An act to add Section 1367.666 to the Health and Safety Code, and to add Section 10123.175 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST
AB 213, as introduced, Liu. Health care coverage for lymphedema.
Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the regulation of health care service plans by the Department of Managed Health Care and makes a violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance.
This bill would require a health care service plan and a health insurer to provide coverage for the treatment of lymphedema.
By creating new requirements for health care service plans, the willful violation of which would be a crime, the bill would impose a state-mandated local program.
The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.
This bill would provide that no reimbursement is required by this act for a specified reason.
The people of the State of California do enact as follows:

SECTION 1. Section 1367.666 is added to the Health and Safety Code, to read:

1367.666. (a) Every health care service plan contract, except a specialized health care service plan contract, that is issued, amended, renewed, or delivered on or after January 1, 2006, that covers hospital, medical, or surgery expenses, shall include coverage for the medical diagnosis and treatment of lymphedema in accordance with the current standard of care of lymphedema. The health care service plan contract shall cover the costs of all of the following:

(1) Differential diagnoses of lymphedema of all body sites from all causes by a qualified physician knowledgeable of the condition.

(2) Treatment in accordance with current standard of lymphedema care of primary lymphedema and secondary lymphedema resulting from surgical or radiation treatments of cancer, other surgical procedures, and other origins such as trauma, burns, inflammation, postbirth, by a qualified lymphedema therapist at the time of initial onset of lymphedema and when medically indicated thereafter.

(3) Medically required compression garments, compression pads, bandages, bandage liners and pads, orthotic devices, and special footwear deemed by the patient’s qualified caregiver to be medically necessary, with replacements provided when required to maintain the compressive function or to accommodate changes in the patient’s dimensions. Fitting and adjustment of compression garments and orthotic devices shall be performed by a fitter who is certified by the garment or orthotic device manufacturer. These items shall be covered during initial treatment, medically indicated follow-up treatment, and at home self-care.

(4) Patient education on home self-care.

(b) The course of therapy shall be determined by a qualified, competent physician knowledgeable in the diagnosis and current treatment standards of lymphedema as defined by the National Lymphedema Network (NLN), International Society of Lymphology (ISL), or the American Cancer Society (ACS).
(c) A treatment plan shall be written defining the goal of the therapy, the schedule, the measurements to be made to validate the efficacy of the treatment, and patient compliance.

(d) Treatment may include, but is not limited to, a course of manual lymph drainage (MLD) with the length, duration, and frequency determined on the basis of medical necessity, and not on guidelines governing rehabilitative therapy. The MLD shall be performed by a therapist who is trained and certified in the specialized treatment of lymphedema from a recognized training program with a minimum of 135 hours.

(e) Patient education shall include the following:

(1) Phase 1. Training of the patient to perform self-treatment in a home setting.

(2) Phase 2. Appropriate bandaging; wearing and care of compression garments; use of specialized, manually adjustable compression orthotic devices, donning aids, and other required ancillary equipment; techniques for self-measurement; skin care and recognition of early infection, and the steps to be taken if infection occurs.

(f) For purposes of this section, the following definitions apply:

(1) Current treatment standards of lymphedema means the accepted medical standards for the diagnosis and treatment of lymphedema as defined by knowledgeable medical specialty groups such as the NLN, ACS, or ISL.

(2) Complex decongestive therapy (CDT) means a number of interrelated treatment modalities that are most efficacious when utilized in an interdependent fashion, and includes all of the following:

(A) Proper skin care, which will optimize the supple texture of the skin and, with the other components of this therapy, minimize the risk of infection through cutaneous portals of entry.

(B) Manual lymph drainage (MLD), a specialized form of massage that has been demonstrated to stimulate and direct lymphatic flow, thereby decreasing the edema and fibrous changes of the involved body part.

(C) Compression therapy, which includes application of multilayered low-stretch bandages with appropriate padding to enhance the effect of muscular activity in the clearance of lymphatic fluid from the affected body part. Nonelastic manually
adjustable compression devices may be worn during nonactive periods and elastic compression garments may be worn during active portions of the day.

(D) Exercise, which may include, but is not limited to, active range of motion, and may be individualized according to the patient’s medical and psychosocial needs and capacity. Exercise is maximally effective when performed while the lymphedematous limb is bandaged.

(g) No individual other than a licensed physician and surgeon competent to evaluate the specific clinical issues involved in the care requested may deny requests for authorization of health care services and materials pursuant to this section.

(h) The copayments and deductibles for the benefits specified in subdivision (a) shall not exceed those established for similar benefits within the given plan.

(i) A plan shall not do any of the following in providing the coverage described in subdivision (a):

1. Reduce or limit the reimbursement of the attending provider for providing care to an enrollee or subscriber in accordance with the coverage requirements.
2. Provide monetary or other incentives to an attending provider to induce the provider to provide care to an enrollee or subscriber in a manner inconsistent with the coverage requirements.
3. Provide monetary payments or rebates to an individual enrollee or subscriber to encourage acceptance of less than the coverage requirements.
4. Reduce or eliminate coverage as a result of the requirements of this section.

(j) On or after July 1, 2006, every health care service plan governed by this section shall include notice of the coverage required by this section in the plan’s evidence of coverage and disclosure forms.

(k) Nothing in this section shall be construed to do any of the following:

1. To limit retrospective utilization review and quality assurance activities by the plan.
2. To establish a new mandated benefit or to prevent application of deductible or copayment provisions in a plan.
(3) To require that a plan be extended to cover any other procedures under an individual or a group health care service plan contract.

