HOUSE HEALTH AND HUMAN SERVICES COMMITTEE SUBSTITUTE FOR
HOUSE HEALTH AND HUMAN SERVICES COMMITTEE SUBSTITUTE FOR
HOUSE BILL 38

57TH LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2026

AN ACT

RELATING TO INSURANCE; AMENDING SECTIONS OF THE HEALTH CARE PURCHASING ACT AND THE NEW MEXICO INSURANCE CODE TO REQUIRE COVERAGE FOR COMPLEX REHABILITATION TECHNOLOGY DEVICES; PROVIDING THAT DENIAL OF A COMPLEX REHABILITATION TECHNOLOGY DEVICE WITH RESPECT TO A HEALTH BENEFITS PLAN IS AN UNFAIR AND DECEPTIVE PRACTICE IN CERTAIN CIRCUMSTANCES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. Section 13-7-46 NMSA 1978 (being Laws 2023, Chapter 196, Section 1) is amended to read:

"13-7-46. PROSTHETIC DEVICES--CUSTOM ORTHOTIC DEVICES--COMPLEX REHABILITATION TECHNOLOGY DEVICES--MINIMUM COVERAGE.--

A. Group health coverage, including any form of self-insurance, offered, issued or renewed under the Health Care Purchasing Act shall provide coverage for [~~prosthetics and~~

~~custom orthotics~~] prosthetic devices, custom orthotic devices and complex rehabilitation technology devices that is at least equivalent to that coverage currently provided by the federal medicare program and no less favorable than the terms and conditions that the group health plan offers for medical and surgical benefits. Covered benefits shall be provided for more than one prosthetic device or custom orthotic device when medically necessary, but shall include no more than three prosthetic devices or custom orthotic devices per affected limb per covered person; provided that if after three years, a prosthetic device or custom orthotic device is no longer the appropriate device to meet the enrollee's needs for the enrollee's preferred physical activity, coverage and payment for new or replacement devices shall not be limited to three prosthetic or custom orthotic devices per affected limb per covered person. [~~B.~~] A group health plan shall cover:

(1) the most appropriate prosthetic [~~or~~] device or custom orthotic device determined to be medically necessary by the enrollee's treating physician and associated medical providers to restore or maintain the ability to complete activities of daily living or essential job-related activities [~~and that is not solely for the comfort or convenience of the enrollee~~]. This coverage shall include all services and supplies necessary for the effective use of a prosthetic [~~or~~] device or a custom orthotic device, including:

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[~~(1)~~] (a) formulation of its design, fabrication, material and component selection, measurements, fittings and static and dynamic alignments;

[~~(2)~~] (b) all materials and components necessary to use it;

[~~(3)~~] (c) instructing the enrollee in the use of it; and

[~~(4)~~] (d) the repair and replacement of it;

(2) [~~C. A group heath plan shall cover~~] a prosthetic [~~or~~] device or a custom orthotic device determined by the enrollee's provider to be the most appropriate model that meets the medical needs of the enrollee for performing physical activities, including running, biking and swimming, and to maximize the enrollee's upper limb function. This coverage shall include all services and supplies necessary for the effective use of a prosthetic [~~or~~] device or a custom orthotic device, including:

[~~(1)~~] (a) formulation of its design, fabrication, material and component selection, measurements, fittings and static and dynamic alignments;

[~~(2)~~] (b) all materials and components necessary to use it;

[~~(3)~~] (c) instructing the enrollee in the use of it; and

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[~~(4)~~] (d) the repair and replacement of it; and

(3) a prosthetic device or custom orthotic device determined by the enrollee's prosthetic or orthotic care provider to be the most appropriate prosthetic device or custom orthotic device that meets the medical needs of the enrollee for purposes of showering or bathing.

B. Coverage for complex rehabilitation technology devices shall be based on an enrollee's specific medical, physical, functional and environmental needs and capacities to engage in normal life activities and shall allow an enrollee to obtain more than one complex rehabilitation technology device, but no more than two complex rehabilitation technology devices per covered person; provided that if after three years, a complex rehabilitation technology device is no longer the appropriate device to meet the enrollee's needs for the enrollee's preferred physical activity, coverage and payment for new or replacement devices shall not be limited to two complex rehabilitation technology devices per covered person. A group health plan shall cover:

(1) complex rehabilitation technology devices for daily use that meet the enrollee's mobility and positioning needs;

(2) complex rehabilitation technology devices to enable the enrollee to participate in physical activities

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necessary to achieve or maintain health goals; and

(3) all services and supplies necessary for the effective use of a complex rehabilitation technology device, including:

(a) configuring, fitting, programming, adjusting or adapting the particular device for use by a person, including the formulation of the device's design, fabrication, material and component selection and measurements;

(b) all materials and components necessary to use the device;

(c) instructing the enrollee in the use of the device; and

(d) the repair and replacement of the device.

[~~D.~~] C. A group health plan's reimbursement rate for prosthetic [~~and~~] devices, custom orthotic devices or complex rehabilitation technology devices shall be at least equivalent to that currently provided by the federal medicare program and no more restrictive than other coverage under the group health plan.

[~~E.~~] D. Prosthetic [~~and~~] device, custom orthotic device or complex rehabilitation technology device coverage shall be comparable to coverage for other medical and surgical benefits under the group health plan, including restorative internal devices such as internal prosthetic devices, and shall

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not be subject to spending limits or lifetime restrictions.

[~~F.~~] E. Prosthetic [~~and~~] device, custom orthotic device or complex rehabilitation technology device coverage shall not be subject to separate financial requirements that are applicable only with respect to that coverage. A group health plan may impose cost sharing on prosthetic [~~or~~] devices, custom orthotic devices or complex rehabilitation technology devices; provided that any cost-sharing requirements shall not be more restrictive than the cost-sharing requirements applicable to the plan's medical and surgical benefits, including those for internal devices.

