BULLETIN NO. 08-10

TO: **ALL HOSPITAL, MEDICAL AND HEALTH SERVICE CORPORATIONS, HEALTH INSURANCE COMPANIES AND HEALTH MAINTENANCE ORGANIZATIONS AUTHORIZED TO TRANSACT BUSINESS IN NEW JERSEY**

FROM: **STEVEN M. GOLDMAN, COMMISSIONER**

RE: **P.L. 2007, c. 345 – HEALTH BENEFITS COVERAGE FOR ORTHOTIC AND PROSTHETIC APPLIANCES**

P.L. 2007, c. 345, approved January 13, 2008 and effective April 11, 2008, requires health insurance carriers, including hospital, medical and health service corporations; individual and group health insurance companies; health maintenance organizations (HMOs); health benefits plans issued pursuant to the Individual Health Coverage (IHC) and Small Employer Health Benefits (SEH) Programs; and the State Health Benefits Plan (SHBP) to provide benefits for orthotic and prosthetic appliances obtained from any licensed orthotist or prosthetist or any certified pedorthist as determined medically necessary by a covered person's physician. The law further states that reimbursement for orthotic and prosthetic appliances shall be at the same rate as reimbursement for such appliances under the Federal Medicare reimbursement schedule. The law incorporates the following definitions:

> "Orthotic appliance" means, solely for the purposes of this act, a brace or support but does not include fabric and elastic supports, corsets, arch supports, trusses, elastic hose, canes, crutches, cervical collars, dental appliances or other similar devices carried in stock and sold by drug stores, department stores, corset shops or surgical supply facilities.
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> "Prosthetic appliance" means, solely for the purposes of this act, any artificial device that is not surgically implanted and that is used to replace a missing limb, appendage or any other external human body part including devices such as artificial limbs, hands, fingers, feet and toes, but excluding dental appliances and largely cosmetic devices such as artificial breasts, eyelashes, wigs, or other devices which could not by their use have a significantly detrimental impact upon the muscular skeletal functions of the body.

Upon signing this legislation, Governor Corzine directed the Departments of Health and Senior Services, Human Services and Banking and Insurance to periodically review the impact of the law's precluding utilization review of orthotic and prosthetic

appliances and of setting the rate of reimbursement for these appliances at the Medicare level.

The Department has received a number of questions concerning implementation of the law. The purpose of this Bulletin is to respond to the various questions received to date and to suggest that health carriers subject to P. L. 2007, c. 345 commence collecting specific information with respect to claims for orthotic or prosthetic appliances pending promulgation by the Department of administrative rules in accordance with the Administrative Procedures Act and applicable procedures.

Questions and Answers

Q1: Can carriers with closed network plans (i.e. HMO plans) limit coverage of orthotic and prosthetic appliances to network providers?
A1: Yes. The law states the benefits for orthotic and prosthetic appliances are to be provided to the same extent as for any other medical conditions under the contract. Since closed network plans do not provide out-of-network benefits for all other medical conditions, coverage for orthotic and prosthetic appliances under such plans can be limited to network providers. As with other services and supplies covered under a closed network plan, referrals may be required for orthotic and prosthetic appliances.

Q2: Can utilization management (i.e. pre-certification and retroactive review for medical necessity) be performed with respect to requests or claims for orthotic and prosthetic appliances?
A2: No. The law states that orthotic and prosthetic appliances are to be covered as determined medically necessary by the covered person's physician. Thus, carriers may not perform any medical necessity review for orthotic and prosthetic appliances, either before the appliance is supplied or when processing a claim for an appliance.

Q3: Can carriers apply the limits associated with durable medical equipment to orthotic and prosthetic appliances since the law states that benefits are to be provided to the same extent as for any other medical condition under the contract?
A3: No. Orthotic and prosthetic appliances are not durable medical equipment and are not subject to the dollar or other limits associated with durable medical equipment. The law does not permit any internal limits on orthotic and prosthetic appliances.

Q4: What cost sharing should be applied to orthotic and prosthetic appliances?
A4: The cost sharing that should be applied to orthotic and prosthetic appliances should be that associated with a primary care provider office visit.

Q5: Does the reference in the law to reimbursing at the federal Medicare reimbursement schedule mean that the benefit paid, after application of cost sharing, must equal the Medicare rate or that the benefit paid is computed by applying cost sharing to the Medicare rate?
A5: The Department has initially determined that the part of the law that states that benefits are to be provided to the same extent as for any other medical conditions means

that carriers may apply cost sharing to the Medicare reimbursement rate, in the same manner that cost sharing is determined for other covered conditions. The Department notes that where the Legislature intends to preclude application of cost sharing it does so explicitly as in the childhood immunization mandate which expressly precludes application of deductible.

