

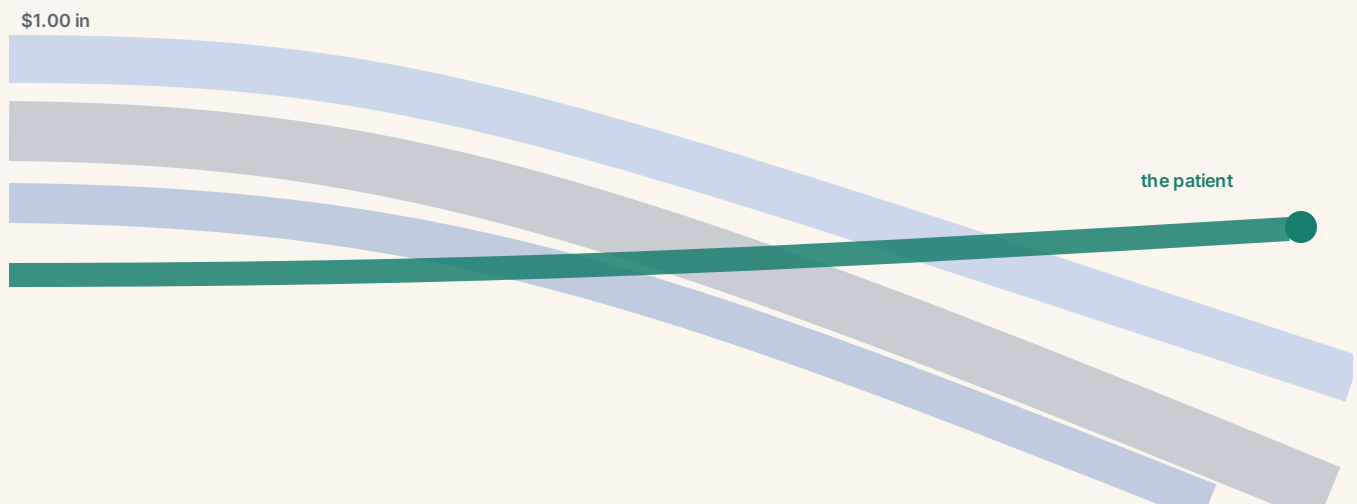
INDUSTRY PERSPECTIVES

Why the money never reaches the patient

Waste, friction, and unmet need in America's \$100 billion market for durable medical equipment, prosthetics, and orthotics

An estimated 60 cents of every dollar is lost before it becomes care.

≈\$60 billion of a ≈\$100 billion annual spend, consumed by administration, improper payment, fraud, mispricing, and rework. Methodology inside.



ABOUT THIS REPORT

This report examines how money moves through the United States market for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) — and why so little of it converts into timely, well-fitting devices for the people who need them.

It draws on public primary sources: CMS National Health Expenditure accounts and Medicare claims public use files, HHS Office of Inspector General audits, GAO reviews, Department of Justice enforcement records, and the peer-reviewed clinical literature. Figures are reported with their source year; where only estimates exist, they are identified as such. Claims-data computations use the CY2023 Medicare DME public use files released in June 2025.

Hike Medical operates in this market, and we believe readers deserve to know that. The analysis that follows is deliberately not about us. It is about a system that spends more on paperwork, error, and fraud than it does on devices — and what the evidence says it would take to fix it.

— The Hike Medical team

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A NOTE ON SCOPE

“DMEPOS” spans custom prosthetic limbs and orthotic braces, wheelchairs and power mobility, diabetic footwear and inserts, CPAP and home respiratory equipment, continuous glucose monitors, and related supplies. National accounts define retail “durable medical equipment” more broadly than Medicare’s benefit; we flag the difference wherever it matters.

60¢

of every dollar America spends on this care never becomes a device on a patient's body — an estimated **\$60 billion of a ~\$100 billion annual spend**, consumed by administration, improper payment, fraud, mispricing, and rework. Hike Medical estimate; ledger and methodology on page 4.

\$86.4B

US retail spending on durable medical equipment in 2024 — up 44% since 2019 and projected to reach \$120.8B by 2033

24.1%

Share of Medicare fee-for-service DMEPOS dollars paid improperly — \$2.3B in one year, the highest error rate of any claim type in the program

\$10.6B

Fraudulent claims billed by a single criminal organization through catheter and DME supply companies, charged in 2025's record takedown

138 days

Average wait from lower-limb amputation to receipt of a prosthesis — 141 days for women, 106 for men

29.3%

Share of assistive devices that end up completely abandoned by their users — mobility aids most of all

America's spending on durable medical equipment, prosthetics, and orthotics is approaching \$100 billion a year and growing faster than healthcare overall. The chapters that follow trace, from primary sources, how roughly \$60 billion of it leaks away — and what the evidence says it would take to close the gap.

The leak is not one hole but four. **Improper payments:** nearly one Medicare DMEPOS dollar in four fails federal payment rules, overwhelmingly for missing or insufficient documentation. **Fraud:** the category has produced some of the largest healthcare fraud schemes ever charged, from the \$1.2 billion "Operation Brace Yourself" telemedicine scheme in 2019 to the \$10.6 billion catheter scheme charged in 2025. **Pricing failure:** Medicare's fee schedule still traces to supplier charges from 1986–87; the program has paid up to \$891 on average for off-the-shelf back braces that retail for a small fraction of that, and 69% above suppliers' actual acquisition cost for glucose monitors. **Administrative complexity:** prior authorization, face-to-face rules, five-level appeals, and accreditation create weeks of delay and consume 30 minutes to 2 hours of staff time per authorization — while three-quarters of appealed Medicare Advantage denials are overturned.

