



CLINICAL GUIDELINES

Breast Imaging Guidelines

Version 3.0.2023

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eviCore healthcare Clinical Decision Support Tool Diagnostic Strategies: This tool addresses common symptoms and symptom complexes. Imaging requests for individuals with atypical symptoms or clinical presentations that are not specifically addressed will require physician review. Consultation with the referring physician, specialist and/or individual's Primary Care Physician (PCP) may provide additional insight.

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General Considerations (BR-Preface1)

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Abbreviations for Breast Guidelines

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Abbreviations for Breast Guidelines	
AAA	abdominal aortic aneurysm
ACE	angiotensin-converting enzyme
AVM	arteriovenous malformation
BI-RADS	Breast Imaging Reporting and Database System
BP	blood pressure
BRCA	tumor suppressor gene
CAD	computer-aided detection
CBC	Complete blood count
CT	computed tomography
CTA	computed tomography angiography
CTV	computed tomography venography
DCIS	ductal carcinoma in situ
DVT	deep venous thrombosis
EM	electromagnetic
EMG	electromyogram
FDA	Food and Drug Administration
FDG	fluorodeoxyglucose
FNA	fine needle aspiration
GERD	gastroesophageal reflux disease
GI	gastrointestinal
HRCT	high resolution computed tomography
IPF	idiopathic pulmonary fibrosis
LCIS	lobular carcinoma in situ
LFTP	localized fibrous tumor of the pleura
MRA	magnetic resonance angiography
MRI	magnetic resonance imaging
MRV	magnetic resonance venography
NCV	nerve conduction velocity

Abbreviations for Breast Guidelines	
PE	pulmonary embolus
PEM	positron-emission mammography
PET	positron emission tomography
PFT	pulmonary function tests
PPD	purified protein derivative of tuberculin
RODEO	Rotating Delivery of Excitation Off-resonance MRI
SPN	solitary pulmonary nodule
SVC	superior vena cava

General Guidelines (BR-Preface1.0)

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- A current clinical evaluation since the onset or change in symptoms is usually required prior to considering advanced imaging.
 - A clinical evaluation should include the following:
 - A relevant history and physical examination since the onset or change in symptoms
 - Appropriate laboratory studies and non-advanced imaging modalities, such as mammogram and/or ultrasound
 - Other meaningful contact (telephone call, electronic mail or messaging) since the onset or change in symptoms by an established individual can substitute for a face-to-face clinical evaluation
- Current clinical evaluation is not required prior to screening studies.
- Throughout this guideline when MRI Breast is indicated any ONE of the following codes is supported:
 - CPT® 77049 MRI Breast Bilateral, including CAD, with and without contrast
 - HCPCS C8908 MRI Breast Bilateral, with and without contrast
- If the individual has breast implants the following code is supported when MRI Breast is indicated in the guidelines:
 - CPT® 77047 MRI Breast Bilateral, without contrast

BI-RADS™ Categories Chart (BR-Preface1.1)

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BI-RADS™ Categories Chart	
Category	Description
Category 0: Incomplete	Need additional imaging evaluation or prior mammograms for comparison. Category 0 classification requires that additional imaging study be specified, e.g. ultrasound, additional mammogram view, MRI.
Category 1: Negative	There is nothing to comment on. The breasts are symmetrical and no masses, architectural disturbances, or suspicious calcifications are present.
Category 2: Benign Finding	This is also a negative mammogram, but the interpreter may wish to describe a finding. Involuting, calcified fibroadenomas, multiple secretory calcifications, fat-containing lesions (such as oil cysts, lipomas, galactoceles, and mixed density hamartomas) all have characteristic appearances, and may be labeled with confidence. The interpreter might wish to describe intramammary lymph nodes, implants, etc. while still concluding that there is no mammographic evidence of malignancy.

