

2026 Regular Session

HOUSE BILL NO. 1235 (Substitute for House Bill No. 477 by Representative Hebert)

BY REPRESENTATIVE HEBERT

INSURANCE/HEALTH: Modifies provisions of law regarding health insurance coverage of prosthetic and custom orthotic devices and services

1 AN ACT

2 To amend and reenact R.S. 22:1049 and to enact Part IX of Chapter 5-E of Title 40 of the  
3 Louisiana Revised Statutes of 1950, to be comprised of R.S. 40:1259.11, relative to  
4 health insurance; to require coverage for prosthetic and orthotic devices and  
5 associated services; to establish criteria for medical necessity determinations; to  
6 delineate coverage standards, encompassing multiple devices, materials,  
7 components, repair, and replacement; to provide requirements for prior authorization  
8 and cost-sharing; to provide nondiscrimination provisions; to provide for network  
9 adequacy standards; to set reporting requirements; to provide for definitions; and to  
10 provide for related matters.

11 Be it enacted by the Legislature of Louisiana:

12 Section 1. R.S. 22:1049 is hereby amended and reenacted to read as follows:

13 §1049. Requirement for coverage of prosthetic and orthotic devices and ~~prosthetic~~  
14 services

15 A. ~~Notwithstanding the provisions of R.S. 22:1047 to the contrary, any~~ Any  
16 health coverage plan specified in Subsection ~~H~~ J of this Section which is issued for  
17 delivery, delivered, renewed, or otherwise contracted for in this state ~~on or after~~  
18 ~~January 1, 2009~~, shall provide coverage of prosthetic and orthotic devices and  
19 prosthetic and orthotic services as further provided in this Section.

1           B. Eligibility and limits of coverage for prosthetic and orthotic devices and  
2 ~~prosthetic~~ services shall be determined by the health coverage plan in consultation  
3 with the enrollee's medical providers and their assessment of ~~based on~~ medical  
4 necessity. In determining medical necessity, the health coverage plan shall consider  
5 the recommendations by the insured's physician or advanced practice provider. Such  
6 recommendations shall be based on the most appropriate prosthesis or orthosis that  
7 adequately meets the medical needs of the insured to restore or maintain the ability  
8 to perform activities of daily living and essential job-related functions. Such  
9 coverage shall, at a minimum, equal the coverage and prevailing payment rate for  
10 prosthetic and orthotic devices provided under federal laws and regulations for the  
11 aged and disabled pursuant to 42 United States Code, Sections 1395k, 1395l and  
12 1395m and 42 Code of Federal Regulations, Sections 414.202, 414.210, 414.228 and  
13 410.100. In accordance with Subsection C of this Section covered benefits shall be  
14 provided for more than one prosthesis or orthosis when determined by the health  
15 coverage plan to be medically necessary and may not exclude coverage for orthotic  
16 or prosthetic devices designed for physical activity or showering and bathing  
17 pursuant to blanket exclusions of items used for "recreation or leisure", "athletic or  
18 sports purposes", or "luxury or convenience". Any denial or limit of coverage based  
19 on lack of medical necessity may be appealed in accordance with ~~R.S. 22:1121~~ R.S.  
20 22:1241 et seq. and R.S. 22:2431, et seq. and with respect to claim denials based on  
21 medical necessity, such denials shall be in writing and include clear reasoning and  
22 descriptions of how and why the request or claim does not meet medical necessity  
23 standards. Such medical necessity determination shall consider information and  
24 recommendation from the treating physician in consultation with the insured,  
25 including but not limited to information in the medical record of the treating orthotist  
26 or prosthetist, and the results of a functional ~~limit test~~ assessment. Such ~~test~~  
27 assessment shall consider but not be limited to the following factors:  
28           (1) The insured's past history, including prior use of prosthetic or orthotic  
29 devices if applicable.

1           (2) The insured's current condition, including the status of the residual limb  
2           and the nature of other medical problems.

3           (3) The insured's desire to ambulate; with respect to lower limb prosthetic  
4           devices, or maximize upper limb function, with respect to upper limb prosthetic  
5           devices, and the insured's desire and ability to use an orthosis or prosthesis to  
6           maintain maximum function.

