SECOND REGULAR SESSION

HOUSE BILL NO. 2034

103RD GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE CATON.

3872H.01I JOSEPH ENGLER, Chief Clerk

AN ACT

To repeal sections 208.152 and 376.1232, RSMo, and to enact in lieu thereof five new sections relating to insurance coverage of orthotic, prosthetic, and assistive devices.

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

Section A. Sections 208.152 and 376.1232, RSMo, are repealed and five new sections enacted in lieu thereof, to be known as sections 208.152, 208.830, 376.1232, 376.1233, and 376.1234, to read as follows:

208.152. 1. MO HealthNet payments shall be made on behalf of those eligible needy persons as described in section 208.151 who are unable to provide for it in whole or in part, with any payments to be made on the basis of the reasonable cost of the care or reasonable charge for the services as defined and determined by the MO HealthNet division, unless otherwise hereinafter provided, for the following:

(1) Inpatient hospital services, except to persons in an institution for mental diseases who are under the age of sixty-five years and over the age of twenty-one years; provided that the MO HealthNet division shall provide through rule and regulation an exception process for coverage of inpatient costs in those cases requiring treatment beyond the seventy-fifth percentile professional activities study (PAS) or the MO HealthNet children's diagnosis length-of-stay schedule; and provided further that the MO HealthNet division shall take into account through its payment system for hospital services the situation of hospitals which serve a disproportionate number of low-income patients;

(2) All outpatient hospital services, payments therefor to be in amounts which represent no more than eighty percent of the lesser of reasonable costs or customary charges for such services, determined in accordance with the principles set forth in Title XVIII A and

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.

B, Public Law 89-97, 1965 amendments to the federal Social Security Act (42 U.S.C. Section 301, et seq.), but the MO HealthNet division may evaluate outpatient hospital services rendered under this section and deny payment for services which are determined by the MO HealthNet division not to be medically necessary, in accordance with federal law and regulations;

(3) Laboratory and X-ray services;

(4) Nursing home services for participants, except to persons with more than five hundred thousand dollars equity in their home or except for persons in an institution for mental diseases who are under the age of sixty-five years, when residing in a hospital licensed by the department of health and senior services or a nursing home licensed by the department of health and senior services or appropriate licensing authority of other states or government-owned and -operated institutions which are determined to conform to standards equivalent to licensing requirements in Title XIX of the federal Social Security Act (42 U.S.C. Section 1396, et seq.), as amended, for nursing facilities. The MO HealthNet division may recognize through its payment methodology for nursing facilities those nursing facilities which serve a high volume of MO HealthNet patients. The MO HealthNet division when determining the amount of the benefit payments to be made on behalf of persons under the age of twenty-one in a nursing facility may consider nursing facilities furnishing care to persons under the age of twenty-one as a classification separate from other nursing facilities;

(5) Nursing home costs for participants receiving benefit payments under subdivision (4) of this subsection for those days, which shall not exceed twelve per any period of six consecutive months, during which the participant is on a temporary leave of absence from the hospital or nursing home, provided that no such participant shall be allowed a temporary leave of absence unless it is specifically provided for in his **or her** plan of care. As used in this subdivision, the term "temporary leave of absence" shall include all periods of time during which a participant is away from the hospital or nursing home overnight because he **or she** is visiting a friend or relative;

(6) Physicians' services, whether furnished in the office, home, hospital, nursing home, or elsewhere, provided, that no funds shall be expended to any abortion facility, as defined in section 188.015, or to any affiliate, as defined in section 188.015, of such abortion facility;

(7) Subject to appropriation, up to twenty visits per year for services limited to examinations, diagnoses, adjustments, and manipulations and treatments of malpositioned articulations and structures of the body provided by licensed chiropractic physicians practicing within their scope of practice. Nothing in this subdivision shall be interpreted to otherwise expand MO HealthNet services;

(8) Drugs and medicines when prescribed by a licensed physician, dentist, podiatrist, or an advanced practice registered nurse; except that no payment for drugs and medicines prescribed on and after January 1, 2006, by a licensed physician, dentist, podiatrist, or an advanced practice registered nurse may be made on behalf of any person who qualifies for prescription drug coverage under the provisions of P.L. 108-173;

(9) Emergency ambulance services and, effective January 1, 1990, medically necessary transportation to scheduled, physician-prescribed nonelective treatments;

