# Expanding Insurance Equity: Enabling Direct Access to Prosthetic Care Through the Prosthetic Prescription Parity Act in Georgia

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**Executive Summary:** Current state and private insurance protocols require a physician's approval in addition to a licensed prosthetist's recommendation for acquiring prosthetic devices in the state of Georgia. The Prosthetic Prescription Parity Act (PPPA) aims to eliminate outdated and burdensome insurance requirements that delay access to these essential prosthetic devices. These redundancies not only increase healthcare costs but significantly delay patient mobility and rehabilitation. To alleviate this, we propose the PPPA, which would legally recognize… in an effort to provide more timely, equitable, and cost-effective care. The PPPA would also introduce the Prosthetist-Doctor Collaboration Framework (PDCF), a structured mechanism for resolving prescription disputes and maintaining appropriate oversight. The Act reduces gaps in Medicare and Medicaid's Local Coverage Determination (LCD) for Lower Limb Prostheses (L33787) (Amputee Coalition 2024) and builds on key precedents, such as *Dobson v. Secretary of Health and Human Services* (2022), where the Federal Circuit affirmed the unlawfulness of arbitrary durable medical equipment denials (Centers for Disease Control and Prevention 2023). State-level policies in New Hampshire and Colorado already serve as models, proving the feasibility and benefit of empowering prosthetists as prescribers. Additionally, by expanding timely access to prosthetic care, the Act reduces long-term government spending, supports economic participation, and ensures equitable healthcare access for underserved communities.

## I. Current prosthetic prescription procedures & clinical recognition of prosthetists

Over two million Americans live with limb loss, with approximately 185,000 new amputations each year (Centers for Medicare & Medicaid Services 2023). Timely access to prosthetics is vital for restoring independence and quality of life. Outdated insurance protocols delay care, often by months (Kombe et al. 2025). For example, both public and private insurers require a physician's signature even when a licensed prosthetist has already evaluated the patient and prescribed the device. In practice, this means the physician must formally attest that the limb is "medically necessary" before coverage can be approved.

Licensed prosthetists differ from physicians in their educational pathway. Physicians complete medical school, residency, and board certification in fields such as internal medicine, primary care, or even orthopedics but are rarely trained in prosthetic usage. Their training equips them to manage complex medical conditions, prescribe pharmaceuticals, and coordinate care across organ systems. Prosthetists, by contrast, follow a specialized path: they obtain a master's degree in orthotics and prosthetics, complete a year-long

clinical residency, and earn national certification through the American Board for Certification (ABC) or Board of Certification/Accreditation (BOC/A). Their curriculum is focused on anatomy, biomechanics, gait analysis, materials science, and device design rather than systemic disease management (Riccio-Ackerman et al. 2023; Van Netten et al. 2020). This allows prosthetics to have a better knowledge of prosthetic limb development and maintenance compared to physicians.

Historically, insurance policies defaulted to physician oversight because prosthetics were classified under "durable medical equipment" (DME). Coverage rules for DME were written when prosthetics were less advanced and the prosthetist profession was still emerging as a formalized, graduate-level discipline. As a result, federal statutes and Medicare's Local Coverage Determination (LCD) embedded physicians as the recognized prescribers of record, with prosthetists treated as ancillary providers (L33787; Centers for Medicare & Medicaid Services 2023). Delays in adjudication further increase the risk of secondary complications—provision postponed beyond 30 days is associated with a 25% increase in falls, joint deterioration, and chronic pain, conditions that drive an additional $2,000–$10,000 in expenditures per patient annually (Frossard et al. 2023; NAAOP 2023).This classification has remained largely unchanged, despite significant advances in prosthetist education and clinical scope.

Agencies and insurers have not revisited these requirements to align them with modern clinical realities, even as states like Colorado and New Hampshire have begun to update their laws (Kehoe et al. 2023; NH SB132). The absence of prescriber recognition is, therefore, less about safety concerns or evidence against prosthetist authority, and more about outdated statutory language with physicians written into insurance law by default. This misalignment persists today, creating delays that serve no clinical purpose.