[~~G.~~] F. A group health plan may limit the coverage for, or alter the cost-sharing requirements for, out-of-network coverage of prosthetic [~~and~~] devices, custom orthotic devices or complex rehabilitation technology devices; provided that the restrictions and cost-sharing requirements applicable to prosthetic [~~or~~] devices, custom orthotic devices or complex rehabilitation technology devices shall not be more restrictive than the restrictions and requirements applicable to the out-of-network coverage for a group health plan's medical and surgical coverage.

[~~H.~~] G. In the event that medically necessary covered [~~orthotics and prosthetics~~] prosthetic devices, custom orthotic devices or complex rehabilitation technology devices are not available from an in-network provider, the insurer

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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.

[~~I.~~] H. A group health plan shall not impose any annual or lifetime dollar maximum on coverage for prosthetic [~~or~~] devices, custom orthotic devices or complex rehabilitation technology devices other than an annual or lifetime dollar maximum that applies in the aggregate to all terms and services covered under the group health plan.

[~~J.~~] I. If coverage is provided through a managed care plan, an enrollee shall have access to medically necessary clinical care and to prosthetic [~~and~~] devices, custom orthotic devices or complex rehabilitation technology devices and technology from not less than two distinct prosthetic [~~and~~] device, custom orthotic device or complex rehabilitation technology device providers in the managed care plan's provider network located in the state.

[~~K.~~] J. Coverage for prosthetic [~~and~~] devices, custom orthotic devices or complex rehabilitation technology devices shall be considered habilitative or rehabilitative benefits for purposes of any state or federal requirement for coverage of essential health benefits, including habilitative and rehabilitative benefits.

[~~L.~~] K. If coverage for prosthetic [~~or~~] devices,

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custom orthotic devices or complex rehabilitation technology devices is provided, payment shall be made for the replacement of a prosthetic [~~or~~] device, a custom orthotic device or a complex rehabilitation technology 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 such a device, is necessary because of any of the following:

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

(2) 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.

L. A complex rehabilitation technology device that is a manual or power wheelchair shall only be covered pursuant to this section if the:

(1) enrollee has undergone a complex rehabilitation technology device evaluation conducted by a licensed physical therapist or occupational therapist who has no financial relationship with the supplier of the complex rehabilitation technology device; and

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(2) complex rehabilitation technology device is provided by a complex rehabilitation technology device supplier that:

(a) employs at least one assistive technology professional certified by the rehabilitation engineering and assistive technology society of North America who specialized in seating, positioning and mobility and has direct, in-person involvement in the wheelchair selection for the enrollee; and

(b) makes at least one qualified complex rehabilitation technology device service technician available in each service area served by the supplier to service and repair devices that are furnished by the supplier.

M. Confirmation from a prescribing health care provider may be required if the prosthetic [~~or~~] device, custom orthotic device or complex rehabilitation technology device or part being replaced is less than three years old.

N. A group health plan subject to the Health Care Purchasing Act shall not discriminate against individuals based on disability, including limb loss, absence or malformation.

O. As used in this section, "complex rehabilitation technology device" means a subset of durable medical equipment that:

(1) consists of complex rehabilitation manual and power wheelchairs and mobility devices, including

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specialized seating and positioning items, options and accessories;

(2) is designed, manufactured, configured, adjusted or modified for a specific person to meet that person's unique medical, physical, functional and environmental needs and capacities;

(3) is generally not useful to a person in the absence of a disability, illness, injury or other medical condition; and

(4) requires specialized services to ensure appropriate use of the item, including:

(a) an evaluation of the features and functions necessary to assist the person who will use the device; or

(b) configuring, fitting, programming, adjusting or adapting the particular device for use by a person."

SECTION 2. Section 59A-16-21.4 NMSA 1978 (being Laws 2023, Chapter 196, Section 2) is amended to read:

"59A-16-21.4. UNFAIR TRADE PRACTICES ON THE BASIS OF DISABILITY PROHIBITED.--

A. Any of the following practices with respect to a health benefits plan are defined as unfair and deceptive practices and are prohibited:

(1) canceling or changing the premiums,

benefits or conditions of a health benefits plan on the basis of an insured's actual or perceived disability;

(2) denying a prosthetic [~~or~~] device, a custom orthotic device or a complex rehabilitation technology device benefit for [~~an individual with limb loss or absence~~] a person with limb loss, limb absence or mobility limitation that would otherwise be covered for a non-disabled person seeking medical or surgical intervention to restore or maintain the ability to perform the same physical activity;

(3) failure 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~~] device, custom orthotic device or complex rehabilitation technology device benefits; and

(4) failure 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 benefit denial.

B. For purposes of this section:

(1) "complex rehabilitation technology device" means a subset of durable medical equipment that:

(a) consists of complex rehabilitation manual and power wheelchairs and mobility devices, including

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specialized seating and positioning items, options and accessories;

(b) is designed, manufactured, configured, adjusted or modified for a specific person to meet that person's unique medical, physical, functional and environmental needs and capacities;

(c) is generally not useful to a person in the absence of a disability, illness, injury or other medical condition; and

(d) requires specialized services to ensure appropriate use of the item, including: 1) an evaluation of the features and functions necessary to assist the person who will use the device; or 2) configuring, fitting, programming, adjusting or adapting the particular device for use by a person; and

(2) "health benefits plan" means a policy or agreement entered into, offered or issued by a health insurance carrier to provide, deliver, arrange for, pay for or reimburse the costs of health care services; provided that "health benefits plan" does not include the following:

[~~(1)~~] (a) an accident-only policy;

[~~(2)~~] (b) a credit-only policy;

[~~(3)~~] (c) a long- or short-term care or disability income policy;

[~~(4)~~] (d) a specified disease policy;

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[~~(5)~~] (e) coverage provided pursuant to Title 18 of the federal Social Security Act, as amended;

[~~(6)~~] (f) coverage provided pursuant to Title 19 of the federal Social Security Act and the Public Assistance Act;

[~~(7)~~] (g) a federal TRICARE policy, including a federal civilian health and medical program of the uniformed services supplement;

[~~(8)~~] (h) a fixed or hospital indemnity policy;

[~~(9)~~] (i) a dental-only policy;

[~~(10)~~] (j) a vision-only policy;

[~~(11)~~] (k) a workers' compensation policy;

[~~(12)~~] (l) an automobile medical payment policy; or

[~~(13)~~] (m) any other policy specified in rules of the superintendent."

