronic Funds Transfer (EFT)

Remittance Advice

Claim Submission Standards

Complete Claims

Incomplete or Invalid Claims

Provider Claim Forms

- Corrected (Replacement) and Voided Claims

Adjusted Claims

Reconsideration Process

Administrative Appeals

Professional and Facility Industry Standard Coding Requirements

- Professional Coding
- Facility Coding
- ICD-9
- ICD-10

Time Limitation for Claim Submission

Behavioral Health Claims

Billing Member and Hold Harmless Provisions

Coordination of Benefits

Claims Auditing

Provider Audits

- Desk Audits
- Onsite Audits

Neighborhood Requirements for CMS-1500 Claim Submission

The following is a listing of the claims information that is required by Neighborhood in order for claims to be reviewed for potential payment. If any of the required information is omitted or invalid, claims will be returned for correction and resubmission. The “Instruction” column indicates whether a particular field is “required” or “optional”:

All professional claims must be filed on a CMS-1500 form (latest version). The original red and white printed version must be used.

	Field Heading:	Instruction:
1	Carrier Type	Optional
1a	Insured’s ID Number	Required
2	Patient’s Name	Required
3	Patient’s Date of Birth and Sex	Required
4	Insured’s Name	Required
5	Patient’s Address	Required
6	Patient’s Relationship to Insured	Required
7	Insured’s Address	Optional * <i>* Per CMS, required when Fields 4, 6, and 11 have data</i>
8	Reserved for NUCC Use	N/A
9	Other Insured’s Name	Required if Field 11d = yes
9a	Other Insured’s Policy or Group Number	Required if Field 11d = yes
9b	Reserved for NUCC Use	N/A
9c	Reserved for NUCC Use	N/A
9d	Insurance Plan Name or Program Name If Applicable	Required if Field 11d = yes
10	Is Patient’s Condition Related to:	
10a	Employment	Required, if applicable
10b	Auto Accident	Required, if applicable
10c	Other Accident	Required, if applicable
10d	Claim Codes (designated by NUCC)	N/A
11	Insured’s Policy Group or FECA Number	Required, if applicable* <i>*Required in instances of COB</i>
11a	Insured’s Date of Birth and Sex	Required, if applicable
11b	Other Claim ID (designated by NUCC)	N/A
11c	Insurance Plan Name or Program Name	Required, if applicable
11d	Is There Another Health Benefit Plan?	Required

	Field Heading:	Instruction:
12	Patient's or Authorized Person's Signature (Medical Records/Information Release) and Date	Required
13	Insured's or Authorized Person's Signature (Payment of Benefits)	Required
14	Date of Current Illness, Injury, Pregnancy (LMP)	Optional
15	Other Date and Qual.	Optional
16	Dates Patient Unable to Work in Current Occupation	Optional
17	Name of Referring Provider or Other Source	Optional * <i>*Per CMS, this field is required for Medicare beneficiaries</i>
17a	Referring Provider ID	Optional
17b	Referring Provider NPI#	Required if there is data in Field 17
18	Hospitalization Dates Related to Current Services	Optional
19	Additional Claim Information (designated by NUCC)	N/A
20	Outside Lab?	Optional
21	Diagnosis or Nature of Illness or Injury; <i>and</i> ICD Ind.	Required
22	Resubmission Code/Original Ref. No.	Required ONLY for a corrected/replacement or voided claim
23	Prior Authorization Number	Required, if applicable
24a	Date(s) of Service, From and To	Required
24b	Place of Service	Required
24c	Emergency Service (EMG)	Optional
24d	Procedures, Services or Supplies (CPT/HCPCS,	Required
24e	Diagnosis Pointer	Required
24f	Charges	Required
24g	Days or Units	Required
24h	EPSDT Family Plan	Optional
24i	ID Qualifier	Optional
24j	Rendering Provider ID #	Required
25	Federal Tax ID Number and SSN/EIN	Required
26	Patient's Account Number	Optional
27	Accept Assignment	Required
28	Total Charge	Required*
29	Amount Paid	Required, if applicable

	Field Heading:	Instruction:
30	Reserved for NUCC Use	N/A
31	Signature of Physician or Supplier and Date	Required
32	Service Facility Location Information	Required
32a	Service Facility NPI	Required, if applicable
32b	Other ID	Optional
33	Billing Provider' Info and Phone Number	Required
33a	Billing Provider NPI #	Required
33b	Non-NPI ID/Neighborhood provider or vendor number assigned by Neighborhood	Optional

Neighborhood Requirements for UB-04 Claim Submission

The following is a listing of the claims information that is required by Neighborhood in order to process claims for potential payment. If any of the required information is omitted or invalid, claims may be returned for correction and resubmission. The “Instruction” column indicates whether a particular field is required or optional. All Institutional claims must be filed on a UB-04 form (latest version). The original red and white printed version must be used.

	Field Heading:	Instruction:
1	Provider Name, Address and Phone	Required
2	Pay-to Name, Address and Secondary Identification Fields	Optional
3a	Patient Control #	Optional
3b	Medical/Health Record #	Optional
4	Type of Bill	Required
5	Federal Tax Number	Required
6	Statement Covers Period (From – Through)	Required
7	Not Used	N/A
8a	Patient ID Number	Required
8b	Patient’s Name	Required
9a-e	Patient’s Address	Required
10	Patient’s Birth Date	Required
11	Patient’s Sex	Required
12	Admission Date	Required, if applicable
13	Admission Hour	Required, if applicable
14	Type of Admission	Required
15	Source of Admission	Required
16	Discharge Hour	Required, if applicable
17	Patient Status	Required
18-28	Condition Codes	Optional
29	Accident State	Optional
30	Not Used	N/A
31-34	Occurrence Codes and Dates	Optional
35-36	Occurrence Span Codes and Dates	Required, if applicable
37	Not Used	N/A
38	Responsible Party Name and Address	Required, if applicable

	Field Heading:	Instruction:
39-41	Value Codes and Amounts	Required, if applicable
42	Revenue Code	Required
43	Revenue Code Description	Optional
44	HCPCS/Rate/HIPPS Code	Required, if applicable
45	Service Date	Required
46	Units of Service	Required
47	Total Charges	Required
48	Non-Covered Charges	Required, if applicable
n/a	Creation Date	Required
n/a	Totals	Required* *Continued claims only require a total on the last page
49	Not Used	N/A
50A	Payer Name	Required
51A	Health Plan ID	Required
52A	Release of Information Certification Indicator	Required
53A	Assignment of Benefits Certification Indicator	Required
54A-C	Prior Payments	Optional
55A-C	Estimated Amount Due	Optional
56	National Provider ID (NPI)	Required
57A-C	Other Provider ID	Optional
58A	Insured's Name	Required
59A	Patient's Relationship to Insured	Required
60A	Insured's Unique ID	Required
61A-C	Insurance Group Name	Optional
62A-C	Insurance Group Number	Optional
63	Treatment Authorization Code	Optional
64	Document Control Number (DCN)	Optional
65	Employer Name	Optional
66	Diagnosis and Procedure Code Qualifier (DX)	Required
67	Principal Diagnosis Code & POA Indicator	Required
68	Not Used	N/A
69	Admitting Diagnosis	Required, if applicable

	Box Heading:	Instruction:
70A-C	Patient Reason for Visit	Required, if applicable
71	Prospective Payment System (PPS) Code	Optional
72A-C	External Cause of Injury (ECI) Code	Optional
73	Not Used	N/A
74	Principle Procedure Code and Date	Required, if applicable
74A-E	Other Procedure Codes and Dates	Required, if applicable
75	Not used	N/A
76	Attending Provider Name and Identifiers (including NPI)	Required, if applicable
77	Operating Provider Name and Identifiers (including NPI)	Required, if applicable
78-79	Other Provider Name and Identifiers (including NPI)	Required, if applicable
80	Remarks	Optional
81a-d	Code-Code Field	Optional

Electronic Claim Submission

Neighborhood currently accepts electronic claims submission of CMS-1500 and UB-04 forms using the federally required ANSI 837 Version 005010 format. Neighborhood is able to accept direct submission of files via FTP or Secure FTP from one of several Clearinghouses.

All claims submission files and any response files transmitted using legacy FTP protocol will require encryption. The selected Clearinghouse 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 third party encryption methodology. This decision was made between the Clearinghouse and Neighborhood's EDI Support Team.

To submit claims electronically to Neighborhood:

1. Select a Clearinghouse and follow the clearinghouse on-boarding process.
2. Once EDI files have been submitted thru the clearinghouse if there is a technical problem the clearinghouse is unable to determine or resolve the submitter can contact Neighborhood EDI team for support:
EDISupport@NHPRI.org

All claims submitted electronically are subject to contractual timely filing limits. The standard timely filing limit is 90 days. Please refer to your Neighborhood contract for specific filing limits.

EDI Response Reports

In addition to the Neighborhood Remittance Advices, practitioners who submit claims electronically also receive the following reports to confirm receipt and verify information received via the EDI process.

- 999 – Functional Acknowledgement File
- 277CA – Health Care Claim Acknowledgment

The 999 file is used to confirm that a file was received. Receipt of a transaction, such as a healthcare claim, does not necessarily mean that the transaction can be processed.

The 277CA is an acknowledged receipt of the claim submission file. This document acknowledges the validity and acceptability of the claims at the pre-processing stage. Claims that are incorrectly formatted or missing mandatory information may not be introduced into Neighborhood's adjudication system and will be considered Rejected claims.

Corrections can be made and claims resubmitted by the provider for processing.

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 lists any submissions that are rejected due to an error on the claim.

If claims are considered non-clean and cannot be entered into Neighborhood's processing system, the original claim(s) will be returned along with a letter stating what required information is missing or invalid. Please refer to the "Non-Complete Claims" section of this manual for more information.

Electronic Funds Transfer (EFT)

Neighborhood supports paying providers electronically via electronic funds transfer. This process ensures timely payment directly into your bank account. We will issue the corresponding Remittance Advice to you electronically as well. If you are not currently set up for EFT please refer to the Forms Section of this manual and complete and return the EFT form as indicated in order to begin this process.

Remittance Advice

Practitioners receive the Neighborhood Remittance Advice (RA) as notification of claims adjudication completion. The Remittance Advice details all claims adjudicated for that period along with a bulk payment, if applicable. Payments are made via Electronic Funds Transfer and a Remittance Advice is sent to providers via secure e-mail address or standard mail. To update your information and preferences, please contact your Provider Network Management Specialist.

The RA details the following information for each claim:

- Member ID Number
- Member Name
- Provider ID number
- Provider NPI Number
- Date of Service
- Claim Number
- Procedure Code
- Modifier
- Billed/Charged Amount
- Allowed Amount
- COB/Other Insurance Amount
- Co-pay/Coinsurance/Patient Share
- Explanation/Reason Code
- Total Paid

Claim 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.

When filing on paper, please submit original red forms. Do not submit carbon copies or photocopies. Claims that are difficult to interpret, faint in image, or missing information will be returned for revision.

Paper claims must be mailed to:
Neighborhood Health Plan of Rhode Island
Attention: CLAIMS
Department P.O. Box 28259
Providence, RI 02908-3700

If you have any questions, please call Provider Services at 1-800-963-1001 between the hours of 8:00 am and 6:00 pm, Monday through Friday.

Complete Claims

Neighborhood defines a complete (clean) claim as a claim or invoice for payment of healthcare services rendered. Clean claims are submitted via approved CMS 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 service is a covered benefit, provided by an eligible provider, and provided to a person covered by Neighborhood.
2. The claim has no material defect or impropriety, including, but not limited to, incorrect coding or any lack of required substantiating documentation.
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 mis-representation.
5. The claim does not require special treatment or review (submission outside of the corporation for external review or requiring additional documentation to be reviewed for consideration) that would prevent the timely payment of the claim.
6. The claim does not require coordination of benefits, subrogation or other third-party liability.
7. Full patient name is provided.
8. Patient's date of birth is provided.
9. Valid and properly formatted member identification number is provided.
10. The proper payer ID for the applicable line of business has been utilized.
 - Medicaid products - Use Payer ID 05047
 - Exchange and INTEGRITY MMP - Use Payer ID 96240
11. Complete service level information is provided:
 - Date of Service
 - Industry standard diagnosis codes
 - Place of service
 - Industry standard procedure codes
 - Charger 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
12. Only one billing provider submitted on each claim
13. No handwriting, stamps, correction fluid, or staples are present

NOTE: Please validate this information prior to submitting the claim.

Incomplete or Invalid 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, complete billing details or operative notes to substantiate payment.

Submissions that are sent back to the provider by Neighborhood are not considered clean.

The notice of rejection does not serve as proof of timely filing. This applies to all methods of claims submission, including paper and electronic submissions. Corrected claims must be resubmitted with all appropriate information within contractually-determined timely filing guidelines.

Provider Claim Forms

If a provider believes that changes should be made to a claim, or to a payment decision rendered on a claim, the Neighborhood website contains a section with forms that may be used to request additional consideration. The Corrected/Voided Claim, Adjustment, Reconsideration, and Appeal request forms can all be found on www.nhpri.org

Corrected (Replacement) and Voided Claims

Neighborhood accepts corrected (replacement) and voided claims for reprocessing via paper submission. Providers must use a Corrected (Replacement)/Voided Claim Request Form to assist with accurate processing of corrected (replacement) and voided claims. This form should be used to void or to submit changes, such as correcting a diagnosis code, CPT or HCPCS code, or date of service, or adding additional information such as an NDC number or modifiers, to a previously processed claim. A corrected or voided claim replaces the previously-submitted version of that claim. Please be sure to use a corrected or voided bill type when resubmitting a UB-04 claim, and populate the applicable resubmission code on a CMS-1500 claim. Corrected claims submitted without replacement or voided bill types/resubmission codes will be rejected or denied.

Adjusted Claims

Providers may request to have an adjustment made to a previously processed claim for reasons such as (but not limited to) Coordination of Benefits or payment modifications and Timely Filing (TF) Denials. Adjustment requests require the submission of a completed Adjustment Request Form, applicable claim number, and Remittance Advice, Explanation of Benefits, and/or Coordination of Benefits documentation, as applicable.

Providers may also request an adjustment to a claim that has denied for Timely Filing if:

1. They have proof that the provider billed another Health Insurer or the patient within at least 180 days of the date of service
2. The provider billed another Health Insurer, an electronic remittance advice, explanation of benefits or other communication from the plan confirming the claim was denied and not paid, or inappropriate payment was returned. If you do not have this type of proof, please file an administrative appeal as described in the section below entitled 'Administrative Appeals.'

Timely Filing Adjustment Requests must include:

1. Copy of TF denial or documentation that clearly lists the claim(s) in question
2. Written documentation that the provider billed another Health Insurer or the patient within at least 180 days of the date of service.
3. If the provider billed another Health Insurer, an electronic remittance advice, explanation of benefits or other communication from the plan confirming the claim was denied and not paid, or inappropriate payment was returned.
4. If the provider billed the patient, acceptable documentation may include:
 - Benefit determination documents from another carrier,
 - Copy of provider's billing system documenting proof of an original carrier claim submission,
 - Patient billing statement that includes initial claim send date and the date of service, or
5. Documentation as to the exact date the provider was notified of member's correct coverage, who notified the provider, how the provider was notified and a brief, reasonable statement as to why the provider did not initially know the patient was not covered by carrier. Practice management and billing system information can be used as supportive documentation for these purposes.

Reconsideration Process

A reconsideration is a review, with medical notes, of a claims payment decision. A provider may submit a request, with complete notes attached, for claim reconsideration. Providers have 365 days from the date of the initial remittance advice to submit for further consideration and must submit the following:

- A completed Reconsideration Request Form must accompany submitted documentation.
- Submit only one cover letter, set of notes, and applicable remittance advice (RA) for each individual claim.
- Multiple claims for the same member must still be submitted separately.
- Providers 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 date of the original RA to appeal a denial.
- Neighborhood is not responsible for administrative fees related to records submitted as part of a claim reconsideration request.