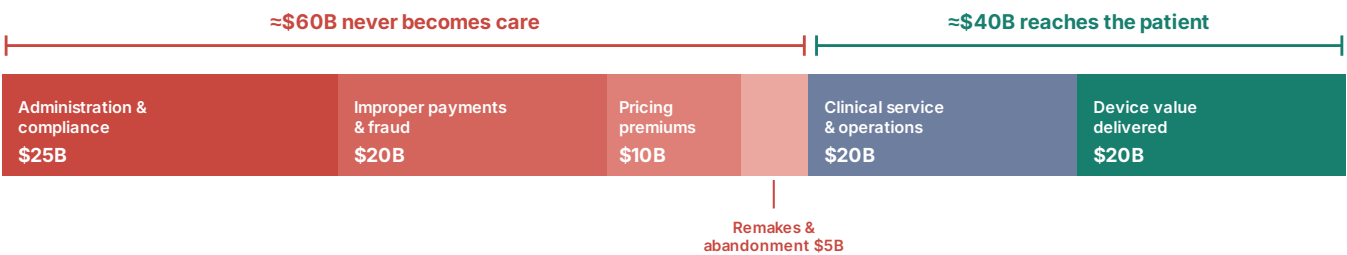
Patients absorb the residual. The average amputee waits four and a half months for a limb. A majority of wheelchair users who need repairs wait a month or more. Nearly a third of issued devices are abandoned; 44% of prosthesis users are dissatisfied with their device. The clinical stakes are severe: diabetic foot ulcers alone affect about 1.6 million Americans a year, and five-year mortality after a diabetic foot ulcer — 49% — rivals many cancers. Yet the evidence shows the inverse, too: patients fitted with a prosthesis within three months of amputation incur roughly 25% lower total healthcare costs over the following year.

Demand will not wait for the system to fix itself. The 65-and-over population will pass 71 million by 2030; 2.3 million Americans live with limb loss today, projected to reach 3.6 million by 2050. Meanwhile the supplier base contracted by roughly 40% in the four years after competitive bidding went national, and the orthotics and prosthetics profession counts only about 10,000 practitioners.

None of this is inevitable. Where digital workflows and additive manufacturing have been deployed at scale — most visibly inside the VA — delivery times for custom orthoses have fallen from 8–12 weeks to 5–7 days, fabrication costs have halved, and patients prefer the result. The last chapter assembles that evidence into five shifts that would let the dollar reach the patient.

The hundred-billion-dollar ledger

No agency publishes a waste figure for this market, so we assembled one from the sources in this report. The ledger applies documented, source-specific rates to total annual US spending of roughly \$100 billion — retail DME of \$86.4 billion in 2024, plus orthotic and prosthetic clinical services and equipment delivered outside retail channels. It is a directional estimate, published with its methodology so it can be challenged. It is also conservative: no dollar is counted twice, and it omits the downstream clinical costs of delay documented in Chapter 3.



Share of ≈\$100B total annual US spending on DMEPOS-type care, Hike Medical estimate, 2026

Administration & compliance · ≈\$25B Billing and insurance activity already consumes ≈14.5% of professional revenue economy-wide; DMEPOS adds prior authorization (30–120 min per request), face-to-face rules, accreditation, and five-level appeals. Range applied: 20–30%.	Improper payments & fraud · ≈\$20B Medicare itself measures 24.1% of DMEPOS dollars as improperly paid; \$14.6B in fraud was charged in 2025 alone. Lower rates assumed for commercial payers. Range: 15–25%.	Pricing premiums · ≈\$10B OIG: CGMs paid 69% above acquisition cost; orthotics \$337.5M above commercial rates in four years; the fee schedule is anchored to 1986–87 charges. Range: 8–12%.
Remakes & abandonment · ≈\$5B 29.3% of assistive devices are abandoned; a traditional socket episode discards 2–3 check sockets; industry remake rates run near 1 in 10. Applied to device value only. Range: ≥5%.	Clinical service & operations · ≈\$20B Legitimate evaluation, fitting, follow-up, and clinic operations — the human work of getting a device onto a body, which good policy should protect.	Device value delivered · ≈\$20B Materials, manufacturing, and the device itself — the only part of the dollar a patient can wear, ride, or walk on.

METHODOLOGY, IN ONE PARAGRAPH

Each component applies a documented rate (sourced in Chapters 1–3 and the endnotes) to the ≈\$100B base, taking the conservative end where evidence is thin and de-duplicating where categories overlap — fraud that appears in Medicare's improper-payment measurement is not counted again, and pricing premiums exclude claims already counted as improper. The plausible range for the total is \$50–70 billion a year; we publish the \$60 billion point estimate to be checked, challenged, and improved. Nothing in this ledger includes the downstream costs of delay — amputations not prevented, falls not avoided — which Chapter 3 suggests are larger still.

A hundred-billion-dollar economy, growing fast

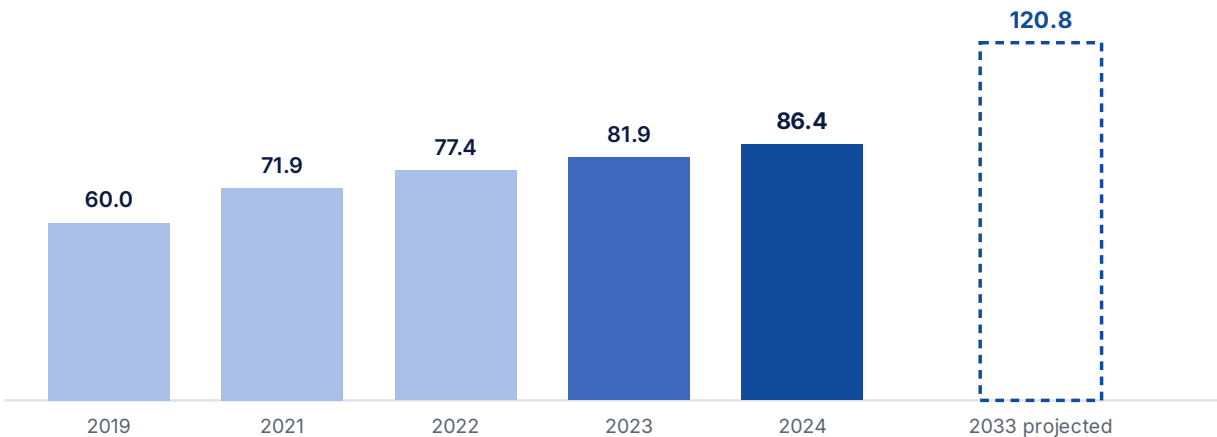
Durable medical equipment is among the fastest-growing categories in American healthcare — and one of the least examined.