The sections that follow outline the urgent need for the Prosthetic Prescription Parity Act (PPPA) in Georgia, using evidence of healthcare disparities, inefficiencies in current insurance protocols, and lessons from other state precedents. While federal reform remains important, state-level action provides a direct, pragmatic pathway for Georgia to modernize coverage rules and serve as a model for other states to amend their legal frameworks.

## II. History of disparities in prosthetic access in Georgia

Prosthetic access in the U.S. reflects broader healthcare inequities. Black, Hispanic, Indigenous, and low-income populations face higher rates of limb loss from preventable conditions like diabetes and trauma, yet receive prosthetic care at disproportionately lower rates (Frossard et al. 2023). African Americans are up to four times more likely to undergo amputation than white patients, but are less likely to be fitted with prosthetics or receive rehabilitation (*Dobson v. Secretary of Health and Human Services* 2022). These disparities stem from limited primary care access, geographic isolation, implicit bias, and restrictive insurance policies.

In Georgia, these barriers are amplified by physician shortages. Nearly 30% of Georgia residents live in federally designated medically underserved areas. Physicians outnumber prosthetists overall, but they are overextended in their ability to provide timely, specialized care for limb loss patients. Prosthetists, though far fewer in number, concentrate their practice entirely on prosthetic care and often reach rural communities through satellite or traveling clinics. This means that for many patients in rural Georgia and other underserved regions, the prosthetist is the most readily available provider to assess, fit, and follow up on prosthetic needs (Grams 2022). Current insurance protocols, however, prevent patients from acting on the prosthetist's expertise until a physician provides approval.

In Georgia, the status quo imposes tangible harms. The result is financial and geographic inequity: extra copays, travel to distant physicians, and months-long delays that disproportionately affect low-income families in rural Georgia (Grams 2022). Claims are denied or delayed not because medical necessity is disputed, but because a physician's secondary approval is missing (Kombe et al. 2025). Patient advocacy surveys confirm that such denials erode trust in insurers, drive lengthy appeals, and in some cases lead patients to abandon claims entirely (Georgia Budget and Policy Institute 2016).

Prosthetists practicing in rural or underserved regions are forced to divert significant time from patient care to administrative coordination (American Orthotics and Prosthetics Association 2025).

In this piece, we propose model state legislation: the Prosthetic Prescription Parity Act (PPPA). Particular consideration by the Georgia legislature is beneficial as the Act would formally recognize licensed prosthetists as prescribers for insurance purposes, eliminating the current requirement for a redundant physician co-signature in Georgia. By targeting state insurance law and Medicaid administration, PPPA positions Georgia to lead nationally while addressing inequities that are especially pressing within the state.

The bill also establishes a Prosthetist-Doctor Collaboration Framework (PDCF), which ensures that physician oversight is available when medically necessary without forcing it in every case. Under the PDCF, prosthetists would be the default prescribers for prosthetic devices. However, if a patient presents with complex comorbidities (such as uncontrolled diabetes, vascular disease, or other conditions that may affect prosthetic fitting), the prosthetist is required to initiate a rapid consultation with the patient's primary care physician (PCP) or specialist. In this model, "needed oversight" is triggered by specific red-flag criteria (ex. active wound complications, cardiovascular instability, or contested payer claims), rather than applied indiscriminately to all cases. This preserves clinical autonomy in routine cases while providing a clear safety net in higher-risk situations.

Each component of PPPA maps onto a core policy concern:

- **Access**: Direct prescriber recognition removes months of administrative delay and expands prosthetic availability.
- **Patient well-being**: Early fitting reduces secondary health complications, accelerates rehabilitation, and strengthens return-to-work rates.
- **Financial efficiency**: Streamlining coverage lowers unnecessary physician visit costs, prevents costly complications from delays, and reduces administrative waste for insurers.
- **Program legitimacy**: The PDCF ensures that prosthetists and physicians collaborate where appropriate, maintaining safeguards against clinical oversight gaps or fraudulent prescribing.

