

Reimbursement of Breast Replacement Prostheses Can Save Medicare Millions

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") mandated that private insurers and health plans provide coverage for all stages of breast surgery and reconstruction for women undergoing medically necessary breast mastectomies. Recognizing the relationship between breast function and appearance, the act included reimbursement for breast prostheses required to restore function and permit a symmetrical appearance.

Until now, the only breast prostheses available were mass produced generic silicone or foam forms that fit into pocketed bras. The bra and generic form, intended to mimic a breast by providing mass and some shape, are typically reimbursed by private insurers, health plans, and Medicare.

Since enactment of WHCRA, however, technological advances have made it possible to restore a lost breast by replacing it with a custom made, functional¹ prosthesis. Although the cost of this product is typically covered by private insurers and health plans, Medicare does not reimburse for it. Even though the custom designed breast replacement has received its own HCPCS treatment and billing codes and is included in the Medicare fee schedules as a discreet device, Medicare will only reimburse patients at the level of the generic form and bra combination.

Medicare has effectively relegated the breast to "second class" status – breasts remain the only body part whose custom prosthetic replacement is not reimbursed by Medicare. Not only

¹ The nomenclature of breast prostheses defines "functional" to mean a individualized, custom-designed breast that replicates the existing breast in almost every way: form, fit, shape, weight, movement, design, nipple size, nipple placement, areola color, areola placement, appearance, and precise fit to the chest wall. A functional prosthetic device such as this addresses not only discrete body part appearance, but also body part behavior, matching the remaining breast in both form and function.

does this deprive patients a valid non-surgical alternative, it also drives them toward reconstructive surgery, with its attendant risks and ironically, increased costs.

This paper discusses the recent evolution of breast prostheses and its potential to impact health care delivery, patient care, current ethnic and social disparities, and escalating Medicare costs. Part I of this discussion analyzes the clinical aspects of mastectomies related to breast cancer. Part II addresses the economic impacts of the allowable options under the *WHCRA* in relation to Congressional Budget Office standards. Part III examines legislative history and the legal impact of post mastectomy treatment options.

Part I: Clinical

Breast cancer is the most common cancer among women. The most significant risk factors for breast cancer are gender (female) and age.² One out of every 8 women will be diagnosed with breast cancer during their lifetime.³ In the United States, approximately 182,460 new cases of invasive breast cancer and 67,770 new cases of non-invasive breast cancer were diagnosed in women in 2008.⁴ In the U. S., nearly 5000 women reach age 50 each day. This will have profound ramifications on benefit utilization: prevalence projections, assuming the incidence plateaus, may reach as high as 420,000 new cases of breast cancer in 2018.⁵

Breast cancer is devastating both physically and psychologically.⁶ For women

² Breast Cancer Statistics,
http://www.breastcancer.org/symptoms/understand_bc/statistics.jsp?gclid=CM3QjJ_Wj5wCFRkMDQodJyO9ww (last accessed August 6, 2009).

³ *Id.*

⁴ National Cancer Institute
<http://www.seer.cancer.gov/statfacts/html/breast.html>

⁵ Edney, J. *Breast Cancer-treatment for the future based on lessons from the past*. *Amer J Surg* 184 (2002) 477-483

⁶ *Management of depression for people with cancer (SMaRT oncology 1): a randomized trial*. Published in the July 5, 2008 issue of *The Lancet*. Corresponding author: Michael Sharpe MD, Professor of Psychological Medicine, University of Edinburgh.

undergoing a unilateral or bilateral mastectomy, the impact is even greater. Every time they look at or touch their chest wall, it is a reminder of their loss. It is not surprising that studies have documented numerous benefits from breast reconstruction, including significant psychological, social and functional gain.⁷

Breast cancer prognosis is impacted by race and ethnicity, thereby creating ethnic and social disparities. For example, white women are more likely to develop breast cancer but are less likely to die from it than African American women. Yet, this difference in survivability is not necessarily directly related to disease stage.⁸ Additionally, African-American and Hispanic women have demonstrated significantly lower reconstruction rates than white women.⁹ What does all this mean? Overall, older women and non-white women are less likely to be offered and/or undergo surgical breast reconstruction.¹⁰ Correspondingly, they are disproportionately disadvantaged by the lack of a viable alternative to reconstructive surgery.