In 2024, US retail spending on durable medical equipment reached \$86.4 billion, up 5.4% in a single year and 44% since 2019.¹ The CMS Office of the Actuary projects the category will surpass \$120 billion by 2033.² These national-accounts figures define DME broadly — they include eyeglasses and hearing aids alongside wheelchairs, prosthetics, and home respiratory equipment — but the narrower Medicare benefit tells the same story. Claims processed by Medicare's DME contractors carried \$16.6 billion in allowed charges in 2023 for fee-for-service beneficiaries alone,³ and FFS now covers under half of Medicare enrollment, implying a Medicare-funded DMEPOS economy roughly twice that size. Add orthotic and prosthetic clinical services and equipment delivered outside retail channels, and total annual spending on this care reaches roughly \$100 billion.

This is not a niche. Within fee-for-service Medicare in 2023, more than 840,000 beneficiaries received home oxygen, more than 710,000 received CPAP devices, about 650,000 received continuous glucose monitor supplies, and nearly 234,000 received therapeutic diabetic shoes.³ Counting Medicare Advantage, Medicaid, commercial insurance, the VA, and cash purchases, tens of millions of Americans depend on this equipment every year. And the categories meet in single bodies: the diabetic patient who moves from insole to ulcer to amputation to prosthesis touches four of them. Chapter 3 follows that arc.

EXHIBIT 1
US spending on durable medical equipment has grown 44% in five years, with another 40% projected by 2033.

US retail DME expenditures, national health accounts, \$ billion



Note: National health accounts define retail DME to include eyeglasses, contact lenses, and hearing aids, a broader scope than Medicare's DMEPOS benefit.
Source: CMS National Health Expenditure Accounts, 2024 release (Table 17); CMS Office of the Actuary projections

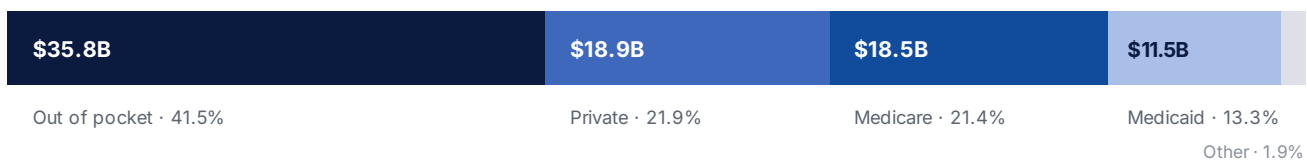
Patients themselves are the largest payer

Of the \$86.4 billion spent in 2024, out-of-pocket payments were the single largest source at \$35.8 billion — 41.5% of the total — followed by private insurance (\$18.9 billion), Medicare (\$18.5 billion), and Medicaid (\$11.5 billion).¹ Part of that out-of-pocket share reflects retail purchases of eyeglasses and hearing aids, but a substantial portion is cost-sharing and denials pushed onto people using covered equipment: Medicare beneficiaries typically owe 20% coinsurance on DMEPOS⁴ — on a microprocessor knee component with an average allowed amount of \$27,366 in 2023, that is more than \$5,400 out of pocket.³

EXHIBIT 2

Out-of-pocket payments are the largest single source of DME funding.

US retail DME expenditures by payer, 2024, \$ billion (% of total)

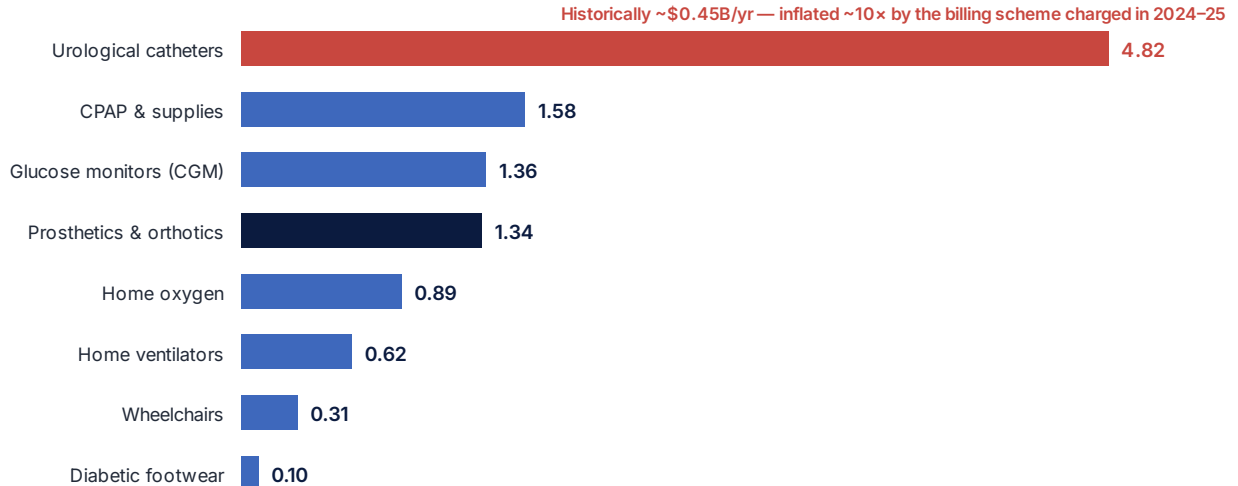


Source: CMS National Health Expenditure Accounts, 2024 release (Table 17)

EXHIBIT 3

One fraud-driven anomaly briefly became Medicare's largest DMEPOS "category."