## III. Legal landscape: federal regulation, judicial precedent, & current gaps

A persistent misconception in insurance regulation is that physician oversight is necessary to ensure the appropriateness of prosthetic care. In practice, this requirement is redundant. The clinical process of prosthetic provision begins with the prosthetist, who evaluates the residual limb, conducts biomechanical assessments, designs and fabricates the device, and supervises multiple fittings and adjustments (Riccio-Ackerman et al. 2023, 77–82). These tasks require specialized graduate-level education and clinical residency training mandated since 2012 (Van Netten et al. 2020, 408–15). Physicians, by contrast, receive limited to no training in prosthetic fitting or device design during medical education (National Academies of Sciences 2018). The mandated physician "co-signature" therefore serves only to affirm what the prosthetist has already determined. For patients in Georgia without a PCP, especially in rural areas, this requirement creates delays, imposes new travel costs, and adds copays, given that PCPs are under-trained in recognizing when and how to refer patients for prosthetic intervention (Georgia Budget and Policy Institute 2016; Ziegler-Graham et al. 2008).

Georgia, a state with nearly 80,000 residents living with limb loss, currently adheres to this outdated framework requiring physician oversight in prosthetic usage (Ziegler-Graham et al. 2008; *Dobson v. Secretary of Health and Human Services* 2022). While Georgia Code Title 33 governs insurance, it contains no statutory language recognizing licensed prosthetists as prescribers (GA R&R – O.C.G.A. § 50-13-1 et seq). The result is a contradiction: physicians who generally lack prosthetic expertise are treated as gatekeepers, while prosthetists whose training is uniquely specialized in this domain are excluded. This incongruity produces avoidable delays, duplicate consultations, and wasted insurance resources (Kombe et al. 2025, 5–10).

This mismatch is compounded by the geographic distribution of prosthetists. Georgia employs only 110–270 prosthetists statewide (Figure 1). For many patients in underserved counties, the prosthetist is likely the most accessible provider, while physicians are either unavailable or overextended (Gotsadze et al. 2005). Requiring a physician co-signature in these regions, therefore, creates an inequitable barrier to care.

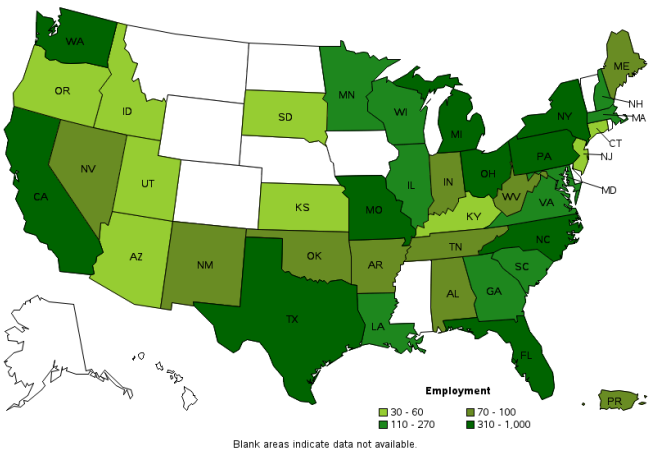


**Figure 1**: Employment of Prosthetists by State, May 2023. Source: U.S. Bureau of Labor Statistics, Occupational Employment and Wage Statistics (OEWS)

At the federal level, Medicare's LCD L33787 codifies the physician-signature requirement for lower-limb prostheses (Centers for Medicare & Medicaid Services 2023). The Federal Circuit in *Dobson v. Secretary of Health and Human Services* (2022) confirmed that the Centers for Medicare & Medicaid Services (CMS) may not arbitrarily deny coverage for durable medical equipment (DME), including prosthetics, absent adequate justification, such as falsification (Centers for Medicare & Medicaid Services 2023). Despite this precedent, physician co-signature remains embedded in coverage determinations for Medicare, Medicaid, and private insurers .

With absent federal regulations and requirements, states have authority. Colorado's HB 23-1136 (2023) authorized prosthetists to prescribe defined classes of prosthetic devices. Within the first year of implementation, outcomes included a 15% reduction in coverage denials, a 20% increase in timely device delivery, and measurable improvements in patient satisfaction (Kehoe et al. 2023). New Hampshire's SB 132 (2025) removed pediatric-only restrictions and required insurers to recognize prosthetic prescriptions at the point of clinical recommendation. While claims initially rose—with projected annual costs of $60 million—state Medicaid expenditures decreased within 18 months due to reductions in long-term care dependency (NH SB132).