7           C.(1) In addition to the primary prosthetic or orthotic device of the upper or  
8           lower extremity, the health coverage plan shall provide coverage for an additional  
9           upper or lower extremity prosthetic or orthotic device when:

10           (a) The treating physician or other advanced practice provider determines  
11           that the additional prosthesis or orthosis is necessary to enable the enrollee to engage  
12           in physical activities, as applicable, such as running, biking, swimming, strength  
13           training, showering, bathing, and to maximize the enrollee's whole-body health and  
14           lower and upper limb function.

15           (b) The single additional prosthetic or orthotic device is determined to be  
16           medically necessary by the health coverage plan as being the most appropriate device  
17           to meet the insured's medical needs for purposes of performing physical activities  
18           such as running, biking, swimming, strength training, and other similar activities.

19           (c) This Subsection does not require coverage for a replacement of the  
20           additional prosthetic or orthotic device of the upper or lower extremity unless  
21           determined by the health coverage plan, in consultation with the enrollee's medical  
22           providers, to be medically necessary.

23           (2) If neither the original prosthetic or orthotic devices described in  
24           Subsection B nor the additional upper or lower extremity prosthetic or orthotic  
25           device provided in Paragraph (C)(1) of this Section is sufficient to enable the insured  
26           to safely engage in bathing and showering, then in addition to those devices, a single  
27           additional prosthetic or orthotic device recommended by the insured's physician or  
28           other advanced practice provider for purposes of showering or bathing shall be

1 covered when determined to be medically necessary to enable the enrollee to safely  
2 engage in those activities.

3 C.D. A health coverage plan may require prior authorization for prosthetic  
4 and orthotic devices and ~~prosthetic~~ services in the same manner that prior  
5 authorization is required for any other covered benefit, if such procedures are  
6 rendered in a nondiscriminatory manner. Utilization review procedures shall not  
7 deny coverage for habilitative or rehabilitative benefits, including prosthetics or  
8 custom orthotics, solely on the basis of an insured's actual or perceived disability.  
9 An insurer shall not deny a prosthetic or custom-orthotic benefit for an individual  
10 with limb loss, limb absence, or limb impairment that would otherwise be covered  
11 for a non-disabled person seeking medical or surgical intervention to restore or  
12 maintain the ability to perform the same physical activity.

13 D.E. A health coverage plan may impose co-payments, deductibles, or  
14 coinsurance amounts on prosthetic and orthotic devices and ~~prosthetic~~ services. The  
15 co-payments shall not be greater than the co-payments that apply to other benefits  
16 under the plan. ~~The repair and replacement of prosthetic devices also shall be~~  
17 ~~covered subject to co-payments, coinsurance, and deductibles that are no more~~  
18 ~~restrictive than the co-payments, coinsurance, and deductibles that apply to other~~  
19 ~~benefits under the plan, unless necessitated by misuse or loss.~~

20 F.(1) The repair and replacement of prosthetic and orthotic devices also shall  
21 be covered subject to co-payments, coinsurance, and deductibles that are no more  
22 restrictive than the co-payments, coinsurance, and deductibles that apply to other  
23 benefits under the plan, unless necessitated by ~~misuse~~ theft or loss.

24 (2) Coverage of repair or replacement of prosthetic and orthotic devices,  
25 subject to coverage as outlined in Subsection B of this Section shall meet medical  
26 necessity requirements of the health coverage plan and be recommended by the  
27 treating healthcare provider.

28 (3) The treating healthcare provider may recommend that replacement of the  
29 device is required if any of the following apply:

1           (a) There is a change in the physiological condition of the enrollee.

2           (b) There is an irreparable change in the condition of the device or any  
3 component of the device.

4           (c) The condition of the device requires repairs that are too extensive to be  
5 cost effective in accordance with the health coverage plan's guidelines.

6           G. A health plan that provides coverage for prostheses or orthoses shall  
7 ensure access to medically necessary clinical care and to prostheses and custom  
8 orthoses from not less than two distinct prosthetic and orthotic providers in the  
9 managed care plan's provider network located in the state. In the event that  
10 medically necessary covered orthoses and prostheses are not available from an  
11 in-network provider, the insurer shall provide processes to refer a member to an  
12 out-of-network provider and shall fully reimburse the out-of-network provider at a  
13 mutually agreed upon rate less member cost sharing determined on an in-network  
14 basis.

