SENATE BILL 2010
By Reeves

HOUSE BILL 1992

By Jernigan

AN ACT to amend Tennessee Code Annotated, Title 8; Title 47; Title 56 and Title 71, relative to insurance coverage of prosthetic and orthotic devices.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, Part 23, is amended by adding the following as a new section:

(a) As used in this section:

(1) "Covered person" means a person on whose behalf a health insurer is obligated to pay benefits or provide services pursuant to a health benefit plan;

(2) "Health benefit plan" means health insurance coverage, as defined in § 56-7-109;

(3) "Health insurer" means a health insurance entity, as defined in § 56-7-109; and

(4) "Healthcare provider" means a person who is licensed, certified, authorized, or permitted by the laws of this state to administer health care in the ordinary course of business or practice of a profession.

(b)

(1) A health insurer shall include in a health benefit plan that provides coverage for hospital, medical, or surgical expenses and is offered, issued, amended, or renewed in this state on or after July 1, 2024, coverage and reimbursement for prosthetic and custom orthotic devices in a manner that:

(A) Equals or exceeds the levels of coverage and reimbursement for such devices under the federal medicare program; and

(B) Is no more restrictive than coverage of and reimbursement for other medical devices provided under the health benefit plan.

(2) Coverage for prosthetic or custom orthotic devices required by subdivision (b)(1) must include:

(A) A prosthetic or custom orthotic device determined by the covered person's healthcare provider to be the most appropriate model that adequately meets the medical needs of the covered person for purposes of completing activities of daily living or essential job-related activities;

(B) A prosthetic or custom orthotic device determined by the covered person's healthcare provider to be the most appropriate model that meets the medical needs of the covered person for purposes of performing physical activities including, but not limited to, running, cycling, swimming, and strength training, or to maximize the covered person's whole-body health and lower or upper limb function;

(C) All materials and components necessary to use the prosthetic or custom orthotic device;

(D) Instruction to the enrollee on using the prosthetic or custom orthotic device; and

(E) Repair or replacement of the prosthetic or custom orthotic device.

(c) A health insurer that issues a health benefit plan that is subject to subsection (b) shall:

(1) Consider coverage benefits for prosthetic and custom orthotic devices as habilitative or rehabilitative benefits for purposes of any state or federal requirement for coverage of essential health benefits;

(2) When performing a utilization review for a request for coverage of a prosthetic or custom orthotic device, apply the most recent version of evidence-based treatment and fit criteria as recognized by relevant clinical specialists or relevant clinical specialist organizations, which the commissioner may identify by rule promulgated in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5;

(3) Render a utilization review determination in a nondiscriminatory manner and shall not deny coverage for a prosthetic or custom orthotic device solely on the basis of a covered person's actual or perceived disability;

(4) Include a prosthetic or custom orthotic device in a covered person's benefits if the treating healthcare provider determines that the prosthetic or custom orthotic device is medically necessary for the purpose of:

(A) Completing activities of daily living or essential job-related activities;

(B) Performing physical activities, including running, cycling, swimming, and strength training; or

(C) Maximizing the covered person's whole-body health and lower or upper limb function;

(5) Not deny coverage of a prosthetic or custom orthotic device for an individual with limb loss or absence that would otherwise be covered for a person without a disability who is seeking medical or surgical intervention to restore or maintain the ability to perform the same physical activity;

(6) Include language describing a covered person's rights pursuant to subdivisions (c)(3) and (4) in its correspondence with the covered person regarding coverage benefits or a denial of coverage;

(7) Not impose cost-sharing requirements on prosthetic or custom orthotic devices unless the cost-sharing requirements do not exceed the cost-sharing requirements applicable to the health benefit plan's coverage for inpatient physician and surgical services;

(8) Ensure access to medically necessary clinical care and to prosthetic and custom orthotic devices and technology from not less than two (2) distinct prosthetic and custom orthotic device providers in the health benefit plan's provider network in this state, or, if medically necessary covered prosthetic and custom orthotic devices are not available from an in-network provider, then provide a process by which the covered person is referred to an out-of-network provider and fully reimburse the out-of-network provider at a mutually agreed upon rate less any cost-sharing requirement as determined on an in-network basis; and

(9) For a covered prosthetic or custom orthotic device, provide reimbursement for the replacement of the prosthetic or custom orthotic device or for any part of such devices, without regard to continuous use or useful lifetime restrictions, if an ordering healthcare provider determines that the provision of a replacement device, or a replacement part of such device, is necessary because:

(A) Of a change in the physiological condition of the covered person;

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

(C) The condition of the device or a part of the device requires repair and the cost of such repair would be more than sixty percent (60%) of the cost of a replacement device or part.

(d) A health insurer may require confirmation from a prescribing healthcare provider if a prosthetic or custom orthotic device or part being replaced pursuant to subdivision (c)(9) is less than three (3) years old.

(e) A health insurer shall not:

(1) Cancel or change the premiums, benefits, or conditions of a health benefit plan on the basis of a covered person's actual or perceived disability;

(2) Deny a prosthetic or custom orthotic device benefit for a covered person with limb loss or absence that would otherwise be covered for a person without a disability who is seeking medical or surgical intervention to restore or maintain the ability to perform the same physical activity;

(3) Fail to apply the most recent version of treatment and fit criteria developed by the professional association with the most relevant clinical specialty when performing a utilization review for a request for coverage of prosthetic or custom orthotic device benefits; or

(4) Fail to apply medical necessity review standards developed by the professional association with the most relevant clinical specialty when conducting utilization management review or processing appeals regarding denial of a prosthetic or custom orthotic device benefit.

(f) A violation of this section may subject the health insurer to any of the sanctions described in § 56-2-305.

(g) No later than January 15, 2025, and on or before January 15 of each subsequent year, a health insurer that provides coverage of prosthetic or custom orthotic

devices pursuant to this section shall report to the department such data as the commissioner may require by rule regarding coverage of prosthetic and custom orthotic devices under this section for the previous calendar year. The department shall submit a report of aggregated and de-identified data to the chair of the commerce and labor committee of the senate, the chair of the insurance committee of the house of representatives, and the legislative librarian by January 31, 2025, and by January 31 of each year thereafter.

SECTION 2. The commissioner of commerce and insurance may promulgate rules to effectuate this act. The rules must be promulgated in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

SECTION 3. This act takes effect upon becoming a law, the public welfare requiring it.