**IV. Remedying Georgia's gaps: the Prosthetic Prescription Parity Act**

The PPPA remedies this misalignment. By recognizing prosthetists as prescribers under Georgia law, PPPA eliminates redundant sign-offs, aligns state practice with federal judicial precedent, and introduces oversight mechanisms to ensure compliance. Implementation would be administered by the Georgia Department of Community Health (DCH), with private and public insurer accountability monitored by the Office of Insurance and Safety Fire Commissioner (GA R&R – O.C.G.A. § 50-13-1 et seq). In doing so, PPPA ensures that coverage determinations reflect clinical expertise rather than misconceptions embedded in outdated statutory language.

Prosthetists hold specialized graduate-level training, residency experience, and national certification, qualifying them to prescribe devices safely (Riccio-Ackerman et al. 2023; Van Netten et al. 2020). Recognizing prosthetists as prescribers accelerates access to mobility, particularly in rural areas where they may be the sole provider, and ensures patients in underserved communities are not left waiting.

Comparative evidence demonstrates that eliminating this requirement improves both efficiency and cost-effectiveness. Colorado's HB 23-1136 (2023) reduced coverage denials by 15% and increased on-time device delivery by 20% within its first year (Kehoe et al. 2023). New Hampshire's SB 132 (2025) initially increased claims volume, but statewide Medicaid expenditures declined within 18 months as earlier prosthetic provision reduced reliance on long-term care (NH SB132).

PPPA advances a distributed model of care. Rather than concentrating prosthetic services in urban

hospital centers that remain inaccessible to many rural residents, the Act supports regional delivery through community-based practices. This approach reduces geographic disparities, strengthens local networks, and builds durable, evidence-based reputations for prosthetic care across Georgia.

PPPA's benefits extend across stakeholders. Patients gain faster recovery and reintegration through timely prosthetic fitting. Prosthetists regain clinical autonomy and redirect time from redundant paperwork to direct care. Insurers reduce waste tied to unnecessary co-signature visits and repeated adjudication cycles. Medicaid avoids long-term expenditures on emergency hospitalizations and custodial care. Federal disability programs benefit when earlier reintegration reduces prolonged SSDI reliance.

PPPA places Georgia at the forefront of equitable, efficient prosthetic care. It aligns prescriptive authority with the providers best trained to exercise it, corrects an outdated statutory oversight, and demonstrates a pragmatic pathway for state-led reform that can inform federal policy.

**V. Patient impacts**

Delays in prosthetic provision carry quantifiable risks. Clinical evidence shows that fitting postponed beyond 30 days increases complication rates by approximately 25 percent, including accelerated joint contractures, progressive muscle atrophy, and skin breakdown that complicate future fitting (Resnik et al. 2025). Falls occur in up to 40 percent of lower-limb amputees waiting for a device, often resulting in secondary fractures and hospitalizations (Frossard et al. 2023). For patients with diabetes or vascular disease, each additional week of delay in receiving a prosthetic raises the probability of rehospitalization by 3–5 percent and increases the risk of limb loss by 1–2% per week (Centers for Disease Control and Prevention 2023; Ziegler-Graham et al. 2008). When prosthetic fitting is deferred longer than 90 days, the likelihood of permanent mobility impairment nearly doubles, and long-term wheelchair dependence rises from 18 percent to 35 percent (Resnik et al. 2025). With nearly 80,000 Georgia residents living with limb loss, this translates into potential state savings of $160–$800 million per year if delays were systematically reduced (Ziegler-Graham et al. 2008).

The individual economic consequences of these complications are equally significant. Preventable contractures and skin breakdown add an estimated $2,000–$10,000 in annual care costs to the insurer (Frossard et al. 2023). Rehospitalizations due to falls or wound deterioration average $17,000 per admission, and patients with contralateral limb amputations incur lifetime costs exceeding $500,000 in care and lost earnings (Amputee Coalition 2024). Psychosocial impacts magnify the burden: more than 60 percent of amputees awaiting prostheses report clinical depression, and rates of labor-force dropout are nearly three times higher when fitting is delayed beyond six months (Resnik et al. 2025). Accordingly, PPPA promotes economic reintegration by removing procedural barriers that extend disability and workforce absence. By ensuring timely prosthetic fitting, it strengthens Georgia's labor market participation and reduces the long-term fiscal burden on employees, employers, and state support systems (Resnik et al. 2025).