There are three post-mastectomy options: reconstruction surgery, mass-produced generic prostheses, and custom-fabricated breast replacement prostheses designed individually for each

⁷ Sullivan, S.R., Fletcher, D.R., Isom, C.D., et. al., *True Incidence of All Complications Following Immediate and Delayed Breast Reconstruction*, *Plast. Reconstr. Surg.* 122(1), 2 (2008).

⁸ When rates and predictors of reconstruction were examined comparing African-Americans and white women, marked disparities were shown and were not entirely related to the proportion of non-white women with advanced stage IV disease at the time of diagnosis. Christian, C.K., Niland, J., Edge, S.B., *A Multi-Institutional Analysis of the Socioeconomic Determinants of Breast Reconstruction*, *Plast. Reconstr. Surg.* 122(1), 2 (2008); Alderman, A.K., McMahon, L., Wilkins, E.G., *The National Utilization of Immediate and Early Delayed Breast Reconstruction and the Effect of Sociodemographic Factors*, *Plast. Reconstr. Surg.*, 111(2) 695-703 (2003); Li Cl, Malone K.E., Daling, J.R., *Differences in Breast Cancer Stage, Treatment, and Survival by Race and Ethnicity*, *Arch. Int. Med.* 163, 49-56 (2003); Figurirodo, M.I., Cullen, J., Hwang, Yi-ting, et al, *Breast Cancer Treatment in Older Women: Does Getting What You Want Improve Your Long-Term Body Image and Mental Health?*, *J. Clin. Onc.* 22(19), 4002-4009 (2004).

⁹ *Id.*

¹⁰ John Bian, Helen Krontiras, Jeroan Allison, *Outpatient Mastectomy and Breast Reconstructive Surgery*, *Annals of Surg. Oncology*, 15(4): 1032-1039, 1035 (2008).

woman. Reconstruction surgery restores the breast contour and mass by internal insertion of a silicone or saline implants, or with autologous (tissue from other areas of the patient's own body) tissue transfer. Mass-produced prefabricated breast prostheses are mounded forms of silicone or foam intended to fill the volume of a pocketed bra. Custom-fabricated prostheses are individually designed to meet each woman's unique needs as to fit, size, shape, weight, design, color, and contour. They provide external, non-surgical replacement of the lost breast with a prosthesis that fits the precise contours of a woman's healed chest wall.

Surgical Reconstruction

Of women undergoing mastectomy, as many as 40% now choose to have surgical breast reconstruction.¹¹ Post-mastectomy breast reconstruction results in improved self-image, psychological well-being, and restoration of physical form.¹² However, reconstructive breast surgery, whether utilizing autologous tissue or artificial implants, is not a panacea. "Breast reconstruction results can be quite variable, and the procedures are not without risk and complications."¹³ In a recent study of 334 total reconstructions performed on 240 consecutive women (94 bilateral and 146 unilateral), the complication rate was 46.4%.¹⁴ In addition to common surgical complications (deep venous thrombosis, pulmonary embolus, atelectasis, and pneumonia), breast reconstruction has additional post-operative risks.¹⁵

Most women undergoing immediate surgical breast reconstruction have tissue

¹¹ Tripti Agarwal and C. Scott Hultman, *Impact of Radiotherapy and Chemotherapy on Planning and Outcome of Breast Reconstruction*, *Breast Disease* 16 (2002) 37, 38.

¹² *Id.*

¹³ *Id.*

¹⁴ *Id.*

¹⁵ Sigurdson, L., Lalonde, D.H. MOC-PS(SM) *CME Article: Breast Reconstruction*, *Plast. Reconstr. Surg.* 121(15), Supplement 1-12 (2008) (relaying that additional postoperative complications of breast reconstruction include: autologous tissue fat necrosis, mastectomy skin flap necrosis, delayed wound healing, flap vessel thrombosis, flap loss, implant capsular contracture (Baker grade II, III, or IV), and implant/expander extrusion).

expander/implant based reconstruction, whereas delayed reconstructions were more likely to be autologous tissue procedures.¹⁶ The FDA found that asymmetry, chest wall deformity, scarring, and unsatisfactory style/size are considered specific to post mastectomy reconstruction patients.¹⁷ Re-operations over the course of a lifetime are needed to replace implants and remedy local complications. “Prospective studies of saline-filled breast implants approved by the FDA in May 2000 showed re-operation rates of 39-40% at 3 years and 43-45% at 5 years for reconstruction patients.”¹⁸ All of this has profound implications for patient risk, patient choice, and Medicare costs. The high rates of complications and re-operations in the already compromised Medicare patient population reinforce why *WHCRA* requires coverage for prostheses at all stages of the mastectomy.¹⁹ It is important to note that much of this risk and consequent cost may not be necessary. There is no requirement that prostheses be internal and *WHCRA* does not limit the non-surgical reconstructive alternatives.²⁰ It is hard to argue that a woman truly has informed choice/consent in the absence of a covered realistic option to surgical breast reconstruction, namely custom fabricated prosthetics similar to what is provided for every body part except the breast.