BI-RADS™ Categories Chart	
Category	Description
<i>Category 3: Probably Benign Finding – Short Interval Follow-up Suggested</i>	A finding placed in this category should have a very high probability of being benign. It is not expected to change over the follow-up interval, but the radiologist would prefer to establish its stability. Data is becoming available that sheds light on the efficacy of short interval follow-up. At the present time, most approaches are intuitive. These will likely undergo future modification as more data accrue as to the validity of an approach, the interval required, and the type of findings that should be followed.
<i>Category 4: Suspicious Abnormality – Biopsy Should Be Considered</i>	There are lesions that do not have the characteristic morphologies of breast cancer but have a definite probability of being malignant. The radiologist has sufficient concern to urge a biopsy. If possible, the relevant possibilities should be cited so that the individual and her physician can make the decision on the ultimate course of action.
<i>Category 5: Highly Suggestive of Malignancy – Appropriate Action Should Be Taken</i>	These lesions have a high probability of being cancer and should be biopsied or treated surgically.
<i>Category 6: Known Biopsy-Proven Malignancy – Appropriate Action Should Be Taken</i>	These lesions have been biopsied and are known to be malignant.

BI-RADS™ Breast Density Categories (BR-Preface1.2)

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BI-RADS™ Breast Density Categories
<i>Category A: Almost entire fatty</i>
<i>Category B: Scattered fibroglandular densities</i>
<i>Category C: Heterogeneously dense</i>
<i>Category D: Extremely dense</i>

Breast Ultrasound (BR-1)

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Breast Ultrasound (BR-1.1)

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- Routine performance of breast ultrasound as stand-alone screening or with screening mammography is inappropriate.^{1,2,3}
 - Breast ultrasound is a supplemental screening alternative for high-risk females (as described in **MRI Breast Indications (BR-5.1)**) with dense breasts on mammography, when MRI Breast without and with contrast cannot be performed. The inability to perform MRI Breast may be because it cannot be tolerated (i.e. insurmountable claustrophobia or body habitus), or there exists a contraindication (i.e. non-MRI compatible implantable devices or an inability to receive MRI contrast). When a MRI Breast has not been performed in the past year for high-risk screening, then a bilateral breast ultrasound requested for supplemental screening in high-risk females with dense breasts on mammography is supported.⁶²
 - Equivocal or Occult Findings:
 - Breast ultrasound (CPT® 76641 or CPT® 76642): Radiologist Report recommendation and inconclusive or conflicting findings on mammography or MRI Breast
- Breast ultrasound (CPT® 76641: unilateral, complete OR CPT® 76642: unilateral, limited) can be used to further evaluate abnormalities found on mammogram, especially in differentiating cysts from solid lesions.¹
 - A clinical office visit is not necessary prior to breast ultrasound when an abnormality has been identified on recent (within the last 60 days) mammogram.
- BI-RADS™ Cat 3 ultrasound follow up imaging for stable findings at 6 months
 - If repeat imaging remains BI-RADS™ 3, repeat at 12 months, 18 months, and 24 months from the date of the initial imaging. After 2 years of stability, the finding should be assessed as benign (Cat 2).¹⁶
 - If repeat imaging is BI-RADS™ 1 or 2, then imaging reverts to routine per individuals risk profile.
- Mammography and breast ultrasound, in any order, regardless of age for palpable breast masses or other clinical abnormalities (such as skin change, pain, nipple inversion). Ultrasound can enhance biopsy.³
- If recent clinical examination is equivocal for rupture of breast implants (saline or silicone), initial imaging is indicated as below:

Evaluation of Suspected Rupture of Breast Implants

Age	Saline Breast Implant	Silicone Breast Implant
<30	Breast Ultrasound	Breast Ultrasound or MRI Breast without contrast (CPT® 77047)

Evaluation of Suspected Rupture of Breast Implants		
30-39	Breast Ultrasound or mammography/Digital breast tomosynthesis (DBT)	Breast Ultrasound, mammography/Digital breast tomosynthesis (DBT) or MRI Breast without contrast (CPT® 77047)
≥40	Mammography/Digital breast tomosynthesis (DBT)	Mammography/Digital breast tomosynthesis (DBT) or MRI Breast without contrast (CPT® 77047)