Medicare fee-for-service allowed charges by selected category, CY2023, \$ billion



Note: Categories are groupings of HCPCS codes and do not sum to total program spending; prosthetics & orthotics is all L-codes. Allowed charges include ~20% beneficiary cost-sharing.

Source: Hike Medical analysis of CMS Medicare DME, Devices & Supplies public use files, CY2023 (released June 2025); NAACOS catheter-claims analysis

Two features of this market matter for everything that follows. First, it is extraordinarily fragmented: 63,988 distinct supplier organizations billed Medicare FFS for DMEPOS in 2023,³ and the orthotics-and-prosthetics patient-care segment is a long tail of independent clinics around a single national player. Second, its largest line items are exactly the ones federal auditors flag most often — a coincidence the next chapter shows is not a coincidence at all.

One Medicare dollar in four spent on medical equipment is paid improperly — the highest error rate of any claim type in the program.

CMS Comprehensive Error Rate Testing program, 2025 reporting period

The four leaks: where the dollar goes

Researchers estimate that roughly a quarter of all US health spending — \$760 billion to \$935 billion a year — is waste. In medical equipment, every major waste category runs hotter than the system average.

The landmark JAMA taxonomy of healthcare waste identifies administrative complexity (\$265.6 billion a year) as the largest category, followed by pricing failure (\$230.7–240.5 billion) and fraud and abuse (\$58.5–83.9 billion).⁵ DMEPOS is a small slice of national spending, but it is a leader in all three — plus a fourth, measurable leak: improper payments.

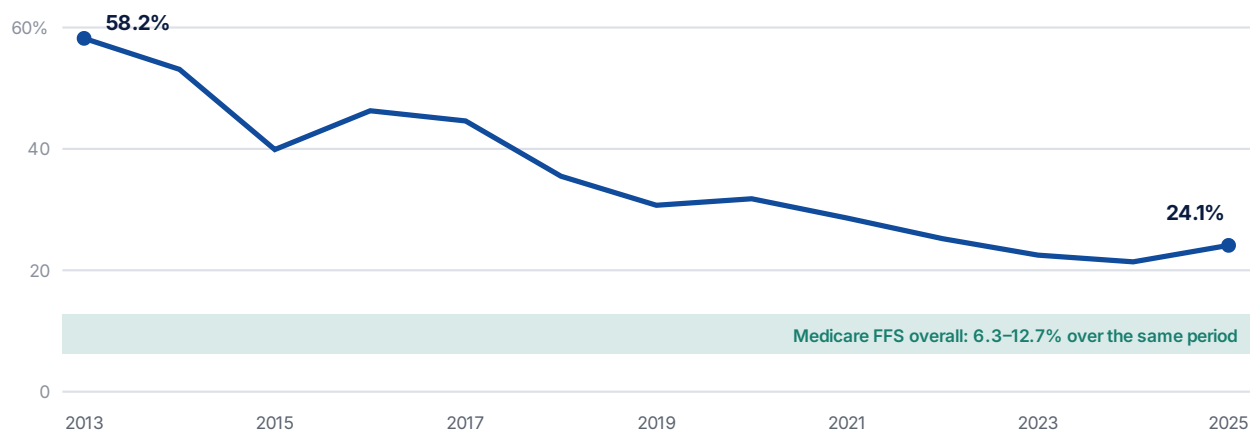
Leak 1: Improper payments — the program's worst error rate, year after year

Medicare's Comprehensive Error Rate Testing program has measured DMEPOS as the highest-error claim type in fee-for-service Medicare for over a decade. In the 2025 reporting period the DMEPOS improper payment rate was 24.1% — \$2.3 billion — against 6.6% for Medicare FFS overall.⁶ The headline driver is not exotic: insufficient documentation accounts for roughly half of all improper payments program-wide, and far more in some equipment categories. Therapeutic diabetic shoes ran a 47.1% improper payment rate in the 2024 data, 85.5% of it from insufficient documentation.⁷ The paperwork, in other words, fails more often than the devices do.

EXHIBIT 4

DMEPOS error rates have improved — and are still three to four times the Medicare average.

Medicare FFS improper payment rate, DMEPOS, % of allowed dollars, CERT reporting periods 2013–25



Source: CMS Comprehensive Error Rate Testing program, annual supplemental improper payment data, 2013–25 reporting periods

Leak 2: Fraud — equipment is the fraud economy's favorite product

Durable medical equipment has anchored nearly every record-setting federal healthcare fraud action of the past decade. The template was set by 2019's "Operation Brace Yourself": telemarketers harvested Medicare numbers, telemedicine doctors signed brace orders for patients they never treated, and supply companies billed Medicare — over \$1.2 billion in losses, with braces that retailed for as little as \$25 reimbursed at hundreds of dollars each.⁸ The Justice Department later estimated that this single action avoided \$1.9 billion in brace payments over the following 20 months.⁹