The scale of this problem is national but acute in Georgia. More than 1.6 million working-age adults in the U.S. live with limb loss, with unemployment among this population estimated at 57 percent, compared to 3.6 percent in the general population (Amputee Coalition 2024). Each month of prosthetic delay prolongs Social Security Disability Insurance (SSDI) reliance; five-year data suggest that early prosthetic fitting can reduce SSDI claims by 15–25 percent, translating into potential national savings of billions annually (U.S. Government Accountability Office 2017). In Georgia, where nearly 80,000 residents of Medicaid live with limb loss (Ziegler-Graham et al. 2008), these delays translate into thousands of preventable complications and millions in avoidable Medicaid expenditures each year.

**VI. Prosthetist and physician impacts**

Physician consultations for prosthetic co-signatures often provide no substantive clinical benefit but cost insurers $75–$150 per visit in Georgia (American Orthotics and Prosthetics Association 2025). When multiplied across tens of thousands of annual prosthetic claims, this amounts to millions of dollars

in avoidable costs. As a result, their mandatory approval can contribute to inappropriate prescriptions, device remakes, and preventable hospitalizations, further inflating costs.

For prosthetists, the current system imposes administrative inefficiencies. More than 65% of Georgia prosthetists report spending over 30% of their workweek managing paperwork and physician liaison tasks tied to co-signatures rather than direct patient care (Ziegler-Graham et al. 2008). This diverts critical clinical time and undermines workforce efficiency in a field already constrained by provider shortages. By granting prosthetists prescriber authority, PPPA restores professional autonomy, reduces dependency on overextended physicians, and ensures that clinical expertise is aligned with decision-making authority.

**VII. Insurer impacts**

Denials are rarely based on lack of clinical justification; they most often arise from the absence of a secondary physician's signature. The financial and administrative implications of this requirement are considerable. Insurers and providers must also manage repeated "pend–request–resubmission" cycles (Kombe et al. 2025). Physician co-signature requirements create a structural inefficiency in prosthetic claims adjudication. Under the current pathway, claims generally proceed as follows: (1) the prosthetist submits a prior-authorization packet; (2) the insurer spends the file pending a "physician attestation of medical necessity," as required by LCD L33787 (Centers for Medicare & Medicaid Services 2023; GA R&R – O.C.G.A. § 50-13-1 et seq); (3) the patient must obtain an additional appointment with a PCP or specialist; (4) the prosthetist resubmits the documentation with the required signature; and (5) if deadlines lapse or forms are incomplete, the claim is denied and directed to appeal. In Georgia, where nearly 30% of residents live in medically underserved areas (Georgia Budget and Policy Institute 2016), this additional step of producing documentation frequently produces delays measured in weeks or months.

**VIII. Policy scope and fiscal relevance**

The PPPA is narrowly crafted to amend Georgia's insurance code and Medicaid administration. The legislation also mandates a public data portal through the Georgia Department of Community Health (DCH). This portal will consolidate best practices, patient testimonials, and regional service maps, addressing the information deficits identified by the National Academies (Ziegler-Graham et al. 2008). By making prosthetic knowledge accessible to both clinics and patients, the portal promotes transparency and informed decision-making.

**IX. Maintaining legitimacy: avoiding monetary schemes**

With increased prescriptive authority comes the concern of potential misuse or fraud with DME. Recent high-profile cases, such as *United States v. Patel* (2023), where a Georgia-based lab owner defrauded Medicare of $187 million via fraudulent genetic testing schemes, demonstrate how profit incentives can corrupt otherwise sound medical programs. The scheme hinged on remote physicians approving prescriptions without review for tests they neither evaluated nor approved. Such abuses erode public trust and raise legitimate concerns about broadening prescriptive authority (Rudowitz et al. 2021).

Under PPPA, all prosthetists authorized to prescribe must be state-licensed and certified by the American Board for Certification in Orthotics, Prosthetics & Pedorthics (ABC) or the Board of Certification/Accreditation (BOC). This ensures that prescribers possess the training, competency, and ethical skills needed for proper prescription. Unlike the remote physicians implicated in *United States v. Patel* (2023), this requirement necessitates direct, hands-on patient care, reducing the risk of fraudulent prescriptions.

