

AmeriHealth Caritas Louisiana

National Imaging Associates, Inc.*	
Clinical guidelines BREAST MRI	Original Date: September 1997
CPT Codes: Unilateral without contrast 77046 Bilateral without contrast 77047 Unilateral without and with contrast 77048 Bilateral without and with contrast 77049	Last Revised Date: May 2020
Guideline Number: NIA(CG)_023	Implementation Date: <u>January</u> <u>2021TBD</u>

GENERAL INFORMATION:

It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. All prior relevant imaging results, and the reason that alternative imaging (gold standard, protocol, contrast, etc.) cannot be performed must be included in the documentation submitted.

INDICATIONS FOR BREAST MRI:

(Please see boxed statements below for [State of Connecticut](#) and [State of North Carolina](#) specific requirements)

NO HISTORY OF KNOWN BREAST CANCER:

For screening examination to detect breast cancer in any of the following situations:

- A Breast Cancer Risk Assessment (preferably using the Breast Cancer Consortium Risk Model (BCSC) which incorporates breast density, the International Breast Cancer Intervention Study model (IBIS); the Breast and Ovarian Analysis of Disease Incidence and Carrier Estimation Algorithm model (BOADICEA), the modified Gail ([NCCN, 2019](#)) (also known as Breast Cancer Risk assessment tool (BCRAT), or Tyler-Cusick or other validated risk assessment models) that identifies the patient as having a lifetime risk of 20% or greater of developing breast cancer.
 - Approve annually beginning 10 years prior to youngest family member's age at diagnosis but not before age 30 ([ACR, 2018](#); [ASBrS, 2017](#); [Levitian, 2019](#); [Marino, 2018](#); [NCCN, 2019](#); [Levitian, 2019](#)).

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- Patients with history~~ries~~ of extensive chest irradiation (usually as treatment for Hodgkin's or other lymphoma between ages ten and thirty).
 - Begin ten years after radiation, but not prior to age 25 (NCCN, 2018).
- Patients with known BRCA 1/2 mutation.
 - Approve annually starting at age 25 (ASBrS, 2017; NCCN, 2019).
- Patients not yet tested for BRCA gene, but with known BRCA mutation in first degree relative.
 - Approve annually starting at age 25 (ASBrS, 2017; NCCN, 2019).
- Personal history of germline mutations known to predispose to a high risk of breast cancer (NCCN, 2019):
 - -Li-Fraumeni syndrome (TP53 mutation)
 - (bBegin age 20-29 or age at earliest diagnosed breast cancer in family),
 - Cowden syndrome (PTEN) or Bannayan-Riley-Ruvalcaba syndrome (BRRS)
 - (bBegin 30-35 or 5-10 y before earliest breast cancer in family),
 - ATM
 - (bBegin age 40),
 - CDH1
 - (bBegin age 30),
 - CHEK2
 - (bBegin age 40),
 - NF1
 - bBegin age 30),
 - PALB2
 - B(begin age 30),
 - Peutz-Jeghers Syndrome (STK 11)
 - sBtarting~~eginat~~ age 25 (NCCN, 2019)

Silicone Implants:

(MRI is not indicated for evaluation of saline implant complications or for asymptomatic silicone implants)

(ACR, 2018; Laurence, 2018)

Confirmation of suspected silicone gel-filled breast implant ruptures in asymptomatic patients, when this diafter an abnormal or indeterminate finding on gnosis cannot be confirmed by mammography or breast ultrasound.

MRI is considered the gold standard for evaluation of symptomatic silicone implant rupture (ACR, 2018; ASBrS, 2017).

For postoperative evaluation of silicone breast implant complications when other imaging is inconclusive.