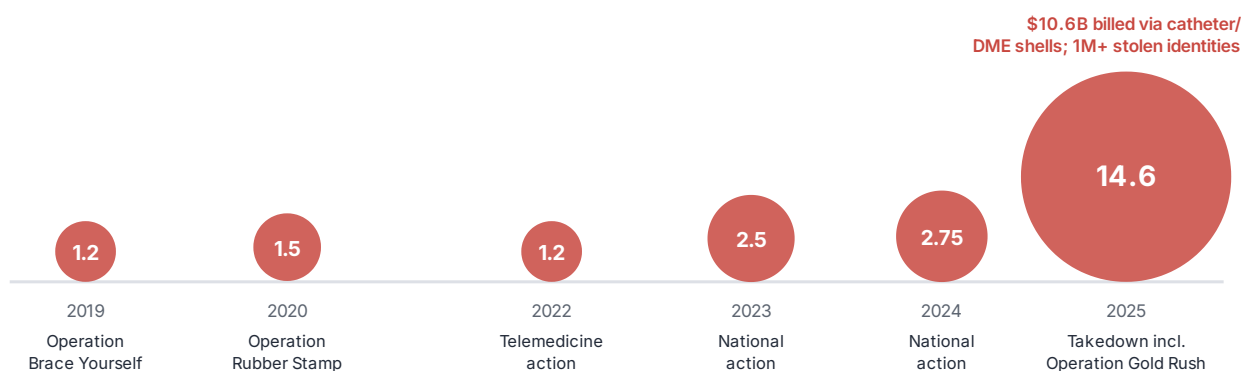
The scheme has only scaled since. In 2023, beneficiaries billed for urinary catheters jumped from roughly 50,000 a year to more than 450,000, concentrated in seven supply companies; catheter payments rose from \$153 million to \$2.1 billion in two years.¹⁰ By June 2025, the conduct was charged as "Operation Gold Rush": a transnational organization that bought shell supply companies, used the stolen identities of more than one million Americans, and submitted \$10.6 billion in fraudulent claims — the centerpiece of the largest healthcare fraud takedown in history (\$14.6 billion in intended losses, 324 defendants).¹¹ CMS's systems stopped most of the payout, but the episode exposed how easily industrial-scale billing can attach itself to the DMEPOS benefit. In February 2026, CMS responded with a nationwide moratorium on enrolling new DMEPOS supply companies.¹²

Fraud of this scale is a symptom as much as a crime: it thrives where products are commodities, prices are administratively set far above cost, and the ordering clinician, supplier, and patient never meet.

EXHIBIT 5

DME has anchored every record federal healthcare fraud action since 2019.

Major federal enforcement actions with DMEPOS components, alleged/intended losses, \$ billion



Note: Figures are alleged or intended losses as charged, not amounts ultimately paid or recovered; in Operation Gold Rush, CMS prevented payment of all but ~\$41 million of the ~\$4.45 billion scheduled for payout.

Source: US Department of Justice press releases, 2019–25; HHS Office of Inspector General

Leak 3: Pricing failure — fee schedules from another era

Medicare's DMEPOS fee schedule still traces, by statute, to average supplier charges from 1986–87, updated for inflation.¹³ Four decades of manufacturing progress later, the gaps are stark. In 2023, Medicare's average allowed amount for an off-the-shelf lumbar brace (L0650) was \$891; comparable braces retail online for \$25–100.^{3,8} The HHS Inspector General found that Medicare and its beneficiaries paid \$337.5 million more than non-Medicare payers for the same orthotic devices over just four years — a finding whose core recommendation has not been implemented.¹⁴ For continuous glucose monitors, OIG found Medicare paying 69% above suppliers' actual acquisition cost (\$377 million in one year) and above ordinary retail prices.¹⁵

The program's main pricing corrective has stalled. Competitive bidding cut payment rates roughly in half where it operated, but the 2021 round produced contracts in only 2 of 15 product categories — bids elsewhere would not have saved money — and those contracts expired at the end of 2023. Since January 2024, no competitive bidding contracts have been in effect at all.¹⁶

EXHIBIT 6

Administratively set prices sit far above what the same products cost elsewhere.

Medicare average allowed amount vs market reference, \$ per item

Off-the-shelf lumbar brace (L0650)



Off-the-shelf knee brace (L1851)



CGM supplies, monthly (A4239)



Medicare avg allowed, CY2023 FFS claims ■ Market reference

Note: Retail references are indicative consumer prices for functionally comparable off-the-shelf products and are not coded equivalents; custom-fabricated and custom-fitted devices involve clinical services not reflected in retail prices. CGM acquisition cost derived from OIG's finding that payments exceeded acquisition cost by 69%.

Source: Hike Medical analysis of CMS Medicare DME public use files, CY2023; DOJ, Operation Brace Yourself records; HHS OIG audits (2019, 2024, 2025)

Leak 4: Administrative complexity — the leak that compounds the other three

Every defense against fraud and error adds process, and DMEPOS now carries more process per dollar than almost any benefit in Medicare. A covered item can require a face-to-face encounter within six months, a written order in the supplier's file before delivery, prior authorization for a growing list of devices including lower-limb prosthetics and power mobility, supplier accreditation and surety bonds, and — when claims are denied — a five-level appeals process.¹⁷ O&P providers report spending 30 minutes to 2 hours of staff time per prior-authorization request,¹⁸ against a healthcare benchmark in which billing and insurance activities already consume about 14.5% of professional revenue.¹⁹

The process does not appear to be selecting the right claims. When Medicare Advantage denials were appealed, plans overturned 75% of their own decisions — yet only 1% of denials were ever appealed, leaving the rest to stand by default.²⁰ A separate OIG review found 13% of MA prior-authorization denials met Medicare coverage rules and should have been approved.²¹ Meanwhile, the documentation regime that drives the error rate in Exhibit 4 sits with clinicians who never billed for the device: a primary-care physician's chart note, not the prosthetist's evaluation, frequently decides whether a limb is “medically necessary.”

The cumulative effect is a system in which compliant suppliers carry heavy fixed costs while determined fraud rings, as Chapter 2 showed, simply route around the controls. After competitive bidding went national in 2013, the traditional supplier base contracted by roughly 41% in four years;²² the administrative load has fallen hardest on exactly the local suppliers patients rely on for fitting and service.