The Act requires annual compliance audits of insurance claims and prescriptive patterns, including random case sampling to identify anomalies. The Georgia Department of Human Services (DHS) would oversee these audits along with insurers, allowing detection of irregularities and deterring misconduct.

To establish greater accountability, PPPA empowers DHS to establish a fraud-reporting portal, open for patients, providers, and insurers to report suspicious activity. Confirmed cases of misconduct would induce civil penalties, and lead to further action, such as suspension, in repeat cases. This

implementation mirrors similar methods of fraud protection in Medicare, and adapts them to the specific field of prosthetic care, allowing for proper documentation through the entire process.

Prosthetic prescription requires physical examination, multiple fittings, and longitudinal patient interaction. The nature of the service inherently limits opportunities for fraud relative to other forms of DME. The safeguards in PPPA are essential to maintaining legitimacy and public confidence and to preventing the exploitation of the very communities the legislation aims to support.

**X. Policy alternatives: public options & basic health programs**

Alternative healthcare expansions, including public option health plans and Basic Health Programs (BHPs), broaden coverage but do not address the procedural inefficiencies specific to prosthetic access. Washington State's public option, launched in 2021, encountered significant implementation barriers: limited provider participation, narrow networks, and uneven geographic availability (Sparer 2020). BHPs, authorized under Section 1331 of the Affordable Care Act, extend coverage to individuals earning up to 200% of the federal poverty level (U.S. Government Accountability Office 2017). Minnesota and New York have demonstrated that BHPs can effectively bridge gaps between Medicaid and private insurance markets, particularly for low-income working populations (Mannat Health 2021). Yet BHPs also defer to conventional insurance design, leaving prescriber authority unaltered. As a result, even when coverage expands, patients remain subject to the same delays and denials that undermine access to prosthetic care.

PPPA should be understood not as a substitute for broader reforms, but as a targeted corrective to a distinct procedural flaw. Broader coverage mechanisms such as Medicaid expansion, public options, or BHPs determine who is insured; PPPA determines how efficiently those insured patients can access prescribed prosthetic care. Comparable inefficiencies exist in orthotics, wheelchairs, oxygen supplies, and physical therapy referrals, where physicians are currently required to authorize services that credentialed specialists are better positioned to prescribe (Centers for Medicare & Medicaid Services 2023). While the Act is deliberately narrow in scope to address Georgia's most urgent gap, its adoption would establish a precedent for streamlining coverage rules in other domains of durable medical equipment and allied health services.

**XI. Building evidence-based reputations**

A persistent challenge in underserved communities is the lack of awareness—among both patients and providers—about prosthetic options. The National Academies of Sciences reported in 2018 that many community health clinics lacked updated information on assistive technologies (Ziegler-Graham et al. 2008). Requiring a physician co-signature under these conditions does not improve quality; it entrenches a bottleneck by placing decision-making authority in the hands of clinicians who often lack the specialized training to act promptly.

The PPPA responds by elevating prosthetists to recognized prescribers. This shift ensures that patients can move directly from prosthetic evaluation to treatment, while also embedding prosthetists more visibly within primary care and rural health networks. Greater visibility incentivizes earlier referral, improves the dissemination of evidence-based information, and builds trust in prosthetic services, especially in communities where delays have historically discouraged engagement.

**XII. Conclusion: a modern, equitable, and economically sound approach to prosthetic care**

The PPPA offers a targeted, evidence-based solution to one of healthcare's most persistent access barriers. By recognizing licensed prosthetists as prescribers for insurance purposes, PPPA eliminates redundant physician approvals that delay care, streamlines and reduces the cost of programs, and implements oversight mechanisms to. In doing so, the Act delivers faster and more equitable access to mobility for patients and strengthens efficiency across the healthcare system as a whole.

This policy benefits all stakeholders: patients receive timely care, providers gain clarity and autonomy, insurers experience lower costs, and governments reduce long-term spending. Georgia has the opportunity to lead in redefining equitable access to

mobility. In enacting PPPA, we uphold the dignity of amputees, empower frontline providers, and reaffirm commitment to accessible, efficient, and equitable care.

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