SECTION 3. Section 59A-22-62 NMSA 1978 (being Laws 2023, Chapter 196, Section 3) is amended to read:

"59A-22-62. MEDICAL NECESSITY AND NONDISCRIMINATION STANDARDS FOR COVERAGE OF [~~PROSTHETICS OR ORTHOTICS~~] PROSTHETIC DEVICES, CUSTOM ORTHOTIC DEVICES OR COMPLEX REHABILITATION TECHNOLOGY DEVICES.--

A. An individual health plan that is delivered,

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issued for delivery or renewed in this state that offers coverage for prosthetic [~~and~~] devices, custom orthotic devices or complex rehabilitation technology devices shall consider these benefits habilitative or rehabilitative benefits for purposes of any state or federal requirement for coverage of essential health benefits.

B. When performing a utilization review for a request for coverage of prosthetic [~~or~~] device, custom orthotic device or complex rehabilitation technology device benefits, an insurer shall apply the most recent version of evidence-based treatment and fit criteria as recognized by relevant clinical specialists or their organizations. Such standards may be named by the superintendent in rule.

C. An insurer shall render utilization review determinations in a nondiscriminatory manner and shall not deny coverage for habilitative or rehabilitative benefits, including [~~prosthetics or orthotics~~] prosthetic devices, custom orthotic devices or complex rehabilitation technology devices, solely on the basis of an insured's actual or perceived disability.

D. An insurer shall not deny a prosthetic [~~or~~] device, a custom orthotic device or a complex rehabilitation technology device benefit for [~~an individual with limb loss or absence~~] a person with limb loss, limb absence or mobility limitation that would otherwise be covered for a non-disabled person seeking medical or surgical intervention to restore or

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maintain the ability to perform the same physical activity.

E. [~~A~~] An individual health [~~benefits~~] plan that is delivered, issued for delivery or renewed in this state that offers coverage for [~~prosthetics and~~] prosthetic devices, custom orthotic devices or complex rehabilitation technology devices shall include language describing an insured's rights pursuant to Subsections C and D of this section in its evidence of coverage and any benefit denial letters.

F. Prosthetic [~~and~~] device, custom orthotic device or complex rehabilitation technology device coverage shall not be subject to separate financial requirements that are applicable only with respect to that coverage. An individual health plan may impose cost sharing on prosthetic [~~or~~] devices, custom orthotic devices or complex rehabilitation technology devices; provided that any cost-sharing requirements shall not be more restrictive than the cost-sharing requirements applicable to the plan's coverage for inpatient physician and surgical services.

G. [~~A~~] An individual health plan that provides coverage for [~~prosthetic or orthotic~~] services related to prosthetic devices, custom orthotic devices or complex rehabilitation technology devices shall ensure access to medically necessary clinical care and to prosthetic [~~and~~] devices, custom orthotic devices or complex rehabilitation technology devices and technology from not less than two

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distinct prosthetic [~~and~~] device, custom orthotic device or complex rehabilitation technology device providers in the [~~managed care~~] plan's provider network located in the state. In the event that medically necessary covered [~~orthotics and prosthetics~~] prosthetic devices, custom orthotic devices or complex rehabilitation technology devices are not available from an in-network provider, the insurer shall provide processes to refer [~~a member~~] an insured to an out-of-network provider and shall fully reimburse the out-of-network provider at a mutually agreed upon rate less [~~member~~] insured cost sharing determined on an in-network basis.

H. If coverage for prosthetic [~~or~~] devices, custom orthotic devices or complex rehabilitation technology devices is provided, payment shall be made for the replacement of a prosthetic [~~or~~] device, a custom orthotic device or a complex rehabilitation technology 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 such a device, is necessary because of any of the following:

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

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

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(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.

I. Covered benefits for prosthetic devices and custom orthotic devices shall provide for more than one prosthetic device or custom orthotic device when medically necessary, but shall include no more than three prosthetic devices or custom orthotic devices per affected limb per covered person; provided that if after three years, a prosthetic device or custom orthotic device is no longer the appropriate device to meet the insured's needs for the insured's preferred physical activity, coverage and payment for new or replacement devices shall not be limited to three prosthetic or custom orthotic devices per affected limb per covered person. An individual health plan shall cover:

(1) the most appropriate prosthetic device or custom orthotic device determined to be medically necessary by the insured's treating physician and associated medical providers to restore or maintain the ability to complete activities of daily living or essential job-related activities. This coverage shall include all services and supplies necessary for the effective use of a prosthetic device or a custom orthotic device, including:

(a) formulation of the device's design,

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fabrication, material and component selection, measurements, fittings and static and dynamic alignments;

(b) all materials and components necessary to use the device;

(c) instructing the insured in the use of the device; and

(d) the repair and replacement of the device;

(2) a prosthetic device or a custom orthotic device determined by the insured's provider to be the most appropriate model that meets the medical needs of the insured for performing physical activities, including running, biking and swimming, and to maximize the insured's upper limb function. This coverage shall include all services and supplies necessary for the effective use of a prosthetic device or a custom orthotic device, including:

(a) formulation of the device's design, fabrication, material and component selection, measurements, fittings and static and dynamic alignments;

(b) all materials and components necessary to use the device;

(c) instructing the insured in the use of the device; and

(d) the repair and replacement of the device; and

(3) a prosthetic device or custom orthotic device determined by the insured's prosthetic or orthotic care provider to be the most appropriate prosthetic device or custom orthotic device that meets the medical needs of the insured for purposes of showering or bathing.

