

Breast Imaging for Screening and Diagnosing Cancer (for New Jersey Only)

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[Instructions for Use](#)

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Related Policy
<ul style="list-style-type: none"> Omnibus Codes (for New Jersey Only)

Application

This Medical Policy only applies to the state of New Jersey.

Coverage Rationale

Note: This policy does not address preventive breast cancer screening (including mammography).

The following are proven and medically necessary for the following individuals:

- Digital mammography for individuals with dense breast tissue
- Diagnostic breast ultrasound
- Breast magnetic resonance imaging (MRI) for individuals who are high risk for breast cancer as defined as having any of the following:
 - Prior thoracic radiation therapy between the ages 10 and 30
 - Lifetime risk estimated at greater than or equal to 20% as defined by models that are largely dependent on family history (e.g., Gail, Claus, Tyrer-Cuzick or BRCAPRO)
 - Personal history of breast cancer (not treated with bilateral mastectomy)
 - Personal history with any of the following:
 - Li-Fraumeni Syndrome (TP53 mutation);
 - Confirmed *BRCA1* or *BRCA2* gene mutations;
 - Peutz-Jehgers Syndrome (STK11, LKB1 gene variations);
 - PTEN gene mutation
 - Family history with any of the following:
 - At least one first-degree relative who has a *BRCA1* or *BRCA2* mutation; or
 - First-degree relative who carries a genetic mutation in the TP53 or PTEN genes (Li-Fraumeni syndrome and Cowden and Bannayan-Riley-Ruvalcaba syndromes, or Peutz-Jehgers Syndrome); or
 - At least two first-degree relatives with breast or ovarian cancer; or

- One first-degree relative with bilateral breast cancer, or both breast and ovarian cancer; or
- First or second-degree male relative (father, brother, uncle, grandfather) diagnosed with breast cancer

The following are unproven and not medically necessary due to insufficient evidence of efficacy:

- Automated breast ultrasound system
- Breast magnetic resonance imaging (MRI) for individuals with dense breast tissue not accompanied by defined risk factors as described above
- [Computer-aided detection \(CAD\)](#)
- Computer-aided tactile breast imaging
- Computed tomography (CT) of the breast
- Electrical impedance scanning (EIS)
- Magnetic resonance elastography (MRE)
- Molecular breast imaging (e.g., Scintimammography, positron emission mammography)

Note: For breast computed tomography (CT), and 3D rendering of the breast, or additional indications for breast MRI, refer to the [Community Plan Radiology & Cardiology Clinical Guidelines](#).

Definitions

Automated Breast Ultrasound (ABUS): Automated Breast Ultrasound is the first and only ultrasound system developed and US Food and Drug Administration (FDA) approved specifically for breast cancer screening in women with dense breast tissue who have not had previous breast biopsies or surgeries. ABUS systems are ultrasound imaging platforms that use high-frequency broadband transducers to automate the acquisition of volume data to provide two-dimensional (2D) and three-dimensional (3D) B-mode Images of breast tissue. It is used as an adjunct to mammography. The high center-frequency significantly sharpens detail resolution while the ultra-broadband performance simultaneously delivers distinct contrast differentiation. (ACS, 2016)

Breast Specific Gamma Imaging (BSGI): BSGI, also known as scintimammography (SMM) or molecular breast imaging (MBI) is a noninvasive diagnostic technology that detects tissues within the breast that accumulate higher levels of a radioactive tracer that emit gamma radiation. The test is performed with a gamma camera after intravenous administration of radioactive tracers. Scintimammography has been proposed primarily as an adjunct to mammography and physical examination to improve selection for biopsy in patients who have palpable masses or suspicious mammograms. (ACS, 2016)

Breast Ultrasound: Ultrasound, also known as sonography, is an imaging method using sound waves rather than ionizing radiation to a part of the body. For this test, a small, microphone-like instrument called a transducer is placed on the skin (which is often first lubricated with ultrasound gel). It emits sound waves and picks up the echoes as they bounce off body tissues. The echoes are converted by a computer into a black and white image on a computer screen. Ultrasound is useful for evaluating some breast masses and is the only way to tell if a suspicious area is a cyst (fluid-filled sac) without placing a needle into it to aspirate (draw out) fluid. Cysts cannot accurately be diagnosed by physical exam alone. Breast ultrasound may also be used to help doctors guide a biopsy needle into some breast lesions. (ACS, 2016)

Computer-Aided Detection (CAD) for Ultrasound: CAD systems for ultrasound use pattern recognition methods to help radiologists analyze images and automate the reporting process. These systems have been developed to promote standardized breast ultrasound reporting. (ACS, 2016)

Computer-Aided Detection (CAD) with MRI of the Breast: Computer-aided detection has been used to aid radiologists' interpretation of contrast-enhanced MRI of the breast, which is sometimes used as an alternative to mammography or other screening and diagnostic tests because of its high sensitivity in detecting breast lesions, even among those in whom mammography is less accurate (e.g., younger women and those with denser breasts). (ACS, 2016)