Q6: Should carriers pay network providers of orthotic and prosthetic appliances the negotiated rate or the Medicare rate?
A6: The law states that the federal Medicare reimbursement schedule applies and does not exempt network providers. However, if a carrier's contract rate with a network provider of orthotic and prosthetic appliances exceeds the Medicare rate, the contract rate should be paid.

Q7: How are professional services associated with orthotic and prosthetic appliances to be reimbursed?
A7: The federal Medicare reimbursement schedule applies only to the appliance. Related professional services should be reimbursed as are other medical services under the policy or contract.

Q8: If a particular orthotic or prosthetic appliance does not have a federal Medicare reimbursement rate, does that mean it does not have to be covered?
A8: No. Where a particular orthotic or prosthetic appliance does not have a federal Medicare reimbursement rate, carriers should provide benefits for such an appliance at the rate for the most similar appliance for which there is a federal Medicare reimbursement rate.

Q9: Can carriers exclude replacement orthotic and prosthetic appliances where the replacement is due to loss or abuse of the appliance by the covered person or for any other reason?
A9: No. The law states that carriers shall provide benefits for orthotic and prosthetic appliances "as determined medically necessary by the covered person's physician." Excluding replacement orthotic and prosthetic appliances due to loss or abuse of the appliance by the covered person or for any other reason seems inconsistent with this directive. As long as the replacement is determined medically necessary by the covered person's physician, the law would appear to require coverage.

Q10: Does the law apply to "Basic and Essential" (B&E) plans issued pursuant to P.L. 2001, c. 368 (N.J.S.A. 17B:27A-4.4 et seq.)?
A10: No. As it relates to individual health benefits plans, the law applies to plans delivered, issued, executed or renewed in this State pursuant to P.L. 1992, c. 161 (N.J.S.A. 17B:27A-2 et seq.) (the Individual Health Coverage (IHC) Program law), or plans approved for issuance or renewal in this State by the Commissioner of Banking and Insurance. The B&E plans are neither issued pursuant to P.L. 1992, c. 161 nor approved by the Commissioner. Further, in finding that the IHC Program did not provide a sufficient variety of policy options, including those that would provide coverage for basic and essential health care services but would not contain the traditional mandated benefits

to which the standard plans were subject, the Legislature required IHC carriers to offer a B&E plan in addition to the standard IHC plans (N.J.S.A. 17B:27A-4.4). B&E plans are required to include *only* those specific coverages set forth by statute (N.J.S.A. 17B:27A-4.5) and thus are not required to provide the coverage for orthotic and prosthetic appliances mandated by P.L. 2007, c. 345.

Q11: When is the law effective?
A11: The law applies to contracts and policies issued and renewed on and after April 11, 2008.

Reporting

As stated above, the Department is charged with assisting in measuring the impact of this mandate on claims costs and intends to promulgate rules requiring the compilation and submission of data related to changes in utilization and cost of coverage for prosthetic and orthotic appliances. Accordingly, the Department is suggesting that carriers issuing plans subject to P.L. 2007, c. 345 (including organized delivery systems if they provide these benefits) commence maintaining certain relevant information on a monthly basis, in order to be able to provide annual (or more frequently, such as quarterly) reports to the Department in a form to be specified by the Department. At this time it is contemplated that the rules will require the annual report to contain the following information by Market Segment and Product Type:

- Period covered by the Report
- Market Segment: Individual, Small Group, Large Group, Total
- Product Type: HMO, POS, PPO, Indemnity, Total
- Member Months Exposed: (for the Market Segment and Product Type)
- Utilization: Number of Prosthetic and Orthotic Services and Appliances (units) per member month
- Average Cost: Cost (prior to cost sharing) per unit of Utilization
- Total Gross Cost per Member Month: Utilization x Average Cost
- Total Net Cost per Member Month: Total Gross Cost after cost sharing

- The report should explain how utilization units are defined and measured.

It is also suggested that carriers maintain, on an annual basis, a record of each member for whom aggregate gross claims for prosthetic and orthotic appliances exceed $20,000 in that year, with the record to include the number of units of service, total gross cost, and total net cost.

The Department suggests that carriers compile this data so as to be able to submit the annual reports commencing with calendar year 2007 upon adoption of the rules to be promulgated.

The 2007 report (summarizing costs prior to the effective date) will constitute the standard of comparison for subsequent reports.

Questions concerning the data compilation and recordkeeping suggested above should be directed to Neil Vance, Managing Actuary, neil.vance@dobi.state.nj.us, (609) 292-5427, ext. 50338. Questions concerning the Q&A should be directed to Gale Simon, Assistant Commissioner, gale.simon@dobi.state.nj.us, (609) 292-5427, ext. 50333.

5/29/08
Date

/s/ Steven M. Goldman
Steven M. Goldman
Commissioner

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