Policy: MP300
Section: Medical Benefit Policy
Subject: Digital Breast Tomosynthesis

I. Policy: Digital Breast Tomosynthesis

II. Purpose/Objective:
To provide a policy of coverage regarding Digital Breast Tomosynthesis

III. Responsibility:
A. Medical Directors
B. Medical Management

IV. Required Definitions
1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions
Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member’s condition, illness, disease or injury;

b. provided for the diagnosis, and the direct care and treatment of the Member’s condition, illness disease or injury;

b. in accordance with current standards of good medical treatment practiced by the general medical community.

d. not primarily for the convenience of the Member, or the Member’s Health Care Provider; and

e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member’s condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment
Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

(i) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.

(ii) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.

(iii) The service or benefit will assist the Member to achieve or maintain maximum functional
capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

**DESCRIPTION:** Digital Breast Tomosynthesis (DBT) is a method for performing high-resolution limited-angle tomography at mammographic dose levels. Digital breast tomosynthesis produces a three dimensional image by taking multiple low-dose images per view along an arc over the breast to improve the sensitivity and specificity of mammography. It has been hypothesized that this technology may be able to decrease the number of false positive and false negative results and decrease recall rates.

**INDICATIONS:** Digital breast tomosynthesis is considered a medically necessary imaging option in the screening or diagnosis of breast cancer for any of the following:

1. Members having a screening or diagnostic mammogram whose prior mammogram reported a breast density of one of the following:
   a. Heterogeneously dense breast tissue
   b. Extremely dense breast tissue
   or
2. Members having a baseline mammogram (first mammogram)

**FOR MEDICAID BUSINESS SEGMENT:**
On October 5, 2015, the Commonwealth of Pennsylvania clarified their existing state mammogram mandate (40 P.S. §764c). Under this state law, digital breast tomosynthesis must be covered at no cost in the same manner as traditional 2D mammography.

**LIMITATIONS:**
Breast density can change over time. Commonly, breast tissue becomes less dense as a person ages. Therefore, it is possible that breast tomosynthesis may not be medically necessary in future studies.

**EXCLUSIONS:**
Requests for Digital Breast Tomosynthesis not meeting the criteria listed above will be considered not medically necessary and therefore NOT COVERED.

**CODING ASSOCIATED WITH:** Digital Breast Tomosynthesis

*The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.*

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>77061</td>
<td>Digital breast tomosynthesis; unilateral</td>
</tr>
<tr>
<td>77062</td>
<td>Digital breast tomosynthesis; bilateral</td>
</tr>
<tr>
<td>77063</td>
<td>Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>G0279</td>
<td>diagnostic digital breast tomosynthesis, unilateral or bilateral</td>
</tr>
</tbody>
</table>


**LINE OF BUSINESS:**
Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD’s and NCD’s will supercede this policy. For PA Medicaid Business segment, this policy applies as written.

**REFERENCES:**

Digital Breast Tomosynthesis. The American College of Obstetricians and Gynecologist – Vol. 121, No. 6, June 2013


Ciatto S, Houssami N, et al. Integration of 3D Digital Mammography with Tomosynthesis for Population Breast-Cancer Screening (STORM): A Prospective Comparison Study http://dx.doi.org/10.1016/S1470-2045(13)70134-7 www. the lancet.com/oncology


Smith A. Breast Tomosynthesis: The Use of Breast Tomosynthesis in a Clinical Setting. Imaging Science, Hologic


This policy will be revised as necessary and reviewed no less than annually.

Devised: 9/15

Revised: 12/15 (clarification), 10/16 (changed language; Added Medicaid Segment)

Reviewed: 10/17, 10/18, 10/19