

GROUP: AMPUTEES NOW BEING DENIED COVERAGE BY PRIVATE INSURERS BASED ON WIDELY CRITICIZED AND UNFINALIZED MEDICARE RULE

“We Warned Last Year That This Would Turn Back the Clock for America’s Amputees ... And It Has.” Portland and Minneapolis Amputees Denied Coverage by United Healthcare Tell Their Story; Cigna Also Criticized for Exploiting Non-Final Medicare Rule.

WASHINGTON, D.C. – April 21, 2016 – A highly controversial Medicare rule proposal to turn back the clock to 1970s-style health care for America’s two million amputees set off a firestorm of protests last summer. Now, the American Orthotic & Prosthetic Association (AOPA) is warning that, as predicted, the Medicare rule is being exploited by private health care insurers to deny coverage to amputees for previously approved medical care and devices.

AOPA said that United Healthcare and Cigna have been identified as using the cover provided by the non-final Medicare rule to deny coverage to amputees. Two amputees from Portland and Minneapolis told reporters today about their experiences with United Healthcare coverage denials. AOPA also produced a February 2016 letter from six groups, including the Amputee Coalition, urging Cigna to reverse a late 2015 coverage statement that is being used by the company to deny coverage to amputees.

In August 2015, the amputee community’s outrage over the proposed Medicare rule boiled over during a public hearing in Baltimore and a subsequent protest outside the Health and Human Services headquarters in Washington, D.C. Amputees also mounted a vigorous #notaluxury social media campaign that culminated in 100,000+ signatures on a White House “We The People” petition. The proposed changes to federal reimbursement for lower limb prosthetic care would create unreasonable and clinically unjustified hurdles to amputees receiving care that is now routinely provided.

AOPA and the Amputee Coalition cautioned last summer that, if not withdrawn, the disputed Medicare rule would be seized upon by private insurers in order to deny coverage to amputees. Among the chief concerns of critics is that the supposed scientific basis for the Medicare rule proposal has been debunked by nine leading researchers who wrote to Medicare that they are “extremely concerned that the [proposed rule to reduce care for amputees] was not based at all on the current literature and science associated with the provision of prosthetic care.”

After facing a firestorm of criticism, the Centers for Medicare & Medicaid Services (CMS) said it would study the rule further, but declined to withdraw it and, in failing to take that step, allowed private insurers to exploit it.

Further compounding the problem is the fact that CMS has continued to handle the draft rule in a secretive and non-transparent fashion. CMS denied a FOIA request asking for the public comments submitted by members of the public about the draft rule. When the draft rule was taken back for further study and review, CMS allowed no clear mechanism for additional public, patient or other stakeholder input to be provided to the committee now handling it. CMS has even gone so far as to decline to even identify the names and titles of the individuals who are handling the review process. All are reported to be government employees, and there is no indication whether there are amputees on this new committee.

Michael Oros, president elect, American Orthotic & Prosthetic Association and CEO, Scheck & Siress, Chicago, IL., said: **“We warned last year that this scientifically unjustified Medicare rule would be exploited by insurance companies if it was not withdrawn. We said that this rule would turn back the clock on the quality of care for two million amputees. And it has. It is very difficult to imagine any other aspect of American healthcare where millions of people would be denied available and appropriate treatment and devices that can speed their return to the fullest and most active possible life. Even worse, there is no medical or other justification for these unreasonable and inappropriate hurdles that would amount to a return to a 1970s standard of care.”**

Mark Martin, 40, Portland, Oregon, lost his left leg due to an aneurysm that struck him during a workout. He ended up as an above the knee amputee.

Martin said: **“I experienced denials from United Healthcare even on my initial preparatory prosthetic. Then, when I advanced to the point of being ready for a definitive prosthetic - capable of letting me run after my three young children, play basketball, and return to a more regular travel schedule for my career with a consulting firm - I was met with wave after wave of denials. These were timed, not coincidentally, after the draft Medicare policy was released. Denial language began to incorporate the draft policy limitations that ran contrary to actual policy provisions.”**

Martin added: **“I was, recently, fortunate to receive an approval but not before significant resources were brought to bear, and multiple denials were challenged to secure an independent review of my case by a medical professional actually experienced in the issues of amputees. Many, many months passed that I could have been advancing my recovery, returning to my activities and better supporting my family. The only barrier in that time was the lack of an appropriate prosthetic. I know that many people would not have the resources or support to fight this the way I did. Getting needed medical care should not depend on having an amazing employer, dedicated medical professionals, and the personal resources to mount a campaign against an insurance company. The system and this not-even-approved policy stood in the way of my reasonable care, and I know it stands in the way of so many others in my situation.”**

Rob Rieckenberg, a 37-year-old amputee from Minneapolis, lost a leg after he was mugged and left on train track where he was struck by a train. He has a vacuum suspension socket and sought continued care through employer-provided group insurance with United Healthcare.

Rieckenberg said: **“In the wake of the draft Medicare rule, United Healthcare was going to deny me coverage. So I had to buy an individual plan through Blue Cross. I’m paying five times as much for premiums because United wouldn’t have extended me the coverage I am due. I had to have a vacuum suspension because of the skin grafts on my stump. Any less-advanced technology would tear up my skin.”**

Rieckenberg added: **“I participated in the summer of 2015 protests in Washington, DC, outside of the Health and Human Services headquarters to protest this attack on amputees. I have been on Capitol Hill this week with the Amputee Coalition to call attention to this injustice. It is unfair to amputees to see coverage denied by insurance companies that are hiding behind a rule that has not even been finalized by Medicare. It’s a bad rule, but it’s even worse when it can lower the care for amputees without even being formally enacted.”**

United Healthcare is not alone in using the draft Medicare rule as the basis for denying medical care to amputees. Cigna also proceeded in the same fashion. In a [February 10, 2016 letter](#) signed by six groups, including AOPA and the Amputee Coalition, Cigna was urged to immediately rescind a coverage policy denying reimbursements for residual limb volume management and moisture evacuation systems, such as vacuum-assisted socket systems.

The joint letter to Cigna notes: **“The technology used in vacuum pump systems for limb prostheses has existed since the mid-1990s. As noted above, Medicare has approved more than 15,000 claims over the last 12 years for these components. The Food and Drug Administration has also approved the manufacture, distribution, and use of this technology, signaling that it vouches for, at minimum, the safety of the components. To counter this evidence and deny amputees access to a clinically-accepted standard of care on the summary conclusion that insufficient clinical evidence exists compromises the medical well-being of individuals with limb loss covered by Cigna. In fact, it suggests the motivation for the new policy may be based primarily on the short term cost-effectiveness of denying coverage.”**

According to the Amputee Coalition there are roughly two million persons in the U.S. living with limb loss, and there are approximately 185,000 new amputees each year.

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EDITOR'S NOTE: A streaming audio replay of this news event will be available as of 5 p.m. EDT on April 21, 2016 at <http://www.aopanet.org/media/press-releases/>.

The American Orthotic & Prosthetic Association is a national trade association committed to providing high quality, unprecedented business services and products to O&P professionals. Since its founding in 1917, AOPA has worked diligently to establish itself as the voice for O&P businesses. Through government relations efforts, AOPA works to raise awareness of the profession and to impact policies that affect the future of the O&P industry. AOPA membership consists of more than 2,000 O&P patient care facilities and suppliers that manufacture, distribute, design, fabricate, fit, and supervise the use of orthoses (orthopedic braces) and prostheses (artificial limbs). Visit AOPA at www.aopanet.org.