(4) To authorize an enrollee to receive the services required to be covered by this section if a nonparticipating provider furnishes those services, unless a participating physician or nurse practitioner providing care refers the enrollee to that provider.

SEC. 2. Section 10123.175 is added to the Insurance Code, to read:

10123.175. (a) Every individual or group health insurance policy that is issued, amended, renewed, or delivered on or after January 1, 2006, that covers hospital, medical, or surgery expenses, shall include coverage for the medical diagnosis and treatment of lymphedema in accordance with the current standard of care of lymphedema. The policy shall cover the costs of all of the following:

1. Differential diagnoses of lymphedema of all body sites from all causes by a qualified physician knowledgeable of the condition.

2. Treatment in accordance with current standard of lymphedema care of primary lymphedema and secondary lymphedema resulting from surgical or radiation treatments of cancer, other surgical procedures, and other origins such as trauma, burns, inflammation, postbirth, by a qualified lymphedema therapist at the time of initial onset of lymphedema and when medically indicated thereafter.

3. Medically required compression garments, compression pads, bandages, bandage liners and pads, orthotic devices, and special footwear deemed by the patient’s qualified caregiver to be medically necessary, with replacements provided when required to maintain the compressive function or to accommodate changes in the patient’s dimensions. Fitting and adjustment of compression garments and orthotic devices shall be performed by a fitter who is certified by the garment or orthotic device manufacturer. These items shall be covered during initial treatment, medically indicated follow-up treatment, and at home self-care.


(b) The course of therapy shall be determined by a qualified, competent physician knowledgeable in the diagnosis and current
treatment standards of lymphedema as defined by the National
Lymphedema Network (NLN), International Society of
Lymphology (ISL), or the American Cancer Society (ACS).
(c) A treatment plan shall be written defining the goal of the
therapy, the schedule, the measurements to be made to validate
the efficacy of the treatment, and patient compliance.
(d) Treatment may include, but is not limited to, a course of
manual lymph drainage (MLD) with the length, duration, and
frequency determined on the basis of medical necessity, and not
on guidelines governing rehabilitative therapy. The MLD shall be
performed by a therapist who is trained and certified in the
specialized treatment of lymphedema from a recognized training
program with a minimum of 135 hours.
(e) Patient education shall include the following:
(1) Phase 1. Training of the patient to perform self-treatment
in a home setting.
(2) Phase 2. Appropriate bandaging; wearing and care of
compression garments; use of specialized, manually adjustable
compression orthotic devices, donning aids, and other required
ancillary equipment; techniques for self-measurement; skin care
and recognition of early infection, and the steps to be taken if
infection occurs.
(f) For purposes of this section, the following definitions
apply:
(1) Current treatment standards of lymphedema means the
accepted medical standards for the diagnosis and treatment of
lymphedema as defined by knowledgeable medical specialty
groups such as the NLN, ACS, or ISL.
(2) Complex decongestive therapy (CDT) means a number of
interrelated treatment modalities that are most efficacious when
utilized in an interdependent fashion, and includes all of the
following:
(A) Proper skin care, which will optimize the supple texture of
the skin and, with the other components of this therapy, minimize
the risk of infection through cutaneous portals of entry.
(B) Manual lymph drainage (MLD), a specialized form of
massage that has been demonstrated to stimulate and direct
lymphatic flow, thereby decreasing the edema and fibrous
changes of the involved body part.
(C) Compression therapy, which includes application of multilayered low-stretch bandages with appropriate padding to enhance the effect of muscular activity in the clearance of lymphatic fluid from the affected body part. Nonelastic manually adjustable compression devices may be worn during nonactive periods and elastic compression garments may be worn during active portions of the day.

(D) Exercise, which may include, but is not limited to, active range of motion, and may be individualized according to the patient’s medical and psychosocial needs and capacity. Exercise is maximally effective when performed while the lymphedematous limb is bandaged.

(g) No individual other than a licensed physician and surgeon competent to evaluate the specific clinical issues involved in the care requested may deny requests for authorization of health care services and materials pursuant to this section.

(h) The copayments and deductibles for the benefits specified in subdivision (a) shall not exceed those established for similar benefits within the given policy.

(i) A health insurance policy shall not do any of the following in providing the coverage described in subdivision (a):

   (1) Reduce or limit the reimbursement of the attending provider for providing care to an insured in accordance with the coverage requirements.

   (2) Provide monetary or other incentives to an attending provider to induce the provider to provide care to an insured in a manner inconsistent with the coverage requirements.

   (3) Provide monetary payments or rebates to an insured to encourage acceptance of less than the coverage requirements.

   (4) Reduce or eliminate coverage as a result of the requirements of this section.

(j) On or after July 1, 2006, every health insurance policy governed by this section shall include notice of the coverage required by this section in the policy’s evidence of coverage and certificate of insurance.

(k) Nothing in this section shall be construed to do any of the following:

   (1) To limit retrospective utilization review and quality assurance activities by the policy.
(2) To establish a new mandated benefit or to prevent application of deductible or copayment provisions in a policy.

(3) To require that a policy be extended to cover any other procedures under an individual or a group health insurance policy.

(4) To authorize an insured to receive the services required to be covered by this section if a nonparticipating provider furnishes those services, unless a participating physician or nurse practitioner providing care refers the insured to that provider.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.