ADDRESSING THE REIMBURSEMENT CHALLENGE: A SHIFT FROM ADLS TO QOL

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ABSTRACT

Contemporary upper-limb prosthetic technologies become clinically irrelevant if payers are not willing to reimburse for them. Risk-averse prosthetists are hesitant to embrace and apply newer technologies even when they are the most appropriate choice to provide their patients with the desired functional outcome. These insurance-driven clinical decisions may be one factor in the historically high level of patient rejection of, and dissatisfaction with, upper-limb prostheses.

Exclusionary language is written in many insurance policies regarding upper-limb prosthetic components. A common reason for non-coverage of specific items is that the technology is considered "experimental and investigational" due to a lack of clinical research proving their effectiveness even when they may have been used clinically with success for many years. Multi-articulated hands, powered digit systems, and any prosthesis for an amputation distal to the wrist are most frequently excluded.

As a profession, the focus has been on defining clinical success as meeting ADL requirements. The definition of ADLs used by insurance companies is based on the theoretical independence of a young child. Particularly, it was intended to assess the care needs of elderly persons: including SNF admittance. This is outdated and does not represent upper-limb prosthetic patients' demands of a pre-injury QOL. There is insufficient clinical evidence specifically quantifying the functional and psychological benefits of contemporary upper-limb prosthetic technologies with respect to improved QOL. Other healthcare fields report and quantify QOL because it provides a broader spectrum in which clinical success is defined. A paradigm shift from assessing and reporting ADLs to QOL in upper-limb prosthetic rehabilitation would help improve our clinical justifications for reimbursement.

The leadership of the Upper-Limb Prosthetics Society of the AAOP is addressing this issue by helping to coordinate and publish research surrounding these contemporary clinical technologies. We have begun to investigate the policies of these insurance companies and tried to determine the requirements that these companies have in place in order for policy guidelines to be changed. The purpose of this presentation is to create awareness surrounding what these requirements are and to initiate a discussion amongst the professionals in attendance at MEC. This is an effort that will need a coordinated international collaboration between manufacturers, clinicians, researchers, physicians, and patient advocacy groups to be successful. Our goal is to establish a body of evidence that can be freely shared amongst those caring for individuals with upper-limb differences so that these prejudicial policies can be overturned.