Computer-Aided Tactile Breast Imaging: Tactile breast imaging includes placing a tactile array sensor in contact with the breast. As the clinician gently moves the hand-held sensor across the breast and underarm area, data signals are then processed into multi-dimensional color images that instantly appear on a computer screen in real-time, allowing the clinician to view the size, shape, hardness and location of suspicious masses immediately. (ACS, 2016)

Computed Tomography (CT): A noninvasive diagnostic imaging procedure that uses a combination of X-rays and computer technology to produce horizontal, or axial, images (often called slices) of the body. A CT scan directs multiple narrow beams of X-rays (radiation) around a specific body site that create a multi-dimensional view of a patient's body. A three-dimensional volume of the breast is reconstructed from the acquired images. It is proposed that breast CT may allow for better accuracy by reducing problems caused by overlapping tissue. (NCI, 2019)

Electrical Impedance Scanning (EIS): EIS was developed as a confirmatory test to be used in conjunction with mammography. The device detects abnormal breast tissue using small electrical currents. Since malignant tissue tends to conduct more electricity than normal tissue, the electrical current produced creates a conductivity map of the breast which automatically identifies sites that appear suspicious. The transmission of electricity into the body is via an electrical patch on the arm or a handheld device which travels to the breast. This is measured by a probe on the surface of the skin. (ACS, 2016)

Magnetic Resonance Elastography (MRE) of the Breast: MRE of the breast is a phase-contrast-based MRI technique that is based upon quantitative differences in the mechanical properties of normal and malignant tissues. Specifically, the elastic modulus of breast cancer tissue is approximately 5- to 20-fold higher than that of the surrounding fibroglandular tissue, i.e., breast cancers are usually harder than normal tissues. This difference can be measured by applying a known stressor and measuring the resulting deformation. MRE is performed by a radiologist in an MRI suite equipped with the electromechanical driver and integrated radiofrequency coil unit. (ACS, 2016)

Magnetic Resonance Imaging (MRI): MRI is a non-invasive imaging modality that uses magnetic and radiofrequency fields to image body tissue producing very detailed, cross-sectional pictures of the body. Inconsistent with CT, MRI uses no ionizing radiation and is generally a safe procedure. MRI is sometimes used in combination with mammography. (National Institute of Biomedical Imaging, 2017)

Molecular Breast Imaging (MBI): Procedure that uses a radioactive tracer and special camera to find breast cancer. Rather than simply taking a picture of a breast, molecular breast imaging is a type of functional imaging. This means that the pictures it creates show differences in the activity of the tissue.

Positron Emission Mammography (PEM): PEM is a new imaging modality that has higher resolution than PET-CT and can be performed on patients unable to have an MRI scan. PEM performs high-resolution metabolic imaging for breast cancer using an FDG tracer. The PEM detectors are integrated into a conventional mammography system, allowing acquisition of the emission images immediately after the mammogram.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Coding Clarification: Computer-aided detection (CAD) is included with the MRI breast CPT code 77048 and 77049 procedures. If CAD is performed with these codes, there is no additional reimbursement.

CPT Code	Description
0422T	Tactile breast imaging by computer-aided tactile sensors, unilateral or bilateral
0633T	Computed tomography, breast, including 3D rendering, when performed, unilateral; without contrast material
0634T	Computed tomography, breast, including 3D rendering, when performed, unilateral; with contrast material(s)
0635T	Computed tomography, breast, including 3D rendering, when performed, unilateral; without contrast, followed by contrast material(s)

CPT Code	Description
0636T	Computed tomography, breast, including 3D rendering, when performed, bilateral; without contrast material(s)
0637T	Computed tomography, breast, including 3D rendering, when performed, bilateral; with contrast material(s)
0638T	Computed tomography, breast, including 3D rendering, when performed, bilateral; without contrast, followed by contrast material(s)
76376	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation
76377	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation
76391	Magnetic resonance (e.g., vibration) elastography
76498	Unlisted magnetic resonance procedure (e.g., diagnostic, interventional)
76499	Unlisted diagnostic radiographic procedure
76641	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete
76642	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited
77046	Magnetic resonance imaging, breast, without contrast material; unilateral
77047	Magnetic resonance imaging, breast, without contrast material; bilateral
77048	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; unilateral
77049	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; bilateral
77065	Diagnostic mammography, including computer-aided detection (CAD) when performed; unilateral
77066	Diagnostic mammography, including computer-aided detection (CAD) when performed; bilateral
77067	Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed

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HCPCS Code	Description
S8080	Scintimammography (radioimmunosintigraphy of the breast), unilateral, including supply of radiopharmaceutical

Description of Services

Regular screening is the most reliable method for detecting breast cancer early when treatment is the most effective. Screening recommendations vary according to breast cancer risk, and several tools are available to approximate breast cancer risk based on various combinations of risk factors. Current methods of breast screening and diagnosis include breast self-examination, clinical breast exam, ultrasonography, mammography, and magnetic resonance imaging.