There is still much unknown about breast implants, including the long-term risks, many of which may not be apparent to women. “Women with breast cancer need to know all of the surgical and non-surgical options after breast cancer surgery, and not be left with the

¹⁶ Alderman, A.K., and Wilkins, E.G., Kim, H.M., et. al. *Complications in Post Mastectomy Breast Reconstruction- Two Year Results of the Michigan Breast Reconstruction Outcome Study*, *Plast. Reconst. Surg.* 109: 225 (2002).

¹⁷ *The FDA Breast Implant Consumer Handbook*, (2004).

¹⁸ *Id.*

¹⁹ P.L. 105-277, §713, *Required Coverage for Reconstructive Surgery Following Mastectomies*, Oct. 21, 1998.

²⁰ *Id.*

misconception that surgical reconstruction is actually a necessary part of cancer treatment.”²¹

Patient incentives for surgery continue to include the “desire for wholeness and body image restoration and avoidance or elimination of external prostheses use.”²² Despite their desire to restore their prior appearance, many women do not opt for reconstruction surgery. Women who chose not to undergo surgery were fearful of complications (25%), and perceived that they were too old for the procedure (22%).²³ Another portion of the study population was not able to undergo surgical reconstructive surgery because of medical pathology considerations.

Generic Prostheses

Developed before reconstruction surgery or replacement breast technology were perfected, generic prostheses were designed to mimic the shape of the breast so that women could look more normal in clothes. For significant numbers of women, generic, mass-produced prefabricated forms neither restore appearance nor permit a return to pre-mastectomy functionality or life activities. Prefabricated forms cannot meet a woman’s needs where there is axillary dissection, lymphedema, or significant chest wall deformity, and they impermissibly restrict a woman’s choice of clothing. Prefabricated forms require special pocketed bras to hold the form because the forms do not conform to any woman’s chest wall. There is no resemblance to the lost breast. In fact, most prefabricated forms are heavy and not secure. They often fall out of the pocket bra. There is no semblance of the areolar-nipple complex, and the attempt to match the skin color of racial or ethnic women such as African Americans or Hispanics is paltry.

²¹ Wood, S. F., Spear, S.L., *What Do Women Need to Know and When Do They Need to Know It?* 120(7) Supplement I, 1355-1395 (2007).

²² Sigurdson, L., Lalonde, D.H. MOC-PS(SM) *CME Article: Breast Reconstruction*, *Plast. Reconstr. Surg.* 121(15), Supplement 1-12 (2008).

²³ Bostwick, J., *Reconstruction After Mastectomy*, *Surg. Clin. North AM*, 70: 1125-1140 (1990); Reaby, L., *Reasons Why Women Who Have Mastectomy Decide to Have or Not Have Breast Reconstruction*, *Plast. Reconstr. Sur.* 101(7), 1810-1818 (1998).

Prefabricated forms neither look nor function like breasts.

Custom Breast Replacement Prostheses

Until recently, the most common methodology for patient molded custom breast prostheses was a cast/positive model procedure. Within the past five (5) years, development and increased utilization of CAD/CAM Scanner Technology has resulted in a precise image of the chest wall and existing breast. The result is an accurate and reproducible process for fabrication of custom breast prostheses. This established technology requires administration by Certified Prosthetists in the DMEPOS industry for all custom prosthetics.

In order to capture a patient's unique post-surgical anatomy, breast replacement is accomplished by utilizing the same hand held scanning technology that is used to capture the anatomy of any other amputated body part. The resulting HIPPA compliant patient record is transmitted electronically to the fabrication center where it drives the same form cutter that produces the form used to create a custom prosthetic limb. Diagnostic fittings to ensure proper weighting and a secure and appropriate fit to the chest wall and axillary region are performed for the custom breast prosthesis just as dynamic fittings and adjustments are made for any other body part prostheses.

Individually crafted breast prostheses can be further customized by utilizing specialized magnetic attachment that emulates the unique suspension utilized when a replacement limb or other body part is attached.

