MAJOR PAYERS SUPPORTING AMPUTEE CARE—ESSENTIALS YOU MAY NEED TO KNOW

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Coverage of prosthetic devices by federally funded insurance programs is a major concern for the amputee community. While advances in technology have resulted in more efficient and better functioning prostheses, they have also increased overall costs for prosthetic devices. Knowing what is covered and what is not covered will help you to make an informed decision when discussing prosthetic care with your physician and prosthetist.

Medicare

By far the largest federally funded Healthcare system, the Medicare program was created in 1965 with the passage of title XVIII of the Social Security Act. Traditional "fee for service" Medicare is broken up into two parts, Medicare Part A, which covers inpatient hospital stays, skilled nursing, and hospice care; and Medicare Part B, which covers services provided on an outpatient basis. These services include physician visits, outpatient hospital services and ancillary services including orthotic and prosthetic services as well as durable medical equipment (DME). In the 1980s, Medicare managed care was introduced and eventually evolved into what is now known as Medicare Part C. Medicare managed care allows individuals to replace their traditional fee for service Medicare benefits by enrolling in a managed care plan that assumes coverage responsibility for all Medicare covered services including both inpatient and outpatient services. While managed care options often offer lower coinsurance and deductibles, they are often more restrictive regarding the beneficiaries choice of provider and may have benefit limits on particular services. Consumers, especially amputees, must make sure they fully understand what coverage will be available for prosthetic services under the fee for service model as well as managed care options when deciding what Medicare plan works best for them.

Fee for service Medicare is an indemnity plan meaning beneficiaries are responsible for a standard annual deductible and a percentage based co-insurance. The 2014 Medicare deductible is $147 and the Medicare co-insurance rate is 20%. This means that Medicare beneficiaries must pay for the first $147 of total medical expenses they accrue in 2014 and then 20% of all remaining expenses for the rest of the calendar year. When discussing prostheses that can cost several thousand dollars, 20% coinsurance may result in significant financial responsibility for Medicare beneficiaries

A patient's financial responsibility will vary under Medicare managed care plans but will most likely represent some percentage of the cost of the prosthesis. While many Medicare managed care plans offer flat rate co-payments for services such as doctor visits, lab work, etc., the relative high cost of a prosthesis usually requires a percentage based co-insurance.

In addition to financial concerns, consumers must also understand that Medicare has published medical policy that limits the type of prosthesis that is considered medically necessary. This policy creates 5 classifications known as functional levels that use the patients past medical history and potential to use a prosthesis effectively to determine the type of prosthesis that will be covered by Medicare. Functional levels range from K0 where a patient has no desire or potential to ambulate with a prosthesis to K4 where a patient is extremely active and requires advanced technology in order to meet their functional needs. Medicare will cover a lower limb prosthesis for patients who meet the functional criteria for K1, K2, K3, or K4. A full assessment of an amputee's current and potential functional abilities should be performed by the physician and the prosthetist, with input from the patient, in order to establish and document the patient's functional level. This will then be used to fabricate a prosthesis using components that are appropriate for the patient's functional needs.

While Medicare managed care plans are free to develop their own policies regarding coverage of prostheses, most have adopted similar language to that which is found in the Medicare fee for service policy.

Consumers who are able to understand the Medicare rules regarding coverage of prostheses will help their prosthetist and physician make the right decision regarding the best prosthesis for their individual needs.

Medicaid

Medicaid is a jointly funded program that combines both federal and state dollars to provide healthcare services to the poor and indigent. While the majority of funding comes from federal dollars, most Medicaid programs are administered by the states that must follow certain federal guidelines.

The federal government has provided what have generally been perceived as fairly generous subsidies for use of the states on Medicaid. Those subsidy funds have tightened in recent years. The largest challenge facing consumers covered by Medicaid programs is the lack of coverage for "optional" services that are not explicitly mandated for coverage under existing statutes and regulations. As states have tried to manage increasing Medicaid enrollment and shrinking budgets many have eliminated coverage for ancillary services such as prosthetics and orthotics. Other states have limited coverage to those under the age of 18.

Medicaid is a central piece in the ACA plan to expand coverage to the uninsured. According to the original ACA plan, federal Medicaid moneys would be expanded, with 100% federal funding for the initial 3+ years, in exchange for the states committing to higher poverty thresholds--so more uninsured (above poverty levels, but unable to afford regular health insurance) would be assured health coverage via Medicaid. While one of the original provisions of the Affordable Care Act focused on increased federal funding and expansion of Medicaid programs, the Supreme Court overturned part of the law that would have withheld all federal funding from states that did not expand their Medicaid eligibility by lowering income thresholds.

This has led to a delay in the expansion of Medicaid coverage at the state level and may impact the states willingness to expand coverage outside of basic services that are required by statute. Many state Governors took this opportunity to say "no" to the ACA's planned expansion of Medicaid, even though the feds would be paying the entire tab, at least for the initial years. In the end, assuming ACA survives, it is expected that virtually all states will accept Medicaid expansions--hospitals and other providers will force it so they get something back for all they and state residents pay to fund ACA.

In order to fully understand what is and is not covered under a specific state Medicaid plan, consumers must look to the resources provided by the state, whether it be the state Medicaid website, working with a case manager, or working directly with their prosthetist,

The Veteran's Administration (VA)

The Veteran's Administration is another significant program that pays for prosthetic services using federal monies. The VA is unique in that they may either provide prosthetic services directly to veterans within VA treatment centers or veterans may receive care within the community through VA contracted providers. Many VA medical centers have dedicated prosthetic departments that are able to manage the prosthetic needs of the veteran population which they serve. In areas where this is not possible, the VA enters into contractual arrangements with local providers who provide prosthetic services to the veteran population. If you are a veteran, it is important to remember that you have input regarding who provides your prosthetic care and whether you receive your care within the VA system or through an outside provider.

It is important to note that VA healthcare services and Medicare services are both federally funded so consumers who are eligible for coverage under both programs must typically decide which program they will utilize for their prosthetic services. Consumers must choose one or the other and should not utilize the benefits of both programs independently.

Worker's Compensation Insurance

While most workers' compensation insurance plans are now administered through private insurance companies, they remain heavily regulated by the states, usually through a workers' compensation board or commission. As its name implies, workers' compensation insurance is designed to only provide coverage of services that are directly related to a workplace injury. When a workplace injury results in amputation consumers must be consider the permanence of the injury and the potential impact of the amputation for the remainder of their lifetime. When dealing with permanent injuries such as amputation, many workers' compensation insurance plans look to negotiate a onetime settlement that will compensate the injured party and cover expected medical costs going forward. Consumers must carefully evaluate any potential settlement offer in order to ensure that it will adequately cover necessary expenses for an extended period of time. This often requires the advice of legal counsel in order to make sure that the injured party's interests are properly represented and protected.

The information above is intended to provide consumers of prosthetic services with a brief snapshot of the different programs that are subject to federal or state regulation and funding. Hopefully it is useful in providing general information about these programs.

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