J. Coverage for complex rehabilitation technology devices shall be based on an insured's specific medical, physical, functional and environmental needs and capacities to engage in normal life activities and shall allow an insured to obtain more than one complex rehabilitation technology device, but no more than two complex rehabilitation technology devices per covered person; provided that if after three years, a complex rehabilitation technology device is no longer the appropriate device to meet the insured's needs for the insured's preferred physical activity, coverage and payment for new or replacement devices shall not be limited to two complex rehabilitation technology devices per covered person. An individual health plan shall cover:

(1) complex rehabilitation technology devices for daily use that meets the insured's mobility and positioning needs;

(2) complex rehabilitation technology devices to enable the insured to participate in physical activities necessary to achieve or maintain health goals; and

(3) all services and supplies necessary for

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the effective use of a complex rehabilitation technology device, including:

(a) configuring, fitting, programming, adjusting or adapting the particular device for use by a person, including the formulation of the device's design, fabrication, material and component selection and measurements;

(b) all materials and components necessary to use the device;

(c) instructing the insured in the use of the device; and

(d) the repair and replacement of the device.

K. A complex rehabilitation technology device that is a manual or power wheelchair shall only be covered pursuant to this section if the:

(1) insured has undergone a complex rehabilitation technology device evaluation conducted by a licensed physical therapist or occupational therapist who has no financial relationship with the supplier of the complex rehabilitation technology device; and

(2) complex rehabilitation technology device is provided by a complex rehabilitation technology device supplier that:

(a) employs at least one assistive technology professional certified by the rehabilitation

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engineering and assistive technology society of North America who specialized in seating, positioning and mobility and has direct, in-person involvement in the wheelchair selection for the insured; and

(b) makes at least one qualified complex rehabilitation technology device service technician available in each service area served by the supplier to service and repair devices that are furnished by the supplier.

[~~I.~~] L. Confirmation from a prescribing health care provider may be required if the prosthetic [~~or~~] device, custom orthotic device or complex rehabilitation technology device or part being replaced is less than three years old.

[~~J.~~] M. The provisions of this section do not apply to excepted benefits plans subject to the Short-Term Health Plan and Excepted Benefit Act.

N. As used in this section, "complex rehabilitation technology device" means a subset of durable medical equipment that:

(1) consists of complex rehabilitation manual and power wheelchairs and mobility devices, including specialized seating and positioning items, options and accessories;

(2) is designed, manufactured, configured, adjusted or modified for a specific person to meet that person's unique medical, physical, functional and environmental

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needs and capacities;

(3) is generally not useful to a person in the absence of a disability, illness, injury or other medical condition; and

(4) requires specialized services to ensure appropriate use of the item, including:

(a) an evaluation of the features and functions necessary to assist the person who will use the device; or

(b) configuring, fitting, programming, adjusting or adapting the particular device for use by a person."

SECTION 4. Section 59A-23-32 NMSA 1978 (being Laws 2023, Chapter 196, Section 4) is amended to read:

"59A-23-32. MEDICAL NECESSITY AND NONDISCRIMINATION STANDARDS FOR COVERAGE OF [~~PROSTHETICS AND ORTHOTICS~~] PROSTHETIC DEVICES, CUSTOM ORTHOTIC DEVICES OR COMPLEX REHABILITATION TECHNOLOGY DEVICES.--

A. A group health plan that is delivered, issued for delivery or renewed in this state that covers essential health benefits or covers prosthetic [~~and~~] devices, custom orthotic devices or complex rehabilitation technology devices shall consider these benefits habilitative or rehabilitative benefits for purposes of state or federal requirements on essential health benefits coverage.

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B. When performing a utilization review for a request for coverage of prosthetic [~~or~~] device, custom orthotic device or complex rehabilitation technology device benefits, an insurer shall apply the most recent version of evidence-based treatment and fit criteria as recognized by relevant clinical specialists or their organizations. Such standards may be named by the superintendent in rule.

C. An insurer shall render utilization review determinations in a nondiscriminatory manner and shall not deny coverage for habilitative or rehabilitative benefits, including [~~prosthetics or orthotics~~] prosthetic devices, custom orthotic devices or complex rehabilitation technology devices, solely based on an insured's actual or perceived disability.

D. An insurer shall not deny a prosthetic [~~or~~] device, a custom orthotic device or a complex rehabilitation technology device benefit for [~~an individual with limb loss or absence~~] a person with limb loss, limb absence or mobility limitation that would otherwise be covered for a non-disabled person seeking medical or surgical intervention to restore or maintain the ability to perform the same physical activity.

E. A group health [~~benefits~~] plan that is delivered, issued for delivery or renewed in this state that offers coverage for [~~prosthetics and~~] prosthetic devices, custom orthotic devices or complex rehabilitation technology devices shall include language describing an insured's rights

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pursuant to Subsections C and D of this section in its evidence of coverage and any benefit denial letters.

F. Prosthetic [~~and~~] device, custom orthotic device or complex rehabilitation technology device coverage shall not be subject to separate financial requirements that are applicable only with respect to that coverage. A group health plan may impose cost sharing on prosthetic [~~or~~] devices, custom orthotic devices or complex rehabilitation technology devices; provided that any cost-sharing requirements shall not be more restrictive than the cost-sharing requirements applicable to the plan's coverage for inpatient physician and surgical services.