(10) Early and periodic screening and diagnosis of individuals who are under the age of twenty-one to ascertain their physical or mental defects, and health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby. Such services shall be provided in accordance with the provisions of Section 6403 of P.L. 101-239 and federal regulations promulgated thereunder;

(11) Home health care services;

(12) Family planning as defined by federal rules and regulations; provided, that no funds shall be expended to any abortion facility, as defined in section 188.015, or to any affiliate, as defined in section 188.015, of such abortion facility; and further provided, however, that such family planning services shall not include abortions or any abortifacient drug or device that is used for the purpose of inducing an abortion unless such abortions are certified in writing by a physician to the MO HealthNet agency that, in the physician's professional judgment, the life of the mother would be endangered if the fetus were carried to term;

(13) Inpatient psychiatric hospital services for individuals under age twenty-one as defined in Title XIX of the federal Social Security Act (42 U.S.C. Section 1396d, et seq.);

(14) Outpatient surgical procedures, including presurgical diagnostic services performed in ambulatory surgical facilities which are licensed by the department of health and senior services of the state of Missouri; except, that such outpatient surgical services shall not include persons who are eligible for coverage under Part B of Title XVIII, Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended, if exclusion of such persons is permitted under Title XIX, Public Law 89-97, 1965 amendments to the federal Social Security Act, as amended;

(15) Personal care services which are medically oriented tasks having to do with a person's physical requirements, as opposed to housekeeping requirements, which enable a person to be treated by his or her physician on an outpatient rather than on an inpatient or residential basis in a hospital, intermediate care facility, or skilled nursing facility. Personal care services shall be rendered by an individual not a member of the participant's family who is qualified to provide such services where the services are prescribed by a physician in accordance with a plan of treatment and are supervised by a licensed nurse. Persons eligible

to receive personal care services shall be those persons who would otherwise require placement in a hospital, intermediate care facility, or skilled nursing facility. Benefits payable for personal care services shall not exceed for any one participant one hundred percent of the average statewide charge for care and treatment in an intermediate care facility for a comparable period of time. Such services, when delivered in a residential care facility or assisted living facility licensed under chapter 198**,** shall be authorized on a tier level based on the services the resident requires and the frequency of the services. A resident of such facility who qualifies for assistance under section 208.030 shall, at a minimum, if prescribed by a physician, qualify for the tier level with the fewest services. The rate paid to providers for each tier of service shall be set subject to appropriations. Subject to appropriations, each resident of such facility who qualifies for assistance under section 208.030 and meets the level of care required in this section shall, at a minimum, if prescribed by a physician, be authorized up to one hour of personal care services per day. Authorized units of personal care services shall not be reduced or tier level lowered unless an order approving such reduction or lowering is obtained from the resident's personal physician. Such authorized units of personal care services or tier level shall be transferred with such resident if he or she transfers to another such facility. Such provision shall terminate upon receipt of relevant waivers from the federal Department of Health and Human Services. If the Centers for Medicare and Medicaid Services determines that such provision does not comply with the state plan, this provision shall be null and void. The MO HealthNet division shall notify the revisor of statutes as to whether the relevant waivers are approved or a determination of noncompliance is made;

(16) Mental health services. The state plan for providing medical assistance under Title XIX of the Social Security Act, 42 U.S.C. Section 1396, et seq., as amended, shall include the following mental health services when such services are provided by community mental health facilities operated by the department of mental health or designated by the department of mental health as a community mental health facility or as an alcohol and drug abuse facility or as a child-serving agency within the comprehensive children's mental health service system established in section 630.097. The department of mental health shall establish by administrative rule the definition and criteria for designation as a community mental health facility and for designation as an alcohol and drug abuse facility. Such mental health services shall include:

(a) Outpatient mental health services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management;

(b) Clinic mental health services including preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management;

(c) Rehabilitative mental health and alcohol and drug abuse services including home and community-based preventive, diagnostic, therapeutic, rehabilitative, and palliative interventions rendered to individuals in an individual or group setting by a mental health or alcohol and drug abuse professional in accordance with a plan of treatment appropriately established, implemented, monitored, and revised under the auspices of a therapeutic team as a part of client services management. As used in this section, mental health professional and alcohol and drug abuse professional shall be defined by the department of mental health pursuant to duly promulgated rules. With respect to services established by this subdivision, the department of social services, MO HealthNet division, shall enter into an agreement with the department of mental health. Matching funds for outpatient mental health services, clinic mental health services, and rehabilitation services for mental health and alcohol and drug abuse shall be certified by the department of mental health to the MO HealthNet division. The agreement shall establish a mechanism for the joint implementation of the provisions of this subdivision. In addition, the agreement shall establish a mechanism by which rates for services may be jointly developed;

