SECOND REGULAR SESSION

HOUSE BILL NO. 2115

102ND GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE TOALSON REISCH.

4827H.01I DANA RADEMAN MILLER, Chief Clerk

AN ACT

To repeal section 376.1232, RSMo, and to enact in lieu thereof two new sections relating to medical devices.

Be it enacted by the General Assembly of the state of Missouri, as follows:

Section A. Section 376.1232, RSMo, is repealed and two new sections enacted in lieu thereof, to be known as sections 334.1150 and 376.1232, to read as follows:

334.1150. 1. An orthotist or prosthetist may evaluate and initiate treatment on a patient without a prescription or referral from a physician, provided that the orthotist or prosthetist is certified in prosthetics or orthotics by the American Board for Certification in Orthotics, Prosthetics, and Pedorthics or the Board of Certification/ Accreditation.

2. An orthotist or prosthetist shall refer to the appropriate health care provider any patient whose condition at the time of evaluation or treatment is beyond the scope of practice of the orthotist or prosthetist.

376.1232. 1. Each health carrier or health benefit plan that offers or issues health benefit plans which are delivered, issued for delivery, continued, or renewed in this state on or after **[**~~January 1, 2010~~**] August 28, 2024**, shall offer coverage for **orthotic and** prosthetic devices and services, including original and replacement devices, **[**~~as prescribed by a physician acting within the scope of his or her practice~~**] provided by an orthotist or prosthetist**.

2. For the purposes of this section, **"enrollee", "facility",** "health carrier"**,** and "health benefit plan" shall have the same meaning as defined in section 376.1350.

EXPLANATION — Matter enclosed in bold-faced brackets **[**~~thus~~**]** in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

3. The amount of the benefit for prosthetic devices and services under this section shall be no less than the annual and lifetime benefit maximums applicable to the basic health care services required to be provided under the health benefit plan. If the health benefit plan does not include any annual or lifetime maximums applicable to basic health care services, the amount of the benefit for prosthetic devices and services shall not be subject to an annual or lifetime maximum benefit level. Any co-payment, coinsurance, deductible, and maximum out-of-pocket amount applied to the benefit for prosthetic devices and services shall be no more than the most common amounts applied to the basic health care services required to be provided under the health benefit plan.

4. **(1) A health carrier that receives a request from a facility for prior authorization for any devices or services described in this section shall exercise due diligence in its response as required under this subsection.**

(2) The due-diligence obligation shall require any denial of a prior authorization request described in subdivision (1) of this subsection by the health carrier to be provided in writing to the facility by the health carrier within fourteen days of receipt of the request. The written notification shall include the reason or reasons for the denial.

(3) The due-diligence obligation shall require any approval of a prior authorization request described in subdivision (1) of this subsection by the health carrier to be provided in writing to the facility by the health carrier within seven days of receipt of the request. If approved, the health carrier shall pay for the prior-authorized devices or services upon receipt of the billed charges in accordance with subsection 13 of section 376.1361.

(4) The health carrier may request a seven-day extension on its due-diligence obligation under this subsection, provided that the health carrier notifies the facility of such request before the seven-day extension begins. The facility shall document the request for the extension in the patient's medical record.

5. If a facility providing any devices or services described in this section is accredited by the American Board for Certification in Orthotics, Prosthetics, and Pedorthics or the Board of Certification/Accreditation, the following provisions shall apply:

(1) All health carriers shall deem the facility to be an in-network facility for billing purposes for any of their enrollees who require orthotic or prosthetic services; and

(2) All health carriers shall allow the facility to negotiate individual facility contracts with a rate of reimbursement not less than the Medicare allowable rate under Medicare rules and regulations.

6. A health carrier shall not consider any request for reimbursement for devices or services described in this section to lack sufficient documentation if:

(1) The orthotist or prosthetist providing the device or service is certified in prosthetics or orthotics by the American Board for Certification in Orthotics, Prosthetics, and Pedorthics or the Board of Certification/Accreditation; and

(2) The orthotist or prosthetist provides documentation that is consistent with the recognized standard of SOAP (subjective, objective, assessment, and plan) without collaboration with any other health care provider.

7. The provisions of this section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, short-term major medical policies of six months or less duration, or any other supplemental policy as determined by the director of the department of commerce and insurance.

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