G. A group health plan that provides coverage for [~~prosthetic or orthotic~~] services related to prosthetic devices, custom orthotic devices or complex rehabilitation technology devices shall ensure access to medically necessary clinical care and to prosthetic [~~and~~] devices, custom orthotic devices or complex rehabilitation technology devices and technology from not less than two distinct prosthetic [~~and~~] device, custom orthotic device or complex rehabilitation technology device providers in the [~~managed care~~] plan's provider network located in the state. In the event that medically necessary covered [~~orthotics and prosthetics~~] prosthetic devices, custom orthotic devices or complex rehabilitation technology devices are not available from an in-

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network provider, the insurer shall provide processes to refer [~~a member~~] an insured to an out-of-network provider and shall fully reimburse the out-of-network provider at a mutually agreed upon rate less [~~member~~] insured cost sharing determined on an in-network basis.

H. If coverage for prosthetic [~~or~~] devices, custom orthotic devices or complex rehabilitation technology devices is provided, payment shall be made for the replacement of a prosthetic [~~or~~] device, a custom orthotic device or a complex rehabilitation technology 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 such a device, is necessary because of any of the following:

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

(2) 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.

I. Covered benefits for prosthetic devices and custom orthotic devices shall provide for more than one

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prosthetic device or custom orthotic device when medically necessary, but shall include no more than three prosthetic devices or custom orthotic devices per affected limb per covered person; provided that if after three years, a prosthetic device or custom orthotic device is no longer the appropriate device to meet the insured's needs for the insured's preferred physical activity, coverage and payment for new or replacement devices shall not be limited to three prosthetic or custom orthotic devices per affected limb per covered person. A group health plan shall cover:

(1) the most appropriate prosthetic device or custom orthotic device determined to be medically necessary by the insured's treating physician and associated medical providers to restore or maintain the ability to complete activities of daily living or essential job-related activities. This coverage shall include all services and supplies necessary for the effective use of a prosthetic device or a custom orthotic device, including:

(a) formulation of the device's design, fabrication, material and component selection, measurements, fittings and static and dynamic alignments;

(b) all materials and components necessary to use the device;

(c) instructing the insured in the use of the device; and

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(d) the repair and replacement of the device;

(2) a prosthetic device or a custom orthotic device determined by the insured's provider to be the most appropriate model that meets the medical needs of the insured for performing physical activities, including running, biking and swimming, and to maximize the insured's upper limb function. This coverage shall include all services and supplies necessary for the effective use of a prosthetic device or a custom orthotic device, including:

(a) formulation of the device's design, fabrication, material and component selection, measurements, fittings and static and dynamic alignments;

(b) all materials and components necessary to use the device;

(c) instructing the insured in the use of the device; and

(d) the repair and replacement of the device; and

(3) a prosthetic device or custom orthotic device determined by the insured's prosthetic or orthotic care provider to be the most appropriate prosthetic device or custom orthotic device that meets the medical needs of the insured for purposes of showering or bathing.

J. Coverage for complex rehabilitation technology

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devices shall be based on an insured's specific medical, physical, functional and environmental needs and capacities to engage in normal life activities and shall allow an insured to obtain more than one complex rehabilitation technology device, but no more than two complex rehabilitation technology devices per covered person; provided that if after three years, a complex rehabilitation technology device is no longer the appropriate device to meet the insured's needs for the insured's preferred physical activity, coverage and payment for new or replacement devices shall not be limited to two complex rehabilitation technology devices per covered person. A group health plan shall cover:

(1) complex rehabilitation technology devices for daily use that meet the insured's mobility and positioning needs;

(2) complex rehabilitation technology devices to enable the insured to participate in physical activities necessary to achieve or maintain health goals; and

(3) all services and supplies necessary for the effective use of a complex rehabilitation technology device, including:

(a) configuring, fitting, programming, adjusting or adapting the particular device for use by a person, including the formulation of the device's design, fabrication, material and component selection and measurements;

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(b) all materials and components necessary to use the device;

(c) instructing the insured in the use of the device; and

(d) the repair and replacement of the device.

K. A complex rehabilitation technology device that is a manual or power wheelchair shall only be covered pursuant to this section if the:

(1) insured has undergone a complex rehabilitation technology device evaluation conducted by a licensed physical therapist or occupational therapist who has no financial relationship with the supplier of the complex rehabilitation technology device; and

(2) complex rehabilitation technology device is provided by a complex rehabilitation technology device supplier that:

(a) employs at least one assistive technology professional certified by the rehabilitation engineering and assistive technology society of North America who specialized in seating, positioning and mobility and has direct, in-person involvement in the wheelchair selection for the insured; and

(b) makes at least one qualified complex rehabilitation technology device service technician available

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in each service area served by the supplier to service and repair devices that are furnished by the supplier.

[~~I.~~] L. Confirmation from a prescribing health care provider may be required if the prosthetic [~~or~~] device, custom orthotic device or complex rehabilitation technology device or part being replaced is less than three years old.

[~~J.~~] M. The provisions of this section do not apply to excepted benefits plans subject to the Short-Term Health Plan and Excepted Benefit Act.

N. As used in this section, "complex rehabilitation technology device" means a subset of durable medical equipment that:

(1) consists of complex rehabilitation manual and power wheelchairs and mobility devices, including specialized seating and positioning items, options and accessories;

(2) is designed, manufactured, configured, adjusted or modified for a specific person to meet that person's unique medical, physical, functional and environmental needs and capacities;

(3) is generally not useful to a person in the absence of a disability, illness, injury or other medical condition; and

(4) requires specialized services to ensure appropriate use of the item, including:

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(a) an evaluation of the features and functions necessary to assist the person who will use the device; or

(b) configuring, fitting, programming, adjusting or adapting the particular device for use by a person."