(17) Such additional services as defined by the MO HealthNet division to be furnished under waivers of federal statutory requirements as provided for and authorized by the federal Social Security Act (42 U.S.C. Section 301, et seq.) subject to appropriation by the general assembly;

(18) The services of an advanced practice registered nurse with a collaborative practice agreement to the extent that such services are provided in accordance with chapters 334 and 335, and regulations promulgated thereunder;

(19) Nursing home costs for participants receiving benefit payments under subdivision (4) of this subsection to reserve a bed for the participant in the nursing home during the time that the participant is absent due to admission to a hospital for services which cannot be performed on an outpatient basis, subject to the provisions of this subdivision:

(a) The provisions of this subdivision shall apply only if:

a. The occupancy rate of the nursing home is at or above ninety-seven percent of MO HealthNet certified licensed beds, according to the most recent quarterly census provided to the department of health and senior services which was taken prior to when the participant is admitted to the hospital; and

b. The patient is admitted to a hospital for a medical condition with an anticipated stay of three days or less;

(b) The payment to be made under this subdivision shall be provided for a maximum of three days per hospital stay;

(c) For each day that nursing home costs are paid on behalf of a participant under this subdivision during any period of six consecutive months such participant shall, during the same period of six consecutive months, be ineligible for payment of nursing home costs of two otherwise available temporary leave of absence days provided under subdivision (5) of this subsection; and

(d) The provisions of this subdivision shall not apply unless the nursing home receives notice from the participant or the participant's responsible party that the participant intends to return to the nursing home following the hospital stay. If the nursing home receives such notification and all other provisions of this subsection have been satisfied, the nursing home shall provide notice to the participant or the participant's responsible party prior to release of the reserved bed;

(20) Prescribed medically necessary durable medical equipment. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(21) Hospice care. As used in this subdivision, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness, and during dying and bereavement and meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the MO HealthNet division to the hospice provider for room and board furnished by a nursing home to an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement which would have been paid for facility services in that nursing home facility for that patient, in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

(22) Prescribed medically necessary dental services. Such services shall be subject to appropriations. An electronic web-based prior authorization system using best medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(23) Prescribed medically necessary optometric services. Such services shall be subject to appropriations. An electronic web-based prior authorization system using best

medical evidence and care and treatment guidelines consistent with national standards shall be used to verify medical need;

(24) Blood clotting products-related services. For persons diagnosed with a bleeding disorder, as defined in section 338.400, reliant on blood clotting products, as defined in section 338.400, such services include:

(a) Home delivery of blood clotting products and ancillary infusion equipment and supplies, including the emergency deliveries of the product when medically necessary;

(b) Medically necessary ancillary infusion equipment and supplies required to administer the blood clotting products; and

(c) Assessments conducted in the participant's home by a pharmacist, nurse, or local home health care agency trained in bleeding disorders when deemed necessary by the participant's treating physician;

(25) Medically necessary cochlear implants and hearing instruments, as defined in section 345.015, that are:

(a) Prescribed by an audiologist, as defined in section 345.015; or

(b) Dispensed by a hearing instrument specialist, as defined in section 346.010;

(26) **Orthotic, prosthetic, and assistive devices, supplies, and services in accordance with section 208.830;**

(27) The MO HealthNet division shall, by January 1, 2008, and annually thereafter, report the status of MO HealthNet provider reimbursement rates as compared to one hundred percent of the Medicare reimbursement rates and compared to the average dental reimbursement rates paid by third-party payors licensed by the state. The MO HealthNet division shall, by July 1, 2008, provide to the general assembly a four-year plan to achieve parity with Medicare reimbursement rates and for third-party payor average dental reimbursement rates. Such plan shall be subject to appropriation and the division shall include in its annual budget request to the governor the necessary funding needed to complete the four-year plan developed under this subdivision.