Mammography remains the generally accepted standard for breast cancer screening and diagnosis. However, efforts to provide new insights regarding the origins of breast disease and to find different approaches for addressing several key challenges in breast cancer, including detecting disease in mammographically dense tissue, distinguishing between malignant

and benign lesions, and understanding the impact of neoadjuvant chemotherapies, has led to the investigation of several novel methods of breast imaging for breast cancer management.

Clinical Evidence

Automated Breast Ultrasound System (ABUS)

Clinical evidence is inconclusive to show whether automated breast ultrasound improves the detection rate of breast cancer in comparison to screening mammography and hand held ultrasound. Future research should include better-designed studies, including prospective studies and randomized controlled trials evaluating this technology.

In the 2021 ECRI Clinical Evidence Assessment Report, Automated Breast Ultrasound Systems for Diagnosing Breast Cancer found that evidence shows that ABUS is as accurate as handheld ultrasound (HHUS) for detecting breast cancer in women with palpable masses, breast cancer symptoms, or abnormalities seen on a screening mammogram. However, too few data are available to determine whether ABUS provides any benefit over HHUS in terms of accuracy or care delivery. Clinical utility studies with randomly assigned patient groups are needed to assess ABUS's potential benefits and drawbacks and should report longer-term clinical outcomes (e.g., quality of life) as well as shorter-term measures of procedure time, pain, patient satisfaction, and cost-effectiveness.

Hellgren et al. (2017) conducted a study to compare the sensitivity and specificity of Automated Breast Volume Scanners (ABVS) to handheld breast US for detection of breast cancer in the situation of recall after mammography screening. A total of 113 women, five with bilateral suspicious findings, undergoing handheld breast US due to a suspicious mammographic finding in screening, underwent additional ABVS. The methods were assessed for each breast and each detected lesion separately and classified into two categories: breasts with mammographic suspicion of malignancy and breasts with a negative mammogram. Results Twenty-six cancers were found in 25 women. In the category of breasts with a suspicious mammographic finding, the sensitivity of both handheld US and ABVS was 88% (22/25). The specificity of handheld US was 93.5% (87/93) and ABVS was 89.2% (83/93). In the category of breasts with a negative mammography, the sensitivity of handheld US and ABVS was 100% (1/1). The specificity of handheld US was 100% (102/102) and ABVS was 94.1% (96/102). The authors concluded that ABVS can potentially replace handheld US in the investigation of women recalled from mammography screening due to a suspicious finding. Due to the small size of this study population, further investigation with larger study populations is necessary before the implementation of such practice.

Kim et al (2016) conducted a prospective study to compare the diagnostic performance of handheld ultrasound (US) and an automated breast volume scanner (ABVS) as second-look US techniques subsequent to preoperative breast magnetic resonance imaging (MRI). From March to September 2014, both types of second-look US examinations were performed on 40 patients with breast cancer who had 76 additional suspicious lesions detected via preoperative breast MRI. Each second-look US modality was reviewed independently and the detection rate of each, the correlation between the detection rate, and the MRI factors (size, distance, and enhancement type) were evaluated. The detection rate of the ABVS was higher than that of handheld US for the second-look examination (94.7% versus 86.8%). Among the 76 total lesions, 7 were only identified by the ABVS, 1 was only found by handheld US, and 3 were not detected by either the ABVS or handheld US. When we analyzed the correlation between the detection rate and MRI factors, the only meaningful factor was the enhancement type. The ability to detect a non-mass lesion was lower than the ability to detect a mass-type lesion for both the ABVS and handheld US. It was concluded that for a second-look US examination subsequent to preoperative breast MRI in patients with breast cancer, the ABVS is a more efficient modality than handheld US for preoperative evaluations. However, both techniques have limitations in detecting non mass lesions. This study is limited to a small sample size.

Prosch et al. (2011) conducted a prospective diagnostic study. The study examined 148 breasts of 76 patients with handheld ultrasound (US) and ABUS. The ABUS data were evaluated separately by two investigators. The inter-observer agreement for the breast imaging reporting and data system (BI-RADS) classification among the two observers using ABUS was high, the agreement with handheld US was moderate. The sensitivity in the detection of breast cancer was 87.5% for handheld US and 75% for the ABUS evaluation by observer 1. The sensitivity was 87.5% for the ABUS evaluation and 83% for mammography by observer 2. The authors concluded that ABUS examinations focusing on the BIRADS classification have low inter-observer variability, compared to handheld US.