SECTION 5. Section 59A-46-72 NMSA 1978 (being Laws 2023, Chapter 196, Section 5) is amended to read:

"59A-46-72. MEDICAL NECESSITY AND NONDISCRIMINATION STANDARDS FOR COVERAGE OF [~~PROSTHETICS AND ORTHOTICS~~] PROSTHETIC DEVICES, CUSTOM ORTHOTIC DEVICES OR COMPLEX REHABILITATION TECHNOLOGY DEVICES.--

A. An individual or group health maintenance organization contract that is delivered, issued for delivery or renewed in this state that covers essential health benefits and covers prosthetic [~~and~~] devices, custom orthotic devices or complex rehabilitation technology devices shall consider these benefits habilitative or rehabilitative benefits for purposes of state or federal requirements on essential health benefits coverage.

B. When performing a utilization review for a request for coverage of prosthetic [~~or~~] device, custom orthotic device or complex rehabilitation technology device benefits, [~~an insurer~~] a health maintenance organization shall apply the most recent version of evidence-based treatment and fit

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criteria as recognized by relevant clinical specialists or their organizations. Such standards may be named by the superintendent in rule.

C. [~~An insurer~~] A health maintenance organization shall render utilization review determinations in a nondiscriminatory manner and shall not deny coverage for habilitative or rehabilitative benefits, including [~~prosthetics or orthotics~~] prosthetic devices, custom orthotic devices or complex rehabilitation technology devices, solely based on an [~~insured's~~] enrollee's actual or perceived disability.

D. [~~An insurer~~] A health maintenance organization shall not deny a prosthetic [~~or~~] device, a custom orthotic device a or complex rehabilitation technology device benefit for [~~an individual with limb loss or absence~~] a person with limb loss, limb absence or mobility limitation that would otherwise be covered for a non-disabled person seeking medical or surgical intervention to restore or maintain the ability to perform the same physical activity.

E. [~~A health benefits plan~~] An individual or group health maintenance organization contract that is delivered, issued for delivery or renewed in this state that offers coverage for [~~prosthetics and~~] prosthetic devices, custom orthotic devices or complex rehabilitation technology devices shall include language describing an [~~insured's~~] enrollee's rights pursuant to Subsections C and D of this section in its

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evidence of coverage and any benefit denial letters.

F. Prosthetic [~~and~~] device, custom orthotic device or complex rehabilitation technology device coverage shall not be subject to separate financial requirements that are applicable only with respect to that coverage. An individual or group health [~~plan~~] maintenance organization contract may impose cost sharing on prosthetic [~~or~~] devices, custom orthotic devices or complex rehabilitation technology devices; provided that any cost-sharing requirements shall not be more restrictive than the cost-sharing requirements applicable to the plan's coverage for inpatient physician and surgical services.

G. An individual or group health [~~plan~~] maintenance organization contract that provides coverage for [~~prosthetic or orthotic~~] services related to prosthetic devices, custom orthotic devices or complex rehabilitation technology devices shall ensure access to medically necessary clinical care and to prosthetic [~~and~~] devices, custom orthotic devices or complex rehabilitation technology devices and technology from not less than two distinct prosthetic [~~and~~] device, custom orthotic device or complex rehabilitation technology device providers in the managed care plan's provider network located in the state. In the event that medically necessary covered [~~orthotics and prosthetics~~] prosthetic devices, custom orthotic devices or complex rehabilitation technology devices are not available

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from an in-network provider, the [~~insurer~~] health maintenance organization shall provide processes to refer [~~a member~~] an enrollee to an out-of-network provider and shall fully reimburse the out-of-network provider at a mutually agreed upon rate less [~~member~~] enrollee cost sharing determined on an in-network basis.

H. If coverage for prosthetic [~~or~~] devices, custom orthotic devices or complex rehabilitation technology devices is provided, payment shall be made for the replacement of a prosthetic [~~or~~] device, a custom orthotic device or a complex rehabilitation technology 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 such a device, is necessary because of any of the following:

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

(2) 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.

I. Covered benefits for prosthetic devices and

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custom orthotic devices shall provide for more than one prosthetic device or custom orthotic device when medically necessary, but shall include no more than three prosthetic devices or custom orthotic devices per affected limb per covered person; provided that if after three years, a prosthetic device or custom orthotic device is no longer the appropriate device to meet the enrollee's needs for the enrollee's preferred physical activity, coverage and payment for new or replacement devices shall not be limited to three prosthetic or custom orthotic devices per affected limb per covered person. An individual or group health maintenance organization contract shall cover:

(1) the most appropriate prosthetic device or custom orthotic device determined to be medically necessary by the enrollee's treating physician and associated medical providers to restore or maintain the ability to complete activities of daily living or essential job-related activities. This coverage shall include all services and supplies necessary for the effective use of a prosthetic device or a custom orthotic device, including:

(a) formulation of the device's design, fabrication, material and component selection, measurements, fittings and static and dynamic alignments;

(b) all materials and components necessary to use the device;

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(c) instructing the enrollee in the use of the device; and

(d) the repair and replacement of the device;

(2) a prosthetic device or a custom orthotic device determined by the enrollee's provider to be the most appropriate model that meets the medical needs of the enrollee for performing physical activities, including running, biking and swimming, and to maximize the enrollee's upper limb function. This coverage shall include all services and supplies necessary for the effective use of a prosthetic device or a custom orthotic device, including:

(a) formulation of the device's design, fabrication, material and component selection, measurements, fittings and static and dynamic alignments;

(b) all materials and components necessary to use the device;

(c) instructing the enrollee in the use of the device; and

(d) the repair and replacement of the device; and

(3) a prosthetic device or custom orthotic device determined by the enrollee's prosthetic or orthotic care provider to be the most appropriate prosthetic device or custom orthotic device that meets the medical needs of the enrollee

for purposes of showering or bathing.