2. Additional benefit payments for medical assistance shall be made on behalf of those eligible needy children, pregnant women and blind persons with any payments to be made on the basis of the reasonable cost of the care or reasonable charge for the services as defined and determined by the MO HealthNet division, unless otherwise hereinafter provided, for the following:

(1) Dental services;

(2) Services of podiatrists as defined in section 330.010;

(3) Optometric services as described in section 336.010;

(4) Orthopedic devices **[**~~or other prosthetics, including~~**],** eye glasses, **and** dentures**[**~~, and wheelchairs~~**]**;

(5) Hospice care. As used in this subdivision, the term "hospice care" means a coordinated program of active professional medical attention within a home, outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness, and during dying and bereavement and meets the Medicare requirements for participation as a hospice as are provided in 42 CFR Part 418. The rate of reimbursement paid by the MO HealthNet division to the hospice provider for room and board furnished by a nursing home to an eligible hospice patient shall not be less than ninety-five percent of the rate of reimbursement which would have been paid for facility services in that nursing home facility for that patient, in accordance with subsection (c) of Section 6408 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989);

(6) Comprehensive day rehabilitation services beginning early posttrauma as part of a coordinated system of care for individuals with disabling impairments. Rehabilitation services must be based on an individualized, goal-oriented, comprehensive and coordinated treatment plan developed, implemented, and monitored through an interdisciplinary assessment designed to restore an individual to **an** optimal level of physical, cognitive, and behavioral function. The MO HealthNet division shall establish by administrative rule the definition and criteria for designation of a comprehensive day rehabilitation service facility, benefit limitations and payment mechanism. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this subdivision shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2005, shall be invalid and void.

3. The MO HealthNet division may require any participant receiving MO HealthNet benefits to pay part of the charge or cost until July 1, 2008, and an additional payment after July 1, 2008, as defined by rule duly promulgated by the MO HealthNet division, for all covered services except for those services covered under subdivisions (15) and (16) of subsection 1 of this section and sections 208.631 to 208.657 to the extent and in the manner authorized by Title XIX of the federal Social Security Act (42 U.S.C. Section 1396, et seq.) and regulations thereunder. When substitution of a generic drug is permitted by the prescriber according to section 338.056, and a generic drug is substituted for a name-brand drug, the MO HealthNet division may not lower or delete the requirement to make a co-payment

pursuant to regulations of Title XIX of the federal Social Security Act. A provider of goods or services described under this section must collect from all participants the additional payment that may be required by the MO HealthNet division under authority granted herein, if the division exercises that authority, to remain eligible as a provider. Any payments made by participants under this section shall be in addition to and not in lieu of payments made by the state for goods or services described herein except the participant portion of the pharmacy professional dispensing fee shall be in addition to and not in lieu of payments to pharmacists. A provider may collect the co-payment at the time a service is provided or at a later date. A provider shall not refuse to provide a service if a participant is unable to pay a required payment. If it is the routine business practice of a provider to terminate future services to an individual with an unclaimed debt, the provider may include uncollected co-payments under this practice. Providers who elect not to undertake the provision of services based on a history of bad debt shall give participants advance notice and a reasonable opportunity for payment. A provider, representative, employee, independent contractor, or agent of a pharmaceutical manufacturer shall not make co-payment for a participant. This subsection shall not apply to other qualified children, pregnant women, or blind persons. If the Centers for Medicare and Medicaid Services does not approve the MO HealthNet state plan amendment submitted by the department of social services that would allow a provider to deny future services to an individual with uncollected co-payments, the denial of services shall not be allowed. The department of social services shall inform providers regarding the acceptability of denying services as the result of unpaid co-payments.

4. The MO HealthNet division shall have the right to collect medication samples from participants in order to maintain program integrity.

5. Reimbursement for obstetrical and pediatric services under subdivision (6) of subsection 1 of this section shall be timely and sufficient to enlist enough health care providers so that care and services are available under the state plan for MO HealthNet benefits at least to the extent that such care and services are available to the general population in the geographic area, as required under subparagraph (a)(30)(A) of 42 U.S.C. Section 1396a and federal regulations promulgated thereunder.

6. Beginning July 1, 1990, reimbursement for services rendered in federally funded health centers shall be in accordance with the provisions of subsection 6402(c) and Section 6404 of P.L. 101-239 (Omnibus Budget Reconciliation Act of 1989) and federal regulations promulgated thereunder.