- Axilla ultrasound (CPT® 76882)
 - For females with clinically suspicious lymph nodes, preoperative axillary ultrasound with a FNA or biopsy can help identify individuals who have positive nodes³
 - See **Axillary Lymphadenopathy (and Mass) (CH-2.2)** in the Chest Imaging Guidelines
 - Bilateral should be coded CPT® 76882 x 2
- US guided breast biopsy (CPT® 19083) includes the imaging component.
 - Additional lesions should be billed using CPT® 19084
- Ultrasound Breast can be repeated at least 6 months after an US directed breast biopsy to document successful lesion sampling if histology is benign and nonspecific, equivocal or uncertain.
- 3D Reconstruction (CPT® 76376 or CPT® 76377) is not considered medically necessary for breast ultrasound. It is commonly requested in conjunction with automated breast ultrasound (ABUS); there is no evidence to support its clinical usefulness.
- State Specific Density Reporting and Imaging Mandate Laws
 - Breast density notification laws have been put into effect by many states. Breast density notification laws vary, but some also contain mandates for additional imaging, which may include MRI and/or ultrasound. For applicable requests involving members in these states, their legislative mandates should be followed.

MRI Breast (BR-2)

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MRI Breast (BR-2.1)

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- The use of gadolinium contrast is required for the evaluation of breast parenchyma.
- The use of gadolinium contrast is not necessary for the evaluation of implant integrity in asymptomatic, average-risk individuals.
- Computer-aided detection (CAD) is included with the MRI Breast CPT® 77049 and CPT® 77048 procedures. The use of HCPCS code C8937 (CAD including computer algorithm analysis of MRI Breast data for lesion detection/characterization, pharmacokinetic analysis, with further physician review for interpretation) is unnecessary with these procedures.
 - The use of CAD has little influence on the sensitivity and specificity of MRI Breast interpretation.⁹
 - The use of HCPCS code C8937 (CAD including computer algorithm analysis of MRI Breast data for lesion detection/characterization, pharmacokinetic analysis, with further physician review for interpretation) is currently considered investigational, experimental, and/or unproven.
 - Since the CAD software automatically performs 3D imaging, CPT® 76376 or CPT® 76377 should not be used in conjunction with MRI Breast.
- MRI guided breast biopsy (CPT® 19085) includes the imaging component and the needle placement under MR guidance (CPT® 77021 MR guidance for needle placement is not an appropriate code to bill for a breast biopsy.).
 - Additional lesions should be billed using CPT® 19086.
 - eviCore does not manage codes CPT® 19085 or CPT® 19086

Background and Supporting Information

- Although MRI Breast has superior sensitivity in identifying new unknown malignancies, it carries a significant false positive risk when compared to mammogram and ultrasound. Incidental lesions are seen on 15% of MRI Breast and increase with younger age. The percentage of incidental lesions that turn out to be malignant varies from 3% to 20% depending on the individual population. Cancer is identified by MRI Breast in only 0.7% of those with “inconclusive mammographic lesions”.^{6,7}

Breast Reconstruction (BR-3)

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Breast Reconstruction (BR-3.1)

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- CTA or MRA of the body part from which the free tissue transfer flap is being taken, can be performed for breast reconstruction preoperative planning.^{2,3}
 - For example, CTA Abdomen and/or Pelvis (CPT® 74175 or CPT® 72191 or CPT® 74174) or MRA Abdomen and/or Pelvis (CPT® 74185 and/or CPT® 72198) for Deep Inferior Epigastric Perforators (DIEP) flap.⁸
- There is currently insufficient evidence-based data to support the need for routine advanced imaging for TRAM flaps or other flaps performed on a vascular pedicle.⁸

MRI Breast is NOT Indicated (BR-4)

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MRI Breast is NOT Indicated (BR-4.1)