Part II: Economics

Policymakers are increasingly focusing on the rising burden of chronic disease in the United States.²⁴ Both the House and the Senate have requirements that bills reported to the

²⁴ Michael J. O'Grady, James C. Capretta, *Health-Care Cost Projections for Diabetes and*

respective chambers be analyzed for cost implications by the Congressional Budget Office (CBO).²⁵ Congress also requires cost estimates over a ten-year period for mandatory spending bills.²⁶ A particular emphasis is placed on the cost impact of the policy changes on federal programs over the 10-year budgetary window.²⁷

Post-Mastectomy Reconstructive Options

The following table shows the cost implications of post-mastectomy options: pocket bras (L8000); pre-fabricated foam prostheses (L8020); pre-fabricated silicone prostheses (L8030); custom external prostheses (L8035); and in-patient surgical procedures including reconstruction with implants, autologous tissue procedures and revisions. (*Table 1*).

Other Chronic Diseases: The Current Context and Potential Enhancements, (May 2009).

http://www.fightchronicdisease.org/pdfs/CBO_whitepaperwPFCDback.pdf

²⁵ CBO's Role in the Budget Process, CBO 2009,

<http://www.cbo.gov/aboutcbo/budgetprocess.shtml>

²⁶ 2 U.S.C. §602, *Congressional Budget and Impoundment Control Act of 1974*, sets the budgetary window at 5 years. 2 U.S.C. §658 limits the window for which CBO can produce budgetary estimates of the effect of new appropriations at 10 years. *See also, supra* note 27.

²⁷ *Supra* note 27, page 5.

Item	Code	# per year	Cost to Medicare	# over 10 years	Total Cost over 10 years
Pocket Bra without (required) inserts	L8000	6+	\$210.77	60+	\$2,107.68
Prefabricated (Foam-unilateral)*	L8020	2	\$386.13	20	\$3,860.32*plus cost of bras=\$5,967.68
Prefabricated (Silicone-unilateral)*	L8030	1 single every two years	\$303.55	5	\$1,517.70* plus cost of bras = \$3,624.32
Custom Prosthesis (unilateral)	L8035	1 single every 5 years	\$2,400.00**	2	\$4,800.00 no special bra required
In-patient Breast Reconstruction, with Tissue Expanders	CPT 19357 plus MS-DRG 584	Varies by patient	\$1,412.80 + \$7,762.00=\$9,174.80	Varies. Calculations based on one procedure	\$9,174.80 plus cost of implants and special compression bras
In-patient Breast Reconstruction with Free Flaps or TRAM Flap	CPT 19364 and 19368 plus MS-DRG584	Varies by patient	\$2,597 or \$2,089 + \$7,762=	Varies. Calculations based on one procedure	\$10,359.00 and \$9,851.00 respectively
In-patient Revision of Reconstructed breast	CPT 19380 plus MS-DRG 584	Varies by patient	\$698.91 + \$7,762.00 = \$8,460.91	Varies / calculation based on 2 procedures in 10 years.	\$16,921.82 plus costs of replacement implants
Nipple/Areola Reconstruction	CPT 19350 plus MS-DRG 585	Single procedure	\$620.71+ \$4,353.00=\$4,973.71	Based on one lifetime procedure	\$4,973.71

Table 1: Cost Comparison of Post-Mastectomy Options.

* indicating the required conjunctive use of a pocket bra. (Pricing reflects the cost to Medicare, based on 80% of the Medicare Fee Schedule. **Cost of L8035 reflects actual cost to Medicare (\$3000 x.80=\$2400).

In every instance except one, custom prostheses are less expensive than their alternatives.

Claims Processing Costs

The figures in Table 1 do not include the cost of claims processing. According to the American Cancer Society, 192,370 women will be diagnosed with breast cancer in 2009. Assume that 40% require some sort of prosthetic. This equates to 76,948 women likely to file claims beginning in 2009. (Table 2)²⁸

Description (One Patient)	Cost to Process One Claim	Claims Over 10 Years	Cost Over 10 Years
Prefabricated foam form and pocket bras	\$0.87	60 + 20 = 80	\$69.60
Prefabricated silicone and pocket bras	\$0.87	60 + 5 = 65	\$56.55
Custom breast prosthetics	\$0.87	2	\$1.74

Table 2: Demonstrates the Significant Claim Savings to CMS Resulting from Custom Breast Prostheses Option.

