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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2025

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A N A C T

RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES --
REGULATE HEALTH INSURANCE PRIOR AUTHORIZATION REQUIREMENTS FOR
REHABILITATIVE AND HABILITATIVE SERVICES ACT

Introduced By: Senators Mack, Lauria, Acosta, Valverde, Thompson, Kallman, DiMario,
Pearson, and Ujifusa

Date Introduced: February 26, 2025

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

1 SECTION 1. Chapter 27-18 of the General Laws entitled "Accident and Sickness Insurance
2 Policies" is hereby amended by adding thereto the following section:

3 **27-18-95. Prior authorization for rehabilitative and habilitative services.**

4 (a) An individual or group health insurance plan shall not require prior authorization for
5 rehabilitative or habilitative services, including, but not limited to, physical therapy or occupational
6 therapy services for the first twelve (12) visits of each new episode of care. For purposes of this
7 section, "new episode of care" means treatment for a new or recurring condition for which an
8 insured has not been treated by the provider within the previous ninety (90) days. After the twelve
9 (12) visits of each new episode of care, an individual or group health insurance plan shall not require
10 prior authorization more frequently than every six (6) visits or every thirty (30) days, whichever
11 time period is longer.

12 (b) An individual or group health insurance plan shall not require prior authorization for
13 physical medicine or rehabilitation services provided to patients with chronic pain for the first
14 ninety (90) days following diagnosis in order to provide the necessary nonpharmacologic
15 management of the pain. After the first ninety (90) days following a chronic pain diagnosis, an
16 individual or group health insurance plan shall not require prior authorization more frequently than
17 every six (6) visits or every thirty (30) days, whichever time period is longer. For purposes of this
18 subsection, "chronic pain" means pain that persists or recurs for more than three (3) months.

1 (c) An individual or group health insurance plan shall respond to a prior authorization
2 request for services or visits in an ongoing plan of care under this section within twenty-four (24)
3 hours. If an individual or group health insurance plan requires more information to make a decision
4 on the prior authorization request, the individual or group health insurance plan shall notify the
5 patient and the provider within twenty-four (24) hours of the initial request with the information
6 that is needed to complete the prior authorization request including, but not limited to, the specific
7 tests and measures needed from the patient and provider. An individual or group health insurance
8 plan shall make a decision on the prior authorization request within twenty-four (24) hours of
9 receiving the requested information.

10 (d) With regard to circumstances in which a prior authorization for covered services under
11 this section is deemed to be approved by an individual or group health insurance plan, a prior
12 authorization is deemed to be approved if an individual or group health insurance plan:

13 (1) Fails to timely answer a prior authorization request in accordance with subsection (c)
14 of this section, including due to a failure of the individual or group health insurance plan's prior
15 authorization platform or process; or

16 (2) Informs a provider that prior authorization is not required orally, via an online platform
17 or program, through the patient's health plan documents or by any other means.

18 (e) An individual or group health insurance plan shall provide a procedure for providers
19 and insureds to obtain retroactive authorization for services under this section that are medically
20 necessary covered benefits. An individual or group health insurance plan shall not deny coverage
21 for medically necessary services under this section only for failure to obtain a prior authorization,
22 if a medical necessity determination can be made after the services have been provided and the
23 services would have been covered benefits if prior authorization had been obtained.

24 (f) An individual or group health insurance plan's failure to approve a prior authorization
25 for all services or visits in a plan of care under this section is subject to the same appeal rights as a
26 denial under the office of the health insurance commissioner's rule or regulation regarding health
27 plan accountability and the provider's network agreement with the carrier, if any.

28 (g) Nothing in this section is intended to prohibit an individual or group health insurance
29 plan from performing a retrospective medical necessity review.

30 SECTION 2. Chapter 27-19 of the General Laws entitled " Nonprofit Hospital Service
31 Corporations " is hereby amended by adding thereto the following section:

32 **27-19-87. Prior authorization for rehabilitative and habilitative services.**

33 (a) An individual or group health insurance plan shall not require prior authorization for
34 rehabilitative or habilitative services, including, but not limited to, physical therapy or occupational

1 therapy services for the first twelve (12) visits of each new episode of care. For purposes of this
2 section, "new episode of care" means treatment for a new or recurring condition for which an
3 insured has not been treated by the provider within the previous ninety (90) days. After the twelve
4 (12) visits of each new episode of care, an individual or group health insurance plan shall not require
5 prior authorization more frequently than every six (6) visits or every thirty (30) days, whichever
6 time period is longer.