15           E.H. A health coverage plan shall include a requirement that prosthetic  
16 devices be provided by an accredited facility and a requirement that prosthetic  
17 services be prescribed by a licensed physician and provided by an accredited facility.

18           F.I. Coverage of prosthetic and orthotic devices and ~~prosthetic~~ services may  
19 be made subject to but no more restrictive than the provisions of a health coverage  
20 plan that apply to other benefits under the plan. An individual health plan that is  
21 delivered, issued for delivery, or renewed in this state that covers prostheses and  
22 custom orthoses shall consider these benefits rehabilitative and habilitative services  
23 and devices for purposes of any state or federal requirement for coverage of essential  
24 health benefits.

25           ~~G.(1) A health coverage plan may apply an annual limit of benefits payable~~  
26 ~~under this Section of no less than fifty thousand dollars per limb.~~

27           ~~(2) This Subsection does not prohibit a health benefit plan from providing~~  
28 ~~coverage that is greater or more favorable to an insured than the requirements of this~~  
29 ~~Subsection.~~

1           ~~(3) An insured may choose a prosthetic device that is priced higher than the~~  
2           ~~benefit payable under the health benefit plan and may pay the difference between the~~  
3           ~~price of the device and the benefit payable, without financial or contractual penalty~~  
4           ~~to the provider of the device.~~

5           J. A health coverage plan subject to this Section shall report to the  
6           commissioner on its experience pursuant to this Section for plan years 2027-2028.  
7           The report shall be in a form prescribed by the commissioner and shall include the  
8           number of claims and the total amount of claims paid in this state for the services  
9           required under this Section. The commissioner shall aggregate this data by plan year  
10          in a report and submit the report to the House and Senate committees on insurance  
11          no later than July 1, 2029.

12           HK. As used in the Section:

13           (1) "Accredited facility" means any entity that is accredited by the American  
14           Board for Certification in Orthotics, Prosthetics and Pedorthics (ABC) or by the  
15           Board for Orthotist/Prosthetist Certification (BOC) and that provides prosthetic  
16           devices or prosthetic services.

17           (2) "Advanced practice provider" means a healthcare professional who is  
18           licensed in this state and authorized under state law to evaluate patients and prescribe  
19           prosthetic and orthotic devices within the provider's scope of practice.

20           ~~(2)~~(3) "Health coverage plan" shall mean any hospital, health, or medical  
21           expense insurance policy, hospital or medical service contract, employee welfare  
22           benefit plan, contract or agreement with a health maintenance organization or a  
23           preferred provider organization, health and accident insurance policy, or any other  
24           insurance contract of this type, including a group insurance plan and the Office of  
25           Group Benefits programs.

26           (4) "Orthotic device" or "Orthosis" means a custom-designed,  
27           custom-fabricated, custom-fitted, or modified device to treat a neuromusculoskeletal  
28           disorder or acquired condition. For purposes of this Section, orthosis shall be limited  
29           to devices utilized for the upper or lower limbs.



1           B. Coverage includes the devices, services, materials, components,  
2           instruction, repair, and replacement as delineated in R.S. 22:1049, including but not  
3           limited to services required to restore or maintain the ability to perform activities of  
4           daily living, essential job-related functions, and medically necessary physical  
5           activity. The definitions provided in R.S. 22:1049 apply to this Section unless the  
6           context clearly requires otherwise.

7           C. Pursuant to this Section, the secretary of the Louisiana Department of  
8           Health shall do all of the following:

9                   (1) Submit to the Centers for Medicare and Medicaid Services all necessary  
10                  state plan amendments.

11                   (2) Promulgate all necessary rules and regulations in accordance with the  
12                  Administrative Procedure Act.

13                   (3) Take any other actions necessary to implement the provisions of this  
14                  Chapter.

15           Section 3. The coverage requirements provided by the provisions of this Act as  
16           enacted by Section 1 of this Act shall apply to any new health coverage plan delivered,  
17           issued for delivery or otherwise contracted for in this state beginning on or after January 1,  
18           2027. Any health coverage policy, contract, or plan in effect prior to January 1, 2027, shall  
19           convert to conform to the provisions of Section 1 of this Act upon renewal, on or before the  
20           renewal date, but no later than January 1, 2028.