A Reconsideration Request Form must accompany submitted documentation in order for a request to be processed. Please **mail** reconsideration requests, with a completed Reconsideration Request form, an RA, and medical notes to:

Neighborhood Health Plan of Rhode Island
Attn: Claims Reconsideration Specialist PO Box 28259
Providence, RI 02908-3700

Reconsiderations may also be e-mailed. Please e-mail a completed Reconsideration Request form, an RA, and medical notes for each claim, each attached in a separate file, to:

ClaimsReconsiderationSubmission@nhpri.org

Reconsideration requests, with a completed Reconsideration Request form, an RA, and medical notes may also be e-faxed to Neighborhood. Please submit only one request per transaction to 401-709-7009.

****Please note that the electronic submission process is not intended for corrected or adjusted claim submission, nor is it to obtain status updates on prior submissions.**

Provider Claim Payment Appeals

A Provider Claim Payment Appeal is a post-service claim appeal requesting a final appeal review following the outcome of a Reconsideration Request, an Adjustment Request, a denial of authorization, a claim denial (i.e., claim denial reflecting that no authorization was requested), or a timely filing denial after Neighborhood Claims Department has reviewed the Timely Filing Denial as an Adjustment Request (See the Adjustment Request Section for details). The majority of these appeals are administrative in nature; however, a retrospective clinical appeal review may occur for claim denials resulting from a Utilization Management Authorization Denial.

- All claim appeals must be received within 365 calendar days of the initial remittance advice.
 - Any request received over 365 calendar days from the date of the initial remittance advice will be rejected as they are over the time limit to appeal.
- Provider Claim Payment Appeals are not acknowledged in writing
- The outcome of the appeal will typically be determined within sixty (60) calendar days of receipt unless additional time is needed.
- There is only one level of appeal review for Provider Claim Payment Appeals
- Claim Payment Appeals are not eligible for external appeal review

To qualify as an appeal, requests submitted to Neighborhood must include an appeal letter on office letterhead and/or a completed Provider Appeal Request Form, a copy of the denied claim/clear reference to the denied claim, and/or a remittance advice as well as specific supporting documentation as to why the denial should be waived or reconsidered.

All administrative appeals for retroactive authorizations must be submitted with a copy of the medical record in order to be processed.

Retroactive authorizations requested more 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.

Only these circumstances will be considered as exceptions to this policy:

- Medicare/Medicaid retractions
- Coordination of Benefits
- Retroactive eligibility as determined by the Executive Office of Health and Human Services (EOHHS)

For more information on authorizations, please see Section 5 of this Manual. Please direct formal appeals in writing to:

Neighborhood Health Plan of Rhode Island Attn: Appeals Coordinator
910 Douglas Pike
Smithfield, RI 02917

Providers and Facilities are entitled to one level of internal appeal for Provider Claim Payment Appeals. No additional and/or external levels of appeal are available for this appeal type as these appeals are payment disputes, not medical necessity / pre-service decisions.

Professional and Facility Industry Standard Coding Requirements

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. Claims with missing or invalid coding are not considered complete claims.

Professional Coding

CPT Codes – All professional services require valid CPT or HCPCS code for the date and nature of service.
HCPCS Level II Codes – All pharmacy, home care, DME, and ambulance services require a valid CPT or HCPCS 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.
Note: Revenue codes must crosswalk with any corresponding CPT or HCPCS code billed.

CPT/HCPCS codes – All outpatient facility services require a corresponding valid CPT or HCPCS code for date and nature of service.

DRG Codes – When contractually reimbursed

ICD-9

Claims for services or discharges prior to 10/1/2015 should be assigned a code using the standard ICD-9 coding guidelines.

ICD-10

Effective for dates of service 10/1/2015 and later, ICD-10 is mandatory for all payers, providers and other organizations covered by the Health Insurance Portability and Accountability Act (HIPAA). ICD-10 CM/PCS (International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System) consists of two parts:

1. ICD-10-CM for diagnosis coding
2. ICD-10PCS for inpatient procedure coding

This change does not affect Current Procedural Terminology (CPT) codes, which will continue to be used for office and outpatient services.

All claims with dates of service on or after 10/1/2015 must be submitted with ICD-10 coding or your claim will be denied as non-compliant.

Time Limitation for Claim Submission

For specific timely filing requirements, please refer to your individual contract terms. 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 must be submitted to our behavioral health partner, Optum, at the following address:

Optum - Attn: Claims Department

PO Box 30760

Salt Lake City, UT 84130-0760

<https://www.providerexpress.com/content/ope-provexpr/us/en/our-network/welcomeNtwk/wRI.html>

Claims must be received by Optum within ninety (90) days from the date of service as determined by the date received at Optum. Electronic claims may be submitted. To obtain a user ID for electronic claims, go online to "chat" with a Provider Express representative (web site above) or call toll-free 1-866-209-9320.

Billing Member and Hold Harmless Provisions

In accordance with the professional services contract with Neighborhood, practitioners accept the lesser of the Neighborhood fee schedule or the providers billed charges as payment in full. Therefore, providers 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. Practitioners may not bill members for missed appointments.

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). For our Medicaid Products, Neighborhood is the payer of last resort. If any member is known to have other insurance coverage, all claims will be denied, but can be reconsidered for payment upon receipt of a claim accompanied by an Explanation of Benefits (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 as secondary for services that are covered benefits under the plan.
- Contracted providers have three hundred sixty five (365) days from the date on the primary carrier's EOB to submit for any secondary balances, unless otherwise dictated by provider contract.

Claims Auditing

Neighborhood utilizes various review methods to audit and verify provider billing 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. 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.
- The frequency of audits varies from pre-payment, post-payment, quarterly, or semi-annually to annually.
- For retrospective audits, a pre-determined sample size based on claims submission volume will be requested and reviewed.
- Any onsite audit will be scheduled at least thirty (30) days prior to the review
- Results will be communicated, in writing, within thirty (30) days post review
- Generally, retrospective claims audits will not exceed one (1) 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
- Third party liability activity
- Any claims activity resulting from legal activity not otherwise defined.

Neighborhood may utilize CMS billing guidelines, Neighborhood Medical Coverage Policies, Neighborhood's Administrative/Coverage Summaries and Billing Guidelines, National Uniform Billing Guidelines along with American Medical Association Current Procedural Terminology (CPT®) guidelines, 1997 Documentation Guidelines for Evaluation and Management Services Standards and other state and federal laws and regulations as they apply to and define services billed. Neighborhood utilizes, but is not limited to, these resources to ensure that audits are conducted in a fair manner as these are widely acknowledged national guidelines for billing practices and support the concept of uniform billing for all payers.

Provider Audits

Neighborhood, or its designee, has the right to conduct audits of provider records related to services rendered to Neighborhood members. The provider must allow Neighborhood access to the medical record and billing documents to conduct audits.

Desk Audits

A desk audit allows the provider to submit medical record and billing documentation to Neighborhood or its designee. The purpose of a desk audit includes, but is not limited to, confirming the following:

- The service meets Neighborhoods definition of “medically necessary”.
 - The setting is appropriate for the service.
 - The service was billed, coded and paid correctly.
 - The supply, setting, or level of service provided to a patient can be substantiated by records and documentation maintained by the provider as safe, the most appropriate, and cost-effective.
1. Neighborhood may conduct reviews of claim payments within twelve (12) months from the original date of payment or such other period as may be required or allowed by applicable law and may request medical records in support of these reviews.
 2. Providers should send copies of requested medical records within thirty (30) calendar days of the provider’s receipt of the request. Providers must mail the records to:

Neighborhood Health Plan of Rhode Island
Attn: Compliance Department
910 Douglas Pike
Smithfield, RI 02917

Onsite Audits

An onsite audit allows an auditor to visit a provider to review the medical record and billing documents in person. Neighborhood has the following on-site audit guidelines:

- Neighborhood or the designee will contact the provider audit representative to schedule the audit. Providers must respond to a scheduling request within thirty (30) calendar days of receipt of the request and schedule the audit on a mutually agreed-upon date and time.
- Neighborhood or the designee will notify the provider of the audit results via letter or by conducting exit conferences with the provider within thirty (30) business days from the date Neighborhood or its designees completed the audit (or upon an alternative agreed upon date).
- In the event a provider wishes to dispute any audit findings, the provider must submit notification of its intent to dispute to Neighborhood’s Compliance Department within thirty (30) calendar days of receipt of the audit findings. The notification of dispute of audit findings must clearly identify the items in dispute, citing relevant authority and attaching relevant documentation specific to the disputed items.

Section 4: Benefits

Medical Coverage Benefits Information

Behavioral Health Services

Interpreter Services

Transportation Benefits

Member Education Services

Medical Coverage Benefits Information

To view covered medical services for our products, please refer to the Coverage Summaries and Billing Guidelines found on the Neighborhood web site www.nhpri.org.

Behavioral Health Services

Neighborhood Health Plan of Rhode Island (Neighborhood) partners with Optum to improve the behavioral health and wellbeing of our members. Optum 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 Optum share an expertise in serving at risk populations. Optum'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, Optum meets the rigorous standards of Utilization Review Accreditation Commission (URAC) and the National Committee for Quality Assurance (NCQA).

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

Neighborhood and Optum make every effort to create a system of care which eliminates barriers for providers and members. 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 Optum representatives can provide assistance to members, Primary Care Physicians and Specialists. Depending on their coverage, members have access to urgent, inpatient, diversionary and outpatient behavioral health care.

Neighborhood may reimburse for some behavioral health services when rendered by a Primary Care Physician if it is covered under the members benefit plan.

To promote clinical integration of medical and behavioral health, Neighborhood and Optum support both integrated and colocated 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.

If you are a provider and need assistance in making a behavioral health referral or wish to speak with a behavioral health case manager, please refer to the Optum Provider Manual, at: <https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html>

Interpreter Services

Neighborhood offers on-site interpreter services for Neighborhood covered services to assist members who speak languages other than English. To use this service, we request that our practitioners/practices or members contact us at least forty eight (48) to 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 interpreter services includes:

- Verify with the member that an interpreter is needed.
- 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 Interpreter Services Fax Request Form is available on our web site www.nhpri.org. This form may be completed and faxed to Neighborhood Member Services at 1- 401-459-6021. Practitioners may also request interpreter services by contacting Neighborhood Member Services at 1-401-459-6020 or 1-800-459-6019.

Important Reminder: If a member or provider cancels an appointment during which an interpreter had been scheduled to attend, Neighborhood requires that you contact us so that we may cancel and/or reschedule interpreter services as necessary.

Transportation Benefits

BUS TRANSPORTATION

Bus transportation is a benefit available to eligible Neighborhood members to make it easy for them to get to their provider visits if they do not have a car or anyone to take them. The following is a breakdown of the available bus passes by our lines of business:

Neighborhood ACCESS/RIte Care (MED, CSN, SUB) members (except Extended Family Planning members) can get a bus ticket through Medical Transportation Management, Inc. (MTM). Bus tickets are available for non-emergency medical appointments. Members can call MTM at 1-855-330-9131 (TTY 1-866-288-3133) to request a bus ticket for each medical appointment.

Neighborhood TRUST / Rhody Health Partners (RHP) members may be eligible for a RIPTA bus pass. To get a RIPTA bus pass, visit the RIPTA Identification Office at One Kennedy Plaza, Providence, RI 02903. They can also go to one of the Road Trip Community Outreach locations. Call RIPTA at 1-401-784-9500 ext. 604 for more information.

Neighborhood TRUST / Rhody Health Partners Expansion can get a bus ticket through Medical Transportation Management, Inc. (MTM) to get to their non-emergency medical appointments. They can call MTM at 1- 855-330-9131 (TTY 1-866-288-3133) to request a bus ticket.

Neighborhood INTEGRITY members may be eligible for a RIPTA bus pass. To get a RIPTA bus pass, visit the RIPTA Identification Office at One Kennedy Plaza, Providence, RI 02903. They can also go to one of the Road Trip Community Outreach locations. Call RIPTA at 1-401-784-9500 ext. 604 for more information.

OTHER TRANSPORTATION OPTIONS

Rhode Island Medical Assistance covers non-emergency transportation services. Their vendor is Medical Transportation Management, Inc. (MTM). They are available Monday through Friday, from 8 am to 5 pm, at 1-855-330-9131 (TTY 1-866-288-3133).

Transportation requests must be scheduled at least two business days before their scheduled appointment. Urgent care transportation can be requested 24 hours a day, seven days a week.

In order to qualify for these services, Neighborhood ACCESS / RIte Care (MED, CSN, SUB) members would need to meet one of the following criteria:

- They live more than a half mile from the nearest bus stop
- Their provider's office is more than a half mile from the nearest bus stop
- They or a covered child has a same day sick appointment
- They have prior authorization for a medical condition

TRUST, ACCESS and INTEGRITY members qualify for these services. All Members can arrange for transportation either through Neighborhood Member Services. They should call at least two business days before their medical appointment to arrange for a ride. The two days includes the day of the call, but not the day of the appointment. For example, call Monday to request transportation on Wednesday. Neighborhood can also help them set up a ride to same-day urgent care appointments.

Member Education Services

Neighborhood Member Services is readily available to assist with member education and outreach for their covered services to ensure that both our member's 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 Member Services in the event a member appears to require re-education on neighborhood benefits, policies, and procedures. Representative from Neighborhood Member Services will attempt to contact the member via telephone or mail in the effort to re-educate and assist them.

Section 5: Authorization Process and Medical Management

Medical Management at Neighborhood

- Utilization Management
- Case Management
- Clinical Program

Prior Authorization Process

- How to Obtain Authorization
- How to Reach Medical Management
- Prior Authorization Requirements
- Provider Notification of Decisions

Emergency and Urgent Care Services

- Post Stabilization

Late or Retroactive Authorizations

Requesting Services from a Non-Participating Provider Medical Review Process

- Medical Necessity Review
- Medical Necessity Decision Criteria

Clinical Medical Policy

Adverse Determination (Denials) and Appeals

Medical Management at Neighborhood

The goal of Neighborhood's Medical Management Department is to ensure positive patient outcomes by addressing and supporting member's medical and social needs in the most cost effective and efficient way. The department is designed into three functional areas including, Utilization Management, Case Management and Clinical Programs.

The Utilization Management (UM) department ensures timely, accessible, and coordinated care for our members. UM confirms that medically necessary utilization occurs in the most appropriate care setting within the benefit plan through the use of approved clinical protocols and guidelines.

- Neighborhood's utilization management decisions are based only on appropriateness of care and service and existence of coverage.
- Neighborhood does not reward staff or practitioners conducting utilization review for denying coverage or service.
- Neighborhood does not offer financial incentives to encourage decisions that result in under-utilization.

UM physicians, nurses, clinical coordinators and other clinical staff work 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.

The Case Management area offers programs that focus on the assessment and coordination of member's 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 by working with providers, community resources, 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. Build 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.

Prior Authorization Process How to Obtain Authorization

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

The following information is required from the referring or treating practitioner to initiate a preservice request and 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
- Principle procedure codes
- Services or level of care requested
- All clinical information that supports medical necessity of the planned procedure, level of care, and place of service requested
- Is there a third party liability to COB (e.g. other insurance, workers compensation, MVA)

Requests for authorization may be faxed directly to Utilization Management (UM). The fax number is 1-401-459-6023. Requests for authorization may also be mailed to Neighborhood:

Neighborhood Health Plan of Rhode Island
Attn: Utilization Management
910 Douglas Pike
Smithfield, RI 02917

NOTE: Prior authorization request forms can be found at NHPRI.org

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 is physically available from 8:30am – 5:00pm during normal business hours to receive inbound communication and conduct outbound communication via telephone, e-mail; and fax, 1-401-459-6023. A phone messaging system is in place for requests/inquiries outside of business hours. The telephone number is 1-401-459-6060 or toll free at 1-800-264-3955.

