

2026 -- H 7347

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LC004486

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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2026

A N A C T

RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES

Introduced By: Representatives McGaw, Fogarty, Carson, Potter, Fellela, Furtado, Morales, Messier, Donovan, and Boylan

Date Introduced: January 28, 2026

Referred To: House 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 **27-18-96. Prior authorization restrictions 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 services for the
6 first twelve (12) visits of each new episode of care. After the twelve (12) visits of each new episode
7 of care, an individual or group health insurance plan may not require prior authorization more
8 frequently than every six (6) visits or every thirty (30) days, whichever time period is longer. For
9 purposes of this section, "new episode of care" means treatment for a new or recurring condition
10 for which an insured has not been treated by the provider within the previous ninety (90) days.

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

18 (c) An individual or group health insurance plan shall respond to a prior authorization
19 request for services or visits in an ongoing plan of care for rehabilitative or habilitative services

1 within twenty-four (24) hours. If an individual or group health insurance plan requires more
2 information to render a decision on the prior authorization request, the individual or group health
3 insurance plan shall notify the patient and the provider within twenty-four (24) hours of the initial
4 request with the information that is needed to complete the prior authorization request including,
5 but not limited to, the specific tests and measures needed from the patient and provider. An
6 individual or group health insurance plan shall render a decision on the prior authorization request
7 within twenty-four (24) hours of receiving the requested information.

8 (d) A prior authorization for rehabilitative or habilitative services is deemed to be approved
9 if an individual or group health insurance plan:

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

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

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

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

26 (g) Nothing in this section shall be construed to prohibit an individual or group health
27 insurance plan from performing a retrospective medical necessity review.

28 SECTION 2. Chapter 27-19 of the General Laws entitled " Nonprofit Hospital Service

29 Corporations " is hereby amended by adding thereto the following section:

30 **27-19-88. Prior authorization restrictions for rehabilitative and habilitative services.**

31 (a) An individual or group health insurance plan shall not require prior authorization for
32 rehabilitative or habilitative services including, but not limited to, physical therapy services for the
33 first twelve (12) visits of each new episode of care. After the twelve (12) visits of each new episode
34 of care, an individual or group health insurance plan may not require prior authorization more

1 frequently than every six (6) visits or every thirty (30) days, whichever time period is longer. For
2 purposes of this section, "new episode of care" means treatment for a new or recurring condition
3 for which an insured has not been treated by the provider within the previous ninety (90) days.

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

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

20 (d) A prior authorization for rehabilitative or habilitative services is deemed to be approved
21 if an individual or group health insurance plan:

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

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

27 (e) An individual or group health insurance plan shall provide a procedure for providers
28 and insureds to obtain retroactive authorization for rehabilitative or habilitative services that are
29 medically necessary covered benefits. An individual or group health insurance plan shall not deny
30 coverage for medically necessary services for failure to obtain a prior authorization, if a medical
31 necessity determination can be made after the rehabilitative or habilitative services have been
32 provided and the services would have been covered benefits if prior authorization had been
33 obtained.

34 (f) An individual or group health insurance plan's failure to approve a prior authorization

1 for all rehabilitative or habilitative services or visits in a plan of care is subject to the same appeal
2 rights as a denial under the health insurance commissioner's rule regarding health plan
3 accountability and the provider's network agreement with the carrier, if any.

4 (g) Nothing in this section shall be construed to prohibit an individual or group health
5 insurance plan from performing a retrospective medical necessity review.

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

8 **27-20-84. Prior authorization restrictions for rehabilitative and habilitative services.**

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

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

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

32 (d) A prior authorization for rehabilitative or habilitative services is deemed to be approved
33 if an individual or group health insurance plan:

34 (1) Fails to timely answer a prior authorization request in accordance with subsection (c)

1 of this section, including due to a failure of the individual or group health insurance plan's prior
2 authorization platform or process; or

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

5 (e) An individual or group health insurance plan shall provide a procedure for providers
6 and insureds to obtain retroactive authorization for rehabilitative or habilitative services that are
7 medically necessary covered benefits. An individual or group health insurance plan shall not deny
8 coverage for medically necessary services for failure to obtain a prior authorization, if a medical
9 necessity determination can be made after the rehabilitative or habilitative services have been
10 provided and the services would have been covered benefits if prior authorization had been
11 obtained.

12 (f) An individual or group health insurance plan's failure to approve a prior authorization
13 for all rehabilitative or habilitative services or visits in a plan of care is subject to the same appeal
14 rights as a denial under the health insurance commissioner's rule regarding health plan
15 accountability and the provider's network agreement with the carrier, if any.

16 (g) Nothing in this section shall be construed to prohibit an individual or group health
17 insurance plan from performing a retrospective medical necessity review.

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

20 **27-41-101. Prior authorization restrictions for rehabilitative and habilitative services.**

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

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

(c) An individual or group health insurance plan shall respond to a prior authorization request for services or visits in an ongoing plan of care for rehabilitative or habilitative services within twenty-four (24) hours. If an individual or group health insurance plan requires more information to render a decision on the prior authorization request, the individual or group health insurance plan shall notify the patient and the provider within twenty-four (24) hours of the initial request with the information that is needed to complete the prior authorization request including, but not limited to, the specific tests and measures needed from the patient and provider. An individual or group health insurance plan shall render a decision on the prior authorization request within twenty-four (24) hours of receiving the requested information.

(d) A prior authorization for rehabilitative or habilitative services is deemed to be approved if an individual or group health insurance plan:

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

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

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

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

(g) Nothing in this section shall be construed to prohibit an individual or group health insurance plan from performing a retrospective medical necessity review.

SECTION 2. This act shall take effect on January 1, 2027.

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EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF
A N A C T
RELATING TO INSURANCE -- ACCIDENT AND SICKNESS INSURANCE POLICIES

- 1 This act would prohibit health insurance plans from requiring prior authorization for a new
- 2 episode of rehabilitative care for twelve (12) visits, or from requiring prior authorization for
- 3 rehabilitative care for chronic pain for ninety (90) days. This act would further mandate that where
- 4 prior authorization is required, the health insurance plan would respond within twenty-four (24)
- 5 hours. In addition, this act would require health insurance plans to provide a procedure for providers
- 6 and insureds to obtain retroactive authorization for services that are medically necessary covered
- 7 benefits.
- 8 This act would take effect on January 1, 2027.

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