7. Beginning July 1, 1990, the department of social services shall provide notification and referral of children below age five, and pregnant, breast-feeding, or postpartum women who are determined to be eligible for MO HealthNet benefits under section 208.151 to the special supplemental food programs for women, infants and children administered by the

department of health and senior services. Such notification and referral shall conform to the requirements of Section 6406 of P.L. 101-239 and regulations promulgated thereunder.

8. Providers of long-term care services shall be reimbursed for their costs in accordance with the provisions of Section 1902 (a)(13)(A) of the Social Security Act, 42 U.S.C. Section 1396a, as amended, and regulations promulgated thereunder.

9. Reimbursement rates to long-term care providers with respect to a total change in ownership, at arm's length, for any facility previously licensed and certified for participation in the MO HealthNet program shall not increase payments in excess of the increase that would result from the application of Section 1902 (a)(13)(C) of the Social Security Act, 42 U.S.C. Section 1396a (a)(13)(C).

10. The MO HealthNet division may enroll qualified residential care facilities and assisted living facilities, as defined in chapter 198, as MO HealthNet personal care providers.

11. Any income earned by individuals eligible for certified extended employment at a sheltered workshop under chapter 178 shall not be considered as income for purposes of determining eligibility under this section.

12. If the Missouri Medicaid audit and compliance unit changes any interpretation or application of the requirements for reimbursement for MO HealthNet services from the interpretation or application that has been applied previously by the state in any audit of a MO HealthNet provider, the Missouri Medicaid audit and compliance unit shall notify all affected MO HealthNet providers five business days before such change shall take effect. Failure of the Missouri Medicaid audit and compliance unit to notify a provider of such change shall entitle the provider to continue to receive and retain reimbursement until such notification is provided and shall waive any liability of such provider for recoupment or other loss of any payments previously made prior to the five business days after such notice has been sent. Each provider shall provide the Missouri Medicaid audit and compliance unit a valid email address and shall agree to receive communications electronically. The notification required under this section shall be delivered in writing by the United States Postal Service or electronic mail to each provider.

13. Nothing in this section shall be construed to abrogate or limit the department's statutory requirement to promulgate rules under chapter 536.

14. Beginning July 1, 2016, and subject to appropriations, providers of behavioral, social, and psychophysiological services for the prevention, treatment, or management of physical health problems shall be reimbursed utilizing the behavior assessment and intervention reimbursement codes 96150 to 96154 or their successor codes under the Current Procedural Terminology (CPT) coding system. Providers eligible for such reimbursement shall include psychologists.

15. There shall be no payments made under this section for gender transition surgeries, cross-sex hormones, or puberty-blocking drugs, as such terms are defined in section 191.1720, for the purpose of a gender transition.

208.830. 1. As used in this section, terms shall have the same meanings given to them in section 376.1232.

2. The MO HealthNet program shall cover orthotic, prosthetic, and assistive devices, supplies, and services furnished under an order by a prescribing physician or licensed health care prescriber who has authority in this state to prescribe orthotic, prosthetic, and assistive devices. The coverage shall be at least equal to the coverage provided under federal law for health insurance for the aged and disabled under 42 U.S.C. Sections 1395k, 1395l, and 1395m, but only to the extent consistent with this section.

3. Coverage for orthotic, prosthetic, and assistive devices, supplies, accessories, and services under this section includes those devices or device systems, supplies, accessories, and services that are customized to the enrollee's needs for purposes of activities of daily living and essential job-related activities. This requirement applies to the type of device as follows:

(1) For orthotic and prosthetic devices, this subsection requires coverage of devices intended for primary or daily use; and

(2) For assistive devices, this subsection requires coverage of:

(a) One wheelchair for daily use; and

(b) One manual wheelchair for backup use.

4. The MO HealthNet program shall cover orthotic, prosthetic, and assistive devices determined by the enrollee's provider to be the most appropriate model that meets the medical needs of the enrollee for purposes of performing physical activities, as applicable, including, but not limited to, running, biking, and swimming, and maximizing the enrollee's whole-body health and function, including coverage of an activity wheelchair if medically necessary.

5. The MO HealthNet program shall cover orthotic, prosthetic, and assistive devices for showering or bathing.

6. The coverage set forth in this section includes the repair and replacement of those orthotic, prosthetic, and assistive devices, supplies, and services described in this section.

