



## Health Insurance Medical Necessity Rights Guide

If you have ever received a letter from your health insurance company denying medication, medical procedures, or other services based on “medical necessity,” your claim has undergone medical necessity review (sometimes called “utilization review”). Medical necessity review is a process that a health insurance company completes to decide if the care, supplies, or medications that your doctor has prescribed are necessary and appropriate. If a health insurer denies a medication, a procedure, or a service based on medical necessity both you and your healthcare provider have legal rights regarding that denial. This information sheet is meant to describe your medical necessity rights, as well as direct you to the right place should you have any questions or believe that your rights have been violated.

Your medical necessity rights in Rhode Island include:

- Medical necessity review may only be conducted in Rhode Island by agencies that have been certified by the Rhode Island Department of Health. A list of all companies certified to perform medical necessity review in Rhode Island is maintained by the Department, which you may request at any time.
- The person who denies your claim must be a licensed physician, a licensed dentist, or the same type of provider who requested the service or medication (for example, a nurse could not deny a request for physical therapy prescribed by a doctor). The person who denies the claim cannot be paid or given an incentive because they issued a denial.
- If your claim is denied, you must be notified of the initial denial within certain timeframes. The timeframe depends on whether the claim is for services that have not been given, are currently being received, or have already happened. The timeframes are also dependent on whether your claim is for urgent or emergency services. Usually, an urgent or emergency situation is when your health may be in serious danger or your doctor thinks your pain cannot be controlled while you wait for a response. Please see the following table for the initial denial timeframes:

<b>Type of service</b>	<b>Timeframe for notification</b>
Urgent or emergency services that have not happened yet (also called prospective urgent/emergent)	72 hours (three days)
Services that are not urgent that have not happened yet (also called prospective non-urgent/emergent)	15 business days*
Services that are currently being received (also called concurrent)	Patient: 1 business day Provider: Before the already-approved services end
Services that have already happened (also called retrospective)	30 business days*

\* A **business day** is considered every official working day of the week. Typically, these are the days between and including Monday to Friday and do not include public holidays and weekends.

- Your healthcare provider has the right to request a peer-to-peer discussion with the person who denied your claim. This discussion gives your healthcare provider the chance to give the insurance company more details about your claim and to explain why you need the service or medication. The insurance company must respond to the request for a peer-to-peer discussion within certain timeframes, and the insurance company must make at least two documented attempts to contact your healthcare provider to schedule a peer-to-peer discussion. Please see the following table for the timeframe in which the insurance company must respond to your doctor’s request for a peer-to-peer discussion:

Type of service	Timeframe for responding to request for peer-to-peer discussion
<ul style="list-style-type: none"> <li>Urgent or emergency services that have not happened yet (also called prospective urgent/emergent)</li> <li>Services that are currently being received (also called concurrent)</li> </ul>	Within a reasonable period of time
<ul style="list-style-type: none"> <li>Services that are not urgent that have not happened yet (also called prospective non-urgent/emergent)</li> </ul>	1 business day*
<ul style="list-style-type: none"> <li>Services that have already happened (also called retrospective)</li> </ul>	Before the decision from a first-level appeal

- You have the right to appeal your claim denial. Your first appeal is called a Level I appeal. If your claim is denied after a Level I Appeal, you can ask for a second appeal, called a Level II Appeal. If your claim is denied after a Level II Appeal, you can ask for an external appeal. An external appeal is performed by an independent review company designated by the Rhode Island Department of Health.
- If a Level I or Level II Appeal is for urgent or emergency services, the insurance company must make a decision in two business days\*. If a Level I or Level II Appeal is for non-urgent or non-emergency services, the insurance company must make a decision in 15 business days\*. These timeframes do not change depending on whether your claim was for services that have not happened yet, are currently being received, or have already been received.
- After you receive notification about your original denial, you have 60 days to ask for a Level I appeal. If your Level I Appeal is denied, you have 60 days to ask for a Level II Appeal. If your Level II Appeal is denied, you have 60 days to ask for an external appeal.
- Any denial that you get from the insurance company must include:
  - Main reason for the denial
  - Documentation of the medical criteria not met
  - The clinical rationale used to make the decision
  - Directions for requesting an appeal
  - Insurance company’s contact information

- If your Level II Appeal is denied, the insurance company must tell you if they charge a fee to you or to your provider for an external appeal, and they must tell you what the fee is. If you are a patient, the most an insurance company may charge you is \$25, and the insurance company's charges cannot be more than \$75 per year. An insurance company may charge a provider up to \$210 for each external appeal.
- If your claim is approved after an external appeal, your health insurance company must refund any external appeal fees that you were charged within 60 days.

The section of the Rhode Island Department of Health that oversees the certification of companies that conduct medical necessity review and processes complaints against such companies is the Office of Managed Care Regulation (OMCR). The OMCR may be contacted using the following information:

Office of Managed Care Regulation  
Rhode Island Department of Health  
Room 410  
3 Capitol Hill  
Providence, RI 02908  
Telephone: (401) 222-6015  
Email: [DOH.ManagedCare@health.ri.gov](mailto:DOH.ManagedCare@health.ri.gov)

Please do not hesitate to contact us if you have any questions about the medical necessity review rights listed above or if you believe that your rights have been violated.