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- MRI Breast should not be used to determine biopsy recommendations for suspicious or indeterminate lesion(s) that can be readily biopsied, either using imaging guidance or physical exam, such as palpable masses and microcalcifications.^{3,6}
- Individuals with dense breasts as determined by mammogram
 - To date, evidence does not suggest improved outcomes for females whose only risk factor is breast density [See “Equivocal or Occult Findings” (Radiologist Report) in **MRI Breast Indications (BR-5.1)**].^{13,14,15}
- Low risk, probably benign (BI-RADS™ 3) lesions
 - Repeat the original type study (mammogram, US, or MRI) in 6 months
 - If repeat imaging remains BI-RADS™ 3, repeat original study at 12 months, 18 months, and 24 months from the date of the initial imaging. After 2 years of stability, the finding should be assessed as benign (Cat 2).¹⁶
 - If repeat imaging is BI-RADS™ 1 or 2, then imaging reverts to routine per individuals risk profile.
- Suspicious (BI-RADS™ 4 or 5) lesion on mammogram and/or ultrasound
 - A lesion categorized as BI-RADS™ 4 or 5 should be biopsied.¹⁶
- Routine surveillance imaging for asymptomatic females to assess the integrity of breast implants (silicone or saline) is not supported. However, certain payors may cover this surveillance and those coverage policies take precedence over eviCore guidelines.^{17,18}
 - Certain payors do not include breast implants in their coverage policies if the breast implants were placed as part of purely cosmetic surgery. Thus, surveillance MRI in these individuals would also not be included in the coverage policy. Their coverage policies will take precedence over eviCore guidelines.
- Routine surveillance MRI Breast following bilateral mastectomy is not indicated.^{45,63}
- MRI Breast Unilateral is not clinically indicated. When MRI Breast imaging is clinically indicated an MRI Breast Bilateral with and without contrast is supported.

MRI Breast Indications (BR-5)

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MRI Breast Indications (BR-5.1)

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- See **Breast Cancer (ONC-11)** in the Oncology Imaging Guidelines for indication for imaging related to breast cancer including:
 - Breast Cancer - Initial work-up/Staging
 - Breast Cancer - Restaging/Recurrence
 - Breast Cancer - Surveillance/Follow-up
 - Annual screening with prior history of breast cancer
- When MRI Breast imaging is clinically indicated an MRI Breast Bilateral with and without contrast is supported. MRI Breast Unilateral is not clinically supported. See **Breast Ultrasound (BR-1.1)** when there is a contraindication to MRI contrast.
- If recent clinical examination is equivocal for rupture of breast implants (saline or silicone), initial imaging is indicated as below:

Evaluation of Suspected Rupture of Breast Implants		
Age	Saline Breast Implant	Silicone Breast Implant
<30	Breast Ultrasound	Breast Ultrasound or MRI Breast without contrast (CPT® 77047)
30-39	Breast Ultrasound or mammography/Digital breast tomosynthesis (DBT)	Breast Ultrasound, mammography/Digital breast tomosynthesis (DBT) or MRI Breast without contrast (CPT® 77047)
≥40	Mammography/Digital breast tomosynthesis (DBT)	Mammography/Digital breast tomosynthesis (DBT) or MRI Breast without contrast (CPT® 77047)

- If initial imaging, per above table, is inconclusive additional imaging maybe indicated
- Phyllodes Tumor (Cystosarcoma Phyllodes)
 - MRI Breast is indicated preoperatively to establish extent of disease where a diagnosis of malignant phyllodes tumor has previously been established by tissue diagnosis.^{18,19,20} (See **Background and Supporting Information**)
- Equivocal or Occult Findings
 - Radiologist Report Recommendation for MRI Breast to assess inconclusive or conflicting findings on mammography or ultrasound that are not associated with a discrete palpable mass. This would include possible fat necrosis which is most commonly due to trauma or surgery.