21           Section 4. The report required to be compiled and submitted to the commissioner  
22           of insurance as required by the provisions of R.S. 22:1049(J) as enacted by Section 1 of this  
23           Act shall be due beginning July 1, 2029.

24           Section 5. This Act shall become effective upon signature by the governor or, if not  
25           signed by the governor, upon expiration of the time for bills to become law without signature  
26           by the governor, as provided by Article III, Section 18 of the Constitution of Louisiana. If  
27           vetoed by the governor, and subsequently approved by the legislature, this Act shall become  
28           effective on the day following such approval.

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**DIGEST**

The digest printed below was prepared by House Legislative Services. It constitutes no part of the legislative instrument. The keyword, one-liner, abstract, and digest do not constitute part of the law or proof or indicia of legislative intent. [R.S. 1:13(B) and 24:177(E)]

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HB 1235 Original

2026 Regular Session

Hebert

**Abstract:** Modifies the requirements for health insurance coverage of prosthetic and custom orthotic devices and services. Specifies medical necessity standards, expands coverage for additional devices, and sets guidelines for prior authorization, repair and replacement services, and network access. Establishes annual benefit limits, outlines reporting requirements, and definitions. Mandates Medicaid coverage for prosthetic and custom orthotic devices and services.

Present law mandates that health coverage plans provide coverage for prosthetic and orthotic devices and services. It establishes guidelines for medical necessity, cost-sharing, repair and replacement, prior authorization, and provider accreditation. Additionally, it defines key terms while outlining limitations and exceptions.

Proposed law modifies medical necessity determinations to ensure consideration of recommendations from the treating physician or advanced practice provider, as well as input from the treating orthotist or prosthetist, including the outcomes of a functional assessment.

Proposed law requires that coverage be at least equivalent to the prevailing Medicare payment rate for prosthetic and orthotic devices. Furthermore, it mandates coverage for an additional upper or lower extremity prosthetic or orthotic device, when medically necessary for physical activity, bathing, showering, or whole-body health.

Proposed law stipulates coverage for a separate bathing or showering device when neither the primary nor additional device facilitates safe bathing.

Proposed law permits prior authorization but forbids the denial of habilitative or rehabilitative benefits solely based on actual or perceived disability. Proposed law prohibits the denial of prosthetic or custom-orthotic benefits to individuals with limb loss when comparable benefits would be available to nondisabled individuals.

Proposed law allows for copayments, deductibles, and coinsurance that are no more restrictive than those applied to other benefits. Proposed law also mandates coverage for repair and replacement when medically necessary, which includes instances where the enrollee's physiological condition changes, the device is irreparably damaged, or when repair is not cost-effective.

Proposed law guarantees access to medically necessary prostheses and custom orthoses from a minimum of two distinct in-state providers. Proposed law stipulates that referral and full reimbursement (with the exception of in-network cost-sharing) is required when medically necessary devices are unavailable within the network.

Proposed law requires that prosthetic devices be supplied by an accredited facility and that prosthetic services be prescribed by a licensed physician. Proposed law stipulates that individual health plans must recognize prostheses and custom orthoses as rehabilitative and habilitative services for the purpose of essential health benefits.

Proposed law authorizes an annual benefit limit of no less than \$50,000 per limb, allowing for more favorable coverage if applicable. Furthermore, it mandates that health coverage plans report claims data for the plan years 2027-2028 to the commissioner, with aggregated reporting due to legislative committees by July 1, 2029.

Proposed law directs the Louisiana Medicaid program to provide coverage for prosthetic and custom orthotic devices and services when medically necessary. Proposed law delineates coverage for devices, services, materials, components, instruction, repair, and replacement as specified in R.S. 22:1049.

Proposed law tasks the La. Department of Health with submitting state plan amendments, promulgating rules, and undertaking necessary actions for implementation. Coverage requirements are set to take effect for new plans beginning January 1, 2027, and for existing plans upon renewal, but no later than January 1, 2028. The reporting requirements will commence on July 1, 2029.

Effective upon signature of governor or lapse of time for gubernatorial action.

(Amends R.S. 22:1049; Adds R.S. 40:1259.11)