7. Coverage of an orthotic, prosthetic, or assistive benefit shall not be denied for an individual with limb loss or absence that would otherwise be covered for a nondisabled person seeking medical or surgical intervention to restore or maintain the ability to perform the same physical activity.

8. If coverage for prosthetic, custom orthotic, or assistive devices is provided, payment shall be made for the replacement of a prosthetic, custom orthotic, or assistive device or for the replacement of any part of such devices, without regard to continuous use or useful lifetime restrictions, if an ordering health care provider determines that the provision of a replacement device, or a replacement part of a device, is necessary because:

(1) Of a change in the physiological condition of the patient;

(2) Of an irreparable change in the condition of the device or in a part of the device; or

(3) The condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than sixty percent of the cost of a replacement device or of the part being replaced.

9. Prior authorization may be required for orthotic, prosthetic, and assistive devices, supplies, and services.

10. Utilization review determinations shall be rendered in a nondiscriminatory manner and shall not deny coverage for habilitative or rehabilitative benefits, including prosthetics, orthotics, or assistive services, solely on the basis of an enrollee's actual or perceived disability.

11. Evidence of coverage and any benefit denial letters shall include language describing an enrollee's rights under subsection 10 of this section. Any denial of coverage shall be issued in writing with an explanation that contains clear reasoning and a description of how and why the request or claim does not meet medical necessity standards.

12. Confirmation from a prescribing health care provider may be required if the prosthetic, custom orthotic, or assistive device or part being replaced is less than three years old.

13. (1) Managed care plans subject to this section shall ensure access to medically necessary clinical care and to prosthetic, custom orthotic, and assistive devices and technology from at least two distinct prosthetic, custom orthotic, and assistive device providers in the plan's provider network located in this state.

(2) If medically necessary covered orthotic, prosthetic, and assistive devices are not available from an in-network provider, the plan shall provide processes to refer an enrollee to an out-of-network provider and shall fully reimburse the out-of-network provider at a mutually agreed-upon rate less enrollee cost sharing determined on an in-network basis.

376.1232. 1. **As used in sections 376.1232 to 376.1234, the following terms mean:**

(1) "Accredited facility", any entity that is accredited to provide comprehensive orthotic, prosthetic, or assistive devices or services by a Centers for Medicare and Medicaid Services-approved accrediting agency;

(2) "Activity wheelchair", a wheelchair that is designed specifically to enable individuals with mobility issues to participate in sports or fitness activities by providing better speed, maneuverability, and balance than a standard wheelchair used for activities of daily living;

(3) "Assistive device":

(a) Any external medical device that:

a. Allows an individual with a mobility impairment to move in indoor and outdoor spaces including, but not limited to, a manual wheelchair, a motorized wheelchair, or an activity wheelchair; and

b. Is deemed medically necessary by a prescribing physician or licensed health care provider who has authority in this state to prescribe assistive devices; and

(b) Any provision, repair, or replacement of the device that is furnished or performed by:

a. An accredited facility in comprehensive assistive services; or

b. A health care provider licensed in this state and operating within the provider's scope of practice that allows the provider to provide assistive devices, supplies, or services;

(4) "Assistive services":

(a) The science and practice of evaluating, fitting, adjusting, or servicing, as well as providing the initial training necessary to accomplish the fitting of, an assistive device for mobility;

(b) Evaluation, treatment, and consultation related to an assistive device;

(c) Assessment of assistive devices to maximize function and provide support and alignment necessary to improve the safety and efficiency of mobility and locomotion;

(d) Continuation of patient care to assess the effect of an assistive device on the patient's mobility; and

(e) Assurance of proper fit and function of the assistive device by periodic evaluation;

(5) "Enrollee", the same meaning given to the term in section 376.1350;

(6) "Health benefit plan", the same meaning given to the term in section 376.1350. The term "health benefit plan" shall also include the Missouri consolidated health care plan established under chapter 103 and any other state-sponsored health insurance program;

(7) "Health carrier", the same meaning given to the term in section 376.1350;

(8) "Orthosis" or "orthotic device":

(a) An external medical device that is:

a. Custom-fabricated or custom-fitted to a specific patient based on the patient's unique physical condition;

b. Applied to a part of the body to correct a deformity, provide support and protection, restrict motion, improve function, or relieve symptoms of a disease, syndrome, injury, or postoperative condition; and

c. Deemed medically necessary by a prescribing physician or licensed health care provider who has authority in this state to prescribe orthotic devices, supplies, and services; and

