Title 23 Public Utilities and Regulated Industries
Subtitle 3. Insurance
Chapter 99 Health Care Providers
Subchapter 4 -- Arkansas Health Care Consumer Act

A.C.A. § 23-99-417 (2010)

23-99-417. Coverage required for orthotic devices, orthotic services, prosthetic devices, and prosthetic services.

(a) (1) Subject to subdivision (a)(2) of this section and subsections (b) and (c) of this section, a health benefit plan that is issued for delivery, delivered, renewed, or otherwise contracted for in this state shall provide coverage for eligible charges within limits of coverage that are no less than eighty percent (80%) of Medicare allowables as defined by the Centers for Medicare & Medicaid Services, Healthcare Common Procedure Coding System as of January 1, 2009, or as of a later date if adopted by rule of the Insurance Commissioner for:

(A) An orthotic device;

(B) An orthotic service;

(C) A **prosthetic** device; and

(D) A **prosthetic** service.

(2) This section does not require coverage for an orthotic device, an orthotic service, a **prosthetic** device, or a **prosthetic** service for a replacement that occurs more frequently than one (1) time every three (3) years unless medically necessary or indicated by other coverage criteria.

(b) (1) Eligible charges and limits of or exclusions from coverage under subsection (a) of this section shall be based on medical necessity or the health benefit plan's coverage criteria for other medical services, which may include without limitation:

(A) The information and recommendation from the treating physician in consultation with the insured; and

(B) The results of a functional limit test.

(2) As used in this section, "functional limit test" includes without limitation the insured's:

(A) Medical history, including prior use of orthotic devices or **prosthetic** devices if applicable;

(B) Current condition, including the status of the musculoskeletal system and the nature of other medical problems; and

(C) Desire to:

(i) Ambulate with respect to lower-limb orthotic devices or **prosthetic** devices; or

(ii) Maximize upper-limb function with respect to upper-limb orthotic devices

or **prosthetic** devices.

(3) A denial or limitation of coverage based on lack of medical necessity is subject to external review under State Insurance Department Rule 76, the Arkansas External Review Regulation.

(c) A health benefit plan:

(1) May require prior authorization for an orthotic device, an orthotic service, a **prosthetic** device, or a **prosthetic** service in the same manner that prior authorization is required for any other covered benefit;

(2) May impose copayments, deductibles, or coinsurance amounts for an orthotic device, an orthotic service, a **prosthetic** device, or a **prosthetic** service if the amounts are no greater than the copayments, deductibles, or coinsurance amounts that apply to other benefits under the health benefit plan;

(3) When the replacement or repair is necessitated by anatomical change or normal use, shall cover the necessary repair and necessary replacement of an orthotic device or a **prosthetic**device subject to copayments, coinsurance, and deductibles that are no more restrictive than the copayments, coinsurance, and deductibles that apply to other benefits under the plan, unless the repair or replacement is necessitated by misuse or loss; and

(4) Shall include a requirement that an orthotic device, an orthotic service, a **prosthetic** device, or a **prosthetic** service be prescribed by a licensed doctor of medicine, doctor of osteopathy, or doctor of podiatric medicine and provided by a doctor of medicine, a doctor of osteopathy, a doctor of podiatric medicine, an orthotist, or a prosthetist licensed by the State of Arkansas.

(d) Coverage of an orthotic device, an orthotic service, a **prosthetic** device, or a **prosthetic** service may be made subject to but no more restrictive than the provisions of the health benefit plan that apply to other benefits under the plan.

HISTORY: Acts 2009, No. 950, § 2.