Medical Management 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

Prior Authorization Requirements

Additional information unique to authorizations for Neighborhood INTEGRITY MMP Members may be found in the respective section of this manual.

Neighborhood's "Prior Authorization Reference Guide", which summarizes which services require prior authorization, is available on our website at www.nhpri.org at Providers>Policies and Guidelines>Prior Authorization Reference Guide.

Planned inpatient stays associated with services or procedures requiring prior authorization must have a prior authorization request initiated for the service or procedure prior to the inpatient admission and in accordance with all other prior authorization guidance.

Authorizations are to be obtained prior to the date of service or elective 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 as soon as scheduling is contemplated or at least 3 business days prior to scheduled date of service, and include required medical necessity documentation.

Retroactive Authorization Requests

Neighborhood requires that providers request authorization for services prior to providing services to our members. Exceptions to this policy are made only under extenuating circumstances as defined below.

Neighborhood will accept a request for retroactive authorization if the request meets either of the following guidelines:

- The request precedes a bill for services (no claim received by Neighborhood) and is within 72 hours of the service OR
- The request precedes a bill for services (no claim received by Neighborhood) and one of the extenuating circumstances detailed below applies

If claims have been submitted and denied, providers should refer to the Neighborhood Provider Manual.

The request for a retro-authorization only guarantees consideration of the request against medical necessity criteria and is not a guarantee of authorization.

Extenuating Circumstances

If Neighborhood receives a request for retroactive authorization that qualifies under the guidelines above, the request may be submitted to Utilization Management for review. If the request is more than 72 hours and less than 14 calendar days after the date of service, the provider must indicate which of the extenuating circumstance apply.

Extenuating Circumstances fall into three categories

- **Unable to Know Situation** – The provider and/or facility is unable to identify from which health plan to request an authorization. The patient was not able to tell the provider about their insurance coverage, or the provider verified different insurance coverage prior to rendering services. Provider to submit with authorization request the verification that was done.
- **Not Enough Time Situation** – The patient requires immediate medical services and the provider is unable to anticipate the need for a pre-authorized immediately before or while performing a service.

- An enrollee is discharged from a facility and insufficient time exists for institutional or home health care services to receive approval prior to the delivery of the service.

In each case (extenuating circumstances), the provider is unable to request prior authorization for services as required by the provider's contract and the member's coverage agreement.

The extenuating circumstances must be detailed within the retroactive authorization request and providers are required to request the authorization as soon as they are able and retroactive requests outside of the above will not be considered by Neighborhood.

For Requests beyond 14 calendar days from the date of service:

1. The GAU is responsible for determining if the retrospective review request meets one of the limited extenuating circumstances or exceptions for review. Providers should send a copy of all supporting documentation to the GAU.
2. Please note that our radiology vendor, eviCore, and our DME vendor, DMEnsions, will also follow this three day retro policy.

Expedited Requests

Neighborhood recognizes the need for expedited requests under certain circumstances. In accordance with applicable regulation, Neighborhood will provide an expedited determination if it is determined that applying the standard timeframe for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. Clinical staff, including the Medical Directors, will determine if requests to expedite the Neighborhood decision meet this established criteria. If it is determined that a request does not meet expedited criteria, the requesting provider and member will receive a prompt verbal notice with subsequent letter mailed in three days notifying member of appeals rights and the request will be processed under standard timeframes

Provider Notification of Decisions

Neighborhood complies with all regulatory turnaround times for prior authorization decisions and communication of authorization status. 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 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.

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 Utilization Management Department must be obtained by calling 1-401-459-6060, or faxing the Out of Network Prior Authorization Form 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 Utilization 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 on our web site www.nhpri.org

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. This process includes the prospective, concurrent, or retrospective assessment of the medical necessity request.

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 a review is required for medical necessity determination, the following elements, are applicable, are requested by the Clinical Management Nurse and/or Associate Medical Director or Neighborhood Physician Reviewer.

- Medical records
- Progress notes describing history of the current problem, status, and current treatment plan
- Diagnostic testing results pertinent to the requested service
- Patient psychosocial history as appropriate and related to the current problem
- Consultant's summaries/notes
- Operative and pathological reports
- Rehabilitation evaluations, progress, attendance, and adherence.

In addition, the following information is requested and considered in order to determine if there are other factors which may impact the plan of care and attribute to the medical necessity of the request:

- Age
- Knowledge and skills for self-care
- Support system deficits, barriers
- Co-morbidities
- Other complications
- Available resources within the local delivery system
- Psychosocial situation
- Home environment, when applicable
- Benefit coverage and potential alternatives available

When the Clinical Management Nurse is not able to confirm the medical necessity and appropriateness of the care setting, the case is referred to a neighborhood physician reviewer for final decision.

Medical Necessity Review

The Medical Management program includes utilization review for medical necessity for inpatient services and some specialty services. Utilization review activities for Behavioral Health are delegated to Optum. Neighborhood's Pharmacy Department and staff are responsible for pharmacy 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 or a request for a planned inpatient or outpatient procedure.
- 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 services have 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

InterQual®

Medically necessary services are defined as those services required for the prevention, diagnosis, cure, or treatment of a health related condition including those necessary to prevent a detrimental change in the member's medical or mental health status. Medically necessary services must be provided in the most cost effective and appropriate setting, and shall not be provided solely for the convenience of the member or service provider.

Neighborhood contracts with Change Healthcare to utilize InterQual®, a criteria-based medical decision support system designed to assist providers and payers in developing cooperative systems for the efficient delivery of high quality health care. InterQual® is the standard criteria utilized by Neighborhood Medical Management Department and Grievances and Appeals Unit for inpatient facility review, as well as, select outpatient surgery and procedures. Change Healthcare uses an evidence-based approach to the development and maintenance of the InterQual® criteria, and employs physicians, nurses and social workers who review literature from nationally and internationally recognized peer reviewed medical journals. In addition, current research, including outcome studies, along with an interactive process with the practitioners, and solicited input from customers, are utilized to continuously update and develop new criteria.

InterQual® criteria is presented to the Clinical Management Committee (CMC) annually, for review and recommendations. Neighborhood's Medical Director gives final approval.

The Medical Directors of each of the eleven (11) Rhode Island hospitals review the InterQual® criteria annually, and are provided with an opportunity to comment. All comments are recorded and included in revisions of the criteria, and a copy of the criteria is available at the Rhode Island Medical Society Office.

Procedure for Requesting InterQual® Criteria

All Neighborhood practitioners have the right to view the criteria utilized to render decisions. When InterQual® is used, practitioners may request a copy of the InterQual® criteria by contacting the Medical Management Department Staff at 1-800-264-3955. Practitioners are welcome to view the complete criteria at Neighborhood Health Plan of Rhode Island, 910 Douglas Pike, Smithfield, RI 02917. 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 InterQual® criteria, one of neighborhood's certified Clinical Management Nurses or Associate Medical Director will be happy to assist you.

Clinical Medical Policy

Neighborhood's Clinical Medical Policies (CMP) 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 Medical Director gives final approval. Please refer to the Neighborhood website to view current Clinical Medical policies.

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

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.

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. Verbal notification of the adverse decision is communicated to the provider by the Clinical Management Nurse. 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 regulatory timelines:

- Pre-service decisions (non-urgent requests) are made within 14 calendar days from the receipt of the request
- Pre-service decisions (qualifying expedited requests) are made within 72 hours of receipt of the request
- Urgent concurrent (hospital inpatient) requests are made within
 - 24 hours of receipt of notification and supporting clinical information for Commercial and Exchange members
 - 72 hours of receipt of notification and supporting clinical information for Medicaid and Medicare members
- 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: 1-401-427-8200.

Detailed Appeals Process information can be found in the Appeals Section.

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.

Section 6: Case and Disease Management

Case and Disease Management

- Case Management
- Disease Management

Breathe Easy Asthma Program

- Evidence Based Clinical Practice Guidelines
- Population Identification
- Program Participation
- Patient Education and Outreach
- Coordination of Care – Working with Our Providers
- Outcome Measurement and Effectiveness of the Breathe Easy Programs

Control for Life Diabetes Program

- Evidence Based Practice Guidelines
- Population Identification
- Program Participation
- Patient Education and Outreach
- Coordination of Care-Working with our Providers

Take a Breath, COPD Program

- Evidence Based Practice Guidelines
- Population Identification
- Program Participation
- Patient Education and Outreach
- Outcome Measurement and Effectiveness of the Take a Breath Program

Bright Start Program

- Evidence Based Practice Guidelines
- Population Identification
- Program Participation
- Patient Education and Outreach
- Case Management
- Coordination of Care-Working with our Providers

Case and Disease Management, *continued*

Healthy Heart, Heart Failure Program

- Evidence Based Practice Guidelines
- Population Identification
- Program Participation
- Patient Education and Outreach
- Outcome Measurement and Effectiveness of the Health Heart Program

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.

Case Management

Neighborhood's Case Management Program design focuses on evaluation and assistance in the coordination of member's care along the health care continuum. Members are identified and referred in a variety of ways including member self-referral, referrals from family members, providers, Medical Review Nurses, Member Service Staff, Disease Management staff, Pharmacy 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 or practice along with the nursing process of assessment, planning, intervention and evaluation in conducting activities.

The Medical Management Department has the following case management programs: Prenatal and Postpartum Case Management; Neonatal Case Management; Pediatric Case Management; Adult Case Management; Transitions of Care; and Complex Case Management. Each program has defined practices and standards for member care planning and documentation as well as case closure criteria.

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 follow-up appointments.

To determine whether a member is eligible for one of Neighborhood's Case Management programs, providers are encouraged to contact Provider Services 1-800-963-1001, Monday through Friday 8:00am – 6:00pm.

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.

Disease management resides within the Medical Management Department at Neighborhood. Disease management programs that are currently offered at Neighborhood include Asthma, Chronic Obstructive Pulmonary Disease, Diabetes and Heart Failure. 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'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, July 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 www.nhpri.org. 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 to 64 years of age and has one or more of 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 Breathe 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 in referrals made by Neighborhood's Member Services, Medical Management or Behavioral Health Departments, our network providers or member self-referral.

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 but are not limited to:

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

Most of the letters sent to member 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 1-401-459-6019.

Additionally if a member is identified as being at the highest risk the member will receive telephonic outreach from a Disease Case manager who will conduct an assessment to determine problems, identify interventions and develop a 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.

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 members receiving 3 or more prescriptions for a short-acting beta agonist and not on a controller medication OR members with 2 or more oral corticosteroid prescriptions without evidence of a PCP visit for asthma during a 6 month period. If you would like to see a sample copy of the report that you might receive, call us at 1-401-459-6019. 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 it's delivery of services to our members and providers. Some of the key measures that A Neighborhood pays attention to assess the program include:

HEDIS measure: Use of Appropriate Asthma Medications

Evidence of at least two or more outpatient visits each year for asthma management

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 1-401-459-6019 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'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. Build 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 visit www.nhpri.org and 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 Control for Life Program have been developed to align with the recommendations detailed in the guidelines.

Population Identification

Neighborhood identifies members 18 years to 75 years of age 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 (using CPT and NDC codes provided by HEDIS/NCQA and updated annually):

- The member was dispensed insulin and/or oral hypoglycemic 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's Member Services, Medical Management or Behavioral Health Departments, our network providers, or member self-referral.

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 but are not limited to:

- 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

Education 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 1-401-459-6019.

Additionally if a member is identified as being a high risk they will 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 with may exacerbate their condition, discuss self-management strategies, evaluate their status and in general, monitor their condition and adherence to treatment goals.

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. A quarterly report is sent in conjunction with HEDIS 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. The report details include whether the practice's members with diabetes have received specific lab tests, such as HbA1C and/or LDL. 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 Control for Life Program, but do have diabetes, will still be included in the quarterly diabetes reports sent to providers.

Take a Breath Program for Members with COPD

The goal of the 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 Member Service Department at 1-401-459-6019 or visit www.nhpri.org. From the top of our home page, click “Providers” and then click “Clinical Resources.” 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 (using CPT and NDC codes provided by HEDIS/NCQA and updated annually):

- Claims evidence of at least one inpatient or one emergency room visit with a primary diagnosis of COPD in the last 24 months OR
- Claims evidence of at least one physicians or specialists office visits with primary diagnosis of COPD within the last 24 months
- Please note the HEDIS now includes ICD-9 Code 493.2 Chronic Obstructive Asthma as a code for COPD.

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 Member Service, Medical Management or Behavioral Health Departments, 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 but are not limited to:

- 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 1-401-459-6019.

Additionally if a member is identified as being at high risk they will 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 COPD 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.

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 in Neighborhood's disease management services (annual survey/complaints data).

For more information, please call us at 1-401-459-6019 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.

Bright Start Program

The goal of Neighborhood's Bright Start Program is to improve birth outcomes for the children born to Neighborhood members. Build on evidence-based guidelines, the Bright Start Program is designed to reinforce the practitioner's care and treatment plan through member's 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 prenatal 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 Member Service Department at 1-401- 459-6019 or visit www.nhpri.org. From our home page, click on “Providers” at the top of the page and then click “Clinical Resources”.

Population Identification

Neighborhood identifies pregnant women for participation in the Bright Start Program based on the practitioners’ submission of a pre-authorization for maternal services, through hospital admissions, and member self-report of pregnancy.

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 is 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 information them of the services, benefits and education materials they can expect to receive. Participation can also result from the referrals made by Neighborhood’s Member Service or Case Management Department, our network providers or member self-referral.

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

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 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.

Coordination of Care-Working with our Providers

Individual case management encounter reports are sent to the pregnant member's provider that include the education provided, referrals, plan of care and other services provided by the case manager. Please call us at 1-401-459-6019 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- 6019.

Healthy Heart Program for Members with heart Failure

The goal of the 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 physician's 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 recognized 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 www.nhpri.org. From the top of our home page, click on "Providers" and then click on "Clinical Resources". 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 18 years to 75 years of age for participation in the Healthy Heart Program.

Members are considered to have HF if claims data meets one or more of the following criteria (using CPT and NDC codes provided by HEDIS/NCQA and updated annually):

- Claims evidence of at least 2 face-to-face encounters in an ambulatory, non-acute inpatient 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 inpatient setting, with a diagnosis of HF within the previous 12 months.

Program Participation

Neighborhood members identified as having HR 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 not to participate 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 Member Service, Medical Management or Behavior Health Department, network providers, or member self-referrals.

Patient Education and 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 but are not limited to:

- 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 letter sent to members. To request a copy of those materials or mailings, please call us at 1-401-459-6019.

Outcome Measurement and Effectiveness of the Health Heart Program

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

Utilization metrics (ER visits/inpatient utilization)

Member satisfaction with Neighborhood's disease management services (complaints data)

Please call us at 1-401-459-6019 if you have any questions about Neighborhood's Healthy Heart Program for members with HR or how we work with your patients with HF.

Section 7: Pharmacy Benefit Overview

Formulary

Coverage Limitations

Pharmacy and Therapeutics Committee

Generic Substitution

Experimental Drugs

Benefit Exception Process

Prior Authorization

Adverse Determination

Pharmacist and Provider Communications

Pharmacy Benefit Overview

The following information applies to Medicaid, Exchange and MMP. For more information on INTEGRITY and supplemental drug coverage, refer to the INTEGRITY section of this manual.

