



Subject: Breast Imaging*

Effective Date: December 12, 2006

Department(s): Utilization Management

Policy: Breast imaging by various techniques, either for screening or diagnostic purposes, is reimbursable under Plans administered by QualCare, Inc., according to criteria enumerated below.

Objective: To provide proper and consistent reimbursement and to delineate circumstances under which various types of breast imaging are covered.

Procedure:

1. The imaging modalities and circumstances under which breast imaging is covered are as follows:
 - a. **Screening mammography (CPT 77067)** with or without computer aided detection(CAD), or screening digital breast tomosynthesis (**CPT 77063**) for women at or over 40 years of age, according to the schedule in QualCare's Wellness Policy
 - b. **Screening mammography or screening digital breast tomosynthesis** for women less than 40 years of age if
 - i. there is increased risk for breast cancer by criteria in QualCare's BRCA Testing Policy

OR

- ii. there is a history of prior high-dose thoracic irradiation (including but not limited to radiation therapy)

OR

- iii. the patient is determined to be at increased risk after consultation with her physician of record

c. **Diagnostic mammography (CPT 77065, 77066)**, with or without computer aided detection (CAD), diagnostic digital breast tomosynthesis (**CPT 77061, 77062**)

- i. following an abnormal screening mammography
- ii. in the presence of signs or symptoms of breast disease
- iii. in women with a personal history of breast cancer
- iv. in women with biopsy-proven benign breast disease

d. **Direct digital breast image production** (“digital mammography”) **HCPCS G0202** [screening], **G0204** [diagnostic bilateral], and **G0206** [diagnostic unilateral]) is reimbursable as an alternative to film-screen mammography.

e. **Needle or wire localization** of breast lesions (**CPT 19283, 19284** [stereotactic], **19285, 19286** [ultrasound guidance] or **19281, 19282** [mammographic]) is reimbursable as a service separate from other breast imaging procedures

f. **Breast ultrasound (CPT 76641, 76642)** is reimbursable

g. **Breast magnetic resonance imaging (MRI) (CPT 77058, or HCPCS C8903, C8904, C8905** [unilateral] or **CPT 77059 or HCPCS C8906, C8907, C8908** [bilateral])

or **77021** [needle placement for biopsy, injection, or localization]) is covered

- i. for evaluation of suspected breast cancer following other imaging studies
- ii. in patients with non-cosmetic breast implants and/or prior silicone injections in whom screening or diagnostic mammography is inconclusive or contraindicated
- iii. to confirm non-cosmetic breast implant rupture when this cannot be confirmed by other imaging modalities
- iv. for surveillance of asymptomatic high-risk women (including but not limited to those with family history of breast cancer- two or more first-degree relatives with breast cancer, a first or second degree male relative with breast cancer, personal or family history of ovarian cancer-two or more first degree relatives, one first degree relative with breast or ovarian cancer diagnosed \leq age 50 yrs, carriers of BRCA-1 or BRCA-2 mutation, Cowden syndrome, Bannayan-Riley-Ruvalcaba syndrome, Li-Fraumeni syndrome [TP53 mutation], pathologic mutations in any of the following genes- ATM, CDH1, CHEK2, PALB2, PTEN, STK1; or a \geq 20% lifetime risk for breast cancer by a genetic or clinical risk estimator, such as the Gail, BRCAPRO or Tyler-Cuzick models.)
- v. when there is a history of prior high-dose thoracic irradiation (including but not limited to radiation therapy)
- vi. for evaluation and monitoring of known breast cancer, including surveillance of the contralateral breast
- vii. when there is otherwise unexplained axillary lymphadenopathy

2. Breast MRI is NOT covered as a primary screening tool in asymptomatic, average-risk patients

3. Breast MRI is NOT covered at facilities that do not perform MRI-guided breast biopsy, because the

biopsy would require repeat breast MRI at the time it is performed.

4. The following imaging studies are NOT covered for any indication because they are deemed experimental, investigational or unproven:
 - Scintimammography (HCPCS S8080, breast specific gamma imaging [Miraluna scan]
 - Thermography (CPT 93740)
 - Molecular breast imaging
 - PET Mammography
 - Impedance mammography
 - Other techniques to detect oxygen consumption, light absorption, microwave transmission, nitrous oxide production

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*Consistent with Summary Plan Description (SPD). When there is discordance between this policy and the SPD, the provisions of the SPD prevail