- Discordance between imaging findings and core needle biopsy findings. Biopsy result does not adequately explain the abnormal findings on mammogram and/or ultrasound (BI-RADS™ 4 or 5). MRI Breast can be used for further evaluation after the discordant biopsy, before consideration for surgical management vs. observation, when there is documentation provided of histopathologic discordance.
- Fat Necrosis (most commonly due to trauma or surgery)
 - Evaluate with MRI if Ultrasound or mammogram reports inconclusive findings of fat necrosis in a female with a history of breast cancer treated with surgery (lumpectomy or mastectomy with or without reconstruction)
- A probably benign lesion on MRI (MRI BI-RADS™ 3) should undergo repeat MRI in 6 months
 - If repeat imaging remains BI-RADS™ 3, repeat at 12 months, 18 months, and 24 months from the date of the initial imaging. After 2 years of stability, the finding should be assessed as benign (Cat 2).¹⁶
 - If repeat imaging is BI-RADS™ 1 or 2, then imaging reverts to routine per individuals risk profile.
- MRI Breast can be repeated at least 6 months after a stereotactic, MRI guided or US directed breast biopsy of lesion initially seen on MRI Breast to document successful lesion sampling if histology is benign and nonspecific, equivocal or uncertain.⁵
- Indications for annual MRI Breast screening See table below:

High Risk Indications

MRI screening to begin at age 20:

1.	Li-Fraumeni Syndrome (TP53 mutation) should start annual breast screening MRI starting at age 20 or at the age of the earliest diagnosed breast cancer in the family, whichever comes first.
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MRI screening to begin at diagnosis but not prior to age 25:

2.	<i>Individuals with a history of :</i> • Atypical ductal hyperplasia (ADH) • Atypical lobular hyperplasia (ALH) • Lobular carcinoma in situ (LCIS)²¹
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MRI screening to begin at age determined by gene mutation:

3.	BRCA 1 or BRCA 2 begin age 25
4.	STK11, Peutz-Jeghers syndrome (PJS), PTEN Mutation (Cowden Syndrome), CDH1, NF1, PALB2, ATM, CHEK2 begin age 30

High Risk Indications	
5.	NBN, BARD1, RAD51C, RAD51D begin age 40
6.	The following have unknown or insufficient evidence of breast cancer risk and additional MRI screening is not indicated at this time: MSH2, MLH1, MSH6, PMS2, EPCAM, Genetic variants of unknown significance, genetic variants favoring polymorphism, genetic variants of intermediate penetrance.⁴¹
<i>MRI screening begins at age 40:</i>	
7.	First-degree relative (parent, sibling, child. Half siblings are considered second degree relatives) with BRCA 1 or BRCA 2, if individual has not been tested for BRCA mutation. (If individual has been tested and negative for mutation then annual screening is not indicated.)
<i>MRI screening begins at age 40, or 10 years before the age of relative (lineage as described below) when first diagnosed with breast cancer, but not prior to the age of 25.^{4,12,22,30,42,43}</i>	
8.	Two or more first-degree relatives with breast or ovarian cancer.
9.	One first-degree relative with breast cancer or ovarian cancer that was diagnosed ≤age 50.
10.	One first-degree relative with bilateral breast cancer, or both breast and ovarian cancer.
11.	A first or second-degree male relative (father, brother, uncle, grandfather) diagnosed with breast cancer.
<i>MRI screening begins at age 40:</i>	
12.	Clinical lifetime risk estimated at greater than or equal to 20% using genetic risk or clinical risk estimator, acceptable models are Gail (NCI), Claus, Tyrer-Cuzick (IBIS) or BRCAPRO.

High Risk Indications

MRI screening to begin at age 25 or 8 years after completion of radiotherapy (whichever occurs later - screening MRI Breast is not supported prior to age 25):

13.	Annual MRI Breast and annual mammogram is recommended for individuals who received therapeutic radiation exposure in the following fields while they were under 30 years of age:. • Chest (thorax) • Whole lung • Mediastinal • Axilla • Mini-mantle, mantle, or extended mantle • Total (TLI) or subtotal (SLTI) lymphoid irradiation • Total body irradiation (TBI)
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Background and Supporting Information