7 (b) An individual or group health insurance plan shall not require prior authorization for
8 physical medicine or rehabilitation services provided to patients with chronic pain for the first
9 ninety (90) days following diagnosis in order to provide the necessary nonpharmacologic
10 management of the pain. After the first ninety (90) days following a chronic pain diagnosis, an
11 individual or group health insurance plan shall not require prior authorization more frequently than
12 every six (6) visits or every thirty (30) days, whichever time period is longer. For purposes of this
13 subsection, "chronic pain" means pain that persists or recurs for more than three (3) months.

14 (c) An individual or group health insurance plan shall respond to a prior authorization
15 request for services or visits in an ongoing plan of care under this section within twenty-four (24)
16 hours. If an individual or group health insurance plan requires more information to make a decision
17 on the prior authorization request, the individual or group health insurance plan shall notify the
18 patient and the provider within twenty-four (24) hours of the initial request with the information
19 that is needed to complete the prior authorization request including, but not limited to, the specific
20 tests and measures needed from the patient and provider. An individual or group health insurance
21 plan shall make a decision on the prior authorization request within twenty-four (24) hours of
22 receiving the requested information.

23 (d) With regard to circumstances in which a prior authorization for covered services under
24 this section is deemed to be approved by an individual or group health insurance plan, a prior
25 authorization is deemed to be approved if an individual or group health insurance plan:

26 (1) Fails to timely answer a prior authorization request in accordance with subsection (c)
27 of this section, including due to a failure of the individual or group health insurance plan's prior
28 authorization platform or process; or

29 (2) Informs a provider that prior authorization is not required orally, via an online platform
30 or program, through the patient's health plan documents or by any other means.

31 (e) An individual or group health insurance plan shall provide a procedure for providers
32 and insureds to obtain retroactive authorization for services under this section that are medically
33 necessary covered benefits. An individual or group health insurance plan shall not deny coverage
34 for medically necessary services under this section only for failure to obtain a prior authorization.

1 if a medical necessity determination can be made after the services have been provided and the
2 services would have been covered benefits if prior authorization had been obtained.

3 (f) An individual or group health insurance plan's failure to approve a prior authorization
4 for all services or visits in a plan of care under this section is subject to the same appeal rights as a
5 denial under the office of the health insurance commissioner's rule or regulation regarding health
6 plan accountability and the provider's network agreement with the carrier, if any.

7 (g) Nothing in this section is intended to prohibit an individual or group health insurance
8 plan from performing a retrospective medical necessity review.

9 SECTION 3. Chapter 27-20 of the General Laws entitled " Nonprofit Medical Service
10 Corporations " is hereby amended by adding thereto the following section:

11 **27-20-83. Prior authorization for rehabilitative and habilitative services.**

12 (a) An individual or group health insurance plan shall not require prior authorization for
13 rehabilitative or habilitative services, including, but not limited to, physical therapy or occupational
14 therapy services for the first twelve (12) visits of each new episode of care. For purposes of this
15 section, "new episode of care" means treatment for a new or recurring condition for which an
16 insured has not been treated by the provider within the previous ninety (90) days. After the twelve
17 (12) visits of each new episode of care, an individual or group health insurance plan shall not require
18 prior authorization more frequently than every six (6) visits or every thirty (30) days, whichever
19 time period is longer.

20 (b) An individual or group health insurance plan shall not require prior authorization for
21 physical medicine or rehabilitation services provided to patients with chronic pain for the first
22 ninety (90) days following diagnosis in order to provide the necessary nonpharmacologic
23 management of the pain. After the first ninety (90) days following a chronic pain diagnosis, an
24 individual or group health insurance plan shall not require prior authorization more frequently than
25 every six (6) visits or every thirty (30) days, whichever time period is longer. For purposes of this
26 subsection, "chronic pain" means pain that persists or recurs for more than three (3) months.

27 (c) An individual or group health insurance plan shall respond to a prior authorization
28 request for services or visits in an ongoing plan of care under this section within twenty-four (24)
29 hours. If an individual or group health insurance plan requires more information to make a decision
30 on the prior authorization request, the individual or group health insurance plan shall notify the
31 patient and the provider within twenty-four (24) hours of the initial request with the information
32 that is needed to complete the prior authorization request including, but not limited to, the specific
33 tests and measures needed from the patient and provider. An individual or group health insurance
34 plan shall make a decision on the prior authorization request within twenty-four (24) hours of

1 receiving the requested information.

2 (d) With regard to circumstances in which a prior authorization for covered services under
3 this section is deemed to be approved by an individual or group health insurance plan, a prior
4 authorization is deemed to be approved if an individual or group health insurance plan:

5 (1) Fails to timely answer a prior authorization request in accordance with subsection (c)
6 of this section, including due to a failure of the individual or group health insurance plan's prior
7 authorization platform or process; or

8 (2) Informs a provider that prior authorization is not required orally, via an online platform
9 or program, through the patient's health plan documents or by any other means.