(b) Any provision, repair, or replacement of the device that is furnished or performed by:

a. An accredited facility in comprehensive orthotic services; or

b. A health care provider licensed in this state and operating within the provider's scope of practice that allows the provider to provide orthotic devices, supplies, or services;

(9) "Orthotics":

(a) The science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, adjusting, or servicing, as well as providing the initial training necessary to accomplish the fitting of, an orthosis for the support, correction, or alleviation of a neuromuscular or musculoskeletal dysfunction, disease, injury, or deformity;

(b) Evaluation, treatment, and consultation related to an orthotic device;

(c) Basic observation of gait and postural analysis;

(d) Assessment and design of orthoses to maximize function and provide support and alignment necessary to prevent or correct a deformity or to improve the safety and efficiency of mobility and locomotion;

(e) Continuation of patient care to assess the effect of an orthotic device on the patient's tissues; and

(f) Assurance of proper fit and function of the orthotic device by periodic evaluation;

(10) "Prosthesis" or "prosthetic device":

(a) An external medical device that is:

a. Used to replace or restore a missing limb, appendage, or other external human body part; and

b. Deemed medically necessary by a prescribing physician or licensed health care provider who has authority in this state to prescribe prosthetic devices, supplies, and services; and

(b) Any provision, repair, or replacement of the device that is furnished or performed by:

a. An accredited facility in comprehensive prosthetic services; or

b. A health care provider licensed in this state and operating within the provider's scope of practice that allows the provider to provide prosthetic devices, supplies, or services;

(11) "Prosthetics":

(a) The science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, aligning, adjusting, or servicing, as well as providing the initial training necessary to accomplish the fitting of, a prosthesis through the replacement of external parts of a human body lost due to amputation or congenital deformities or absences;

(b) The generation of an image, form, or mold that replicates the patient's body segment and that requires rectification of dimensions, contours, and volumes for use in the design and fabrication of a socket to accept a residual anatomic limb to, in turn, create an artificial appendage that is designed either to support body weight or to improve or restore function or anatomical appearance, or both;

(c) Observational gait analysis and clinical assessment of the requirements necessary to refine and mechanically fix the relative position of various parts of the prosthesis to maximize function, stability, and safety of the patient;

(d) The provision and continuation of patient care in order to assess the prosthetic device's effect on the patient's tissues; and

(e) Assurance of proper fit and function of the prosthetic device by periodic evaluation;

(12) "Utilization review", the same meaning given to the term in section 376.1350.

2. 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, shall **[**~~offer~~**] provide** coverage for **orthotic,** prosthetic**, and assistive** devices**, supplies,** and services, including **[**~~original~~**] repair** and replacement **[**~~devices, as prescribed by a physician acting within the scope of his or her practice~~**]**. **The coverage shall be at least equal to the coverage provided under federal law for health insurance for the aged and disabled under 42 U.S.C. Sections 1395k, 1395l, and 1395m, but only to the extent consistent with this section.**

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

3. The amount of the benefit for **orthotic,** prosthetic**, and assistive** 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 **orthotic,** prosthetic**, and assistive** 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 **orthotic,** prosthetic**, and assistive** 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. **A health carrier or health benefit plan may limit the benefits for, or alter the financial requirements for, out-of-network coverage of orthotic, prosthetic, and assistive devices, except that the restrictions and requirements that apply to those benefits shall not be more restrictive than the financial requirements that apply to the out-of-network coverage for the basic health care services to be provided under the health benefit plan.**

5. A health carrier or health benefit plan shall not subject coverage for orthotic, prosthetic, and assistive devices, supplies, and services to any limitations for preexisting conditions.

6. A health carrier or health benefit plan shall cover orthotic, prosthetic, and assistive devices when furnished under an order by a prescribing physician or licensed health care prescriber who has authority in this state to prescribe orthotic, prosthetic, and assistive devices. The coverage for orthotic, prosthetic, and assistive devices, supplies, accessories, and services shall include those devices or device systems, supplies, accessories, and services that are customized to the covered individual's needs for purposes of activities of daily living and essential job-related activities.

