Medical Policy

Magnetic Resonance Imaging (MRI) Breast
Also referred to as MR Mammography (MRM)

Table of Contents

- Policy: Commercial
- Authorization Information
- Coding Information
- Policy History
- References
- Information Pertaining to All Policies
- Endnotes

Policy Number: 774
BCBSA Reference Number: N/A

Related Policies

- Medicare Advantage: High-Technology Radiology and Sleep Disorder Management Clinical and Utilization Guidance Redirect, #923
- Fetal MRI, #770
- Functional Magnetic Resonance Imaging (fMRI) Brain, #771
- Magnetic Resonance Imaging (MRI) Abdomen/ Cholangiopancreatography (MRCP) Abdomen, #773
- Magnetic Resonance Imaging (MRI) Bone Marrow Blood Supply, #798
- Magnetic Resonance Imaging (MRI) Cardiac, #835
- Magnetic Resonance Imaging (MRI) Cervical Spine, #775
- Magnetic Resonance Imaging (MRI) Chest, #776
- Magnetic Resonance Imaging (MRI) Head/Brain, #777
- Magnetic Resonance Imaging (MRI) Lower Extremity (Joint & Non-Joint), #779
- Magnetic Resonance Imaging (MRI) Lumbar Spine, #778
- Magnetic Resonance Imaging (MRI) Orbit, Face & Neck (Soft Tissues), #780
- Magnetic Resonance Imaging (MRI) Pelvis, #781
- Magnetic Resonance Imaging (MRI) Temporomandibular Joint (TMJ), #782
- Magnetic Resonance Imaging (MRI) Thoracic Spine, #783
- Magnetic Resonance Imaging (MRI) Upper Extremity (Any Joint), #784
- Magnetic Resonance Imaging (MRI) Upper Extremity (Non-Joint), #785
- Magnetic Resonance Spectroscopy (MRS), #488

Policy^1
Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Magnetic Resonance Imaging (MRI) Breast is considered **MEDICALLY NECESSARY** for the following conditions:
For Breast Carcinoma: Diagnostic Evaluation

BI-RADS category 3 findings
- A single follow-up MRI may be performed at 6 months following a breast MRI with BI-RADS category 3 findings

Differentiation of palpable mass(es) from surgical scar tissue
- Following breast surgery, breast reconstruction or radiation therapy

Invasion of breast cancer deep to fascia
- MRI evaluation of breast prior to surgical treatment may be useful in both mastectomy and breast conservation candidates to define the relationship of the tumor to the fascia and its extension into the pectoralis major, serratus anterior, and/or intercostal muscles

Invasive carcinoma and ductal carcinoma in situ (DCIS)
- To determine the extent of disease and the presence of multifocality and multicentricity

Lesion characterization
- 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., possible distortion on only one mammographic view without a sonographic correlate)

Metastatic cancer
- Primary is unknown and suspected to be of breast origin.
- In patients presenting with metastatic disease and/or axillary adenopathy and no mammographic or physical findings of primary breast carcinoma.

Neoadjuvant chemotherapy
- MR mammography may be performed before, during and after chemotherapy to assess response to treatment and extent of residual disease, prior to surgery.

Post-lumpectomy with positive margins
- To evaluate for residual disease in patients whose pathology specimens demonstrate close or positive margins for residual disease

Post-operative tissue reconstruction
- To evaluate suspected cancer recurrence in patients with tissue transfer flaps (rectus, latissimus, dorsi, and gluteal)

Recurrence of breast cancer
- In women with a prior history of breast cancer and suspicion of recurrence when clinical, mammographic, and/or sonographic findings are inconclusive

For Breast Carcinoma: Annual Screening

Individuals who received radiation to the chest between ages 10 and 30 years

Individuals with a genetic predisposition to breast cancer, in either themselves or a first degree relative, which may include any of the following:
- Bannayan-Riley-Ruvalcaba syndrome
- BRCA1 and BRCA2
- Cowden syndrome
- Li-Fraumeni syndrome
Individuals known to have any of the following genetic mutations:
- ATM
- CDH1
- CHEK2
- PALB2

History of lobular carcinoma in situ (LCIS), atypical ductal hyperplasia (ADH) or atypical lobular hyperplasia (ALH) on biopsy

Lifetime risk ~ 20% or greater
- As defined by BRCAPRO or other models that are largely dependent on family history

For Breast Implant Rupture: Not Requiring Breast Carcinoma Diagnosis

Breast MRI is indicated to screen for asymptomatic rupture of a silicone breast implant beginning 3 years after implantation and every other year thereafter

Evaluation of symptomatic patients with breast implants, for detection of implant rupture

Prior Authorization Information

Pre-service approval is required for all inpatient services for all products.
See below for situations where prior authorization may be required or may not be required.
Yes indicates that prior authorization is required.
No indicates that prior authorization is not required.
N/A indicates that this service is primarily performed in an inpatient setting.

<table>
<thead>
<tr>
<th>Commercial Managed Care (HMO and POS)</th>
<th>The requirements of BCBSMA Radiology Management Program may require a precertification/prior authorization via AIM Specialty Health. These requirements are member-specific: please verify member eligibility and requirements through Online Services by logging onto Provider Central (<a href="http://www.bluecrossma.com/provider">www.bluecrossma.com/provider</a>). Refer to our Quick Tip (<a href="https://provider.bluecrossma.com/ProviderHome/portal/home/office-resources/plans-and-products/bluecard-and-out-of-area-programs/">https://provider.bluecrossma.com/ProviderHome/portal/home/office-resources/plans-and-products/bluecard-and-out-of-area-programs/</a>) for an overview of pre-certification and prior authorization requirements. Ordering clinicians should request pre-certification from AIM Specialty Health at <a href="http://www.aimspecialtyhealth.com">www.aimspecialtyhealth.com</a> or call 1-866-745-1783 (when applicable).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial PPO and Indemnity</td>
<td></td>
</tr>
</tbody>
</table>

CPT Codes / HCPCS Codes / ICD Codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list. The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity:
CPT Codes

<table>
<thead>
<tr>
<th>CPT codes:</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>77058</td>
<td>MRI of breast, without and/or with contrast material(s); unilateral</td>
</tr>
<tr>
<td>77059</td>
<td>MRI of breast, without and/or with contrast material(s); bilateral</td>
</tr>
</tbody>
</table>

Policy History

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/2018</td>
<td>Prior authorization information for Medicare HMO Blue and Medicare PPO Blue removed. 1/1/2018</td>
</tr>
<tr>
<td>5/2017</td>
<td>Prior Authorization Information clarified. 5/1/2017</td>
</tr>
</tbody>
</table>

Information Pertaining to All Blue Cross Blue Shield Medical Policies
Click on any of the following terms to access the relevant information:
Medical Policy Terms of Use
Managed Care Guidelines
Indemnity/PPO Guidelines
Clinical Exception Process
Medical Technology Assessment Guidelines

References


Endnotes