30–120

min

Reported staff time per O&P prior-authorization request

75%

Of appealed Medicare Advantage denials overturned by the plans themselves, 2014–16 — while only 1% of denials were appealed

51.5%

Of Medicare FFS improper payments caused by insufficient documentation alone

-41%

Change in traditional HME supplier base in the four years after competitive bidding went national (2013–17)

THE COMPLIANCE PARADOX

DMEPOS controls are calibrated to catch yesterday's scheme. Braces drove the 2019 fraud wave, so brace edits tightened — and the fraud economy moved to catheters, which carried no prior-authorization requirement. Each cycle adds permanent process for legitimate suppliers while displacing, not eliminating, the fraud. Breaking the cycle requires making the honest path cheap — documentation that writes itself correctly the first time — rather than making every path expensive.

The patient pays twice

To see what the leaks cost, stop following claims and follow one patient: a 64-year-old with diabetes. Her path — insole, ulcer, amputation, prosthesis — runs through every failure in this report.

Prevention fails first. She is one of 38.4 million Americans with diabetes.⁴¹ The cheapest intervention she will ever be offered — therapeutic footwear and custom inserts — is also the most error-prone purchase in Medicare, with a 47.1% improper payment rate, 85.5% of it paperwork.⁷ And if the footwear arrives, the odds are she will not wear it: objective studies find only 22–36% of high-risk patients wear prescribed footwear more than 80% of the day, with fit and comfort among the leading reasons.³¹

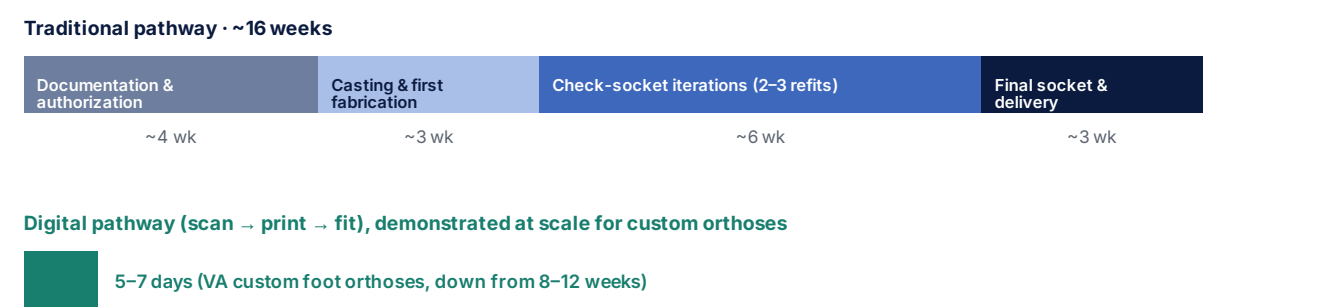
Then the ulcer. About 1.6 million Americans develop a diabetic foot ulcer each year; roughly one in five cases leads to amputation, recurrence reaches 65% within five years, and five-year mortality after an ulcer — 49% — is worse than many common cancers.^{34,36} Ulcer care alone adds \$9–13 billion a year to US payer costs.³⁵

Then the wait. If she joins the roughly 465,000 Americans who undergo amputation each year,⁴² she enters the queue: the average patient waits 138 days from amputation to prosthesis — and as a woman she waits longer, 141 days against 106 for men.²³ The socket episode itself averages around 16 weeks and consumes two to three discarded check sockets before a definitive fit.²⁴

EXHIBIT 7

A custom prosthetic socket episode averages about 16 weeks — most of it process, not fabrication.

Illustrative lower-limb socket episode based on published averages; weeks



Each handoff — prescriber to payer to fabricator to fitter — adds queue time; the 138-day average from amputation to prosthesis includes healing as well as process.

Source: Miller et al., PM&R (2022); direct-casting outcomes literature, JPO (2023); US Department of Veterans Affairs (2021)

Devices that don't fit don't get used

Now suppose the system delivers her device. In the most-cited study of assistive technology use, 29.3% of all devices were eventually abandoned outright, with poor fit to user needs among the strongest predictors.²⁸ Scoliosis braces are worn, on objective sensor measurement, only about 47% of the prescribed time;³⁰ upper-limb prostheses are rejected by a quarter to nearly half of users depending on device type;²⁹ and in a 2024 survey of 1,736 lower-limb prosthesis users, 44% were dissatisfied with their device and 37% with the service around it.³² Every abandoned device is a full unit of spending with zero units of benefit — waste no claims audit will ever catch, and the reason the ledger on page 4 counts remakes and abandonment as their own line.

EXHIBIT 8

What the system delivers, as patients experience it.

Selected published measures of device use and experience

29.3% of assistive devices completely abandoned by users (mobility aids highest)	44% of 1,736 lower-limb prosthesis users dissatisfied with their device (2024)	47% of prescribed wear time actually achieved for scoliosis braces, by sensor measurement	62% of wheelchair users report typical repairs taking 4+ weeks
22–36% of high-risk diabetic patients adherent to prescription footwear (>80% of the day)	<50% of people living with limb loss have ever been prescribed a prosthesis	2–3 check sockets fabricated and discarded in a typical traditional socket episode	6.25 socket refits needed per transtibial patient per decade, on average

Source: Phillips & Zhao (1993); Prosthetics & Orthotics International (2024); Spine (2004); US PIRG “Stranded” (2022); Diabetes Care (2013); MOST Policy Initiative (2023); JPO (2023); prosthetic socket literature (2022)

THE SAME STORY ON WHEELS

Her path is not unique — it is the pattern. Complex rehab wheelchairs average roughly six months from recommendation to delivery.²⁵ More than half of wheelchair users with spinal cord injury need a repair within six months, and 42% of them suffer consequences — stranded at home, stuck in bed — lasting a median of five days.²⁷ Nationally, 62% say a typical repair takes four weeks or more,²⁶ and the two private-equity-backed firms that dominate the category after 67+ combined acquisitions tell customers repairs can take up to three months.³³ Fragmented service, weak accountability for outcomes: the same disease, a different limb.