NO HISTORY OF KNOWN BREAST CANCER:

For screening examination to detect breast cancer in any of the following situations:

Aninconclusive screening mammogram when category 0 has been specifically assigned due to breast characteristics limiting the sensitivity of mammography (e.g., extremely or heterogeneously dense breasts, implants obscure breast tissue) with dense breast tissue:

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~~A Breast Cancer Risk Assessment (by preferably using the Breast Cancer Consortium Risk Model (BCSC) which incorporates breast density, the International Breast Cancer Intervention Study model (IBIS); the Breast and Ovarian Analysis of Disease Incidence and Carrier Estimation Algorithm model (BOADICEA), the modified Gail (also known as Breast Cancer Risk assessment tool (BCRAT), or modified Gail risk Tyler Cusick or other validated breast cancer risk assessment models) that identifies the patient as having a lifetime risk of 20% or greater of developing breast cancer (Approve annually beginning 10 years prior to youngest family member's age at diagnosis but not before age 30) (ACR, 2018; ASBrS, 2017; Marino, 2018; NCCN, 2019; Levitan, 2019).~~

~~Patients with histories of extensive chest irradiation (usually as treatment for Hodgkin's or other lymphoma between ages ten and thirty). Begin ten years after radiation, but not prior to age 25 (NCCN, 2018).~~

~~Patients with known BRCA 1/2 mutation. Approve annually starting at age 25 (ASBrS, 2017; NCCN, 2019).~~

~~Patients not yet tested for BRCA gene, but with known BRCA mutation in first degree relative. Approve annually starting at age 25 (ASBrS, 2017; NCCN, 2019).~~

~~Personal history of germline mutations known to predispose to a high risk of breast cancer: Li-Fraumeni syndrome (TP53 mutation) (begin age 20-29 or age at earliest diagnosed breast cancer in family), Cowden syndrome (PTEN) or Bannayan-Riley-Ruvalcaba syndrome (BRRS) (begin 30-35 or 5-10 y before earliest breast cancer in family), ATM (begin age 40), CDH1 (begin age 30), CHEK2 (begin age 40), NF1 (begin age 30), PALB2 (begin age 30), Peutz-Jeghers Syndrome (STK 11) starting at age 25 (ASBrS, 2017; NCCN, 2019)~~

For evaluation of identified lesion, mass or abnormality in breast in any of the following situations:

- Evaluation of suspected breast cancer when other imaging examinations, such as ultrasound and mammography, and physical examination are inconclusive for the presence of breast cancer, and biopsy could not be performed (e.g. seen only in single view mammogram without ultrasound correlation).
 - Includes skin changes of suspected inflammatory breast cancer if conventional imaging and skin biopsies are first performed and negative (ASBrS, 2017; Geiss, 2017; Yader, 2018).
- Inconclusive or conflicting findings on a screening mammogram or ultrasound when the finding is not a palpable or a discrete mass, due to breast characteristics limiting the sensitivity of mammography (e.g., extremely or heterogeneously dense breasts, implants) (ACR, 2018).
- For cases of new nipple inversion when mammographic and sonographic findings are inconclusive and a biopsy cannot be performed (Killelea, Jan 28, 2019).
- When the presence of a palpable lesion is questionable (does not meet the criteria for biopsy by clinical exam) and remains indeterminate on mammography and ultrasound (ASBrS, 2017).

For evaluation of axillary node metastasis or adenocarcinoma with normal physical examination and normal breast mammogram (ASBrS, 2017; Zhou, 2018).

- Patients diagnosed with biopsy-proven lobular neoplasia, i.e., or ADH/ALH (atypical ductal hyperplasia/Atypical Lobular Hyperplasia) or, LCIS (Lobular Carcinoma in Situ) (ASBrS, 2017; Monticciolo, 2017; Hartman, 2015; McLaughlin, 2015; NCCN, 2019).
- Spontaneous unilateral serous or bloody nipple discharge when conventional imaging is normal and there is no palpable mass (ASBrS, 2017; Bahl, 2015; NCCN, 2019).