J. Coverage for complex rehabilitation technology devices shall be based on an enrollee's specific medical, physical, functional and environmental needs and capacities to engage in normal life activities and shall allow an enrollee to obtain more than one complex rehabilitation technology device, but no more than two complex rehabilitation technology devices per covered person; provided that if after three years, a complex rehabilitation technology device is no longer the appropriate device to meet the enrollee's needs for the enrollee's preferred physical activity, coverage and payment for new or replacement devices shall not be limited to two complex rehabilitation technology devices per covered person. An individual or group health maintenance organization contract shall cover:

(1) complex rehabilitation technology devices for daily use that meets the enrollee's mobility and positioning needs;

(2) complex rehabilitation technology devices to enable the enrollee to participate in physical activities necessary to achieve or maintain health goals; and

(3) all services and supplies necessary for the effective use of a complex rehabilitation technology device, including:

(a) configuring, fitting, programming,

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adjusting or adapting the particular device for use by a person, including the formulation of the device's design, fabrication, material and component selection and measurements;

(b) all materials and components necessary to use the device;

(c) instructing the enrollee in the use of the device; and

(d) the repair and replacement of the device.

K. A complex rehabilitation technology device that is a manual or power wheelchair shall only be covered pursuant to this section if the:

(1) enrollee has undergone a complex rehabilitation technology device evaluation conducted by a licensed physical therapist or occupational therapist who has no financial relationship with the supplier of the complex rehabilitation technology device; and

(2) complex rehabilitation technology device is provided by a complex rehabilitation technology device supplier that:

(a) employs at least one assistive technology professional certified by the rehabilitation engineering and assistive technology society of North America who specialized in seating, positioning and mobility and has direct, in-person involvement in the wheelchair selection for

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the enrollee; and

(b) makes at least one qualified complex rehabilitation technology device service technician available in each service area served by the supplier to service and repair devices that are furnished by the supplier.

[~~I.~~] L. Confirmation from a prescribing health care provider may be required if the prosthetic [~~or~~] device, custom orthotic device or complex rehabilitation technology device or part being replaced is less than three years old.

[~~J.~~] M. The provisions of this section do not apply to excepted benefits plans subject to the Short-Term Health Plan and Excepted Benefit Act.

N. As used in this section, "complex rehabilitation technology device" means a subset of durable medical equipment that:

(1) consists of complex rehabilitation manual and power wheelchairs and mobility devices, including specialized seating and positioning items, options and accessories;

(2) is designed, manufactured, configured, adjusted or modified for a specific person to meet that person's unique medical, physical, functional and environmental needs and capacities;

(3) is generally not useful to a person in the absence of a disability, illness, injury or other medical

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condition; and

(4) requires specialized services to ensure appropriate use of the item, including:

(a) an evaluation of the features and functions necessary to assist the person who will use the device; or

(b) configuring, fitting, programming, adjusting or adapting the particular device for use by a person."

SECTION 6. Section 59A-47-66 NMSA 1978 (being Laws 2023, Chapter 196, Section 6) is amended to read:

"59A-47-66. MEDICAL NECESSITY AND NONDISCRIMINATION STANDARDS FOR COVERAGE OF [~~PROSTHETICS AND ORTHOTICS~~] PROSTHETIC DEVICES, CUSTOM ORTHOTIC DEVICES OR COMPLEX REHABILITATION TECHNOLOGY DEVICES.--

A. An individual or group health care plan that is delivered, issued for delivery or renewed in this state that covers essential health benefits and covers prosthetic [~~and~~] devices, custom orthotic devices or complex rehabilitation technology devices shall consider these benefits habilitative or rehabilitative benefits for purposes of state or federal requirements on essential health benefits coverage.

B. When performing a utilization review for a request for coverage of prosthetic [~~or~~] device, custom orthotic device or complex rehabilitation technology device benefits,

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[~~an insurer~~] a health care plan shall apply the most recent version of evidence-based treatment and fit criteria as recognized by relevant clinical specialists or their organizations. Such standards may be named by the superintendent in rule.

C. [~~An insurer~~] A health care plan shall render utilization review determinations in a nondiscriminatory manner and shall not deny coverage for habilitative or rehabilitative benefits, including [~~prosthetics or orthotics~~] prosthetic devices, custom orthotic devices or complex rehabilitation technology devices, solely based on [~~an insured's~~] a subscriber's actual or perceived disability.

D. [~~An insurer~~] A health care plan shall not deny a prosthetic [~~or~~] device, a custom orthotic device or a complex rehabilitation technology device benefit for [~~an individual with limb loss, or absence~~] a person with limb loss, limb absence or mobility limitation that would otherwise be covered for a non-disabled person seeking medical or surgical intervention to restore or maintain the ability to perform the same physical activity.

E. A health [~~benefits~~] care plan that is delivered, issued for delivery or renewed in this state that offers coverage for [~~prosthetics and~~] prosthetic devices, custom orthotic devices or complex rehabilitation technology devices shall include language describing an [~~insured's~~] a subscriber's

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rights pursuant to Subsections C and D of this section in its evidence of coverage and any benefit denial letters.

F. Prosthetic [~~and~~] device, custom orthotic device or complex rehabilitation technology device coverage shall not be subject to separate financial requirements that are applicable only with respect to that coverage. An individual or group health care plan may impose cost sharing on prosthetic [~~or~~] devices, custom orthotic devices or complex rehabilitation technology devices; provided that any cost-sharing requirements shall not be more restrictive than the cost-sharing requirements applicable to the plan's coverage for inpatient physician and surgical services.