7. A health carrier or health benefit plan shall cover orthotic, prosthetic, and assistive devices determined by the enrollee's provider to be the most appropriate model that meets the medical needs of the enrollee for purposes of performing physical activities, as applicable, including, but not limited to, running, biking, and swimming, and maximizing the enrollee's whole-body health and function.

8. A health carrier or health benefit plan shall cover orthotic, prosthetic, and assistive devices for showering or bathing.

9. A health carrier or health benefit plan shall cover at least the following for an enrollee entitled to coverage of prostheses or orthoses:

(1) One prosthesis or orthosis for daily use;

(2) One prosthesis or orthosis designed for physical activity; and

(3) One prosthesis or orthosis for showering or bathing.

10. A health carrier or health benefit plan shall cover at least the following for an enrollee entitled to coverage of assistive devices:

(1) One wheelchair for daily use;

(2) One manual wheelchair for backup use; and

(3) One activity wheelchair if medically necessary to enable the enrollee to engage in physical activities, as applicable, including, but not limited to, running, biking, swimming, and strength training, and to maximize the enrollee's whole-body health and lower or upper limb function.

11. A health carrier or health benefit plan may require prior authorization for orthotic, prosthetic, and assistive devices, supplies, and services in the same manner and to the same extent as prior authorization is required for any other covered benefit.

12. Except as provided in subsection 13 of this section, 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.

13. Notwithstanding section 376.998 or any other provision of law to the contrary, the provisions of this section shall apply to a Medicare supplement policy.

376.1233. 1. A health carrier or health benefit plan shall render utilization review determinations in a nondiscriminatory manner and shall not deny coverage for habilitative or rehabilitative benefits, including prosthetics, orthotics, or assistive services, solely on the basis of an enrollee's actual or perceived disability.

2. A health carrier or health benefit plan shall not deny a prosthetic, orthotic, or assistive benefit for an individual with limb loss or absence that would otherwise be covered for a nondisabled person seeking medical or surgical intervention to restore or maintain the ability to perform the same physical activity.

3. A health benefit plan offered, issued, or renewed in this state that offers coverage for prosthetics, custom orthotic devices, and assistive devices shall include language describing an enrollee's rights under subsections 1 and 2 of this section in its evidence of coverage and any benefit denial letters. Any denial of coverage shall be issued in writing with an explanation that contains clear reasoning and a description of how and why the request or claim does not meet medical necessity standards.

4. A health carrier or health benefit plan that provides coverage for prosthetic, orthotic, or assistive services shall ensure access to medically necessary clinical care and

to prosthetic, custom orthotic, and assistive devices and technology from not less than two distinct prosthetic, custom orthotic, and assistive device providers in the plan's provider network located in this state. If medically necessary covered orthotics, prosthetics, and assistive services are not available from an in-network provider, the health carrier or health benefit plan shall provide processes to refer a member to an out-of-network provider and shall fully reimburse the out-of-network provider at a mutually agreed-upon rate less member cost sharing determined on an in-network basis.

5. If coverage for prosthetic, custom orthotic, or assistive devices is provided, payment shall be made for the replacement of a prosthetic, custom orthotic, or assistive device or for the replacement of any part of such devices, without regard to continuous use or useful lifetime restrictions, if an ordering health care provider determines that the provision of a replacement device, or a replacement part of a device, is necessary because:

(1) Of a change in the physiological condition of the patient;

(2) Of an irreparable change in the condition of the device or in a part of the device; or

(3) The condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than sixty percent of the cost of a replacement device or of the part being replaced.

6. Confirmation from a prescribing health care provider may be required if the prosthetic, custom orthotic, or assistive device or part being replaced is less than three years old.

376.1234. 1. Before October 1, 2027, each health carrier that issues a health benefit plan providing coverage of orthotic, prosthetic, and assistive devices, supplies, and services as required under sections 376.1232 to 376.1234 shall report to the director of the department of commerce and insurance on its experience with the requirements of sections 376.1232 to 376.1234 for the first year following the effective date of this section. The report shall be in a form prescribed by the director and shall include the number of claims and the total amount of claims paid in this state for the services required by sections 376.1232 to 376.1234. The director shall aggregate this data in a report and submit the report to the house and senate standing committees having jurisdiction over health insurance matters before December 1, 2027.

2. The director may promulgate any necessary rules and regulations to implement sections 376.1232 to 376.1234. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of

chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2026, shall be invalid and void.

✓