Formulary

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

The Neighborhood Formulary (Formulary) is a list of covered and preferred drug agents for Neighborhood members. There are separate formularies for each line of business that include Medicaid, Exchange, EFP (Extended Family Planning) and MMP. The Formulary is available on Neighborhood's website, www.nhpri.org or www.nhpri.org/INTEGRITY.

Drugs are listed by their drug class and alphabetically. Certain drugs on the Formulary have restrictions which are identified as PA (Prior Authorization), QL (Quantity Limits), ST (Step Therapy), B/D (Medicare B vs D; MMP only), LA (Limited Access for drugs that require a specialty pharmacy), NDS (Non-Extended Days' Supply; 30-day supply max), OTC (Over the counter), and DP (Not a Medicare Part D drug but covered under the Medicaid benefit; MMP only). Drug tier information is also available on the Formulary. A key for these restrictions can be found at the bottom of each formulary.

Coverage Limitations

The Formulary does not provide information regarding all coverage and limitations associated with an individual member's prescription drug plan. There are other drugs and services that are excluded and or not covered that are not present on the Formulary.

The Formulary applies only to outpatient drugs provided to members, and does not apply to those used in an inpatient settings such as medically administered drugs. If a member has any specific questions regarding their coverage, they should contact Neighborhood Member Services at 1-800-459-6019 for Medicaid; 1-855-321-0945; INTEGRITY 1-844-812-6896.

The following general provisions pertain to all covered individuals:

- Some over-the-counter products are covered for members if they have a written prescription from an in network provider.
- Drugs that are not listed in the Formulary at www.nhpri.org or www.nhpri.org/INTEGRITY, are not covered.
- Any drugs used for cosmetic purposes are not covered.
- Experimental drugs, or any drug used in an experimental manner are not covered (except as required by law or regulation).
- Replacement of lost or stolen medications coverage is evaluated on a case-by-case basis. If the drug is a controlled substance, verbal authorization from the provider is required.
- Infertility treatment is not covered for Medicaid members.
- Any drugs that do not meet industry-standard patient safety screens will not be dispensed at the pharmacy without further information from the prescriber.

Please refer to www.nhpri.org for information on formularies available by each plan.

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 regularly to consider addition of new pharmaceuticals, and to review the adequacy of the current Formulary. 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.

Safety: the potential for adverse reactions, side effects and drug interactions.

Efficacy: the potential effects of treatment under optimal conditions.

Effectiveness: the actual effects of treatment under real life conditions.

Relevant benefits of current formulary agents of similar use.

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.

Condition of potential duplication of similar drugs currently on the formulary

Any restrictions that should be delineated to assure safe, effective, or proper use of the drug.

Requirements and restrictions set forth in the Medicaid Managed Care Services Pharmacy Benefit Plan Protocols established (and amended) by the RI Executive Office of Health and Human Services or for the Commercial product established by the Office of the Health Insurance Commissioner.

*Please refer to the INTEGRITY section for information on the INTEGRITY P&T Committee.

Generic First

When available, FDA approved generic drugs are to be used in all situations. 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 to Neighborhood's Pharmacy and Therapeutics Committee.

As permitted by Rhode Island pharmacy statutes, generic substitution using all forms of A-rated generics is allowed, 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.

Experimental Drugs

The P&T Committee using current medical literature will determine the appropriateness experimental nature or use of drug products. Drugs used experimentally without supporting clinical documentation or literature will be excluded from coverage.

Non-formulary Exception Process

To request coverage of a non-formulary drug, providers can submit a Formulary Exception for review by the Neighborhood Pharmacy department and/or Medical Management. Formulary Exception forms can be found on our website.

The provider must include the following formation:

- Rationale for use of Non-formulary drug
- Previous medications tried and failed
- Diagnosis being treated
- Supporting statement from provider
- Any clinical support applicable

Application of the above information will reflect patient safety screens, and P&T Committee approved Step Therapy protocols.

Prior Authorization

Drug listed on the formulary with PA restriction require prior authorization. Prior authorization criteria and forms can be found at www.nhpri.org. To submit a coverage request, a prescriber may:

Fax a completed Prior Authorization Request to Neighborhood at 1-866-423-0945 for Medicaid and Exchange members **or** 1-855-829-2875 for MMP INTEGRITY members; **or**

Submit an electronic prior authorization request via Cover My Meds (link available at www.nhpri.org); **or**

Contact Provider Services to submit the request verbally: Medicaid 1-800-459-6019; Exchange 1-855-321-9244; or MMP 1-844-812-6896

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, denial rationale and Formulary alternatives will be provided to the provider.

If the requesting provider does not agree with the denial, the Medical Director upon request can conduct a peer-to-peer review. To request a peer-to-peer review, call 401-459-6069.

In the event of a denial under peer-to-peer review, the Medical Director will discuss with the provider 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 5 for information on the standard appeals process

Pharmacist and Provider Communications

The Formulary is a tool to promote cost-effective prescription drug use. The Neighborhood P&T as well as PBM P&T Committee for the INTEGRITY Plan have 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 910
Douglas Pike
Smithfield, RI 02917

Section 8: Practitioner Information

Primary Care

The Role of the Primary Care Practitioner

The Role of the Specialty Care Practitioner Provider Availability

After Hours Coverage Reimbursement CurrentCare

Closing Your Practice to New Members

Practitioner Termination

- Primary Care Practitioner Terminations
- Specialty Practitioner Terminations Continuity of Care

Practitioner Information Changes

Primary Care

A primary care practitioner (PCP) is a practitioner who practices in the following areas of medicine:

- Pediatrics, Obstetrics and Gynecology, Family Practice, Internal Medicine, inclusive of nurse practitioners and physician assistants; he/she is credentialed by Neighborhood 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:

- Develop, maintain and monitor Plan of Care for the member; Arrange for the furnishing of covered services for each member, including admissions to inpatient facilities, coordination between medical and behavioral health services, in compliance with Neighborhood policies and procedures.
- Provide information to member regarding LTSS services.
- 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 Provider Relations at 1-800-963-1001 or the Provider Relations Representative 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. Primary Care Sites may also complete the On-Call Provider Group Notification Form found in the form section of this manual.
- 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 a minimum of six (6) additional evening or weekend hours. 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 PCP's, eligible for accepting assignments of Neighborhood members, only those practitioners who are regularly schedule 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 Participating Professional Provider 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 of 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.

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 reasonable timeframe.

Provider Availability

Primary Care Providers (PCP's) and Specialists must provide coverage for their practice and its associated patients twenty-four hours a day, seven days a week. Both PCP(s) and Specialists sites must have a published after hours telephone number. The member must be able to reach a provider after hours. A voicemail in place after hours with no providers accessible is not acceptable. Both PCP's and Specialists must offer hours of operation that are consistent with patients that are not insured by Neighborhood but are covered with other insurance plans, whether commercial or any other programs.

After Hours Coverage Reimbursement

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 Provider Relations at 1-800-963-1001 or their Provider Services Representative of their on-call coverage group(s). Primary Care Sites may also complete the On-Call Provider Group Notification Form.

24/7 ACCESS

INTEGRITY MMP members will have access to timely authorization of Medically Necessary Services twenty-four (24) hours per Day. More information will be provided when CMS and EOHHS approve Neighborhood's contract.

CurrentCare

Neighborhood supports the Rhode Island Quality Institute (RIQI) and the statewide health information exchange known as CurrentCare. Neighborhood strongly encourages their Providers to engage with the RIQI to gain access to the statewide health information exchange (CurrentCare), and use patient data and alert notifications for treatment and coordination of care purposes.

Providers **shall** initiate the relationship with CurrentCare (if not already in place) by doing the following:

- A. Executing a Letter of Agreement with **Rhode Island Quality Institute** and offer all Provider's members the opportunity to enroll in CurrentCare. The practice will use best efforts to enroll at least 40% of their Neighborhood members;
- B. Executing a Data Use Agreement with CurrentCare, accessing and using the CurrentCare Viewer (the online provider portal), and
- C. Obtaining a Direct secure messaging account through a health information service provider (HISP) and subscribing to CurrentCare Hospital Alerts. Providers will cooperate with the CurrentCare data submission requirements.

Closing Your Practice to New Members

Neighborhood participating providers agree to make reasonable accommodations to maintain open panels and accept Neighborhood members for care. 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 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 reopened 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 9.

Mainstreaming

Neighborhood participating providers agree they will not treat Neighborhood members any differently than other members of another health plan with whom they participate.

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 provider.

Primary Care Practitioner Terminations

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 Practitioner Terminations

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 Network Management department by using the Practitioner Termination Notification Form located on our web site www.nhpri.org. The Practitioner Termination Notification form may be faxed to your Provider Network Administrator at 1-401-709-7066.

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 that 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" 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 and/or hospital privileges, etc. Please contact Neighborhood Provider Relations at 1-800-963-1001 with this information.

Section 9: Credentialing and Standards of Care

Medical Record Keeping and Documentation Standards

- Medical/Treatment Record Keeping, Availability and Confidentiality Standards
- Confidentiality
- Performance Measure and Quality Improvement

Access to Care Standards

Credentialing and Re-Credentialing for Practitioners

- Documentation needed for credentialing/re-credentialing
- Office Site Assessment

Initial and Ongoing Assessment of Organization Providers

- Accrediting bodies accepted by Neighborhood

Remedial Action, Disciplinary Action & Appeal Process

Medical Record Keeping and Documentation Standards

It is the expectation of Neighborhood that comprehensive medical records detailing all aspects of our enrolled members' care and treatment are maintained by our contracted providers to aid the information 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 Executive Office of Health and Human Services (EOHHS) for purposes directly related to the administration of the RItE Care or Rhody Health Partners programs. Reviews external to EOHHS are made in accordance with applicable state and federal regulations and law.

Medical/Treatment Record Keeping, Availability and Confidentiality Standards

Neighborhood requires all participating practitioners' medical record keeping system and practices are in accordance with state and federal regulation and records are assessable to Neighborhood and/or other practitioners as necessary.

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 RItE Care Program. Reviews external to DHS are made in accordance with applicable state and federal regulations and laws.

Performance Measure and Quality Improvement

To assure compliance with established medical record standards, Neighborhood conducts review of medical/health records of their enrollees using standard 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 and other administrative data files 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 Neighborhood. 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 Executive Office of Health and Human Services every June. Neighborhood collects reports and uses HEDIS® results in the development of our quality work plans and in the development of continuous improvement processes.

Access to Care Standards

Neighborhood has developed standards to ensure our members' access to primary and specialty health care services. Neighborhood monitors primary and specialty providers and office sites for compliance with the access standards during and outside of established business hours. Neighborhood requires the hours of operation that providers offer must be the same for all patients regardless of payer.

Intervention and remedial action will be initiated whenever a provider 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 provider site may be suspended should remedial action fail to bring the site into compliance. Provider sites 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, either by a practitioner located on site, by referral to a covering practitioner, or through emergency instructions. Urgent care describes care that is necessary for a 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 patient's health in serious jeopardy, or
- serious impairment to bodily function; or
- serious dysfunction of any bodily organ or part.

Appointments for routine care will be available within thirty (30) calendar days, or as determined clinically necessary by the provider, including the diagnosis/treatment of conditions to prevent the need for more complex treatment, as well as, to minimize the risk of developing chronic illness (e.g., family planning, chronic pain, etc.).

New patients who do not have an existing relationship with the provider/site will be able to obtain appointments within sixty (60) calendar days of the date of request.

Appointments for routine physical examinations will be available within one hundred eighty (180) days of the date of request.

Appointments for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) will be available within six (6) weeks of the date of request.

Provider coverage will be available twenty-four (24) hours a day, seven (7) days per week. To ensure twenty-four hour coverage, providers must have one of the following mechanisms in place to handle incoming member phone calls outside of normal business hours:

- Answering machine or service that directs the member to visit the closest Emergency Room.
- Answering machine that directs the member to contact the provider or the designated on-call provider; or answering service that contacts the provider or designated on-call provider on behalf of the member. For after-hours calls where the patients identifies an illness or that it is an urgent matter, the standard for call back from the covering provider is 30 minutes.

Providers are encouraged to establish a policy and procedure outlining their standard call back time thresholds. The linguistic capabilities of the answering service representatives with whom the provider is contracted and/or the outgoing message on the provider sites' answering machine should represent the linguistic needs of the population serviced.

PCPs will exhibit compliance with the Neighborhood's member to provider ratio, which states that no more than fifteen hundred (1,500) RIte Care members may be assigned to any single PCP. A PCP practicing within a primary care team may have up to 3,000 members assigned. A "lead physician" is designated and held accountable within the PCP team.

Credentialing and Re-credentialing: Practitioners

Neighborhood effectively manages the credentialing and re-credentialing of practitioners through a thorough review process. Neighborhood's credentialing and re-credentialing standards are consistent with managed care standards 42CFR§438.214 and 42 CFR§422.204, regulatory requirement from Executive Office of Health and Human Services (EOHHS), §27-18.8 Health Care Accessibility and Quality Assurance Act, and National Committee for Quality Assurance (NCQA) standards. Before a practitioner's contract can become effective in Neighborhood's network, Neighborhood's Clinical Affairs Committee (CAC) must approve his/her application. Neighborhood uses the Council for Affordable Quality Healthcare (CAQH) application for practitioner credentialing and re-credentialing. Neighborhood re-credentials its network practitioners every 3 years to ensure that they continue to meet Neighborhood's standards for network participation. CAC is responsible for reviewing and approving all practitioners for network appointment and reappointment.

The process for credentialing and re-credentialing is conducted in a confidential, non-discriminatory manner and decisions are based on established criteria and recruitment standards. Credentialing and recredentialing of practitioners include primary source verification of information provided on the application and information collected from monitoring other secondary source verification. Neighborhood issues a decision regarding the practitioner's credentialing within 45 calendar days of receipt of a complete credentialing application. Practitioners are notified of the status of their credentialing application at least once every 15 calendar days, informing practitioners of any missing information. Practitioners are informed within 5 business days when the application is deemed complete.

Practitioners have the right to:

- Check on the status of their credentialing application by calling the credentialing department at 401-459-6000. Neighborhood will provide a response by phone and/or in writing within 2 business days of the request. Neighborhood can only share information that is permissible by law.
- Review information submitted to support their credentialing application and correct erroneous information at any time by submitting a written request to the credentialing department.
- Be informed of the status of the application at least once every 15 calendar days.
- Be informed that the application is deemed complete within 5 business days.
- Be informed of the credentialing decision within 45 calendar days from receipt of a complete application.
- Appeal the credentialing decision (please note that this process is separate and distinct from the Appeals Processes outlined in the Appeals Section above).

A credentialing application is considered complete when all of the following applicable documents have been received:

- Updated and current CAQH application
- Signed copies of Neighborhood's regulatory requirements attestation and contract addendum
- Completed PA questionnaire
- Job duties (applicable to PA and CRNA)
- Attestation for practitioners working at Urgent Care facilities (as applicable)
- Copy of current and valid professional license in the state of practice
- Copy of current Federal DEA and State Control Substance Registration certificate in each state of practice
- Copy of current professional liability face sheet with a minimum coverage of \$1M/\$3M
- Education and training information
- Work history for past 5 years by including a CV and/or provided on the CAQH application (gap in work history 6 months or greater must be explained)
- Copy of board certification certificate (if applicable)
- Copy of current CLIA certificate (if applicable)
- Receipt of all necessary primary source verification of documents and credentialing information, including and not limited to education and training, board certification, hospital affiliation, sanction against professional license, Medicare and Medicaid sanction and exclusion
- Onsite visit (when applicable)

Allopathic Physicians (MD)
Osteopathic Physicians (DO)
Oral Surgeons (DMD/DDS)
Podiatrists (DPM)
Chiropractors (DC)
Occupational Therapists (OT)
Physical Therapists (PT) Speech
Pathologists (ST) Licensed
Lactation Consultants(LLC)
Massage Therapists (MT)

Optometrists (OD)
Nurse Practitioners (NP)
Certified Nurse Midwives (CNM)
Physician Assistants (PA)
Nutritionists (LDN)
Certified Diabetic Outpatient Educators (CDOE)
Certified Asthma Educators (AE-C)
Tobacco Treatment Specialists (TTS)
Certified Registered Nurse Anesthetists (CRNA)
Doctor of Acupuncture (DA)

Neighborhood delegates the credentialing and re-credentialing of behavioral health practitioners and general dentistry providers. This includes primary source verification of credentials and decision making for credentialing and re-credentialing of practitioners. Behavioral health practitioners (psychiatrists, psychologists, clinical social workers, clinical nurse specialists, masters prepared therapists, substance abuse counselors, other behavior health care specialists who are licensed, certified or registered by the state to practice independent) must contact Optum at www.providerexpress.com to request credentialing and re-credentialing. General dentistry providers must contact Delta Dental of Rhode Island at 1-800-846-3582 to request credentialing and re-credentialing.

Credentialing and re-credentialing 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/re-credentialing:

- Completed CAQH application
- Signed copies of the Neighborhood's regulatory requirements attestations
- 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 professional liability face sheet with a minimum coverage of \$1M per claim and \$3M aggregate
- Copy of current Curriculum Vitae which includes education and 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)
- Facility attestation form (applicable to obstetrics and gynecology and primary care practices)
- Office Site Assessment

Neighborhood credentialing staff conducts site assessments to ensure that individual patient care site(s) meet Neighborhood's standards for quality, safety and accessibility. Neighborhood's site assessment tools set performance standards for practitioner/provider office expectations within the following categories: Physical Accessibility; Physical Appearance; Adequacy of waiting and examining room space; Adequacy of Medical/Treatment Record Keeping; Emergency Response, Medication and Equipment; Access to Care; Office Personnel / Policy and Procedures; Supplies (supplies are applicable to Urgent Care / walk in treatment only).

Site assessments are conducted:

- At all urgent care/walk-in treatment centers at the time of initial credentialing, every 3 years (re-credentialing), and when physical location changes;
- At pain management facilities at the time of initial credentialing, every 3 years (re-credentialing), and when physical location changes. Pain management facility is defined by the following procedures: spinal facet, sacroiliac, epidural, radiofrequency facet injections are provided)
- At all provider offices, in response to individual complaints received from a member or a member representative about the quality, safety and/or accessibility of any practitioner office site or provider location where care is delivered; and in response to data analyses or medical record chart reviews that reveal opportunities for improvement
- At the request of Neighborhood staff/departments when warranted and approved by a department manager
- Primary care and obstetrics & gynecology providers must attest to the following areas of competencies by completing a Neighborhood Facility Attestation form and submit to credentialing department for review. Neighborhood retains the right to conduct an on-site assessment prior to the provider joining the network if criteria is not met:
 - Ability to handled medical emergencies
 - Physical accessibility and maintenance
 - Medical record keeping and confidentiality
 - Office internal policies and procedures

Site assessments are not required:

- For network entry and re-credentialing when the facility is accredited by an accrediting agency accepted by Neighborhood
- A practitioner joins an existing practice previously assessed

Initial and Ongoing Assessment of Organization Providers:

To ensure the quality of care afforded its members, Neighborhood Health Plan of Rhode Island conducts initial and ongoing assessments of all organizational providers to verify that each organization has met Neighborhood's requirements for participating in the network.

Prior to contacting with an organizational provider and every three years thereafter, Neighborhood evaluates each organizational provider to verify that:

- The provider has met all state and federal licensing and regulatory requirements, including Medicare and Medicaid (CMS) certification
- The provider has been accredited by an organization approved by CMS the medical director of the facility must be credentialed with Neighborhood.

Neighborhood conducts onsite quality site assessment (as applicable) in the absence of accreditation. Proof of CMS or state certification and a copy of the full report from CMS or the State of licensure (Rhode Island and/or Massachusetts), may be submitted for consideration, along with a copy of the provider's quality improvement program description and evaluation, in lieu of an organizational site assessment.

CMS and/or DOH reports submitted for consideration must be no greater than 3 years old when the application is reviewed and approved. Site assessments conducted at non-accredited provider sites include a review of the provider's policies and procedures to specifically ensure that the provider verifies that its practitioners are credentialed, license and/or certified as applicable.

Site assessments will confirm that the organization conducts ongoing monthly screening of employees, consultants, subcontractors and governing officials, including any individual with a direct or indirect controlling interest of any percentage in the organization, or anyone else performing services on behalf of the organization against the LEIE/SAM databases to insure individuals are not excluded from participation in the state and federal health care programs.

Site assessments are performed by credentialing staff . Initial and ongoing assessments apply to all organizational providers seeking participation or continued participation in Neighborhood's network, regardless of the number of members treated.

Neighborhood reserves the right to conduct site assessments as necessary and off cycle (earlier than 3 years) as deemed appropriate and warranted.

Neighborhood's site assessment tools set performance standards for: physical environment (including accessibility and appearance, patient care standards, record keeping standards and policy and procedures.

Accrediting bodies accepted by Neighborhood:

American Academy of Sleep Medicine	AASM
American Association for Accreditation of Ambulatory Surgery Facility	AAAASF
Accreditation Association for Ambulatory Healthcare	AAAHC
American Academy of Pain Management	AAPM
American Academy of Sleep Medicine	AASM
Accreditation Commission for Health Care, Inc.	ACHC
American Health Care Association	AHCA
American Osteopathic Association	AOA
Center for Medicare and Medicaid Services	CMS
College of American Pathologists	CAP
Commission on Accreditation of Rehabilitation Facilities	CARF
Continuing Care Accreditation Commission	CCAC
Community Health Accreditation Program	CHAP
Clinical Laboratory Improvement Amendments	CLIA
Commission on Office Laboratory Accreditation	COLA
Det Norske Veritas Healthcare	DNV
Joint Commission	JC

Neighborhood requires the following documentation for initial assessment and every 3 years thereafter:

- A signed Neighborhood contract (applicable for initial assessment only)
- A completed Neighborhood organizational provider application
- Signed copies of the Neighborhood's regulatory requirements attestations
- Documentation of unrestricted state licensure (NOTE: An actual copy of the state license is required; attesting to the accreditation is not sufficient)
- Documentation of DOH site visit and report as necessary
- Malpractice and general liability certificate of insurance
- Malpractice claim history
- Medicare and Medicaid sanction information
- Proof of accreditation status with an approved accrediting body (NOTE: An actual copy of the accreditation report is required; attesting to the accreditation is not sufficient)
- Copies of the CMS certificate / report and the provider's quality improvement program description and evaluation may be submitted as necessary.

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 providers 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 Quality Assurance Committee (QAC), the Clinical Affairs Committee (CAC), and/or by the Chief Medical Officer (CMO) and Medical Director in collaboration with QAC and CAC upon identification of a clinical quality care complaint or concern.

Remedial Action may include one of the following activities with the practitioner under review:

- Telephone discussion with the involved practitioner; written correspondence with the involved practitioner require informal or formal practitioner education; review of medical records; on-site quality assessment; implementation of a corrective action plan and other measures as appropriate.
- Remedial action is warranted before disciplinary action occurs, except for those circumstances in which the Neighborhood's CMO and/or Medical Director believe that failure to take such action may pose an imminent danger to the health of an individual.

Disciplinary Action

Neighborhood's CMO and Medical Director are 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 in the State of practice
- Failure to comply with accepted ethical and professional standards and behavior

A provider under review receives written notification of the prospect of disciplinary action and the reason therefore, the right to request a hearing, and his/her rights at such a hearing.

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: Medical Director 910
Douglas Pike
Smithfield, RI 02917

For additional information on practitioner/provider appeal, please call the Neighborhood Credentialing department at 1-800-963-1001.

Section 10: Compliance and Fraud, Waste and Abuse

Compliance at Neighborhood

Definition of Fraud, Waste, and Abuse Federal False
Claims Act

State of Rhode Island False Claims Act

Other Fraud, Waste and Abuse Laws

- Civil Money Penalties for False Claims in Federal Health Care Programs (“CMPL”):
- Federal Anti-Kickback Statute
- Federal Anti-Self-Referral Statute (Stark Laws)
- Health Insurance Portability and Accountability Act (HIPAA)

Provider Audits

Legally Responsible Individuals

Sanction Monitoring

Compliance at Neighborhood

Neighborhood requires compliance with all laws applicable to the organization's business including insistence on compliance with all applicable federal and state laws dealing with false claims and false statements. It is the policy of Neighborhood to aggressively prevent, detect, and eliminate fraud, waste and abuse. Eliminating fraud, waste and abuse in the delivery of healthcare is an obligation, a responsibility and a legal requirement of all Neighborhood employees, including our contracted providers. Neighborhood employees, providers, contractors, consultants and agents may report issues of suspected fraud, waste and abuse to their supervisor, the Compliance Hotline (888-5791551) or the Neighborhood Compliance Department as applicable. Such reports may be made anonymously.

Definition of Fraud, Waste, and Abuse

Fraud is a crime that involves knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. 18 U.S.C. §1347. Fraud is punishable by imprisonment and/or fines and can result in the exclusion of individuals and organizations from participation in government health care programs, such as Medicare and Medicaid. Exclusion means that you could be barred (i.e., not able to work for any company in the health care industry that contracts for government health care programs) for a number of years or permanently.

Waste includes overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a government healthcare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources. Waste can result in fines and other penalties.

The following are common examples recognized 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 payer 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 diagnosis

- 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 services
- Underutilization of services
- Solicitation for payment for covered services outside of co-payment amounts
- Duplicate billing defined as repetitive billing less than thirty (30) days from the 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 for 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
- Residing outside the State of RI and receiving RI Medicaid coverage

Abuse includes actions that may, directly or indirectly, result in unnecessary costs to a government healthcare program. Abuse involves payment for items or services when there is not a legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Typically, situations categorized as abusive may be characterized as inconsistent with accepted medical or business practices, or which are improper or excessive. Abuse includes provider practices that are inconsistent with sound fiscal, business, or medical services that are not medically necessary or that fail to meet professionally recognized standards of health care. It also includes member practices that result in unnecessary cost to a government healthcare program resulting in increased costs or utilization of medical services or products. Abuse can result in fines and other penalties.

Federal False Claims Act

The False Claim Act (FCA) is a federal law that makes it a crime for any person or organization to knowingly make a false record or file a false claim regarding any federal health care program, which includes any plan or program that provides health benefits, whether directly, through insurance or otherwise, which is funded directly, in whole or in part, by the United States Government or any state healthcare system. Under FCA, "knowingly" does not require proof of specific intent to defraud. "Actual knowledge of the information" or acting "in deliberate ignorance of the truth or falsity of the information" or "in reckless disregard of the truth or falsity of the information" is enough.

Examples of the types of activities prohibited by the FCA include billing for services that were not actually rendered, double-billing for items or services, upcoding (the practice of billing for a more highly reimbursed item or service than the one provided) or unbundling (the practice of billing services separately to secure a higher reimbursement).

Moreover, the Affordable Care Act (ACA) mandates that providers and suppliers who are aware that they have retained Medicare or Medicaid funds in error must report and return those funds within sixty (60) days. Under ACA, “overpayments” are defined as “any [Medicare or Medicaid] funds that a person receives or retains...to which the person, after applicable reconciliation, is not entitled.” Any overpayment retained after the deadline becomes an “obligation” for purposes of the FCA. Accordingly, a failure to return overpayments by the deadline may result in a false claim liability for the provider.

Violation under the federal False Claims Act can result in significant fines and penalties. Financial penalties may be imposed on a person or organization including recovery of three times the amount of the false claim(s), plus an additional penalty of \$5,500.00 to \$11,000.00 per claim. An individual (called a qui tam plaintiff or relator) who is an original source of information can sue for violations of the False Claims Act. Under both the federal False Claims Act or qui tam plaintiff can receive between 15-25% if litigated by the qui tam plaintiff.

The federal False Claims Act has provisions to protect individuals who report a violation of the law in good faith.

State of Rhode Island False Claims Act

In addition to the federal law, the state has adopted similar laws under the Rhode Island False Claims Act. The Rhode Island False Claims Act is designed to prevent fraud, kickbacks and conspiracies in connection with government healthcare programs (e.g. Medicare/Medicaid).

Any person or entity that violates the provisions of the Rhode Island False Claims Act is liable to the state for a civil penalty of not less than five thousand five hundred dollars (\$5,500) and not more than eleven thousand dollars (\$11,000), plus three (3) times that amount of the damages which the state sustains because of the act of that person. In addition, the person that violates this law will also be liable to the state for the costs of a civil action brought to recover any such penalty or damages.

The Rhode Island False Claims Act allows whistleblowers to bring suit in the name of the State of Rhode Island where an individual is identified as engaging in conduct that defrauds the state or local governments of taxpayer dollars. The Rhode Island False Claims Act provides protection for whistleblowers against retaliation for filing a claim or assisting the state with its own claim.

Other Fraud, Waste and Abuse Laws

Civil Money Penalties for False Claims in Federal Health Care Programs (“CMPL”)

CMPL provides for monetary penalties against anyone who presents a claim to a federal or state officer, employee or agency that he or she knows or should have known was not provided as claimed. CMPL can also be imposed on a provider who: 1) submits a bill for services provided by a person who is not licensed or is excluded from federal or state health care programs; 2) violates the anti-kickback statutes, or 3) violates the prohibition on physician self-referral, or Stark Laws Criminal Penalties for False Claims in Federal Health Care Programs

A fine of up to \$25,000.00 and/or imprisonment of up to five (5) years may be imposed on any person in connection with the furnishing of items or services under a federal health care program and who is convicted of a felony for knowingly and willfully:

- Making a false statement or representation of material fact in any application for a benefit or payment under or for use in determining rights to such benefit or payment in a federal health care program; Concealing or failing to disclose, with intent to defraud, any event affecting his or her initial or continued right to any benefit or payment;
- Presenting or causing to be presented a claim for a provider’s service for which payment may be made under a federal health care program and knowing that the individual who furnished the service was not a license provider; or
- For a fee, counseling or assisting an individual to dispose of assets in order for the individual to become eligible for medical assistance under a state Medicaid program if disposing of the assets results in the imposition of a period of ineligibility for such assistance.

Federal Anti-Kickback Statute

The Anti-Kickback Statute was designed to prevent fraud and abuse in federal health care programs by making it a crime for anyone who knowingly and willfully solicits, receives, or pays anything of value (remuneration) including any kickback, bribe, or rebate in return for referring an individual to a person for any item or service for which payment may be made in whole or in part under a federal health care program. Punishment for felony conviction for violating the anti-kickback law is a fine of not more than \$25,000 or imprisonment for not more than five (5) years or both, administrative civil money penalties of up to \$50,000 per violation, and exclusion from participation in federal health care programs. The law contains several “safe harbors” that provide protection from prosecution for certain transactions and business practices with further guidelines provided in 42.C.F.R.§1001.952. A violation of the Federal Anti-Kickback Statute constitutes a false and fraudulent claim under the Federal False Claims Act.

Federal Anti-Self-Referral Statute (Stark Laws)

Subject to specific exceptions, the law prohibits a physician from referring federal health care program patients for certain designated health services to an entity with which the physician or an immediate family member has a financial relationship. No specific intent is required. A financial relationship is either a direct or indirect ownership interest or compensation arrangement. Certain regulatory exceptions apply. The law prohibits the designated health services entity from submitting claims to Medicare for those services resulting from a prohibited referral. A physician who violates the Stark Laws is subject to substantial civil money penalties and exclusion from participation in the federal health care program for improper claims.

The Stark Laws impose specific reporting requirements on entities that receive payment for services covered by federal health care programs. Failure to report would subject the entity to civil money penalties of up to \$10,000 for each day which reporting is required to have been made. There is a potential for \$15,000 civil money penalties for each service and exclusion from participation in federal health care programs for knowing violations. Intent is required for civil monetary penalties.

Health Insurance Portability and Accountability Act (HIPAA)

As part of the Health Insurance Portability and Accountability Act (HIPAA), the U.S. Criminal Code was amended, and it is a crime to knowingly and willfully execute, or attempt to execute a scheme or artifice to defraud any federal health care program or obtain by means of false or fraudulent pretenses, representations or promises, any money or property owned by or under the custody or control of any federal health care program. (18 U.S.C. §1347)

**If you suspect fraud, waste or abuse, please
call our Compliance Hotline at 1-888-579-1551**

Provider Audits

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.

Applicable state agencies overseeing the Medicaid Program have a right to conduct audits, where duties under Neighborhood's Agreement with the State are being performed, to inspect, monitor and evaluate compliance with state law.

In the event Neighborhood determines that an overpayment has been made to the Provider by inaccuracy or fraud in the Provider's submission of claims, the Provider agrees that an amount equal to that overpayment may be withheld by Neighborhood. In the event no payment is received or no current payment is forthcoming to Neighborhood, the Provider agrees that an amount equal to the overpayment, described above, shall be paid to Neighborhood by the Provider.

Legally Responsible Individuals

For Medicaid products, Neighborhood does not make payments to legally responsible individuals for furnishing any health care related services. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or (b) a spouse. Except at the option of the State and under extraordinary circumstances specified by the State, Neighborhood cannot make payment to a legally responsible individual for the provision of any health care related services that the legally responsible individual would ordinarily perform on behalf of a Medicaid beneficiary regardless of the professional qualifications of the legally responsible individual.

Sanction Monitoring

As part of detecting and preventing fraud, providers are responsible to ensure that they are not employing or contracting with individuals or entities that are excluded from participation in state or federal health care programs. Providers are expected to conduct initial and ongoing monthly checks of employees, consultants, subcontractors, and governing individuals, including any individual with a direct or indirect controlling interest of any percentage in the provider or anyone else performing services on behalf of the provider, against OIG LEIE & SAM databases to ensure that individuals or entities are not excluded from participation in state and federal health care programs. Provider will notify Neighborhood immediately of any identified excluded individuals or entities.

Section 11: Quality Improvement

Overview of Quality Improvement Program

Quality Improvement Methodology

Neighborhood's Quality Improvement Activities

- Healthcare Effectiveness Data Information Set (HEDIS)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Medicare Health Outcomes Survey (HOS)
- Provider Satisfaction Survey

Disease Management Programs

Clinical Practice Guidelines

Peer Review Activity

Actions to Address Quality of Care Complaints

Overview of Quality Improvement Program

Neighborhood's Quality Improvement (QI) Program strives to ensure that members have access to high quality health care services that are responsive to their needs and result in positive health outcomes. In order to meet this high level goal, Neighborhood's QI Program targets clinical quality of care, member and provider satisfaction and internal operations. The Neighborhood Board of Directors has the ultimate oversight for the healthcare and services provided to its members and annually approve the QI Program Description and Work Plan.

Within the scope of its QI Program, Neighborhood monitors and evaluates care and services rendered to members, with particular emphasis on access to care, availability of services, member satisfaction, and health outcomes, as captured through routine health plan reporting, annual HEDIS and CAHPS results, assessment of provider and member satisfaction, accessibility and availability standards, utilization trends, and especially designed quality improvement studies. Neighborhood assesses its performance, including the performance of its contractors and its network providers, against goals and objectives that are evidence-based and align with industry standards. Neighborhood expects all providers to cooperate with quality improvement activities and to allow Neighborhood to use provider performance data to enhance the success of its QI Program.

Neighborhood recognizes the critical role that provider involvement plays in the success of its QI Program, and highly encourages provider involvement in various levels of the process through provider representation. Neighborhood encourages primary care providers, specialists, and OB/GYN representation on key quality committees such as the Clinical Affairs Committee, Clinical Management Committee and Pharmacy and Therapeutics Committee.

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.

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 series delivery to identify opportunities for improvement. Neighborhood uses HEDIS® and CAHPS® results, program evaluation results, member and provider satisfaction surveys, the Member Services 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 in the data and identify opportunities for improvement. Based on the data, the Plan's QI committee, subcommittees, and ad-hoc QI workgroups identify, prioritize and implement interventions to address the opportunities for improvement.

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 and 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 objective are being met, each quality improvement activity is reviewed and discussed by the designated committee or subcommittee regularly. Modification to the initiatives are implemented as necessary and incorporated into Neighborhood's annual Quality Improvement Work Plan.

Neighborhood's Quality Improvement Activities

Healthcare Effectiveness Data Information Set (HEDIS) Rates

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA). HEDIS provides purchasers and consumers the ability to distinguish between health plans based on comparative quality. HEDIS is one of the most widely used systems of health care performance measures in the United States. As both Federal and State governments move toward a healthcare system that is quality-driven, HEDIS performance is becoming increasingly important for providers as well as for health plans. HEDIS results are based on statistically valid samples of members and are rigorously audited by an NCQA certified HEDIS auditor using a process designed by NCQA. NCQA requires accredited health plans to report the required audited HEDIS performance measures to NCQA.

HEDIS measures are collected and calculated in two methodologies: administrative and hybrid. The administrative method uses claims data and other administrative data files submitted to Neighborhood to identify the denominator and numerator. In this case the denominator will include all members who meet the eligibility criteria based on the HEDIS Technical Specifications defined under each measure. Examples of HEDIS measures that are collected through this method include: Chlamydia Screening in Women, Breast Cancer Screening and Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis.

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 Neighborhood. The hybrid data requires review of a random sample of medical records to extract data relative to services provided but not reported to Neighborhood via claims or encounter data. Examples of HEDIS measures that usually require chart review are: Childhood Immunizations, Cervical Cancer Screening, Controlling High Blood Pressure, and Postpartum Care.

How Can Providers Improve Their HEDIS Rates?

Submit claims and encounter data for every service that is delivered.

Submit accurate and timely claims and encounter data.

Document services completely and accurately in the medical record.

Understand the HEDIS Technical Specifications for each HEDIS measure.

Identify patients who meet the HEDIS measure specification and ensure they receive those services.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The CAHPS survey is a standardized survey administrated annually to Neighborhood members by an NCQA-certified survey vendor, and it is required as part of HEDIS submission and NCQA Accreditation. CAHPS assesses members' experience with the services provided by Neighborhood and the services provided by the members' providers. Neighborhood uses the results from the annual CAHPS survey to identify areas of member dissatisfaction and opportunities for improvement. CAHPS survey results are supplemented with regular review of member complaints and appeals for a more robust assessment of members' needs.

Medicare Health Outcomes Survey (HOS)

The Medicare HOS is a patient-reported outcomes measure used in Medicare managed care. The goal of the HOS is to collect data to facilitate targeted quality improvement activities and resources; to monitor health performance and reward top-performing health plans; and to help Medicare beneficiaries make informed health care choices. All the Medicaid-Medicare health plans are required to participate in the HOS survey. HOS is annually administered by an NCQA-certified vendor.

Provider Satisfaction Survey

Neighborhood conducts an annual Provider Satisfaction survey to assess and identify opportunities to improve providers' satisfaction with Neighborhood's services to providers and support for clinical practice. Neighborhood partners with an external vendor to administer this survey. The survey assesses respondents' satisfaction with operational 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.

Disease Management Programs

Disease management is a multi-disciplinary, approach to health care delivery that focuses on the identification of populations with, or at risk for, common medical conditions. Neighborhood's disease management programs strive to: support the relationship between providers and their patients and reinforce the established plan of care; emphasize the prevention of exacerbations and complications through cost-effective evidence-based practice guidelines and patient empowerment strategies such as self-management and patient education and outreach; and evaluate clinical outcomes and patterns of utilization with the goal of improving overall health. Neighborhood currently has disease management programs for asthma, diabetes, chronic obstructive pulmonary disease (COPD), and congestive heart failure. See full details and program descriptions of Neighborhood's Disease Management programs in the Medical Management section of the Provider Manual.

Clinical Practice Guidelines

Neighborhood's Medical Directors' Office develops and/or adopts and maintains clinical practice guidelines to ensure the delivery of age-appropriate, evidence-based care to enrolled members. Clinical practice guidelines for behavioral health are developed by Neighborhood's behavioral health vendor. Neighborhood annually assesses practitioner adherence to the guidelines to identify opportunities for performance improvement. Clinical practice guidelines are updated no less than every two (2) years and are accessible to network providers via the Neighborhood website.

Peer Review Activity

Neighborhood's peer review program is conducted according to the Rhode Island Board of Medical Licensure and Discipline Regulations. The Chief Medical Officer (CMO) manages the peer review process internally for presentation and review by the Clinical Affairs Committee. Cases requiring

peer review are identified through member or provider complaints, utilization review, and other sources. 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. Any necessary remedial and disciplinary actions are 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 clinical 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 a Medical Director (MD) assigned to the case. For complicated cases, the MD may defer the case to the internal Quality Assurance Committee (QAC) for discussion prior to rendering a final decision. Complaints deemed to be issues of quality of care by the reviewing MD and/or QAC are reported to the Clinical Affairs Committee on a regular basis. In addition, member concerns specific to access for urgent or current conditions or illnesses are addressed by a clinician in Neighborhood's Medical Directors' Office.

Section 12: Commercial Plans Offered through HealthSource RI

Marketplace Plans Overview

Member Eligibility

Advance Premium Tax Credit (APTC) Grace Period

Marketplace Plans Benefit Overview

Services Requiring Authorization

Claims Submission

Marketplace Plan Overview

We believe that offering Marketplace plans through HealthSource RI allows Neighborhood to further our current work and mission to secure access to high quality, cost-effective health care for Rhode Island's at-risk populations. A significant portion of Rhode Island's previously uninsured population will move back and forth between having coverage through plans available on HealthSource RI and Medicaid, due to fluctuating income. By offering plans through HealthSource RI, Neighborhood helps ensure continuity of care, maintains member relationships with their patient-centered medical homes, and makes the complicated business of health insurance less cumbersome.

Neighborhood offers plans through HealthSource RI for eligible individuals and families and small businesses with 2-50 employees (Small Business Health Options Program, SHOP).

Member Eligibility

HealthSource RI retains the responsibility for determination of member eligibility for Neighborhood's Marketplace plans. An enrollment file is sent to Neighborhood indicating members who are have enrolled in Neighborhood's plans and their effective dates. Once received, Neighborhood issues a welcome packet, including an ID card, to each member.

Members and/or their appointed designee are instructed to carry their ID card with them and to show their ID card when seeking health care services. Providers should verify a member's eligibility when providing services to a member(s) who presents a Neighborhood identification card.

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 – 24 hours a day, seven days a week, and is current up to the prior business day. If you have questions regarding NaviNet, please call 1-888-482-8057 for Customer Support.

Participating providers without internet access may also call Neighborhood Provider Services to verify member eligibility at 1-800-963-1001, 8:00 a.m. to 6:00 p.m. Monday through Friday.

Advance Premium Tax Credit (APTC) Grace Period

In accordance with federal law and regulation, and Neighborhood's contract with HealthSource RI for individuals enrolled in Neighborhood's individual plans, an advance premium tax credits (APTC) grace period of three consecutive months where a member does not lose coverage is required if a member is receiving advance premium tax credits (APTCs) and has previously paid at least one full month's premium for coverage.

What you need to know:

Some of Neighborhood's members enrolled in its individual plans will be receiving APTCs and so the APTC grace period will apply to them. Grace period will not apply to any Neighborhood SHOP members.

The APTC grace period starts at the beginning of the month for which premium has not been paid. During this APTC grace period, information about the member's status will be available through Neighborhood Member Services.

- Neighborhood will pay claims submitted during the first month of the APTC grace period.
- For claims submitted during the second and third months of the APTC grace period, Neighborhood will pend claims.
- If a member pays past due premiums before the end of the APTC grace period, previously pended claims will be automatically reprocessed and paid. Providers do not need to resubmit the claims. If a member's grace period ends without premiums being paid, pended claims will be denied. For members whose eligibility cannot be verified or who are in the APTC grace period, you have the same options available, with respect to billing the member for services, as you do with any other Marketplace members.

Marketplace Plan Benefits Overview

An overview of plans offered through HealthSource RI is available on our website at www.nhpri.org.

Individuals who enroll in Neighborhood may have different cost-sharing based on the plan variation in which they are enrolled. Appropriate copay amounts will be noted on the member ID cards.

Please refer to our Certificates of Coverage and Summaries of Benefit and Coverage which are available at www.nhpri.org for more information about plan benefits.

Services Requiring Authorization

Some services will require authorization prior to services being rendered. Please review Section 5 of this manual for information on the authorization process. Services needing an authorization for Marketplace members will be posted at www.nhpri.org.

Claims Submission

Please refer to the Billing and Reimbursement section of the Provider Manual for detail on claims submission. Marketplace plans include copayments, coinsurance and deductibles at various levels, depending on the plan. We encourage providers to collect these amounts from members as they would members of other Marketplace carriers. Any amounts collected at the times of service should be reflected on the claim.

Section 13: Neighborhood INTEGRITY / Medicare Medicaid Plan (MMP)

INTEGRITY Overview and Model of Care

Enrollee Benefits

- Medical, Behavioral Health and Long Term Services and Supports
- MMP Pharmacy Program

Formulary

- Prescribers of Medicare Part D Drugs
- Prior Authorization
- Step Therapy

Transition Policy

Medication Therapy Management Program

Enrollee Ombudsman Services

Role of the Enrollment Counselor

Quality Improvement

Mandatory Reporting

Alternative Payment Arrangements

Medical Management

Authorization Requirements for INTEGRITY

Member Billing

Care Management

- Care Management for INTEGRITY member residing in nursing facilities
 - Neighborhood Care Management staff responsibilities:
 - Nursing Facility Responsibilities:
- Care Management for INTEGRITY members residing in the community

Service (Subcontracted) Providers Marketing Guidelines

Provider Education and Training

INTEGRITY Overview and Model of Care

The goal of Rhode Island's Integrated Care Initiative (ICI) is to improve the care and quality of life for elders and adults with disabilities who are eligible for both Medicare and Medicaid.

Rhode Island's ICI is being implemented in two phases. Phase I started in November 2013 with the enrollment of eligible individuals into managed care for their Medicaid and Long Term Services and Supports (LTSS) only. That was formerly offered by Neighborhood through UNITY (termination effective as of September 30, 2018).

Based on successful Readiness Review and a signed three-way contract between the Centers for Medicare & Medicaid Services (CMS) and the State of Rhode Island, Neighborhood offered INTEGRITY, a Medicare Medicaid Plan for eligible persons in July 2016. Phase II offers a fully integrated model that combines all of the Medicare and Medicaid benefits and is based on an approved CMS Model of Care.

The overall goal of Neighborhood's Model of Care is to coordinate high-quality, member- centered, cost-effective care by implementing an integrated, interdisciplinary approach with a focus on high-touch care management.

Neighborhood has developed the following objectives for our Model of Care:

- To systemically identify moderate- and high-risk members who require medical, behavioral and non-medical support services to meet their needs as defined by the members, their informal support caregivers (if appropriate), key providers and participants in Neighborhood's Interdisciplinary Care Team;
- To prevent moderate-risk members from becoming high-risk and to ensure their health and wellbeing;
- To address active medical needs; and
- To maintain the health and wellbeing of low-risk members.

These high-level objectives translate into the following concrete objectives that drive the programmatic design of the Model of Care:

- To offer quality primary and preventive care, integrated across the full continuum of care that builds and enhances the role of the Patient-Centered Medical Home (PCMH) and primary care practices;
- To integrate the full continuum of Medicare and Medicaid benefits through collaborative relationships among Neighborhood's care management staff and with medical, behavioral and other community-based partners;
- To facilitate informed member- and family-centric decision-making that meets the self-defined and varied needs of members, in collaboration with the informal supports and Neighborhood;
- To improve members' health outcomes by coordinating care efficiently across the plan and with medical, behavioral and non-medical social supports and providers; and

- To develop effective, efficient operations that leverage strong interpersonal and technical communications to deliver high-quality clinical and non-clinical care.

Neighborhood has identified specific goals and measures which we will employ to evaluate the programs, processes and initiatives developed within the Model of Care (and presented in subsequent elements) and to support the Quality Improvement Program.

Providers must comply with federal and state regulations. They will receive information and be expected to attest to their understanding of the INTEGRITY MMP program and Model of Care and cultural competency expectations. For further information, please contact Member Services.

Enrollee Benefits

Medical, Behavioral Health and Long Term Services and Supports

INTEGRITY MMP benefits include comprehensive medical, behavioral health and long term services and supports. In addition, Neighborhood will provide Medicare Part D and over-the-counter drug benefits, through the INTEGRITY formulary.

If applicable, members will be responsible for any patient share that EOHHS determines. Detailed information on INTEGRITY benefits are available on Neighborhood's website, www.nhpri.org/INTEGRITY.

MMP Pharmacy Program

As part of the contract providers must comply with all CMS regulations that govern the MMP product including all Medicare Part D requirements. This section outlines INTEGRITY MMP pharmacy program, including general information on our formulary and utilization management programs. Also included is a description of Neighborhood's Step Therapy program and Medication Therapy Management program (MTM).

Neighborhood contracted with CVS/Caremark, a national pharmacy benefits management company, to administer the Medicare Part D pharmacy benefit provided to INTEGRITY members. In addition to many smaller independent pharmacies, Neighborhood's pharmacy network includes CVS, Rite Aid, Walgreens, Walmart and many others. A complete list of contracted pharmacies is available on our web site, www.nhpri.org

Formulary

The INTEGRITY formulary is CMS-approved to include Medicare Part D and Medicaid over-the-counter drugs. Please refer to Neighborhood's website for more information at www.nhpri.org/INTEGRITY.

Prescribers of Medicare Part D Drugs

As of January 1, 2019, CMS is requiring physicians and eligible professionals who prescribe covered Part D drugs be enrolled in Medicare, or have a valid record of opting out of Medicare, in order for their prescriptions to be covered under Part D per 42 CFR.423.120(c)(6).

Prior Authorization

INTEGRITY approved Medicare Part D and supplemental formularies may require prior authorization before a pharmacy can fill the prescription. Information on how clinicians may request prior authorizations are available at www.nhpri.org/INTEGRITY. Information regarding grievances, appeals and exceptions is also available.

Step Therapy

In support of efforts to provide members with the best medical care, CVS/Caremark and the Pharmacy and Therapeutics (P&T) Committee has developed step therapy programs that apply to the INTEGRITY MMP formulary. These programs initiate drug therapy for a medical condition with the most cost-effective and safest drug and step up through a sequence of alternative drug therapies as a preceding option fails.

Transition Policy

Neighborhood will provide an appropriate transition process with regard to:

- The transition of new enrollees into prescription drug plans at the beginning of a contract year;
- The transition of newly eligible Medicare beneficiaries from other coverage at the beginning of a contract year;
- The transition of individuals who switch from one plan to another after the start of the contract year;
- Enrollees residing in long term care facilities;
- Enrollees who change treatment setting due to changes in level of care;
- In some cases, current enrollees affected by formulary changes from one contract year to the next, consistent with the requirements set forth in CMS guidance for participation in the Medicare Part D Drug Program. CVS/Caremark also provides an appropriate transition process that meets the criteria above and any other criteria established by the state and CMS.

This transition process is applicable to medications that require a:

Prior Authorization (PA) edit (except edits required for safety) Step

Therapy (ST) edit,

Quantity Limit (QL) edit, or

Not on the formulary.

Medication Therapy Management Program

Neighborhood offers a Medication Therapy Management (MTM) program to members who meet the specified targeting criteria per CMS requirements and who meet other plan-specific targeting criteria and have chronic diseases such as arthritis, diabetes, or chronic heart failure. If members meet these qualifications, they may be eligible for comprehensive medication review, telehealth consultation or additional mailings.

Enrollee Ombudsman Services

Rhode Island's Executive Office of Health and Human Services (EOHHS) has a contract with Rhode Island Parent Information Network (RIPIN) to provide Ombudsman services for the Medicare-Medicaid eligible population in Rhode Island. The goal of the Integrated Care Initiative (ICI) Ombudsman is to ensure that members:

1. Understand their rights;
2. Get help accessing services; and
3. Get help resolving complaints.

The ICI Ombudsman will work closely with and coordinate with the other agencies that are working with consumers who are eligible for and/or enrolled in the Integrated Care Initiative.

RIPIN Healthcare Advocates (<http://ripin.org/healthcareadvocate/>) can be reached Monday – Friday 8 a.m. to 5 p.m., plus extended Thursday hours to 7 p.m. by calling toll-free 1-855-747-3224 or via [email: HealthcareAdvocate@ripin.org](mailto:HealthcareAdvocate@ripin.org)

Role of the Enrollment Counselor

The State contracts with an independent entity, which will be responsible for processing all enrollment and disenrollment transactions. The enrollment counselor will provide unbiased education to enrollees on MMPs and other potential enrollment choices, and ensure ongoing customer service related to outreach, education and support for individuals eligible for the Demonstration. The enrollment counselor incorporates the option of PACE enrollment into its scripts and protocols.

The State works with the independent Enrollment Counselor and the Ombudsman program to ensure ongoing outreach, education and support to individuals eligible for the Demonstration.

Providers can receive more information with The POINT/Medicare-Medicaid Counselors by calling 401-462-4444 (TTY 711) during the following hours: Monday, Wednesday, Friday 8:30am – 4:00pm; Tuesday and Thursday, 8:30am – 8:00pm; and Saturday 8:30am -12 noon.

Quality Improvement

Neighborhood's Quality Improvement Program strives to ensure members have access to high quality health care services that are responsive to their needs and result in positive health outcomes. To meet this goal, Neighborhood's program targets clinical quality of care, member and provider satisfaction and internal operations. Annually the Quality Improvement Program Description is approved by Neighborhood's Board of Directors.

Neighborhood's RHO Quality and Operations Committee will monitor and review the operations and improvement activities of INTEGRITY, including the Model of Care. Providers are responsible for ensuring compliance with quality improvements standards. Providers must meet specific levels of quality outcomes using evidenced-based practices.

Findings and issues will be presented to the Clinical Affairs Committee for review and approval and be shared with the Chief Medical Officer and the Vice President of Medicare & Medicaid Integration. The INTEGRITY Quality Improvement Program is in compliance with CMS and EOHHS quality standards, expectations and priority initiatives.

Mandatory Reporting

Neighborhood's INTEGRITY plan is based on a signed three-way contract with CMS and EOHHS. Collaboration with Neighborhood's contracted providers is critical to the program. Contracted providers actively assist with the data collection, reporting and performance review components of the plan as defined in the three-way contract. Additionally, Neighborhood collaborates with contracted providers to identify opportunities for improvement.

Alternative Payment Arrangements

One of the goals of the Medicare-Medicaid Program is to promote Alternative Payment Arrangements as a means to transform the delivery of high quality and cost-effective care within CMS requirements. Alternative Payment Arrangements are defined as methods of payment that are not solely based on fee-for-service reimbursements, and may include, but shall not be limited to, bundled payments, global payments, and shared savings arrangements. Alternative Payment Arrangements may include fee-for-service payments, which are settled or reconciled with a bundled or global payment. As part of the Duals Demonstration, Neighborhood is required to utilize Alternative Payment Arrangements to support this delivery system transformation. The details of these Alternative Payment Arrangements will be developed collaboratively with network providers, and will be implemented in Demonstration Year two and three (DY 2 and 3).

Medical Management

The Medical Management department is responsible for ensuring positive patient outcomes by addressing and supporting member's medical and social needs in the most cost effective and efficient way. Medical Management handles many requests including, but not limited to: notification of inpatient admissions or other services requiring prior authorization, inquiries about utilization management policies and procedures, and requests for additional information needed for medical review decision making.

As one of many efforts to improve transitions of care for members, facilities are required to fax (401-459-6023 UM Fax) Neighborhood Health Plan of Rhode Island a copy of the transition of care document (Rhode Island Department of Health Continuity of Care Form) at member's discharge to another setting (hospital, SNF, etc.) (<http://www.health.ri.gov/forms/continuityofcare/Form.pdf>).

During the transition period, Neighborhood will advise enrollees and providers if and when they have received care that would not otherwise be covered in-network.

Neighborhood seeks to minimize the disruption to members' continuity of care during the transition into the MMP product. For this reason members will be able to maintain current providers and service levels at the time of enrollment for at least six months after enrollment.

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 is 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. The telephone number is 1-401-459-6060 or toll free at 1-800-264-3955.

Note: During implementation member's transition period, authorizations already in place for RHO members transitioning to Neighborhood will be honored for a period of six (6) months.

Authorization Requirements for INTEGRITY

Certain benefits for INTEGRITY members require prior authorization. These benefits include both skilled and unskilled services. Please refer to the Prior Authorization Reference Guide and Medical Management Request Forms found on Neighborhood's website (www.nhpri.org) to determine which services require prior authorization:

<https://www.nhpri.org/Providers/ResourcesFAQs/PriorAuthorizationReferenceGuide.aspx>

<https://www.nhpri.org/Providers/MedicalManagementRequestForms.aspx>

Member Billing

Under 42 CFR §422.504(g) (1) (iii), all MAOs --without exception-- must educate providers about balance billing protections applicable to dual eligible enrollees. Federal law bars Medicare providers from collecting Medicare Part A and Medicare Part B deductibles, coinsurance, or copayments from those enrolled in the Qualified Medicare Beneficiaries (QMB) program, a dual eligible program which exempts individuals from Medicare cost-sharing liability. (See Section 1902(n) (3) (B) of the Social Security Act, as modified by 4714 of the Balanced Budget Act of 1997). Balance billing prohibitions may likewise apply to other dual eligible beneficiaries in MA plans if the State Medicaid Program holds these individuals harmless for Part A and Part B cost sharing. See 42 CFR §422.504(g) (1) (iii).

Care Management

Conflict-free case management must be provided. Individuals performing evaluations, assessments, and plans of care cannot be related by blood or marriage to the individual or any of the individual's paid caregivers, financially responsible for the individual or empowered to make financial decisions or health-related decisions on behalf of the individual.

Care Management for Nursing Home Residents

Neighborhood works in partnership with nursing home social workers and admission staff to ensure that INTEGRITY members have access to all available resources to make informed decisions about their health and care. The Care Management department consists of various professionals, all dedicated to assisting members in accessing health care in the most appropriate cost effective setting while achieving their health and wellbeing goals. The department has RNs, Social Workers, Community Care Coordinators, Housing Specialists and Rehab Specialists all available to help nursing homes assess members' needs, help in obtaining needed services, assistance in transitioning from one level of care to another, or help in guiding members through the health care and social services systems. The Care Management staff contacts members and providers by phone or in person, depending on the need and situation. The Care Managers will see to coordinate all participants of a member's care team (PCP, specialists, agencies, nursing facilities) to increase communication and decrease duplication. Referrals come from internal data mining, providers or members. The following responsibilities will help define this collaboration:

Neighborhood Care Management staff responsibilities:

- The Lead Care Manager (LCM) meets with nursing home administrative staff to review roster of INTEGRITY members
- Review and screen the most recent MDS assessments, especially Section Q, to stratify members as 1) current opportunity for discharge 2) potential opportunity for discharge or 3) permanent nursing home resident.
- Meet with nursing facility staff to verify the initial stratification of members
- Partner with facility staff to meet with members and or family when needed
- Offer assistance to facility staff and member to develop a discharge plan and make referrals for community based services and supports when needed
- Assist facility staff in the completion of any program applications (e.g. CORE, Rhode to Home)
- Ensure the member is connected to a PCP and other specialists as needed
- Ensure that long term care counseling is provided
- Identify affordable housing options for members transitioning to the community work with facility staff to develop a Plan of Care for each member

- Provide ongoing care management to members transitioned to the community

Nursing Facility Responsibilities:

- Provide Neighborhood staff with access to members and their records
- Assist Neighborhood in identifying members for discharge opportunities
- Partner with Neighborhood in discharge planning meetings
- Assist Neighborhood in identifying a member's strengths, needs and goals
- Partner with Neighborhood in developing a discharge plan and Plan of Care
- Assist with making referrals to community providers

Care Management for INTEGRITY members residing in the community

Neighborhood works in partnership with members, community providers and agencies to ensure that INTEGRITY members have access to all available resources to make informed decisions about their health care. The Care Management department consists of various professionals, all dedicated to assisting members in accessing health care in the most appropriate, cost effective setting while achieving their health and wellbeing goals. The department has RNs, Social Workers, Community Outreach Specialists, Housing Specialists and Resource Specialists all available to help address members' needs, assist in obtaining needed services, assistance in transitioning from one level of care to another, or help in guiding members' through the health care and social services systems. The Care Management staff contacts members and providers by phone or in person, depending on the need and situation. The Care Managers will coordinate all participants of a member's care team (PCP, specialists, agencies) in order to increase communication and decrease duplication. Referrals come from internal data mining, providers or members. The following responsibilities will help define this collaboration:

- All INTEGRITY members receiving LTSS receive a comprehensive functional needs assessment to determine their strengths, weaknesses, goals and needs
- Lead Care Managers refer to and collaborate with providers, social/community agencies, members and their significant others to ensure members' needs are met
- LCM develops a plan of care to be share with all involved participants of the interdisciplinary care team

Service (Subcontracted) Providers

To ensure continuity of care, please notify Neighborhood's Provider Network Management staff of any service provider that performs patient care in your facility. Service providers would include vendors like physical therapists, podiatrists, oxygen suppliers or wound vacuum suppliers who

would bill Neighborhood directly for their services. If you are not sure whether or not your service provider is in the Neighborhood network, our provider directory will be posted on our website. Service providers do not require a referral by the nursing facility.

Neighborhood will outreach to these service providers to invite them to participate in the Neighborhood network if they do not already. Please call Provider Network Management at 1-401459-6000 or fax the information to 1-401-709-7066. Please include the provider's name and contact information.

Marketing Guidelines

Neighborhood's contract with CMS and EOHHS defines how we and our providers can market and advertise INTEGRITYMMP. Providers may not include any references to their affiliation with INTEGRITY MMP in their marketing or advertising without prior approval. Neighborhood will submit all designated marketing materials and scripts to CMS and EOHHS to obtain approval prior to distribution or display. Neighborhood's Marketing and External Affairs department and Compliance staff will submit these materials. Providers will comply with marketing guidelines outlined in the Medicare Marketing Guidelines including any limited English proficiency provisions. Please contact Neighborhood prior to beginning any communications or marketing initiatives.

Provider Education and Training

Providers will ensure that a designated staff member has attested to taking the following web based module trainings as well as disseminating relevant information to other staff members. These training include:

1. Introduction to Integrity
2. Enrollee Rights and Protections
3. Cultural Competence, Disability Literacy, and the ADA
4. Model of Care, Assessment, and Care Planning
5. Putting Cultural and Disability Competence into Practice
6. Integration of Behavioral Health and Long Term Services and Supports

Providers will abide by critical incident (preventing abuse/neglect/exploitation of members, information on reporting fraud, waste and abuse) guidelines.

Network Providers must comply with the American with Disabilities Act (ADA) (28 C.F.R. § 35.130) and Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) and maintain capacity to deliver services in a manner that accommodates the needs of its Enrollees.

INTEGRITY Member Appeals

INTEGRITY members have the right to file a grievance if they have concerns or problems related to their coverage or care as discussed in the Complaints and Appeals section, above. However, this section focuses on member appeals following an adverse Organization Determination. INTEGRITY members have five (5) types of appeals available, each with variable additional levels of appeal available to the member:

1. A Part C appeal is defined as: Any of the procedures that deal with the review of adverse organization determinations on the health care services an enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), as defined in 42 CFR 422.566(b). These procedures include reconsideration (internal appeal) by Neighborhood, and if necessary, an independent review entity (MAXIMUS), hearings before Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC) and judicial review. Please note that Part B Medication Appeals fall into the Part C appeal category.
2. A Part D appeal is defined as: Any of the procedures that deal with the review of adverse coverage determinations made by Neighborhood relative to benefits covered under a Part D plan the enrollee believes he or she is entitled to receive, including a delay in providing or approving the drug coverage (when a delay would adversely affect the health of the enrollee) as defined in §423.566(b). These procedures include redetermination (internal appeal) by Neighborhood or our delegated entity, CVS Caremark, reconsiderations by the independent review entity (MAXIMUS), Administrative Law Judge (ALJ) hearings, reviews by the Medicare Appeals Council (MAC), and judicial reviews.
3. A Fast Track Appeal is a type of appeal when the member disagrees with the coverage termination decision from a skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF), or upon notification of discharge for an inpatient hospital stay. CMS contracts with Quality Improvement Organizations (QIOs) to conduct fast-track appeals.
4. A clinical appeal is a request for reconsideration of an initial adverse clinical organization determination.
5. An administrative appeal is a request to reverse an administrative (non-clinical/non utilization management) determination such as payment of claims or coverage of services relative to a member's available benefits.

Applicable appeal rights are determined by whether the services are covered by Medicare, Medicaid or by both Medicare and Medicaid. For services covered by both Medicare and Medicaid, members are entitled to all appeal rights available to services covered by Medicare and Medicaid.

Standard Member Appeals Procedure for Services Covered by Medicare

The member, member's authorized representative, or treating provider initiates a request for reconsideration to the Neighborhood Grievances and Appeals Unit either verbally, in writing or in person.

The Grievances and Appeals Unit receives and reviews the appeal request and, if needed, will request additional documentation.

The member can identify an Authorized Representative (AOR) to act on their behalf during the appeal process.

NOTE: If the member does have an AOR or activated Health Care Proxy, all correspondence regarding the appeal must be sent to the AOR.

The Grievances and Appeals Unit consults with other Neighborhood departments when appropriate, and completes the investigation and notifies the member as expeditiously as the member's health condition requires. Decisions on standard appeal requests may not exceed 30 calendar days for pre-service requests, and must not exceed 60 calendar days for post-service requests from the date the appeal request was received by the Plan. Effective January 1, 2020, the turnaround time Part B Medication appeals is 72 hours for expedited and seven (7) calendar days for standard. At the conclusion of the appeal investigation, all interested parties are notified of the appeal disposition via written correspondence and are provided with additional appeal rights, if available.

Neighborhood can extend a service review time frame up to 14 calendar days, but only if the extension is requested by the member or if Neighborhood determines the delay is in the best interest of the member. For example, an extension may be appropriate if additional diagnostic testing or consultation with medical specialists is pending. Effective January 1, 2020, extensions are not allowed for Part B Medication appeals.

NOTE: Lack of availability of plan provider medical records is not an acceptable reason for delay in rendering an appeal decision.

If the organization determination was not overturned, and the service may be covered by Medicare, the notice informs the member that all relevant information was forwarded to the CMS Independent Review Entity (IRE) contractor, MAXIMUS Federal Services, Inc.

NOTE: Forwarding an appeal to Maximus does not apply to services or supplies which are covered by Medicaid-only. For services or supplies covered by Medicaid-only, interested parties to the appeal are notified of additional external appeal rights.

Standard Member Appeals Procedure for Services Covered by Part D

The member, member's authorized representative, or treating provider initiates a request for redetermination to the CVS Caremark Coverage Determination and Appeals Department either verbally, in writing or in person.

The CVS Caremark Coverage Determination and Appeals Department receives and reviews the written appeal and, if needed, will request additional documentation.

The member can identify an Authorized Representative (AOR) to act on their behalf during the appeal process.

NOTE: If the member does have an AOR or Legal Representative, all correspondence regarding the appeal must be sent to the AOR.

The CVS Caremark Coverage Determination and Appeals Department completes the investigation as expeditiously as the member's health condition requires, not exceeding 72 hours for expedited appeals or seven (7) calendar days for standard appeals from the date the redetermination request was received. No extensions are allowed for Part D appeals.

The member/AOR receives written notice within 7 calendar days, regardless of whether or not the coverage determination was overturned.

If the coverage determination was not overturned and the drug may be covered by Medicare, the notice informs the member of the right to submit a reconsideration request to MAXIMUS Federal Services, Inc. Included with the decision notice is a Request for Reconsideration notice for the member to send to the MAXIMUS Federal Services, Inc.

Independent Review Entity (IRE) Review and Additional Appeal Levels for Services Covered by Medicare:

1. MAXIMUS Federal Services, Inc. is the Independent Review Entity (IRE) that reviews the information provided by Neighborhood and requests any additional documentation needed from

either CVS Caremark/Neighborhood or the member. MAXIMUS Federal Services, Inc. is a separate entity from the QIO, which (in this area) is KEPRO.

2. MAXIMUS Federal Services, Inc.'s reconsideration determination is final and binding, unless a request for a hearing before an Administrative Law Judge (ALJ) is filed within 60 calendar days of receiving the reconsideration notice.

3. Anyone, including CVS Caremark/Neighborhood, can request a judicial review (after notifying other parties) of an ALJ decision, if the amount in controversy meets the appropriate threshold (new thresholds are published by CMS every fall) and the Medicare Appeals Council (MAC) denied the member's request for review.

Any decision by CVS Caremark/Neighborhood, MAXIMUS Federal Services, Inc., the ALJ, or the MAC can be reopened for good cause when requested within CMS Regulation timeframes. Once a revised determination or decision is issued, any party can file an appeal.

Fast-Track Appeals for Services Covered by Medicare

To initiate a fast-track review, the member or his/her authorized representative must submit a fast track appeal request within the required time frame to:

KEPRO

BFCC-QIO Program
5700 Lombardo Center Dr., Suite 100
Seven Hills, OH 44131
Toll-free Phone: 888-319-8452
TTY: 855-843-4776
Toll-free Fax: 833-868-4055

Once an appeal is filed, members remain entitled to continuation of coverage for their inpatient hospital stay, skilled nursing services, home health services, or comprehensive outpatient rehab services until KEPRO renders a decision. KEPRO may be contacted by the member or member's representative, attorney, or court-appointed guardian (either by telephone, in writing, or by fax). KEPRO is authorized by Medicare to review the services noted above provided to the INTEGRITY member.

When the member contacts KEPRO for a fast-track appeal, Neighborhood requires the provider to make the medical record and a copy of the Important Message (IM) and/or the Notice of Medicare Non-Coverage (NOMNC) issued to the member readily available upon request.

The delivery of a valid NOMNC with very specific supporting documentation from the medical record that support the member's discharge from the services noted above will be required for payment of claims for these services for INTEGRITY members. This ensures that all CMS and Neighborhood documentation requirements are being adhered to and to ensure that documentation in the medical record supports the discharge plan. Failure to submit the required components of the medical record and a valid NOMNC upon request by Neighborhood after a Fast Track Appeal has been filed with KEPRO may result in the denial of the claim for the services noted above.

Please refer to the CMS notification form IM/OMB number 0938-0692 or OMB number 00938 – 0953 for the requirements to prepare and deliver a valid IM or NOMNC.

Please refer to the “KEPRO Fax Cover Sheet for Fast Track Appeals” for the required medical record documentation list located on the KEPRO web page www.keproqio.com website. All sections of the medical record are to be faxed to Neighborhood’s Grievance and Appeal Unit at (401) 709-7005.

The specific documentation from the medical record that supports the member’s discharge from the current level of services will be required for payment of the claims is as follows:

- Valid IM or NOMNC
- Medical record – at a minimum must include all of the following:
 - All items listed on the Neighborhood Medical Record Collection Sheet for Fast-Track Appeals
 - An attending practitioner (e.g. MD or NP) progress note – written within two (2) calendar days of delivery of IM or NOMNC, and must include all of the following:

- A statement that the member's current condition is stable and they are ready for discharge
- A statement that member no longer requires or will no longer benefit from current level of services
- An outline of the member's discharge plan; where he/she will be discharged to and what the transition of care plan is
- A statement that addresses any open medical issues and how they are going to be managed
- An attending practitioner's order to discharge patient from the current level of services, documented in the medical record by the date that the IM or NOMNC is issued
- A progress note from each applicable rehabilitation service (PT, OT, ST) which describes the patient's current functional level, stability of their medical condition and a description of the discharge plan including any treatments to be carried out after discharge (examples - met goals, will no longer benefit from current level of services, will be discharged home with outpatient rehab services, will remain at facility at a custodial level, etc.)

During the fast track appeals process, the member is not to be held financially responsible for coverage of the requested services until an appeal determination has been made by KEPRO.

If KEPRO agrees with the member and overturns the decision to discharge, the member will be reinstated. The process recommences if/when the member is ready to be discharged again.

Neighborhood monitors compliance with the time frame associated with KEPRO hospital discharge appeals. If the member misses the KEPRO deadline (up until 12:00 p.m. on the day of discharge), he/she has the right to call Neighborhood Member Services at 1-844-812-6896 to request an expedited appeal. Neighborhood generally makes a decision on expedited appeals within 72 hours. During the expedited appeal process, the member is not to be held financially responsible for coverage of the requested services until an appeal determination has been made.

Standard and Expedited Appeals for Services Covered by Medicare and Medicaid

General Appeal Information:

A Neighborhood member, a member's authorized representative, or provider acting on the member's behalf, can appeal any of the procedures that deal with the review of adverse organization determinations or coverage determinations a member believes he/she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the member).

In most cases the organization determination and coverage determinations are final unless a member contacts Neighborhood within 60 calendar days of receiving the determination, (or longer, if there is a reason for a good cause extension). If a member requests reconsideration (appeal) of a denial, we

follow either the Standard Member Appeals Procedure for Services Covered by Medicare or the Standard Member Appeals Process for Services Covered by Medicaid or a combination of both Standard Member Appeals Procedures. The appeal takes place after the adverse organization determination has been issued by Neighborhood.

Standard appeals are decided as soon as the member's health requires and within 30 days of receipt for pre-service or within 60 days of receipt for post-service and/or payment appeals.

Expedited Appeals

An expedited appeal is a review of a time-sensitive adverse organization determination or coverage determination that a member believes that he/she is entitled to receive, including:

- Any delay in providing, arranging for, or approving health care services/medications that would adversely affect the health of the member
- Reduction or stoppage of treatment or services that would adversely affect the member's health

NOTE: Time-sensitive is defined as a situation in which applying the standard decision time frame could seriously jeopardize a member's life, health, or ability to regain and/or maintain maximum function.

Members, their authorized representatives, or any treating or prescribing physician (regardless of whether the provider is affiliated with Neighborhood) can request an expedited appeal. Verbal and written requests for expedited appeals are accepted.

If the request meets the necessary time-sensitive criteria, a decision will be made within 72-hours of receipt of the request, unless an extension is needed. Extensions of up to 14 calendar days can be granted if in the best interest of the member. NOTE: Extensions are not allowed for expedited Part D appeals or Part B Medication appeals.

Quality of Care Grievances (Clinical Complaints Filed By Integrity Members)

Per regulatory guidelines and as part of Neighborhood's commitment to ensuring member satisfaction and safety, we have established a forum for members or authorized representatives to express concerns regarding their experiences with health care providers. The member grievance procedure, allows for the documentation and review of member grievances related to quality of care or quality of services, as follows:

Upon receipt of a verbal or written complaint, the Quality Assurance Specialist acknowledges in writing that the complaint was received and will be reviewed within 30 calendar days.

All grievances pertaining to clinical care and/or services issues are reviewed within the Quality Assurance Committee which reports to the Medical Director.

As noted in the Appeals and Grievance Section above, all administrative grievances pertaining to operations and activities of Neighborhood or Neighborhood providers/vendors are reviewed within the Grievance and Appeals Unit.

The Quality Assurance Committee and Grievance and Appeal Unit can accept any information or evidence concerning a grievance orally or in writing and collaborate to ensure all aspects (clinical and administrative) of member grievances are addressed.

In most instances, providers or their office managers (depending on the specific situation) are notified either verbally or in writing about the complaint and asked for input.

All grievances are entered into our secure system of record for tracking and trending purposes. This data may become part of the provider's credentialing file.

It is the responsibility of all network providers to participate in our grievance review process.

Please note that the outcome of a Quality of Care investigation will not be shared with members due to peer review laws protecting the confidentiality of the investigation, outcome/findings. Additionally, Quality of Care investigations may result in recommendations for provider/facility process improvement and/or Corrective Action Plans (CAP) to ensure the safety of all members.

If a provider receives an inquiry from Neighborhood requesting information to aid in the investigation and resolution of a member complaint or grievance, the provider is required to comply with Neighborhood's request as soon as possible and within fourteen (14) calendar days.

Response due dates are established to ensure that Neighborhood meets its regulatory and accreditation requirements to ensure continued adherence with all state and federal (CMS) requirements.

If a member is dissatisfied with the response from our Quality Assurance Committee, they may contact Rhode Island's Quality Improvement Organization (QIO) KEPRO.

Quality Improvement Organization Complaint Process for Services Covered by Medicare

For Neighborhood members concerned about the clinical quality of the care received, members or their AOR can also file a complaint with the Rhode Island Quality Improvement Organization (QIO) KEPRO at 1-866-815-5440. QIOs, such as KEPRO, are groups of doctors and health professionals that monitor the quality of care provided to Medicare beneficiaries. KEPRO is the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for Rhode Island. The KEPRO review process is designed to help prevent any improper practices. This process is separate and distinct from the Neighborhood grievance (complaint) process.

The QIO is under contract to the CMS to conduct medical reviews and other functions with respect to Medicare beneficiaries.

KEPRO

KEPRO is responsible for the quality of care review of services provided to Rhode Island Medicare patients enrolled in Medicare products with CMS. This includes INTEGRITY members.

KEPRO Reviews

KEPRO maintains a review system to ensure that services provided to Medicare beneficiaries enrolled in Medicare health plans are of adequate quality across all settings. This review system addresses the following issues:

- Appropriateness of treatment
- Potential for under-utilization of services
- Accessibility to services
- Potential for premature discharge of patients
- Timeliness of services provided
- Appropriateness of the setting for the provision of services
- Appropriateness of Neighborhood's activities to coordinate care, such as the adequacy of discharge planning and follow-up of abnormal diagnostic studies

KEPRO will notify Neighborhood regarding issues that include results of KEPRO's review activities, unless otherwise specified in the KEPRO/CMS contract. These issues will be identified as Quality of Care concerns or documentation concerns.

###