- myRisk® Hereditary Cancer (Myriad Genetics, Inc.) is not accepted as a risk calculator to determine high risk for breast cancer
- MRI should not be used in lieu of biopsy of mammographically, clinically, and/or sonographically suspicious findings (ACR Practice Guidelines).
- State Specific Density Reporting and Imaging Mandate Laws
 - Breast density notification laws have been put into effect by many states. Breast density notification laws vary, but some also contain mandates for additional imaging, which may include MRI and/or ultrasound. For applicable requests involving members in these states, their legislative mandates should be followed.
- Phyllodes Tumor (Cystosarcoma Phyllodes)
 - Phyllodes tumor is usually benign and has clinical characteristics of fibroadenoma, although they may exhibit rapid growth. MRI Breast has not been shown to be of value in distinguishing fibroadenoma from phyllodes tumor.
 - Diagnosis is made by tissue diagnosis (percutaneous core biopsy or excisional biopsy). FNA biopsy is inaccurate in phyllodes tumor diagnosis and is not recommended.
 - Treatment is wide local excision. Axillary lymph node dissection is not necessary. It has a predilection for local recurrence following local excision.
 - If biopsy establishes a diagnosis of malignant phyllodes (cystosarcoma phyllodes), it should be treated as a soft tissue sarcoma (See **Sarcomas –**

Bone, Soft Tissue and GIST (ONC-12) in the Oncology Imaging
Guidelines).^{18,19,20}

Nipple Discharge/Galactorrhea (BR-6)

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Nipple Discharge/Galactorrhea (BR-6.1)

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- Pathologic nipple discharge
 - Initial imaging should include diagnostic mammogram and ultrasound (CPT® 76641: unilateral, complete or CPT® 76642: unilateral, limited). If these are negative or inconclusive, MRI Breast is the next appropriate imaging study.^{31,32,33,34}
- Physiologic nipple discharge
 - If nipple discharge is physiologic, there are no suspicious findings on clinical exam, and mammogram and ultrasound are negative, no additional imaging is necessary, and the individual can be reassured.^{31,32,33,34}

Background and Supporting Information

- Physiologic nipple discharge is predominantly bilateral, but may be unilateral. It is commonly multi-duct. It is predominantly milky, but may be white or a variety of colors including serous, yellow, green, brown, or gray. Evaluation for hyperprolactinemia can be considered.^{31,32 33,34}
- For milky discharge, prolactin and TSH levels are recommended to diagnose prolactinoma; pituitary imaging is not needed if normal serum Prolactin.
- Pathologic nipple discharge is defined as unilateral, bloody or serous, arising from a single duct, persistent, and spontaneous.

Breast Pain (Mastodynia) (BR-7)

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Breast Pain (Mastodynia) (BR-7.1)

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- Mammogram and ultrasound are the initial imaging for breast pain.³⁹
- Advanced imaging is NOT routinely indicated in individuals with breast pain and negative evaluation (evaluation includes individual history and physical exam, pregnancy test, mammogram and ultrasound (CPT® 76641: unilateral, complete or CPT® 76642: unilateral, limited)).³⁹
 - If evaluation is not negative, See **MRI Breast Indications (BR-5.1)**.

Background and Supporting Information

- The risk of malignancy following a negative clinical examination (clinical breast exam, mammogram, ultrasound) has been estimated to be only 0.5%.³⁹

Alternative Breast Imaging Approaches (BR-8)

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Alternative Breast Imaging Approaches (BR-8.1)

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- New and/or alternative breast imaging techniques include:
 - Nuclear breast imaging, including:
 - Scintimammography
 - Molecular breast imaging (MBI)
 - Breast specific gamma imaging (BSGI)
 - PET Mammography (PEM)
 - Thermography
 - Impedance Mammography
 - Other techniques to detect oxygen consumption, light absorption, microwave transmission, nitrous oxide production
 - CT Breast (CPT® 0633T, CPT® 0634T, CPT® 0635T, CPT® 0636T, CPT® 0637T, or CPT® 0638T)
 - Cone Beam CT Breast
- While alternative breast imaging techniques may have FDA approval, they remain investigational with respect to both screening and diagnosis of breast cancer.