10 (e) An individual or group health insurance plan shall provide a procedure for providers
11 and insureds to obtain retroactive authorization for services under this section that are medically
12 necessary covered benefits. An individual or group health insurance plan shall not deny coverage
13 for medically necessary services under this section only for failure to obtain a prior authorization,
14 if a medical necessity determination can be made after the services have been provided and the
15 services would have been covered benefits if prior authorization had been obtained.

16 (f) An individual or group health insurance plan's failure to approve a prior authorization
17 for all services or visits in a plan of care under this section is subject to the same appeal rights as a
18 denial under the office of the health insurance commissioner's rule or regulation regarding health
19 plan accountability and the provider's network agreement with the carrier, if any.

20 (g) Nothing in this section is intended to prohibit an individual or group health insurance
21 plan from performing a retrospective medical necessity review.

22 SECTION 4. Chapter 27-41 of the General Laws entitled " Health Maintenance
23 Organizations " is hereby amended by adding thereto the following section:

24 **27-41-100. Prior authorization for rehabilitative and habilitative services.**

25 (a) An individual or group health insurance plan shall not require prior authorization for
26 rehabilitative or habilitative services, including, but not limited to, physical therapy or occupational
27 therapy services for the first twelve (12) visits of each new episode of care. For purposes of this
28 section, "new episode of care" means treatment for a new or recurring condition for which an
29 insured has not been treated by the provider within the previous ninety (90) days. After the twelve
30 (12) visits of each new episode of care, an individual or group health insurance plan shall not require
31 prior authorization more frequently than every six (6) visits or every thirty (30) days, whichever
32 time period is longer.

33 (b) An individual or group health insurance plan shall not require prior authorization for
34 physical medicine or rehabilitation services provided to patients with chronic pain for the first

1 ninety (90) days following diagnosis in order to provide the necessary nonpharmacologic
2 management of the pain. After the first ninety (90) days following a chronic pain diagnosis, an
3 individual or group health insurance plan shall not require prior authorization more frequently than
4 every six (6) visits or every thirty (30) days, whichever time period is longer. For purposes of this
5 subsection, "chronic pain" means pain that persists or recurs for more than three (3) months.

6 (c) An individual or group health insurance plan shall respond to a prior authorization
7 request for services or visits in an ongoing plan of care under this section within twenty-four (24)
8 hours. If an individual or group health insurance plan requires more information to make a decision
9 on the prior authorization request, the individual or group health insurance plan shall notify the
10 patient and the provider within twenty-four (24) hours of the initial request with the information
11 that is needed to complete the prior authorization request including, but not limited to, the specific
12 tests and measures needed from the patient and provider. An individual or group health insurance
13 plan shall make a decision on the prior authorization request within twenty-four (24) hours of
14 receiving the requested information.

15 (d) With regard to circumstances in which a prior authorization for covered services under
16 this section is deemed to be approved by an individual or group health insurance plan, a prior
17 authorization is deemed to be approved if an individual or group health insurance plan:

18 (1) Fails to timely answer a prior authorization request in accordance with subsection (c)
19 of this section, including due to a failure of the individual or group health insurance plan's prior
20 authorization platform or process; or

21 (2) Informs a provider that prior authorization is not required orally, via an online platform
22 or program, through the patient's health plan documents or by any other means.

23 (e) An individual or group health insurance plan shall provide a procedure for providers
24 and insureds to obtain retroactive authorization for services under this section that are medically
25 necessary covered benefits. An individual or group health insurance plan shall not deny coverage
26 for medically necessary services under this section only for failure to obtain a prior authorization,
27 if a medical necessity determination can be made after the services have been provided and the
28 services would have been covered benefits if prior authorization had been obtained.

29 (f) An individual or group health insurance plan's failure to approve a prior authorization
30 for all services or visits in a plan of care under this section is subject to the same appeal rights as a
31 denial under the office of the health insurance commissioner's rule or regulation regarding health
32 plan accountability and the provider's network agreement with the carrier, if any.

33 (g) Nothing in this section is intended to prohibit an individual or group health insurance
34 plan from performing a retrospective medical necessity review.

1 SECTION 2. This act shall take effect on January 1, 2026.

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EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF

A N A C T

RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES --
REGULATE HEALTH INSURANCE PRIOR AUTHORIZATION REQUIREMENTS FOR
REHABILITATIVE AND HABILITATIVE SERVICES ACT

1 This act would limit prior authorization requirements for rehabilitative and habilitative
2 services. This act would prohibit prior authorization for the first twelve (12) visits of a new episode
3 of care and for ninety (90) days following a chronic pain diagnosis. This act would also require that
4 insurers must respond to requests within twenty-four (24) hours, and delays result in automatic
5 approval. This act would further allow retroactive authorization for medically necessary services
6 and provides appeal rights for denied requests.

7 This act would take effect on January 1, 2026.

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