- Paget's disease of the nipple: to detect underlying ductal carcinoma when conventional imaging is normal and there is no palpable mass (ASBrS, 2017).
- For a phyllodes tumor diagnosed by biopsy, breast MRI may help determine extent of disease and resectability in selected cases. However routine use for surgical planning is controversial (Grau, Jan 2019).
- Follow-up of a probably benign (BI-RADS 3) lesion seen only on prior MRI (when prior mammogram and ultrasound did not show the abnormality) (Lee, 2018; Panigrahi, 2019; Spick, 2018).

HISTORY OF KNOWN BREAST CANCER:

- Yearly surveillance for history of breast cancer and dense breast tissue on mammography (ACR, 2018).
- Yearly surveillance for individuals with personal history of breast cancer diagnosed before age 50 (ACR, 2018)
- To identify primary cancer in a patient with axillary nodal adenocarcinoma and unidentified primary tumor (NCCN, 2019).

Staging, treatment, and surveillance of patients with a known history of Breast Cancer:

- Approve initial staging when conventional imaging is indeterminate in defining multifocal, multicentric, contralateral cancer or there is a discrepancy in estimated tumor size between physical exam and imaging (ASBrS, 2017; NCCN, 2019).
~~Approve initial staging when conventional imaging is indeterminate in defining multifocal, multicentric, contralateral cancer or there is a discrepancy in estimated tumor size between physical exam and imaging (ASBrS, 2017; NCCN, 2019).~~
- For invasive lobular carcinoma that is poorly defined by mammography, ultrasound and physical exam (NCCN, 2019).
- During or after treatment: To identify candidates for breast conserving therapy or evaluate response to treatment, including preoperative neoadjuvant therapy [within three (3) months] (ASBrS, 2017).
- Yearly surveillance in patients with genetic or other risk factors placing them at high risk for a new cancer or recurrence (ASBrS, 2017; Park, 2018). (move up to top)

For evaluation of identified lesion, mass or abnormality in breast in any of the following situations:

- For evaluation of breast lesion, identifying whether single or multi-focal, in patient with newly diagnosed breast cancer (ASBrS, 2017; NCCN, 2018).
- For evaluation of suspicious mass, lesion, distortion or abnormality of breast in patient with history of breast cancer when other imaging is inconclusive.

Silicone Implants:

(MRI is not indicated for evaluation of saline implant complications or for asymptomatic silicone implants).

(ACR, 2018; Laurence, 2018)

- **Confirmation of suspected silicone gel-filled breast implant ruptures in asymptomatic patients, after an abnormal or indeterminate finding on mammography or breast ultrasound.**
- **MRI is considered the gold standard for evaluation of symptomatic silicone implant rupture (ACR, 2018; ASBrS, 2017).**
- **For postoperative evaluation of silicone breast implant complications when other imaging is inconclusive.**

Pre-operative:

- For preoperative evaluation for known breast cancer when surgery planned within thirty (30) days **to be determined on a case-by-case basis** (ASBrS, 2017; [NCCN, 2019](#); Susnik, 2018; Wong, 2018; [NCCN, 2019](#)).

Post-operative/procedural evaluation:

- A follow-up study may be needed to help evaluate a patient's progress after treatment, procedure, intervention or surgery. Documentation requires a medical reason that clearly indicates why additional imaging is needed for the type and area(s) requested (ACR, 2018).

*****FOR STATE OF CONNECTICUT ONLY*****

Coverage for breast MRI is mandated within the State of Connecticut without coinsurance, copay of more than \$20 deductible, or other out of pocket expenses for women with dense breast tissue if the woman is believed to be at increased risk of breast cancer because of family or personal history of breast cancer, positive genetic testing. Coverage is also mandated for other indications determined by a woman's physician, or when screening is recommended by a physician and the woman is over age 40, has a family or prior history of breast cancer or has breast disease diagnosed through biopsy as benign. This applies to high deductible plans unless plans are used to establish an HRA or HSA to the extent permitted by federal law. Though not designated in the original intent of the bill, language includes the above provisions and criteria for breast MRI.