Background and Supporting Information

- CT Breast
 - CT Breast is evolving and currently being studied as a mode of breast cancer detection. It remains under investigation, and is not to be used in lieu of conventional breast imaging modalities.
- Positron Emission Mammography
 - There is currently insufficient data available to generate appropriateness criteria for this modality, and this procedure should be considered investigational at this time
 - High-resolution positron-emission mammography (PEM) by Naviscan™ PET Systems, also referred to as Naviscan™ or PET mammography, 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.
 - Requesting providers often ask for PEM as CPT® 78811 or “PET scan of the breast”.
 - The spatial resolution of this technique is at the individual duct level (1.5 mm) and allows visualization of intraductal as well as invasive breast cancers. This technique is especially adept at detecting ductal carcinoma in situ.

- Early clinical trials have shown high clinical accuracy in characterizing lesions identified as suspicious on conventional imaging or physical examination, as well as in detecting incidental breast cancers not seen on other imaging modalities
- A prospective multi-center clinical trial for females with newly diagnosed breast cancer anticipating breast-conservation surgery was performed. These females underwent both high-resolution PEM imaging and breast MRI. Results showed that PEM and MRI had comparable breast-level sensitivity, although MRI had greater lesion-level sensitivity and more accurately depicted the need for mastectomy. PEM had greater specificity at the breast and lesion levels. Of these, 3.6% of the females had tumors seen only with PEM.
- The radiation exposure from a PEM study is 23 times higher than for digital mammography.

Suspected Breast Cancer in Males (BR-9)

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Suspected Breast Cancer in Males (BR-9.1)

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See **Breast Ultrasound (BR-1.1)**

- There is limited evidence on the use of MRI in the evaluation of male breast disease.
- Further diagnostic pathway for suspicious clinical or imaging findings usually requires tissue diagnosis.

Background and Supporting Information

- Breast cancer in males presents as a mass, skin/nipple change, or pathologic nipple discharge.

Breast Evaluation in Pregnant or Lactating Females (BR-10)

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Breast Evaluation in Pregnant or Lactating Females (BR-10.1)

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- Breast US (CPT® 76641 or CPT® 76642) is first-line imaging in pregnant and lactating females.
- If pregnant/lactating female has a palpable mass OR has persistent unilateral bloody nipple discharge and US is negative or suspicious, follow with diagnostic mammogram (with lead abdominal shielding).
- IV Gadolinium is required with MRI to evaluate breast parenchyma, but is contraindicated in pregnancy. Biopsy, rather than advanced imaging, is recommended after inconclusive mammogram and US.

Transgender Breast Cancer Supplemental Screening (BR-12)

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Transgender Breast Cancer Supplemental Screening (BR-12.1)

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- Annual supplemental Ultrasound and/or MRI Breast screening is indicated for the following:
 - Transmasculine (female-to-male) with ALL the following risk factors⁶⁴:
 - Reduction mammoplasty or no chest surgery
 - Age ≥ 25
 - High-risk ($\geq 20\%$ lifetime risk)
 - Transfeminine (male-to-female)
 - Transmasculine (female-to-male), who have had bilateral mastectomies
 - Transmasculine (female-to-male), who have NOT had mastectomies AND are at average risk or intermediate risk

Acceptable models of calculating clinical lifetime risk are: Gail (NCI), Claus, Tyrer-Cuzick (IBIS) or BRCAPRO.)

3D Rendering (BR-13)

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3D Rendering (BR-13.1)

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- 3D rendering (CPT® 76376 or CPT® 76377) should not be used in conjunction with any 3D mammography code.
- 3D rendering (CPT® 76376 or CPT® 76377) is not considered medically necessary for breast ultrasound. It is commonly requested in conjunction with automated breast ultrasound (ABUS); there is no evidence to support its clinical usefulness.
- 3D rendering, CPT® 76376 or CPT® 76377 should not be used in conjunction with MRI Breast.

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