ILLINOIS STATE MEDICAL SOCIETY

Resolution 04.2024-04
(A-25)

Introduced by: Divya Meher Surabhi, MD, ISMS Member

Subject: Advocating for All Payer Coverage for Custom Breast Prostheses for Patients with History of Mastectomy Secondary to Breast Cancer Treatment

Referred to: Council on Economics

Whereas, treatment of breast cancer commonly includes a combination of surgery, chemotherapy, radiation therapy, and/or hormone therapy; and

Whereas, more than 100,000 women in the United States undergo some form of mastectomy to surgically treat breast cancer per year[1]; and

Whereas, patients who undergo mastectomy are often provided the option of breast reconstruction; and

Whereas, however, an estimated 25-50% of patients opt for breast reconstruction[2, 3, 4]; and

Whereas, patients who do not undergo breast reconstruction typically opt for a breast prosthesis; and

Whereas, women who use breast prostheses report that prostheses can increase confidence, enhance body image and self-esteem, and provide a sense of normalcy[5]; and

Whereas, the three main types of breast prostheses are leisure prostheses, silicone prostheses, and custom prostheses; and

Whereas, a leisure breast prosthesis is typically made of foam, fiberfill, polyester fiberfill, or beaded materials encased in a cloth shell; designed to slip into a pocketed mastectomy bra; and are lighter in weight which can be helpful for patients when exercising; and

Whereas, a silicone breast prosthesis is heavier, designed to wear inside a pocketed mastectomy bra, but are typically uncomfortable to wear in hot weather; and

Whereas, pocketed mastectomy bras are an added expense that patients must account for when purchasing leisure and silicone breast prostheses; and

Whereas, a custom breast prosthesis is worn directly on the chest wall and allows for a precise fit[6]; and

Whereas, the benefits of custom breast prostheses include appropriate weight distribution; alleviation of stress and friction against sensitive areas of the chest wall; and a precise match of skin tone, breast shape, and areola size and color[7]; and

Whereas, the alleviation of stress and friction along with a precise fit against the chest wall can be especially helpful, as patients' may have scarring secondary to mastectomy or radiation therapy; and

Whereas, patients who wear custom breast prostheses also have less sweating and perceived dislodgement[8]; and

Whereas, patients report that, compared to conventional prostheses, custom prostheses were more satisfying, comfortable, easy to wear, and coupled with a sense of feeling less like a victim[9]; and

Whereas, Medicare and some insurance companies do not cover custom breast prostheses[10, 11, 12]; and

Whereas, the wholesale cost of a breast prosthesis is $1,500[13], and the retail cost of a custom breast prosthesis can be as high $5,000[14]; and

Whereas, custom breast prostheses evidently provide a better fit, comfort, and appearance; therefore, be it

RESOLVED, that our ISMS urge all payers to consider that custom breast prostheses may have significant benefits to improve the quality of life for patients who have had mastectomy secondary to breast cancer treatment; and be it further

RESOLVED, that our ISMS work with relevant stakeholders such as the American Medical Association and the Centers for Medicare and Medicaid Service to encourage payers to cover costs associated with custom breast prostheses for patients who have had mastectomy secondary to breast cancer treatment; and be it further

RESOLVED, that our ISMS seek or cause to be introduced legislation to the Illinois General Assembly to require all third-party payers, including Medicaid MCOs, to reimburse custom breast prosthesis for patients who have had mastectomy secondary to breast cancer treatment; and be it further

RESOLVED, that our ISMS Delegation to the AMA introduce a similar resolution to the next AMA House of Delegates directing the AMA to work with all relevant medical specialty societies, third party payers, including CMS, and other national stakeholders as deemed appropriate to require third party payers to include reimbursement for custom breast prosthesis for patients who have had mastectomy secondary to breast cancer treatment.

References:

1. Breast cancer facts & figures. Cancer.org. Published 2017. https://www.cancer.org/research/cancer-facts-statistics/breast-cancer-facts-figures.html
2. Greenberg CC, Lipsitz SR, Hughes ME, et al. Institutional variation in the surgical treatment of breast cancer: a study of the NCCN. Ann Surg. 2011;254(2):339-345. doi:10.1097/SLA.0b013e3182263bb0
3. Kruper L, Holt A, Xu XX, et al. Disparities in reconstruction rates after mastectomy: patterns of care and factors associated with the use of breast reconstruction in Southern California. Ann Surg Oncol. 2011;18(8):2158-2165. doi:10.1245/s10434-011-1580-z
4. Morrow M, Li Y, Alderman AK, et al. Access to breast reconstruction after mastectomy and patient perspectives on reconstruction decision making. JAMA Surg. 2014;149(10):1015-1021. doi:10.1001/jamasurg.2014.548
5. Fitch MI, McAndrew A, Harris A, Anderson J, Kubon T, McClennen J. Perspectives of women about external breast prostheses. Can Oncol Nurs J. 2012;22(3):162-174. doi:10.5737/1181912x223162167
6. Types of Breast Forms. www.breastcancer.org. https://www.breastcancer.org/treatment/surgery/breast-forms/types
7. Breast Prostheses and Bras Services Offered | Dana-Farber Cancer Institute. www.dana-farber.org. https://www.dana-farber.org/patient-family/support-services/friends-place-boutique/services/breast-prostheses-bras
8. Ng RP, Allen JC, Chia YY, Lim GH. Conventional standard-sized bra with prosthesis or patient's bra with customized hand-knitted external prosthesis after mastectomy: Mixed-methods evaluation of patients' preferences. Breast Dis. 2023;42(1):375-382. doi:10.3233/BD-230040
9. Kubon TM, McClennen J, Fitch MI, McAndrew A, Anderson J. A mixed-methods cohort study to determine perceived patient benefit in providing custom breast prostheses. Curr Oncol. 2012;19(2):e43-e52. doi:10.3747/co.19.851

10. Understanding Your Options for Breast Forms. www.breastcancer.org. Accessed March 26, 2024. https://www.breastcancer.org/treatment/surgery/breast-forms?gad_source=1&gclid=CjwKCAjw5ImwBhBtEiwAFHDZxzXAlRQuI5KDU8QZnynBXSgmur1p6UfgO8Zx22VPcBjvYNO_Yk8gfRoChsUQAvD_BwE
11. LCD - External Breast Prostheses (L33317). www.cms.gov. Accessed March 26, 2024. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=33317
12. Billing and Insurance. www.mywhb.com. Accessed March 26, 2024. https://www.mywhb.com/insurance-faq-rsquo-s-resources/faqs/billing-and-insurance
13. Mastectomy Services: The Hidden Gem Among DMEPOS | VGM & Associates. www.vgm.com. Accessed March 26, 2024. https://www.vgm.com/communities/mastectomy-services-the-hidden-gem-among-dmepos/
14. https://www.cbcn.ca. Breast Prosthetics. Canadian Breast Cancer Network. Accessed March 26, 2024. https://www.cbcn.ca/en/breast_prosthetics

Fiscal Note:

n/a

Existing ISMS policy related to this issue:

ISMS opposes any tax on any medical services or procedures, including those that are cosmetic. (HOD 2005; Reaffirmed 2006; Last BOT Review 2012)

Reconstructive surgery is surgery which is intended to correct deformities caused by disease or accident. (HOD 1985; Last BOT Review 2013)

It is the policy of ISMS to take a stand against allowing denial of payment from the Centers for Medicare and Medicaid Services (CMS) and all insurers when evaluation services and procedures are separate and billed correctly. (HOD 2017; Reaffirmed 2018)

ISMS encourages changes in U.S. law to permit Medicare to negotiate prices for prescription drugs with pharmaceutical manufacturers. (HOD 2016; Reaffirmed 2018; Reaffirmed 2019)

ISMS strongly supports subsidization of prescription drugs for Medicare patients based on means testing. (HOD 2003; Last BOT Review 2014)

ISMS supports development of appropriate Medicare reimbursement methodologies for all aspects of medical treatment, including preventive care, based upon the actual costs of service provision plus a reasonable and rational margin which makes it practical for physicians to provide their services. (HOD 2002; Reaffirmed 2017; Last BOT Review 2014)

ISMS supports the following health care system reform principles:
1. Health care delivery and financing reform should build on and leverage the benefits of our pluralistic system, including public and private financing mechanisms, to increase access and equity; maintain cost-consciousness; and reduce administrative burdens on physicians and medical practices. ISMS will only consider other health system financing reform proposals, including a single payer system, only if such a proposed system is consistent with these principles.
2. Any health reform proposal should take into account the social determinants of health and their impact on access to and delivery of care, and should support comprehensive, evidence-based strategies to advance health equity.
3. All patients should have access to an affordable health benefit plan that includes coverage for comprehensive preventative care, catastrophic care, appropriate screening, primary and specialty care, hospitalizations, immunizations, and affordable prescription drug coverage.
4. Health benefit plans must include an adequate supply of primary care and specialty medicine physicians, to ensure patient access to medically necessary care, and must provide patients with price and policy coverage transparency.
5. All health insurance coverage should be portable, such that existing coverage can be moved from one health plan to another; additionally, health benefit plans should cover telehealth interactions, including the retention of telehealth enhancements provided during the COVID-19 pandemic.
6. Health care reform should prioritize the development and improvement of payment models and coverage plans that reward care that improves patient outcomes, properly recognizes the value that physicians provide to patient care and provides coverage and payment for care based on the best available medical evidence.
7. All health care expenditures, including health savings accounts and high-deductible coverage plans, should receive equal treatment for purposes of tax deduction and tax credits.
8. Professional liability reform – including caps on noneconomic damages – should continue to be pursued and defended as a way to reduce direct and indirect costs (defensive medicine) and to address the adverse effect the current medical liability system has on the physician-patient relationship and access to health care.
9. Information technology in health care delivery should focus on interoperability, reduction of administrative burden, enhanced efficiency of care, and improvement in patient outcomes. Health information technology should enhance and improve clinical decision-making, rather than encumbering or restricting treatment decisions.

10. Health care delivery and financing reform should prioritize the importance and impact of consumer education and health literacy on improved patient outcomes.
11. Health care reform proposals should include provisions for physicians to set and negotiate fees in order to adequately compensate physicians and other health care providers for the promotion of personal and public health.
12. Evidence-based protocols should support, not replace, the patient-physician relationship. Clinical practice and treatment guidelines should serve to support, not control, clinical decision-making.
13. ISMS objects to third parties, including insurance carriers, commercial agencies, and government payers, interfering with the practice of medicine and the patient physician relationship. (BOT - FEB 2024)(HOD 2007; BOT 2015-JAN; Revised 2008; Reaffirmed 2011; Reaffirmed 2012; Reaffirmed 2015-JAN; Reaffirmed 2016; Reaffirmed 2017; Reaffirmed 2018; Reaffirmed 2019; Revised 2023; Revised 2024; Last BOT Review 2024)
It is the policy of ISMS to support surgical modification of the second breast as a part of the staged reconstruction of the breast following mastectomy in whom it is medically indicated. (HOD 1987; Last BOT Review 2011)

The Illinois State Medical Society supports the American Cancer Society guidelines for breast cancer screening as a means to identify and treat early stage breast cancers. (HOD 1986; Last BOT Review 2011)

Relevant ISMS Past Actions

House of Delegates adopted Resolution 59 (A-03), which directed that the ISMS submit a resolution to the AMA urging Medicare to include a section in its beneficiary manual specifically listing the services that are not covered by Medicare, including but not limited to: screening physician exams, screening blood tests including cholesterol panels, prescription medications, cosmetic procedures and services provided for the convenience of the patient or family; and that the ISMS submit a resolution to the AMA urging Medicare to list in its beneficiary manual the penalties for physicians who defraud or abuse Medicare benefits seeking to have non-covered services paid by Medicare misrepresenting services as medically necessary; and that the ISMS submit a resolution to the AMA urging Medicare to include information in its beneficiary manual explaining the limits on physician charges imposed by Medicare and the fact that supplemental insurance covers only the portion of the Medicare-approved charge not covered by Medicare. (HOD 2003)

House of Delegates adopted Resolution 57 (A-08), as amended, which directed that the Illinois State Medical Society support and urge reimbursement by insurance companies and the government for diagnostic mammograms in both males and females in order to detect at an earlier stage, carcinoma of the breast. (HOD 2008)

House of Delegates adopted Res. 27 (A-02) which directed that the Illinois State Medical Society urge all health insurers in the state to continue to provide health insurance coverage for screening mammography, and that the Illinois State Medical Society remind physicians in the state that mammograms are a vital weapon in the arsenal for detecting and treating breast cancer in its earliest stages, and that all at-risk female patients should be strongly encouraged to continue regular screenings. (HOD 2002)

House of Delegates adopted Res. 50 (A-87) which directed that the Society support surgical modification of the second breast as a part of the staged reconstruction of the breast following mastectomy in whom it is medically indicated. (HOD 1987)

Board of Trustees adopted Resolution 12.2022-30 (A-23), as amended: RESOLVED, that our ISMS urge all payers to consider that wigs, cold caps and medically necessary cranial prosthetics may have significant benefits to improve the quality of life for patients with cancer; and be it further RESOLVED, that our ISMS work with relevant stakeholders such as the American Medical Association and the Centers for Medicare and Medicaid Services to encourage payers to cover costs associated with wigs, cold caps and medically necessary cranial prosthetics for patients with alopecia secondary to cancer treatments; and be it further RESOLVED, that our ISMS seek or cause to be introduced legislation to the Illinois General Assembly to require all third-party payers, including Medicaid MCOs, to reimburse wigs, cold caps and medically necessary cranial prosthetics provided to patients with alopecia secondary to cancer treatment; and be it further RESOLVED, that our ISMS Delegation to the AMA introduce a similar resolution to the next AMA House of Delegates directing the AMA to work with all relevant medical specialty societies, third party payers, including CMS, and other national stakeholders as deemed appropriate to require third party payers to include reimbursement for wigs, cold caps and medically necessary cranial prosthetics for patients with alopecia secondary to cancer treatment.

Existing AMA policy related to this issue:

Symptomatic and Supportive Care for Patients with Cancer H-55.999

Our AMA recognizes the need to ensure the highest standards of symptomatic, rehabilitative, and supportive care for patients with both cured and advanced cancer. The Association supports clinical research in evaluation of rehabilitative and palliative care procedures for the cancer patient, this to include such areas as pain control, relief of nausea and vomiting, management of complications of surgery, radiation and chemotherapy, appropriate hemotherapy, nutritional support, emotional support, rehabilitation, and the hospice concept. Our AMA actively encourages the implementation of continuing education of the practicing American physician regarding

the most effective methodology for meeting the symptomatic, rehabilitative, supportive, and other human needs of the cancer patient.
CSA Rep. H, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Sub. Res. 514, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Breast Reconstruction H-55.973

Our AMA: (1) believes that reconstruction of the breast for post-treatment rehabilitation of patients with in situ or invasive breast neoplasm should be considered reconstructive surgery rather than aesthetic surgery; (2) supports education for physicians and breast cancer patients on breast reconstruction and its availability; (3) recommends that third party payers provide coverage and reimbursement for medically necessary breast cancer treatments including but not limited to prophylactic contralateral mastectomy and/or salpingo-oophorectomy; and (4) recognizes the validity of contralateral breast procedures needed for the achievement of symmetry in size and shape, and urges recognition of these ancillary procedures by Medicare and all other third parties for reimbursement when documentation of medical necessity is provided.
CCB/CLRPD Rep. 3, A-14; Modified: Res. 912, I-18

Quality Cancer Care Preservation Act H-330.897

Our AMA continues to support existing policy principles in evaluating legislative language on matters relating to Medicare reimbursement for physician acquisition and administration of prescription drugs.
BOT Action in response to referred for decision Res. 129, A-03; Reaffirmed: BOT Rep. 28, A-13; Reaffirmation A-15

Adequacy of Health Insurance Coverage Options H-165.846

1. Our AMA supports the following principles to guide in the evaluation of the adequacy of health insurance coverage options:
A. Any insurance pool or similar structure designed to enable access to age-appropriate health insurance coverage must include a wide variety of coverage options from which to choose.
B. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as a reference when considering if a given plan would provide meaningful coverage.
C. Provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations.

D. Mechanisms must be in place to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and excluded services.
2. Our AMA advocates that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program be used as the model for any essential health benefits package for children.
3. Our AMA: (a) opposes the removal of categories from the essential health benefits (EHB) package and their associated protections against annual and lifetime limits, and out-of-pocket expenses; and (b) opposes waivers of EHB requirements that lead to the elimination of EHB categories and their associated protections against annual and lifetime limits, and out-of-pocket expenses.
CMS Rep. 7, A-07; Reaffirmation I-07; Reaffirmation A-09; Reaffirmed: Res. 103, A-09; Reaffirmation I-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmed: CMS Rep. 2, A-11; Appended: CMS Rep. 2, A-11; Reaffirmed in lieu of Res. 109, A-12; Reaffirmed: CMS Rep. 1, I-12; Reaffirmed: CMS Rep. 3, A-13; Reaffirmed in lieu of Res. 812, I-13; Reaffirmed: CMS Rep. 6, I-14; Reaffirmed: CMS Rep. 6, I-15; Appended: CMS Rep. 04, I-17; Reaffirmed in lieu of: Res. 101, A-19

Insurance Coverage for Compression Stockings H-330.876

Our AMA supports Medicare payment for gradient compression stockings as prescribed by a physician under Medicare benefits coverage.
Res. 126, A-17

Third Party Responsibility for Payment H-185.981

Our AMA (1) will develop, with the assistance of the Blue Cross and Blue Shield Association, the Group Health Association of America, the Health Insurance Association of America, and other relevant health care organizations, guidelines for a standardized system of verifying eligibility for health benefits; (2) will assume a leadership role with these organizations in the development of guidelines for a standardized system of verifying eligibility for health benefits; and (3) following the development of such guidelines, will work with major insurers and managed care plans to promote the development of a standardized, national health benefits verification system based on the guidelines, which would include an obligation on the part of the insurer or managed care plan to pay physicians for any services rendered to patients whose eligibility for benefits have been verified erroneously.
Sub. Res. 721, A-92; Reaffirmed: Sub. Res. 828, A-99; Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: Sub. Res. 813, I-13

Reference Pricing H-185.935

Our AMA supports the appropriate use of reference pricing as a possible method of providing health insurance coverage of specific procedures, products or services, consistent with the following principles:
1. Practicing physicians must be actively involved in the identification of services that are appropriate for a reference pricing system.
2. Appropriate reference pricing strategies may be considered for elective services or procedures for which there is evidence of a significant variation in cost that does not correspond
to a variation in quality of care. Additional considerations include the relative complexity of the service, the potential for variation either across patients or during the course of a treatment, and the sufficient availability of providers in a geographic region.
3. Reference prices should be set at a level that reflects current market conditions and ensures that patients have access to a choice of providers. Prices should be reviewed annually and adjusted as necessary based on changes in market conditions.
4. Hospitals or facilities delivering services subject to reference pricing should avoid cost-shifting from one set of services to another.
5. Information about the services subject to reference pricing and the potential patient cost-sharing obligations must be fully transparent and easily accessible to patients and providers, both prior to and at the point of care. Educational materials should be made available to help patients and physicians understand the incentives and disincentives inherent in the reference pricing arrangement.
6. Insurance companies must notify patients of all services subject to reference pricing at the time of health plan enrollment. Patients must be indemnified against any additional charges associated with changes to reference pricing policies for the balance of the contract period.
7. Insurers that use reference pricing must develop and maintain systems that allow patients to effectively and appropriately compare prices among providers, including systems that help patients calculate their estimated costs for each provider prior to seeking care.
8. Plan sponsors should continually monitor and evaluate the effect of reference pricing policies on access to high quality patient care, and ensure that procedures are in place to make plan modifications as necessary.
CMS Rep. 3, I-14

Value-Based Insurance Design H-185.939

Our AMA supports flexibility in the design and implementation of value-based insurance design (VBID) programs, consistent with the following principles:

a. Value reflects the clinical benefit gained relative to the money spent. VBID explicitly considers the clinical benefit of a given service or treatment when determining cost-sharing structures or other benefit design elements.
b. Practicing physicians must be actively involved in the development of VBID programs. VBID program design related to specific medical/surgical conditions must involve appropriate specialists.
c. High-quality, evidence-based data must be used to support the development of any targeted benefit design. Treatments or services for which there is insufficient or inconclusive evidence about their clinical value should not be included in any targeted benefit design elements of a health plan.
d. The methodology and criteria used to determine high- or low-value services or treatments must be transparent and easily accessible to physicians and patients.
e. Coverage and cost-sharing policies must be transparent and easily accessible to physicians and patients. Educational materials should be made available to help patients and physicians understand the incentives and disincentives built into the plan design.
f. VBID should not restrict access to patient care. Designs can use incentives and disincentives to target specific services or treatments, but should not otherwise limit patient care choices.
g. Physicians retain the ultimate responsibility for directing the care of their patients. Plan designs that include higher cost-sharing or other disincentives to obtaining services designated as low-value must include an appeals process to enable patients to secure care recommended by their physicians, without incurring cost-sharing penalties.
h. Plan sponsors should ensure adequate resource capabilities to ensure effective implementation and ongoing evaluation of the plan designs they choose. Procedures must be in place to ensure VBID coverage rules are updated in accordance with evolving evidence.
i. VBID programs must be consistent with AMA Pay for Performance Principles and Guidelines (Policy H-450.947), and AMA policy on physician economic profiling and tiered, narrow or restricted networks (Policies H-450.941 and D-285.972).
CMS Rep. 2, A-13; Reaffirmed in lieu of Res. 122, A-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmed: CMS Rep. 05, I-16; Reaffirmation I-16; Reaffirmed: Joint CMS/CSAPH Rep. 01, I-17; Reaffirmed: CMS Rep. 07, A-18; Reaffirmed: Joint CMS CSAPH Rep. 01, I-18; Reaffirmed: CMS Rep. 06, A-19

Oppose Local Coverage Determination for Lower Limb Prostheses H-330.882

Our AMA (1) opposes local coverage determinations on lower limb prostheses that undermine physician judgment and compromise patient access; and (2) will request that the Centers for Medicare and Medicaid Services expeditiously host a national meeting open to all interested parties to focus on appropriate standards for lower limb prostheses that optimize care for patients. Sub. Res. 818, I-15

Survivorship Care Plans H-55.969

Our American Medical Association supports the voluntary use of survivorship care plans for cancer survivors when deemed appropriate by a patient's treating physician and supports reimbursement for physician preparation of survivorship care plans for patients. Res. 108, A-15; Reaffirmation: A-18

Breast Implants H-525.984

Our AMA: (1) supports that individuals be fully informed about the risks and benefits associated with breast implants and that once fully informed the patient should have the right to choose; and (2) based on current scientific knowledge, supports the continued practice of breast augmentation or reconstruction with implants when indicated.
CSA Rep. M, I-91; Modified: Sunset Report, I-01; Reaffirmed: Res. 727, I-02; Modified: CSAPH Rep. 1, A-12; Modified: CSAPH Rep. 1, A-22