FOR STATE OF NORTH CAROLINA ONLY

Medicaid and NCHC cover magnetic resonance imaging (MRI) for the detection of:

1. Breast cancer in beneficiaries who are at a high genetic risk for breast cancer:
 - A. known BRCA 1 or 2 mutation in beneficiary;
 - B. known BRCA 1 or 2 mutation in relatives; or
 - C. pattern of breast cancer history in multiple first-degree relatives, often at a young age and bilaterally.
2. Breast cancer in beneficiaries who have breast characteristics limiting the sensitivity of mammography (such as dense breasts, implants, scarring after treatment for breast cancer).
3. A suspected occult breast primary tumor in beneficiaries with axillary nodal adenocarcinoma with negative mammography and clinical breast exam.
4. Breast cancer in beneficiaries with a new diagnosis of breast cancer. It can be used to determine the extent of the known cancer and/or to detect disease in the contralateral breast.
5. To evaluate implant integrity in beneficiaries with breast implants.

BACKGROUND:

Magnetic resonance imaging (MRI) of the breast is a useful tool for the detection and characterization of breast disease, assessment of local extent of disease, evaluation of treatment response, and guidance for biopsy and localization (Panourgias, 2018). Breast MRI should be bilateral except for those with a history of mastectomy or when the MRI is being performed expressly to further evaluate or follow findings in one breast. MRI findings should be correlated with clinical history, physical examination, and the results of mammography and any other prior breast imaging.

OVERVIEW:

Staging of newly diagnosed breast cancer- The decision to use breast MRI as an adjunct to clinical exam, mammography and ultrasound should be made by the physician on a case-by-case basis, taking into account frequent false positives, increased time to treatment, and increased mastectomy rates. “There is no convincing evidence that MRI reduces re-excision Lumpectomy rates, local recurrence, or overall survival in patients with invasive breast cancer or ductal carcinoma in situ.” (ASBrS, 2017; NCCN, 2019).

MRI and dense breasts- Women with extremely dense breasts are 4-6x more likely to develop breast cancer than women with fatty tissue. Between 40- 50% of US women aged 40-74 years have dense breast tissue. Breast density decreases the sensitivity of mammography and is associated with aggressive tumors and worse outcomes. A movement to notify women of their breast density has now expanded, as of April 2019 to 38 states and the District of Columbia. Although there has been an increase in notification and awareness of breast density, no clear guidelines have been established for supplemental screening in this subset of women. A recent study showed that the

majority of practices are utilizing supplemental screening, but the modalities used and referral patterns are quite variable depending on several factors including location, type of practice ie. private or academic, and whether the practice has breast specialists. Also, the exact notification requirements vary as well as insurance coverage from state to state. Screening ultrasound was most utilized (53%) and most available in the Northeast (80%). Connecticut requires insurance to cover supplemental ultrasound exams. In this study 19.5% had MRI for supplemental screening and 87% of these were private practice settings (Choudhery, 2020).

-There are four categories for breast density- almost entirely fatty, scattered areas of fibroglandular tissue, heterogeneously dense, and extremely dense. The last two are considered dense. Women with dense breasts and a BCSC risk of $\geq 2.5\%$ (about 21%) are at greatest risk for interval stage IIb or higher cancers. Thus, knowing a woman's risk along with density identifies subgroups who will benefit most from supplemental testing such as ultrasound or MRI. Without considering overall breast cancer risk, MRI could result in more harm than good in terms of anxiety, overdiagnosis and increased benign breast biopsies. (Kerlikowske, 2019). For women whose only risk is increased breast density, ultrasound can be considered for adjunctive screening (Monticciolo, 2018). At the present time, except in states that require it, more research is needed before approval of MRI for supplemental screening based on breast density alone, without other risk factors (Bakker, 2019; Destounis, 2020; Bakker, 2019; Kerlikowske, 2019)

MRI and Breast Cancer Risk Associated with certain Syndromes-

Lynch Syndrome- Women with Lynch syndrome and mismatch repair genes MLH1 and MSH2 may be at increased risk for breast cancer, however breast screening is not recommended beyond what is recommended for an average risk patient (NCCN, 2019).

NF-1- Mammography starting at age 30; breast MRI may be considered.

There is currently no evidence that RAD51C and RAD51D genes are associated with increased risk of breast cancer. Insufficient evidence for FANCC, MRE11A, or MUTYH heterozygotes, or RECQL4, RAD50, RINT1, SLX4, SMARCA4, or XRCC2.

For STK11 (associated with Peutz-Jeghers syndrome) breast cancer risk is 8% at age 40, 13% age 50 and 31% at age 60, 45% age 70.

Abbreviated Breast MRI- Among women with dense breasts undergoing screening, this technique, compared with digital breast tomosynthesis, was associated with significantly higher rate of detection of invasive cancer and further research is needed. A clinical trial is now underway (ClinicalTrials.gov:NCT02933489). A total acquisition time of 10 minutes is needed to image the breasts. (Comstock, 2020).

~~MRI as First Line Screening Modality~~ - Only recently has the use of MRI for screening been encouraged. It is now used for screening in patients with increased risk for breast cancer due to certain factors, e.g., history of mediastinal irradiation for Hodgkin disease, mutation in a breast cancer susceptibility gene, and familial clustering of breast cancer. Certain mutations, including BRCA1 and BRCA2 genes confer significantly elevated risk of breast cancer. Even when a patient tests negative for BRCA mutations, this patient may still be at risk for breast cancer if the patient has first degree relatives with a history of breast cancer or positive BRCA mutations.

MRI in Patient with Normal Physical Examination and Normal Mammogram but with Clinical Signs of Breast Cancer – Metastatic spread in the axillary lymph nodes suggest the breast as the site of the primary cancer even when the results of a mammogram are normal. MRI is useful in detecting primary breast malignancies in these cases. A negative MRI may also be used to prevent an unnecessary mastectomy.

Surgical excision vs MRI- Select patients may be suitable for monitoring in lieu of excision (although MRI is not indicated) e.g., Flat epithelial hyperplasia, papillomas without atypia, fibroepithelial lesions favoring fibroadenoma, radial scars adequately sampled or incidental. Other pathologies that may require excision include mucin-producing lesions, potential phylloides tumor, papillary lesions, radial scar, or other histologies of concern to the pathologist (NCCN, 2019).

MRI during or after Neoadjuvant Chemotherapy – Dynamic contrast enhanced MRI may be used to monitor response of a tumor to neoadjuvant chemotherapy used to shrink the tumor before surgery. This is very important in clinical decision making as alternative therapies may be selected based upon the results obtained from the MRI. It may also be used to depict residual disease after neoadjuvant chemotherapy. MRI-compatible localization tissue markers should be placed prior to neoadjuvant chemotherapy to evaluate the location of the tumor in the event of complete response (ACR, 2018).

MRI and Breast Implants – For asymptomatic women with silicone implants, no imaging is recommended for evaluation. However, MRI may be used in asymptomatic patients with silicone breast implants to evaluate breast implant integrity when a mammogram and/or ultrasound is suspicious for implant rupture. It may also detect cancers arising behind an implant that may not be diagnosed with mammography.

For evaluation of unexplained axillary adenopathy in a patient under age 30, ultrasound (US) of the axilla is the recommended initial test. For age over 30, a mammogram and/or US of the axilla are recommended.

MRI after mastectomy – Most breast tissue is removed after mastectomy; however recurrence may occur in residual tissue. The majority occur in the skin, subcutaneous tissues or deep to the pectoralis muscle and are reported to be about 1-2% annually. Clinical evaluation is the mainstay of the post mastectomy breast. For a palpable lump or pain on the side of mastectomy with or without reconstruction, or a high risk patient post bilateral prophylactic mastectomy with reconstructions, MRI is not indicated. There is no relevant literature to support MRI to screen the post mastectomy breast (although may be indicated for contralateral native breast based on breast cancer risk). MRI may be useful for a palpable lump to help characterize malignancy once identified by ultrasound. Note that tissue expanders may be a contraindication to MRI. (ACR, 2020).

MRI and Invasive Lobular Carcinoma – Invasive lobular carcinoma (ILC) is not the most common type of breast carcinoma but it is second to invasive ductal carcinoma. Because of its multicentric nature, MRI is used in the evaluation of ILC and can measure the extent of the disease with high reliability.

Breast pain - ~~NCCN Guidelines and the ASBrS do not recommend breast MRI for evaluation of breast pain (ASBrS, 2017).~~ **Breast pain is a common complaint with the incidence of breast cancer with breast pain as the only symptom, 0-3%. Clinically insignificant breast pain is cyclical, non-focal or diffuse. There is no relevant literature regarding the use of MRI for focal or ~~non-cyclical~~ ~~non-cyclical~~ breast pain at any age.** (ACR, 2018).

MRI for a mass - **“Any highly suspicious breast mass detected by imaging should be biopsied, irrespective of palpable findings; and any suspicious breast mass detected by palpation should be biopsied, irrespective of imaging findings.”** (ACR, 2016).

MRI and Known Breast Cancer - “The ASBrS does not recommend routine diagnostic MRI in newly diagnosed breast cancer patients except as part of a scientific study.....Routine annual MRI is not indicated for screening of women with a prior history of breast cancer unless they have a known genetic or other significant risk factor placing them at high-risk for a new breast cancer ...” (ASBrS, 2017). **Clinical indications and applications per NCCN state that Breast MRI may be used for staging evaluation to define extent of cancer or presence of multifocal or multicentric disease in the ipsilateral breast, or as screening of the contralateral breast at time of initial diagnosis (Category 2B), however there are no high level data to demonstrate that the use of MRI to facilitate local therapy decision-making improves local recurrence or survival. False positive findings are common and surgical decisions should not be based solely on MRI, tissue sampling of areas of concern recommended (NCCN, 2019).**

MRI and breast cancer in men - **Breast MRI is generally not indicated for palpable masses or axillary adenopathy prior to biopsy. Studies are limited as to the diagnostic accuracy or clinical usefulness of MRI in male patients (ACR, 2018).**

Nipple Discharge - Nipple discharge is a common complaint with at least 80% of women having at least 1 episode. Discharge that is considered pathologic is unilateral, spontaneous, from one duct orifice and serous or bloody. Physiologic discharge will be bilateral, from multiple ducts, and white, green, or yellow in color. “In general, MRI should be considered in cases in which other approaches have failed to identify an underlying cause of pathologic nipple discharge. The sensitivities of breast MRI for detection of underlying cause of pathologic nipple discharge are 86% to 100% for invasive cancer and 40% to 100% for noninvasive disease” (ACR, 2016). Ductography (galactography) has the ability to demonstrate very small lesions in the specific duct that is secreting the pathologic nipple discharge. However, it is invasive and may cause discomfort and pain. It can be time-consuming and technically challenging and the rate of incomplete ductography is as high as 15%. The discharge must be present on the day of the study so that a cannula can be placed in the appropriate duct. Failure to cannulate the discharging duct may occur and cannulation of the wrong duct may cause a false-negative ductogram (ACR, 2016).

BI-RADS 3 (Probably Benign) MRI and Follow-up - A follow up MRI study may be indicated to confirm stability of a probably benign mass seen only on prior MRI. In a review of sixteen studies of high-risk

patients the frequency of MRI examinations reported as BI-RADS 3 was between 6 and 12% (Lee, 2018). In an average risk screening population of 2120 women and 3,861 MRI exams 4.9% of MRI exams were BI-RADS 3 (Kuhl, 2017). Specific features of what constitutes a BI-RADS 3 lesion were not described in these studies, is at the discretion of the reporting radiologist, and the definition was still evolving during the study periods. At this writing the appropriate use of BI-RADS 3 for breast MRI has not been fully defined (Panigrahi, 2019). “The most appropriate and common use of BI-RADS 3 assessment is for a round- or oval-shaped mass with circumscribed margins and hyperintense T2 signal, which has either homogeneous enhancement or dark internal septations on a baseline examination. A mass meeting these criteria is most likely an intramammary lymph node or fibroadenoma” (Lee, 2018). The reported malignancy rate is ≤ 2% for lesions classified as BI-RADS 3 (Lee, 2018; Spick, 2018).

POLICY HISTORY:

Review Date: April 2019

Review Summary:

- For silicone implants indication, added qualifying terms to assure patient is symptomatic and other imaging is inconclusive
- For ‘No history of breast cancer, screening examinations’ added specifics about when the screening should be done
- Removed indication “Two or more first degree relatives (parents, siblings, and children) have history of breast cancer”
- Provided specifics on chest radiation including when to start screening: “Patients with histories of extensive chest irradiation (usually as treatment for Hodgkin’s or other lymphoma between ages ten and thirty. Begin ten years after radiation, but not prior to age 25”
- For indication: “Personal history of germline mutations”, removed ‘or first degree relative with’ and added some of the different mutations and when screening should begin
- For indication: “For evaluation of identified lesion, mass, or abnormality in breast in any of the following situations”, removed “Two or more first degree relatives with history of breast cancer”
- For “Evaluation of breast cancer when other imaging exams are inconclusive” added “includes skin changes of suspected inflammatory breast cancer”
- Expanded the suspicious precursor lesions to include “atypical lobular hyperplasia and lobular carcinoma in situ”
- Added indications: “Spontaneous unilateral serous or bloody nipple discharge when conventional imaging is normal and there is no palpable mass” AND “Paget’s disease of the nipple: to detect underlying ductal carcinoma when conventional imaging is normal and there is no palpable mass”
- Added indication: “Follow-up of a BI-RADS 3 lesion seen only on prior MRI when prior mammogram and US did not show the abnormality”

- History of Known Breast Cancer: Changed subheading from “Screening exam to detect breast cancer” to “Staging, treatment, and surveillance of patients with a known history of breast cancer” AND added specific indications including:
 - Approve initial staging when conventional imaging is indeterminate in defining multifocal, multicentric, contralateral cancer or there is a discrepancy in estimated tumor size between physical exam and imaging
 - During or after treatment to identify candidates for breast conserving therapy or evaluate response to treatment, including preoperative neoadjuvant therapy [within three (3) months]
 - Yearly surveillance in patients with genetic or other risk factors placing them at high risk for a new cancer or recurrence”
- For evaluation of suspicious mass, lesion, distortion or abnormality of breast in patient with history of breast cancer: added - ‘when other imaging is inconclusive’
- Added Background information on Nipple Discharge and specifics on screening for newly diagnosed or patients with breast cancer history
- Updated references

POLICY HISTORY:

Review Date: September 2019

Review Summary:

- Added state specific language boxes for State of Connecticut and State of North Carolina

Review Date: May 2020

Review Summary:

- Added not indicated for saline implants, or asymptomatic silicone without prior imaging
- Added gold standard for symptomatic saline implant rupture
- Removed section on increased breast density
- Improved section on breast assessment tools
- Improved section on germline mutations from NCCN 2019
- Added indication of new nipple inversion
- Added phylloides
- Added ACR for known breast cancer surveillance with dense tissue or dx < age 50
- Added comment section on MR for dense breast, syndromes, implants, after mastectomy, breast pain, cancer in male

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