G. An individual or group health care plan that provides coverage for [~~prosthetic or orthotic~~] services related to prosthetic devices, custom orthotic devices or complex rehabilitation technology devices shall ensure access to medically necessary clinical care and to prosthetic [~~and~~] devices, custom orthotic devices or complex rehabilitation technology devices and technology from not less than two distinct prosthetic [~~and~~] device, custom orthotic device or complex rehabilitation technology device providers in the [~~managed~~] health care plan's provider network located in the state. In the event that medically necessary covered [~~orthotics and prosthetics~~] prosthetic devices, custom orthotic devices or complex rehabilitation technology devices are not

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available from an in-network provider, the [~~insurer~~] health care plan shall provide processes to refer a [~~member~~] subscriber to an out-of-network provider and shall fully reimburse the out-of-network provider at a mutually agreed upon rate less [~~member~~] subscriber cost sharing determined on an in-network basis.

H. If coverage for prosthetic [~~or~~] devices, custom orthotic devices or complex rehabilitation technology devices is provided, payment shall be made for the replacement of a prosthetic [~~or~~] device, a custom orthotic device or a complex rehabilitation technology 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 such a device, is necessary because of any of the following:

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

(2) 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.

I. Covered benefits for prosthetic devices and

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custom orthotic devices shall provide for more than one prosthetic device or custom orthotic device when medically necessary, but shall include no more than three prosthetic devices or custom orthotic devices per affected limb per covered person; provided that if after three years, a prosthetic device or custom orthotic device is no longer the appropriate device to meet the subscriber's needs for the subscriber's preferred physical activity, coverage and payment for new or replacement devices shall not be limited to three prosthetic or custom orthotic devices per affected limb per covered person. A health care plan shall cover:

(1) the most appropriate prosthetic device or custom orthotic device determined to be medically necessary by the subscriber's treating physician and associated medical providers to restore or maintain the ability to complete activities of daily living or essential job-related activities. This coverage shall include all services and supplies necessary for the effective use of a prosthetic device or a custom orthotic device, including:

(a) formulation of the device's design, fabrication, material and component selection, measurements, fittings and static and dynamic alignments;

(b) all materials and components necessary to use the device;

(c) instructing the subscriber in the

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use of the device; and

(d) the repair and replacement of the device;

(2) a prosthetic device or a custom orthotic device determined by the subscriber's provider to be the most appropriate model that meets the medical needs of the subscriber for performing physical activities, including running, biking and swimming, and to maximize the subscriber's upper limb function. This coverage shall include all services and supplies necessary for the effective use of a prosthetic device or a custom orthotic device, including:

(a) formulation of the device's design, fabrication, material and component selection, measurements, fittings and static and dynamic alignments;

(b) all materials and components necessary to use the device;

(c) instructing the subscriber in the use of the device; and

(d) the repair and replacement of the device; and

(3) a prosthetic device or custom orthotic device determined by the subscriber's prosthetic or orthotic care provider to be the most appropriate prosthetic device or custom orthotic device that meets the medical needs of the subscriber for purposes of showering or bathing.

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J. Coverage for complex rehabilitation technology devices shall be based on a subscriber's specific medical, physical, functional and environmental needs and capacities to engage in normal life activities and shall allow a subscriber to obtain more than one complex rehabilitation technology device, but no more than two complex rehabilitation technology devices per covered person; provided that if after three years, a complex rehabilitation technology device is no longer the appropriate device to meet the subscriber's needs for the subscriber's preferred physical activity, coverage and payment for new or replacement devices shall not be limited to two complex rehabilitation technology devices per covered person. A health care plan shall cover:

(1) complex rehabilitation technology devices for daily use that meet the subscriber's mobility and positioning needs;

(2) complex rehabilitation technology devices to enable the subscriber to participate in physical activities necessary to achieve or maintain health goals; and

(3) all services and supplies necessary for the effective use of a complex rehabilitation technology device, including:

(a) configuring, fitting, programming, adjusting or adapting the particular device for use by a person, including the formulation of the device's design,

fabrication, material and component selection and measurements;

(b) all materials and components necessary to use the device;

(c) instructing the subscriber in the use of the device; and

(d) the repair and replacement of the device.

K. A complex rehabilitation technology device that is a manual or power wheelchair shall only be covered pursuant to this section if the:

(1) subscriber has undergone a complex rehabilitation technology device evaluation conducted by a licensed physical therapist or occupational therapist who has no financial relationship with the supplier of the complex rehabilitation technology device; and

(2) complex rehabilitation technology device is provided by a complex rehabilitation technology device supplier that:

(a) employs at least one assistive technology professional certified by the rehabilitation engineering and assistive technology society of North America who specialized in seating, positioning and mobility and has direct, in-person involvement in the wheelchair selection for the subscriber; and

(b) makes at least one qualified complex

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rehabilitation technology device service technician available in each service area served by the supplier to service and repair devices that are furnished by the supplier.

[~~I.~~] L. Confirmation from a prescribing health care provider may be required if the prosthetic [~~or~~] device, custom orthotic device or complex rehabilitation technology device or part being replaced is less than three years old.

[~~J.~~] M. The provisions of this section do not apply to excepted benefits plans subject to the Short-Term Health Plan and Excepted Benefit Act.

N. As used in this section, "complex rehabilitation technology device" means a subset of durable medical equipment that:

(1) consists of complex rehabilitation manual and power wheelchairs and mobility devices, including specialized seating and positioning items, options and accessories;

(2) is designed, manufactured, configured, adjusted or modified for a specific person to meet that person's unique medical, physical, functional and environmental needs and capacities;

(3) is generally not useful to a person in the absence of a disability, illness, injury or other medical condition; and

(4) requires specialized services to ensure

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appropriate use of the item, including:

(a) an evaluation of the features and functions necessary to assist the person who will use the device; or

(b) configuring, fitting, programming, adjusting or adapting the particular device for use by a person."

SECTION 7. APPLICABILITY.--The provisions of this act apply to policies, plans, contracts and certificates delivered or issued for delivery or renewed, extended or amended in this state on or after January 1, 2027.

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