At first glance, there is an immediate disparity over 10-years with the custom breast prosthetic representing an additional savings that range from \$54.81 to \$67.86 per person. When the additional savings are multiplied by the 76,948 women who are potential candidates for external prosthetics, the savings to Medicare exceeds \$4 million in 2009 alone.²⁹ The savings are substantially larger when the hundreds of thousands of breast cancer survivors currently

²⁸ AHIP Center for Research and Policy, *An Updated Survey of Health Care Claims Receipt and Processing Times* (May 2006) (Figure 6: showing the average cost to process a clean claim received electronically to equal \$0.85). The figure in *Table 2* reflects a slight increase in inflation and remains constant over the 10-year period. Additionally, the claims per year reflects foam that is justified as medically necessary while the patient is healing post-operatively, silicone prosthetics that may be added later, and the cost of 6 bras annually. Twelve claims per year could also be arrived at if 8 bras were deemed medically necessary, no silicone prosthesis was claimed, and 4 foam prosthetics were claimed.

²⁹ (76,948 women diagnosed in 2009 who are likely to need external prosthetics over 10 years) x (\$56.55 for silicone) = \$4,351,409; or (76,948 x \$69.60 for foam) = \$5,355,580; versus (76,948 x \$1.74 for custom) = \$133,889. When the total custom claims processing fees are subtracted from the prefabricated claims processing fees, the difference exceeds \$4 million over 10 years for just the women diagnosed in 2009.

accessing Medicare benefits are considered. (There are approximately 2.5 million breast cancer survivors in the U.S.) In sum, the custom breast prostheses is a better clinical choice for the patient and a better economic choice for private insurers and public health plans.

Part III: Legislative

Congress has a long history of protecting people with cancer. Beginning in the 1930's, the National Cancer Institute Act of 1937 established the National Cancer Institute within the Public Health Service, directed the Surgeon General to promote research, and established the National Advisory Cancer Council.³⁰ Over the ensuing 75 years, extensive legislation related to research and coverage was promulgated.³¹ In its October 1998 conference report on H.R. 4328, Congress wrote legislative history significant implications for women with breast cancer.³²

“The conference agreement includes a provision not contained in either the House or Senate bills which would require health insurers to provide coverage of reconstruction of the breast on which mastectomies have been performed and prostheses and complications of mastectomies including lymphedemas.”

As a result, *The Women's Health and Cancer Rights Act of 1998 (WHCRA)*, was enacted. It applies to self-funded group health plans, fully insured health plans, and individual (non-employment based) health insurance policies.³³

³⁰ Public Law 92-218, *National Cancer Institute Act of 1937*, <http://training.seer.cancer.gov/disease/history/dates/html> (last accessed August 6, 2009).

³¹ Public Law 92-218, *National Cancer Act of 1971*; Public Law 99-158, *Health Research Extension Act* (1985); Public Law 101-354, *Breast and Cervical Cancer Mortality Prevention Act* (1990); *Balanced Budget Act of 1997 (Subtitle B: Prevention Initiatives)*; and Public Law 105-340 *Women's Health and Cancer Rights Act of 1998*.

³² <http://thomas.loc.gov/cgi-bin/query/F?r105:1./temp/~r1054cvKIU:e3983170>: (last accessed August 6, 2009).

³³ Federal Women's Health and Cancer Rights Act of 1998, 29 U.S.C.A. § 1185b (expressing that Medicare and Medicaid are not issuers of health insurance because they are public health plans).

The mandate defines coverage for breast reconstruction following a mastectomy as:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction on the other breast to produce symmetrical appearance;
- Prostheses and treatment of physical complications in all stages of mastectomy, including lymphedemas.

Under this mandate, benefits for breast reconstruction services following mastectomy must be provided to men and women. Timing of breast reconstruction services is not a factor in coverage. Any limitation to the number of prostheses or the length of time from the date of the mastectomy is prohibited.³⁴ As a result of this legislation, private insurers have listed L8035 (custom breast prostheses) as being covered if medically necessary.³⁵

While there is no express provision that *WHCRA* applies to Medicare, Medicare is required to provide beneficiary access to necessary medical care.³⁶ Although Medicare interprets this to require reimbursement for all body parts, even penis pumps, it denies reimbursement for replacement breasts.³⁷

³⁴ American Cancer Society, *Detailed Guide: breast cancer. What happens after treatment for breast cancer?* Revised September 17, 2007
http://www.cancer.org/docroot/CRI/content/CRI_2_4_5X_What_happens_after_treatment_5.asp?rnav=cri Centers for Medicare & Medicaid Services (CMS). Nordin Administrative Services: http://www.cms.hhs.gov/mcd/viewlcd.asp?lcd_id=11569&lcd_version=16&show=all; Centers for Medicare & Medicaid Services (CMS), *The Women's Health and Cancer Rights Act*, updated June 8, 2007, http://www.cms.hhs.gov/HealthInsReformforConsume/06_TheWomen'sHealthandCancerRightsAct.asp.