The downstream bill is far larger than the device budget

The cruel arithmetic of this market is that its cheapest items prevent its most expensive events. Once our patient's ulcer becomes an amputation, Medicare spends on the order of \$52,000 a year on her care.³⁶ The falls that walkers, braces, and wheelchairs exist to prevent cost older Americans roughly \$50 billion in medical spending a year.³⁷ Against numbers like these, every device in her story is a rounding error — which is what makes the system's delays so expensive.

The inverse is also documented. Patients fitted with a prosthesis within three months of amputation incurred about 25% (~\$25,000) lower total healthcare costs over the following 12 months than comparable patients who were not fitted — and patients fitted late showed no savings at all.³⁸ Medicare beneficiaries who received lower-extremity orthoses cost the program 10% less over 18 months than matched patients who needed but did not receive them.³⁹ Speed is not a convenience metric in this market; it is the treatment effect.

EXHIBIT 9

Timely fitting pays for itself: early prosthesis receipt is associated with ~25% lower total cost of care.

Total 12-month healthcare costs after lower-limb amputation, commercially insured cohort, indexed (not fitted = 100)



Savings include the cost of the device. Patients fitted at 4–9 months showed costs comparable to never-fitted patients — the window closes.

Source: IMPACT study, American Journal of Physical Medicine & Rehabilitation (2020); n=510, MarketScan commercial claims

WHY “WASTE” UNDERSTATES THE PROBLEM

Audit-able waste — improper payments, fraud, price gaps — is only the measurable layer. The larger losses are the ones no ledger records: the ulcer that became an amputation while documentation cycled, the wheelchair user who missed work for a month awaiting a repair, the 138 days of reduced mobility, deconditioning, and lost independence between amputation and limb. A full accounting of this market's inefficiency must include the care it failed to deliver, not just the dollars it misdelivered.

Demand is rising; capacity is not

Every trend that drives DMEPOS demand is accelerating. The 65-and-over population reached 61.2 million in 2024 and will pass 71 million by 2030, when one in five Americans will be of retirement age.⁴⁰ Some 38.4 million Americans have diabetes — about 29% of all seniors.⁴¹ The population living with limb loss, 2.3 million today (5.6 million counting limb difference, with roughly 465,000 amputations a year), is projected to reach 3.6 million by 2050.^{42,43} And 12.2% of US adults already report serious difficulty walking or climbing stairs.⁴⁴

The delivery system is moving the other way. The orthotics and prosthetics profession counts only about 10,100 practitioners nationally; a decade-old workforce study projected demand outstripping the supply of credentialed providers by 60% by 2025, and federal projections still show the occupation growing far faster than average.⁴⁵ The supplier base shrank roughly 41% in the four years after competitive bidding went national, consolidation has concentrated complex-rehab service in two firms, and as of February 2026 a nationwide moratorium bars new DMEPOS supply companies from enrolling in Medicare at all.^{12,22} Capacity constraints and fraud controls are now the same policy lever — and patients sit at the intersection.

EXHIBIT 10

The gap between need and delivery capacity is set to widen.

Selected indicators of demand and capacity

DEMAND ↑	CAPACITY ↓
61.2M → 71.6M Americans 65+, 2024 → 2030	~10,100 orthotists & prosthetists nationwide
38.4M Americans with diabetes	60% projected excess of demand over credentialed supply by 2025 (2015 study)
2.3M → 3.6M living with limb loss, today → 2050	–41% traditional HME suppliers, 2013–17
~465,000 amputations per year	2 firms dominate complex rehab wheelchairs after 67+ acquisitions
12.2% of adults with serious mobility difficulty	0 new DMEPOS supply companies admitted to Medicare under the 2026 moratorium

Source: US Census Bureau (2024–25); CDC (2021–22); Amputee Coalition/Avalere (2024); Ziegler-Graham et al. (2008); BLS (2024); NCOPE/Dobson DaVanzo (2015); AAHomecare (2017); STAT News (2024); Federal Register (2026)

A market in which demand compounds, qualified labor is scarce, and entry is administratively frozen cannot scale by adding people and process. It can only scale by changing how each device gets made and documented — which is where the evidence turns hopeful.

What good looks like

None of the four leaks requires new science to fix. Each has been closed somewhere, by someone, with technology that already exists. The task is to make the fixes the default.

1. Make the record write itself

Half of Medicare's improper payments stem from insufficient documentation, not bad care.⁶ The fix is structural: capture the clinical encounter, coverage criteria, and ordering logic in one system at the point of care, so that the chart, the order, and the claim are generated from the same data — complete, consistent, and auditable by construction. AI-assisted documentation and eligibility screening before the visit turn compliance from a retrospective audit into a property of the workflow. A record that writes itself correctly the first time is also the cheapest fraud control ever devised: it restores the treating relationship that the brace and catheter schemes exploited.

2. Replace plaster with pixels — and warehouses with printers

The strongest natural experiment comes from the VA, which moved custom foot orthoses from outsourced plaster workflows to in-house scanning and 3D printing — and cut delivery from 8–12 weeks to 5–7 days.⁴⁶ Controlled studies point the same way: 3D-printed hand orthoses more than halved production time and cost versus conventional fabrication, with 79% of patients preferring the printed device;⁴⁷ conventional orthosis fabrication takes about a week where printing takes about a day;⁴⁸ and AI-generated prosthetic sockets have proven non-inferior in comfort to clinician-led designs in randomized testing.⁴⁹ Digital files also end the remake ratchet: a socket that exists as data can be reprinted in hours, not recast over weeks.

3. Integrate prescription to product

The 16-week episode in Exhibit 7 is mostly queue time between organizations — prescriber, payer, central fabricator, fitting clinic — each with its own intake, backlog, and error surface. Vertically integrated models that scan, design, manufacture, and fit under one accountable roof remove the handoffs in which both delay and documentation failure live. The wheelchair repair crisis shows the cost of the opposite design: service fragmented away from accountability.^{26,33}

4. Price against reality, not 1987

A fee schedule anchored in 1986–87 charge data¹³ will always misprice a category whose manufacturing economics change by the year — too high for commodity braces, arguably too low for clinically intensive custom work. Reference pricing against observable market and acquisition costs, as OIG has repeatedly recommended,^{14,15} would drain the arbitrage that attracts industrial fraud while leaving room to pay properly for clinical service. The collapse of the 2021 bidding round¹⁶ is an invitation to design the next mechanism around real cost data rather than gamed bids.

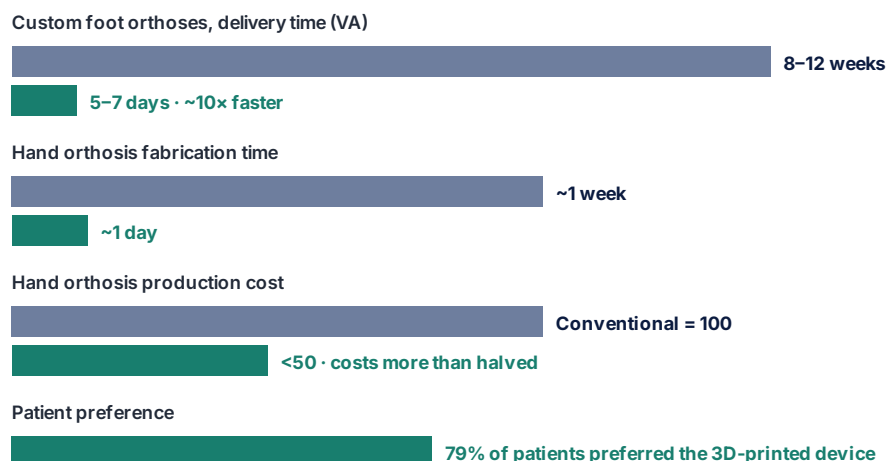
5. Pay for devices that work, not paperwork that clears

The system measures claims accuracy obsessively and device outcomes almost never. Time-to-device, remake rate, abandonment, and functional outcomes are all measurable today — and the IMPACT evidence shows early fitting pays for itself within a year.³⁸ Tying payment, even modestly, to delivery speed and sustained use would redirect billions from process to product. What gets measured gets funded.

EXHIBIT 11

Where digital workflows are deployed, the gains are not incremental.

Published before/after comparisons, digital vs conventional O&P workflows



Source: US Department of Veterans Affairs (2021); Journal of Rehabilitation Medicine (2024); Polymers (2024)

AN HONEST CAVEAT

The clinical evidence base for additive manufacturing in O&P is promising but still maturing: systematic reviews rate study quality as low, and at least one randomized trial found early 3D scanning workflows no faster than plaster once remakes were counted.^{50,51} The technology is necessary, not sufficient — it pays off when embedded in an integrated clinical workflow, and merely shifts the bottleneck when bolted onto a fragmented one.

The pattern across all five shifts is the same: move information instead of plaster, integrate instead of hand off, and let evidence — not incumbency — set the price. The \$60 billion ledger on page 4 is not a forecast — it is a running annual total. The question is not whether this transition happens, but who is accountable for making it happen before the demographic wave arrives.



ABOUT HIKE MEDICAL

We wrote this report because we operate inside the problem it describes.

Hike Medical builds the operating system this report argues for: a single workflow from prescription to product. AI agents handle referral processing, eligibility, and compliant documentation before the visit; clinicians work with 3D scanning and software that turns a 45-minute evaluation into minutes; and devices are produced in our own purpose-built, government-approved 3D-printing factory — so the device is made right, in-house, and delivered in days.

In our operating experience to date, that design delivers care at less than half the typical cost, roughly ten times faster — days instead of weeks — with remake rates near 1 in 400 against an industry norm closer to 1 in 10. We publish these figures as operating data, not independent research, and we hold them to the same standard this report applies to everyone else: they should be measured, audited, and challenged.

If you are a clinician, health system, payer, or policymaker working on any of the five shifts in Chapter 5, we want to compare notes.

hikemedical.com

HIKE OPERATING DATA

<50%

of typical cost, same care

~10×

faster — days, not weeks

1 in 400

remakes, vs ~1 in 10 industry norm

Operating metrics reflect Hike Medical internal data across insole and orthotic production as of 2026 and are not independently audited.

This report may be quoted with attribution: "Hike Medical, *Why the money never reaches the patient*, June 2026." It is provided for general information and is not legal, clinical, or investment advice.

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Data integrity notes. The \$100 billion / \$60 billion headline is a Hike Medical directional estimate; its components, ranges, and methodology appear on page 4. Enforcement figures are alleged or intended losses as charged by DOJ, not adjudicated or recovered amounts. The 2023 catheter anomaly appears in both NAACOS claims analysis (2024) and Operation Gold Rush charges (2025); this report treats them as one scheme. National-accounts DME includes eyeglasses and hearing aids; Medicare-specific figures use the narrower DMEPOS benefit. The 75% appeals-overturn figure covers Medicare Advantage denials generally, not DME alone. The 60% workforce-shortfall figure is a 2015 projection, not an observed measurement. Medicare claims computations use fee-for-service allowed amounts, which include roughly 20% beneficiary cost-sharing and exclude Medicare Advantage.