Magnetic Resonance Imaging of the Breast

Clinical Practice Guidelines

American Cancer Society (ACS, 2017)

The ACS guidelines specifically recommended against annual MRI screening in women at less than a 15% lifetime risk of breast cancer. The available data for MRI imaging is inconclusive for its use for routine screening in women who are not at high risk.

American College of Obstetricians and Gynecologists (ACOG, 2020)

In the ACOG reaffirmed their recommendation for routine screening with use of digital mammography for women diagnosed with dense breasts. They do not recommend routine use of alternative or adjunctive tests to screening mammography in women with dense breasts who are asymptomatic and have no additional risk factors. The College strongly supports additional research to identify more effective screening methods that will enhance meaningful improvements in cancer outcomes for women with dense breasts and minimize false-positive screening results. ACOG also recommends that health care providers comply with state laws that may require disclosure to women of their breast density as recorded in a mammogram report.

American College of Radiology Appropriateness Criteria for Breast Cancer Screening (2017)

The American College of Radiology Appropriateness Criteria for Breast Cancer Screening considers MRI for screening high-risk women including women with a BRCA gene mutation and their untested first-degree relatives, women with a history of chest irradiation between 10 to 30 years of age, and women with 20% or greater lifetime risk of breast cancer usually appropriate.

American Society of Breast Surgeons (ASBrS, 2017)

A consensus guideline by the American Society of Breast Surgeons on diagnostic and screening magnetic resonance imaging of the breast also supports the use of MRI as a screening technique in women. The guideline particularly supports women age 25 or older with a BRCA gene mutation, women with other germline mutations known to predispose to a high risk of breast cancer, women with a history of chest irradiation, and women with a 20%-25% or greater estimated lifetime risk of breast cancer based on models primarily based on family history.

Computer-Aided Detection with MRI of the Breast

The BCBSA TEC completed a technology assessment in 2006 for CAD with MRI and concluded that there is insufficient evidence to assess whether the use of CAD systems would maintain or increase the sensitivity, specificity, and recall rates of MRI of the breast. Given the inability to evaluate these intermediate outcomes, it is not possible to assess the impact of CAD on health outcomes such as treatment success among breast cancer patients or survival. (BCBSA, 2006c)

Clinical Practice Guidelines

American College of Radiology (ACR, 2017)

In 2017, the ACR revised the practice parameter for performing and interpreting Magnetic Resonance Imaging. The use of computer aided detection (CAD)/computer aided evaluation (CAE) with breast MRI is not specifically recommended or addressed.

National Comprehensive Cancer Network (NCCN)

The NCCN guidelines for Breast Cancer Screening and Diagnosis (2021) does not address the use of computer aided detection (CAD)/computer aided evaluation (CAE) for breast MRI testing.

Computer-Aided Detection for Ultrasound

Clinical evidence has not yet shown that CAD improves patient outcomes or lowers breast cancer mortality when added to ultrasonography. Future research should include better-designed studies, including prospective studies and randomized controlled trials evaluating this technology in large numbers of screening ultrasounds.

Cho et al (2016) conducted a retrospective study to compare the detection of breast cancer using full-field digital mammography (FFDM), FFDM with computer-aided detection (FFDM+CAD), ultrasound (US), and FFDM+CAD plus US (FFDM+CAD+US), and to investigate the factors affecting cancer detection. This study was conducted from 2008 to 2012, and 48,251 women underwent FFDM and US for cancer screening. The clinical and pathological data was reviewed to investigate

factors affecting cancer detection and used generalized estimation equations to compare the cancer detectability of different imaging modalities. The results of this study showed the detectability of breast cancer by US or FFDM+CAD+US to be superior to that of FFDM or FFDM+ CAD. However, cancer detectability was not significantly different between FFDM versus FFDM+CAD and US alone versus FFDM+CAD+US. The tumor size influenced cancer detectability by all imaging modalities. In FFDM and FFDM+CAD, the non-detecting group consisted of younger patients and patients with a denser breast composition. In breast US, carcinoma *in situ* was more frequent in the non-detecting group. The authors concluded that for breast cancer screening, breast US alone is satisfactory for all age groups, although FFDM+ CAD+US is the perfect screening method. Patient age, breast composition, and pathological tumor size and type may influence cancer detection during screening. The study is also limited by small sample size, retrospective and non-blinded study design.

Computed Tomography of the Breast

The current evidence consists of very low-quality, uncontrolled studies for computed tomography of the breast. The impact of this device on patient outcomes has not been determined. Future research should include better-designed studies, including comparative, prospective and randomized controlled trials evaluating this technology.

In the 2020 ECRI Clinical Evidence Assessment Report, Breast Computed Tomography for Breast Cancer Screening found limited information to support the use of this technology for breast cancer screening. The authors concluded that the evidence is inconclusive and has no clinical validity or utility data.

Uhlig (2019) published a systematic review of the diagnostic accuracy of cone beam breast CT. A total of 362 studies were screened, of which 6 with 559 patients were included. All studies were conducted between 2015 and 2018 and evaluated female participants. Five studies included non-contrast cone beam breast computed tomography (NC-CBBCT) and three included contrast-enhanced cone beam breast computed tomography (CE-CBBCT). Overall, the study quality was high, except for one study of NC-CBBCT which was presented as a conference abstract and was given a lower rating due to lack of complete study design and conduct details. There was high between-study heterogeneity among the NC-CBBCT studies ($I^2=98.4\%$, 95% CI 80.6 to 94.2%). Using NC-CBBCT, pooled sensitivity was 0.789 (95% CI 0.66 to 0.89) and pooled specificity was 0.697 (95% CI 0.471 to 0.851). The NC-CBBCT partial area under the curve (AUC), calculated from only regions with reported study specificities and standardized to the whole space, was 0.817. There was no statistically significant heterogeneity among the three studies that evaluated CE-CBBCT ($I^2=57.3$, 95% CI 0 to 84.1%). Protocols for administration of iodinated intravenous contrast media were different in each study. The pooled sensitivity was 0.899 (95% CI 0.785 to 0.956) and the pooled specificity was 0.788 (95% CI 0.709 to 0.85). The CE-CBBCT partial AUC for was 0.869. The evidence available for CBBCT tends to show superior diagnostic performance for CE-CBBCT over NC-CBBCT regarding sensitivity, specificity, and partial area under the curve (AUC). Diagnostic accuracy of CE-CBBCT was numerically comparable to that of breast MRI with meta-analyses reporting sensitivity of 0.9 and specificity of 0.72. The authors conclude that the results are encouraging but that additional “further large-scale, prospective studies and long-term follow-up studies are required.

Clinical Practice Guidelines

American College of Radiology (ACR, 2018)

In 2018 the ACR revised practice parameter for the performance of screening and diagnostic mammography to state “Double reading and computer-aided detection (CAD) may slightly increase the sensitivity of mammographic interpretation and may be used. However, this sensitivity is usually at the expense of decreased specificity with increased recall and biopsy rates.”

Computer-Aided Tactile Breast Imaging

The current evidence consists of very low-quality, uncontrolled studies of the diagnostic efficacy for either tactile breast imaging device. The impact of these devices on patient outcomes has not been determined.

There is significant potential for bias in these studies that could result in hyper-inflated estimates of diagnostic accuracy of tactile breast imaging relative to other screening modalities. Limitations to the research include insufficient reporting of the referral process and work-up prior to tactile breast imaging, lack of randomization, unclear blinding, and inconsistent application of the gold standard. Future research should include better-designed studies, including comparative, prospective and randomized controlled trials evaluating this technology.

Tasoulis et al. (2014) unnecessary referrals of patients with breast lumps represent a significant issue, since only a few patients actually have lumps when examined by a breast specialist. Tactile imaging (TI) is a novel modality in breast diagnostics armamentarium. The aim of this study was to assess TI's diagnostic performance and compare it to clinical breast examination (CBE). This is a prospective, blinded, comparative study of 276 consecutive patients. All patients underwent conventional imaging and tissue sampling if either a radiological or a palpable abnormality was present. Sensitivity, specificity and positive and negative predictive values for CBE and TI were calculated. Radiological findings and final diagnosis based on histology and/or cytology were used as reference standards. Receiver operator characteristic (ROC) curve analysis was also performed for each method. Sensitivity and specificity of TI in detecting radiologically proven abnormalities were 85.5% and 35%, respectively. CBE's sensitivity was 80.3% and specificity 76%. In detecting a histopathological entity according to histology/cytology, sensitivity was 88.2% for TI and 81.6% for CBE. Specificity was 38.5% and 85.7% for TI and CBE, respectively. These results suggest a trend towards higher sensitivity of TI compared to CBE but significantly lower specificity. Subgroup analysis revealed superior sensitivity of TI in detecting a histological entity in pre-menopausal women. However, CBE's overall performance was superior compared to TI's according to ROC curve analysis. Although further research is necessary, the use of TI by the primary care physician as a selection tool for referring patients to a breast specialist should be considered especially in pre-menopausal women.

Electrical Impedance Scanning (EIS)

There is a lack of evidence in the published literature to show that electrical impedance scanning for the detection and classification of breast lesions can predict clinical events, alter treatment or is effective as or more effective than currently used methods. Additional well-designed studies are needed to determine whether or not EIS is effective as an adjunct to mammography or provides a positive clinical benefit and outcome.

In a prospective, multi-center study, Wang et al (2010) reported the sensitivity and specificity for the combination of EIS and ultrasound in identifying breast cancer and calculated the relative risk of breast cancer in young women. The young women (583 cases) scheduled for mammary biopsy underwent EIS and ultrasound, respectively. EIS and ultrasound results were compared with final histopathology results. Of the 583 cases, 143 were diagnosed with breast cancer. The relative probability of breast cancer for the young women was detected by EIS, ultrasound, and the combination method. The authors concluded that the combination of EIS and ultrasound is likely to become an applicable method for early detection of breast cancer in young women.

A prospective, multicenter clinical trial by Stojadinovic et al. (2005) evaluated EIS in 1,103 women. Twenty-nine cancers with a mean tumor size 1.7 cm were confirmed thru biopsy. Electrical impedance scanning had 17% sensitivity, 90% specificity, and a negative predictive value (NPV) of 98%. Statistically significant increases in specificity were observed for women who were premenopausal and women who were not using hormone replacement therapy. False-positive rates were increased in postmenopausal women and those taking exogenous hormones. While the authors concluded that EIS appears promising for early detection of breast cancer, the increased false positive rates in postmenopausal women and those taking exogenous hormones is concerning.

In 2006, Stojadinovic et al. conducted a follow-up study. The results were reported for 1,361 consecutively enrolled asymptomatic women ages 30–39 years (used to measure specificity), and 189 women ages 30–45 years who had a suspicious breast abnormality and were referred for biopsy (used to measure sensitivity). (14) The researchers assumed that none of the women in the first group had breast cancer and, consequently, that any positive EIS results were false positives; no follow-up data were collected on these women. In the second group of women with breast abnormalities, 59.3% were aged 40–45. The specificity in the first group was 95% (assuming all positive results were incorrect); the specificity in the second group among women with benign breast disease was 80.7%. The sensitivity in the second group was 38%, but it ranged from 29% among women aged 30–39 to 42% among women aged 40–45. The authors concluded that the relative probability that a woman with a positive EIS result currently has breast cancer is 7.68 and that about one cancer would be detected for every 77 women referred for follow-up. This study has a number of limitations, including the assumption that none of the women in the specificity arm had cancer (the authors argue that this assumption is likely to have little impact on the overall results given the low prevalence of cancer in this population); the age difference between the two groups (and the difference in sensitivity by age, although whether or not this is statistically significant is not reported), and the measurement of sensitivity and specificity in two different populations. The authors themselves conclude that the results are encouraging but that “further large-scale, long-term follow-up studies are required and underway in the intended use populations.

Clinical Practice Guidelines

National Comprehensive Cancer Network (NCCN)

The 2021 NCCN Clinical Practice Guideline for Breast Cancer Screening and Diagnosis does not mention EIS as a diagnostic tool in the diagnosis or management of breast tumors.

Magnetic Resonance Elastography of the Breast (MRE)

Researchers have tested the feasibility of breast elastography and the results confirm the hypothesis that breast elastography can quantitatively depict the elastic properties of breast tissues and reveal high shear elasticity in known breast tumors. However, the clinical benefits of elastography imaging are still under evaluation and no clinical diagnosis can be made other than being able to tell whether or not a structure inside the patient is stiffer than another one. Further research is needed to evaluate the potential clinical applications of breast elastography, such as detecting breast carcinoma and characterizing suspicious breast lesions.

A prospective study by Siegmann et al. (2010) evaluated the value of adding magnetic resonance elastography (MRE) to contrast-enhanced MR imaging (MRI) for evaluating breast lesions in 57 patients. The sensitivity of MRI was 97.3% whereas specificity was 55%. If contrast-enhanced MRI was combined with $\alpha 0$ (indicator of tissue stiffness), the diagnostic accuracy could be significantly increased. The authors concluded that combining MRE with MRI increase the diagnostic performance of breast MRI; however, larger studies are needed to validate the results and to identify the patients best suited for a combined procedure.

Molecular Imaging

The published literature on molecular breast imaging is limited by a number of factors. The studies include populations that usually do not represent those encountered in clinical practice and that have mixed indications. There are methodologic limitations in the available studies, which have been judged to have medium to high risk of bias, and they lack information on the impact on therapeutic efficacy. Limited evidence on the diagnostic accuracy of molecular imaging reports that these tests have a relatively high sensitivity and specificity for detecting malignancy. However, the evidence does not establish that this imaging improves outcomes when used as an adjunct to mammography for breast cancer screening. Larger, higher-quality studies are required to determine whether molecular imaging has a useful role as an adjunct to mammography.

Guo et al (2016). In a 2016 systematic review and meta-analysis, the authors sought to establish if Tc-99m sestamibi scintimammography is useful in the prediction of neoadjuvant chemotherapy responses in breast cancer. Electronic database were searched for relevant publications in English, and fourteen studies, for a total of 503 individuals, fulfilled the inclusion criteria. The results indicated that Tc-99m MIBI scintimammography had acceptable sensitivity in the prediction of neoadjuvant chemotherapy response in breast cancer; however, its relatively low specificity showed that a combination of other imaging modalities would still be needed. Subgroup analysis indicated that performing early mid-treatment Tc-99m MIBI scintimammography (using the reduction rate of one or two cycles or within the first half-courses of chemotherapy compared with the baseline) was better than carrying out later (after three or more courses) or post-treatment scintimammography in the prediction of neoadjuvant chemotherapy response.

Brem et al (2016). The authors conducted this retrospective review to determine the incremental increase in breast cancer detection when BSGI is used as an adjunct to mammography in women at increased risk for breast cancer. 849 patients undergoing BSGI from April 2010 through January 2014 were retrospectively reviewed. Eligible patients were identified as women at increased risk for breast cancer and whose most recent mammogram was benign. Examinations exhibiting focally increased radiotracer uptake were considered positive. Incremental increase in cancer detection was calculated as the percentage of mammographically occult BSGI-detected breast cancer and the number of mammographically occult breast cancers detected per 1,000 women screened. Reviewed for this study were patients in whom 14 BSGI examinations detected mammographically occult breast cancer. Patients ranged in age from 26 to 83 with a mean age of 57. Eleven of 14 cancers were detected in women with dense breasts. The addition of BSGI to the annual breast screen of asymptomatic women at increased risk for breast cancer yields 16.5 cancers per 1,000 women screened. When high-risk lesions and cancers were combined, BSGI detected 33.0 high-risk lesions and cancers per 1,000 women screened. The authors concluded that BSGI is a reliable adjunct modality to screening mammography that increases breast cancer detection by 1.7% (14/849) in women at increased risk for breast cancer, comparable to results reported for breast MRI. BSGI is beneficial in breast cancer detection in women at increased risk, particularly in those with dense breasts. Limitation of this study is retrospective study design.

In the 2013 ECRI Evidence Report, Noninvasive Diagnostic Tests for Breast Abnormalities found that only women with a pre-scintimammography suspicion of malignancy of 5 percent or less will have their post-scintimammography suspicion of malignancy change sufficiently to suggest that a change in patient management may be appropriate.

A 2013 TEC Assessment by the Blue Cross Blue Shield Association evaluated the use of BSGI, or scintimammography with breast-specific gamma camera as a diagnostic modality for screening to detect breast tumors and concluded that there is no evidence of improved health outcomes.

Kim (2012) evaluated the adjunctive benefits of BSGI versus MRI in breast cancer patients with dense breasts. This study included a total of 66 patients with dense breasts (breast density greater than 50%) and already biopsy-confirmed breast cancer. All of the patients underwent BSGI and MRI as part of an adjunct modality before the initial therapy. Of 66 patients, the 97 undetermined breast lesions were newly detected and correlated with the biopsy results. Twenty-six of the 97 breast lesions proved to be malignant tumors; the remaining 71 lesions were diagnosed as benign tumors. The sensitivity and specificity of BSGI were 88.8% and 90.1% respectively, while the sensitivity and specificity of MRI were 92.3% and 39.4%, respectively. MRI detected 43 false-positive breast lesions, 37 (86.0%) of which were correctly diagnosed as benign lesions using BSGI. In 12 malignant lesions less than 1 cm, the sensitivities of BSGI and MR imaging were 83.3% and 91.7% respectively. The author concluded that BSGI showed an equivocal sensitivity and a high specificity compared to MRI in the diagnosis of breast lesions. In addition, BSGI had a good sensitivity in discriminating breast cancers less than or equal to 1 cm. The results of this study suggested that BSGI could play a crucial role as an adjunctive imaging modality which can be used to evaluate breast cancer patients with dense breasts. The study was limited by small sample size, larger prospective studies are needed to determine the true sensitivity and specificity of BSGI.

A meta-analysis of scintimammography included 5,473 patients from studies performed since 1997. The overall sensitivity was 85% and the specificity was 84% for single-site trial studies, and for multi-center trial studies the overall sensitivity was 85% and the specificity was 83%. (Hussain and Buscombe, 2006) Another meta-analysis evaluating scintimammography included 5,340 patients from studies published between January 1967 and December 1999. The aggregated summary estimates of sensitivity and specificity for scintimammography were 85.2% and 86.6% respectively. The authors concluded that scintimammography may be used effectively as an adjunct to mammography when additional information is required to reach a definitive diagnosis. The authors also indicated that the role of scintimammography should be assessed on the basis of large, multi-center studies. (Lieberman et al., 2003)

Clinical Practice Guidelines

American Cancer Society (ACS, 2016)

According to ACS guidelines, routine breast cancer screening with scintimammography is not recommended.

In a 2016 update on experimental breast imaging, the ACS states that while this test is approved by the Food and Drug Administration (FDA) to help classify tumors found on mammograms, at this time there hasn't been enough clinical testing to use it in breast cancer screening.

American College of Obstetricians and Gynecologists (ACOG, 2017)

The American College of Obstetricians and Gynecologists (2017) updated its 2011 practice bulletin on breast cancer screening in average-risk women. There was no discussion or recommendation for scintimammography or any other gamma imaging techniques for routine screening.

American College of Radiology (ACR, 2017)

According to the 2017 practice parameter for the performance of molecular breast imaging (MBI) using a dedicated gamma camera, there is insufficient evidence to support the use of breast specific gamma imaging (BSGI). Also, the relatively high radiation dose currently associated with BSGI/MBI has prompted the American College of Radiology to recommend against the use for screening.

National Comprehensive Cancer Network (NCCN)

The 2021 NCCN Clinical Practice Guideline for Breast Cancer Screening and Diagnosis states: Current evidence does not support the routine use of molecular imaging (e.g. breast-specific gamma imaging, sestamibi scan, or positron emission

mammography) as screening procedures, but there is emerging evidence that these tests may improve detection of early breast cancers among women with mammographically dense breasts. However, the whole-body effective radiation dose with these tests is substantially higher than that of mammography.”

Society of Breast Imaging (SBI, 2018)

In the 2018 revised SBI Position Statement entitled ‘Use of Alternative Imaging Approaches to Detection of Breast Cancer’ states that the following: Molecular Breast Imaging (MBI) is not recommended for screening surveillance in any higher-risk population.

Society of Nuclear Medicine and Molecular Imaging (SNMMI, 2012) (formerly Society of Nuclear Medicine)

SNM published updated 2012 procedure standards for breast scintigraphy with breast-specific gamma cameras that indicate that further study is needed to determine the population and usefulness most likely to benefit from this procedure. This guideline lists potential indications and cites references for each indication but does not provide a systemic review of the literature, including assessment of study quality. The guideline is based on consensus, and most of it is devoted to procedures and specifications of the examination, documentation and recording, quality control and radiation safety.

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Mammographic x-ray systems are classified as Class II devices. The FDA regulates the marketing of mammography devices and regulates the use of such devices via the Mammography Quality Standards Act (MQSA). The FDA has granted pre-market approval to several digital mammography systems (product code MUE) for breast cancer screening and diagnosis.

Magnetic Resonance Elastography of the Breast

Refer to the following website for more information on devices used for elastography of the breast (search by product name LNH in device name section): <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm>.

Breast Specific Gamma Imaging (BSGI)

BSGI for diagnosing breast cancer is a procedure and, therefore, is not subject to FDA regulation. However, the equipment used to conduct BSGI is subject to FDA regulation. The cameras used during BSGI are considered Class I radiologic devices. A scintillation (gamma) camera is a device intended to image the distribution of radionuclides in the body by means of a photon radiation detector. <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm>.

Automated Breast Ultrasound System (ABUS)

Automated breast (or whole breast) ultrasound devices are regulated by the FDA as Class III devices. Refer to the following website for more information on devices used for Automated Breast Ultrasound systems (search by product name in device name section): <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm>.

Electrical Impedance Scanning

These devices are approved as an adjunct to mammography in patients whose lesions are American College of Radiology (ACR) Breast Imaging-Reporting and Data System (BI-RADS) category III (probably benign) or IV (suspicious abnormality), based on mammography. Refer to the following website for more information on devices used for Electrical Impedance Scanning (search by product name in device name section): <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm>.

Computer-Aided Detection for MRI of the Breast

Refer to the following website for more information on devices used for Computer-Aided Detection for MRI of the Breast (search by product name in device name section): <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm>.

Computer-Aided Detection for Ultrasound

Refer to the following website for more information on devices used for Computer-Aided Detection for Ultrasound (search by product names MYN and LLZ in device name section): <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm>. (Accessed June 3, 2020)

Computed Tomography of the Breast

Refer to the following website for more information on devices used for computed tomography of the breast (search by product name JAK in device name section): <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm>.

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Policy History/Revision Information

Date	Summary of Changes
07/01/2022	<p>Coverage Rationale</p> <ul style="list-style-type: none">Added instruction to refer to the <i>Community Plan Radiology & Cardiology Clinical Guidelines</i> for breast computed tomography (CT) and 3D rendering of the breast <p>Unproven and Not Medically Necessary</p> <ul style="list-style-type: none">Added language to indicate computed tomography (CT) of the breast is unproven and not medically necessary <p>Definitions</p> <ul style="list-style-type: none">Added definition of “Computed Tomography (CT)”Updated definition of “Automated Breast Ultrasound (ABUS)” <p>Applicable Codes</p> <ul style="list-style-type: none">Added CPT codes 0633T, 0634T, 0635T, 0636T, 0637T, and 0638T <p>Supporting Information</p> <ul style="list-style-type: none">Updated <i>Clinical Evidence</i>, <i>FDA</i>, and <i>References</i> sections to reflect the most current informationArchived previous policy version CS010NJ.Q

Instructions for Use

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