³⁵ CIGNA HealthCare, *External Breast Prosthesis and Mastectomy Bras Following Mastectomy or Lumpectomy*, Policy No. 0185 (September 15, 2008); Blue Cross of Idaho, *Allograft Use in Breast Reconstructive Surgery*, http://www.bcidaho.com/providers/medical_policies/sur/mp_701113.asp.

³⁶ *Federal Register*, Vo. 73, No. 161, August 19, 2008/Rules and Regulations; 2009 National Average DRG Payment.

³⁷ In fact, for CPT 54405, physician payment is \$839 PLUS the inpatient hospital charge for MS-DRG 673 of \$15,372.00 allowing for penile implants to be reimbursed at over \$16,000.00.

Medicare universally covers penis pumps for men, but creates a nearly insurmountable barrier for women to access custom breast prostheses that do not require a special bra, do not fall out of the bra pocket, but do allow a woman to look and feel whole again.³⁸

Medicare provides coverage for a custom fabricated prostheses for every missing or amputated body part, except breasts.

Women are constantly facing Medicare's policy of down-coding a claim for custom prostheses from L8035 to L8030 under a Least Cost Alternative (LCA) rationale that is inaccurate, incomplete, and denies thousands of Medicare beneficiaries access to restorative medical care. As a result, the down-coding by Medicare often impacts the secondary private insurer, resulting in the complete denial of benefits.

Another inconsistency is that some beneficiaries who have filed appeals from denial of their claims for custom fitted breast prostheses (L8035) have been approved while others have been denied. The few instances of Medicare payment for custom breast prostheses that have occurred were a result of exhausting the appeals process all the way to hearing before an Administrative Law Judge (ALJ).

To close the gap in the disparity of treatment between women of different ages, races, and socio-economic status, Medicare needs to reimburse custom breast prosthetics. As evidenced in the *Part II: Economics* section, the custom breast prosthesis upholds rather than undermines the LCA rationale.

³⁸ AMS, *2009 Most Commonly Billed Codes*, www.americanmedicalsystems.com/DAM_public/5829.pdf (last accessed August 2009) (indicating that for an insertion of a penile prosthesis in an outpatient hospital, Medicare reimburses \$10,103.00 (C1813: Prosthesis, penile, inflatable. Payment for device included in global APC payment) plus physician reimbursement ranging from \$839.00 to \$1,057 (CPT Codes: 54405-54411).

Conclusion

Custom breast prosthesis are less expensive, less invasive, and more functional than the generic mass produced prostheses available to post-mastectomy breast cancer patients. It is not only more costly for Medicare not to provide coverage for custom fabricated breast prostheses, it is inequitable given that Medicare provides payment for every other missing or malformed body part. Further, this lack of parity in coverage has a disparate impact on older and non-white women. In claims processing costs alone, Medicare could save millions over the next ten years for the future claims of women diagnosed with breast cancer in this year alone. Additionally, the broad language of the *WHRCA* is what led health insurers to give their subscribers the option of custom external breast prosthetics. By amending Section 1861 of the Social Security Act (42 U.S.C. 1395x) to expressly include language that custom breast prostheses will be covered, Medicare will come out ahead fiscally as demonstrated by the 10-year projections. Patient care will also be less disparate, and women losing their breasts will receive the same level of coverage as currently exists for every other body part.

¹ Section 1. Short Title

This Act may be cited as the ‘[insert title....of 2009]’.

Section 2. Medicare Coverage of Customized Fabricated External Breast Prosthesis

(a) Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended--

(1) in subsection (s)(8)--

(A) by inserting ‘and customized fabricated external breast prosthesis following the surgical removal of the breast’ after ‘colostomy care’; and

(B) by inserting ‘and customized fabricated external breast prostheses’ after ‘such devices’.

The above insert would modify current law as follows:

1861(s) The term "medical and other health services" means any of the following items or services:

1861(s)(8) prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care) **and customized fabricated external breast prosthesis following the surgical removal of the breast**, including replacement of such devices **and customized fabricated external breast prostheses**, and including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens;