Neighborhood Health Plan OF RHODE ISLAND™
910 Douglas Pike, Smithfield, RI 02917

Prior Authorizations Requirements Removed from Chiropractic Services

Q: What is the purpose of this notification?
A: Effective **October 1, 2024**, Neighborhood Health Plan of Rhode Island (Neighborhood) will no longer require prior authorizations for providers offering chiropractic services to Medicaid and Commercial members. Neighborhood will instead adhere to a member's benefit limit based on their line of business.

Q: What are the member benefit limits?
A:

- Medicaid members: 12 visits per rolling year (365 days; ex. October 1, 2024 – September 30, 2025)
  - No authorization required
- Commercial members: 12 visits per calendar/plan year (i.e., January 1, 2024 - December 31, 2024)
  - No authorization required

Q: What lines of business will be impacted?
A: This update impacts the Medicaid and Commercial lines of business.

Q: Where can providers find more information on chiropractic services?
A: More information can be found in the following Neighborhood payment policies:

- Chiropractic Services Payment Policy (Commercial and INTEGRITY [MMP] members)
- Complementary and Alternative Medicine (CAM) Services Payment Policy (Medicaid members)

Changes to Provider Appeals Submission Process

Q: What is the purpose of this notification?
A: Effective **December 1, 2024**, two new forms will be available for providers submitting administrative appeals and clinical appeals.

Q: What is the current process for submitting an administrative appeal or clinical appeal?
A: Currently, providers use one appeal form to submit appeals.

Q: What will be the new process?
A: The existing appeal form will be replaced by two new forms:

- Provider Administrative Appeal Form
- Provider Clinical Appeal Form

Q: When should a provider administrative appeal form be used?
A: A provider administrative appeal can only be submitted if a provider has **first submitted a claim adjustment request or claim reconsideration request**. If either of those requests are denied, an

administrative appeal can then be submitted. These requests must be submitted to Neighborhood within 60 days from the date of the claim denial, reconsideration request denial, or adjustment request denial.

Q: When should a provider clinical appeal form be used?
A: A clinical appeal is a request for review of an initial adverse clinical determination, such as services requiring prior authorization or those based on medical necessity. Providers should use this form in the following circumstances:

- Medicaid appeals (within 60 days of receiving the initial denial)
- Commercial/Exchange appeals (within 180 days of receiving the initial denial)
- INTEGRITY (MMP) appeals (within 60 days of receiving the initial denial/organization determination)

Q: Where can providers find these new forms?
A: The new appeal forms will be available on the Provider Forms page of our website beginning **December 1, 2024**.