


UCLA MEDICAL GROUP – Managed Care Operations		
DEPARTMENT:	Utilization Management	POLICY NUMBER: TBD
SECTION:	UM Program	
TITLE:	SCREENING MAMMOGRAPHY FOR BREAST CANCER	ISSUE: EFFECTIVE:
SUPERCEDES:	9/05, 5/07, 5/09, 5/11, 06/13, 6/17, 07/2019, 8/2021	
APPROVED BY UMC:	9/05, 5/07, 5/09, 5/11, 06/13, 5/15, 6/17, 08/2019, 8/2021	

UCLA Health Care/UCLA Medical Group Practice Guidelines

SCREENING MAMMOGRAPHY FOR BREAST CANCER

The UCLA Medical Group has adopted a guideline that combines the USPSTF and ACS breast cancer screening guidelines.

UCLA Medical Group Guideline:

1. For women aged 39 or less, **authorization** is required.
2. For women aged 40-74, every 1-2 years without preauthorization
3. For women 75 and older, mammography **may** be ordered every 1-2 years if clinically appropriate without preauthorization.

Senate Bill 1538 requires the following language to be added to the mammogram result letter that the patients receive: *“Your mammogram shows that your breast tissue is dense. Dense breast tissue is common and is not abnormal. However, dense breast tissue can make it harder to evaluate the results of your mammogram and may also be associated with an increased risk of breast cancer. This information about the results of your mammogram is given to you to raise your awareness and to inform your conversations with your doctor. Together, you can decide which screening options are right for you. A report of your results was sent to your physician.”*

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There is no evidence-based standard of care for a woman with dense breast tissue, thus the decision to add ultrasound should be based on the breast imaging radiologist's recommendation. Tomosynthesis is consider appreciate for breast screening.

Clinical practice guidelines made available by UCLA Medical Group are informational in nature and are intended as a resource for patient care. They are not a substitute for the professional medical judgment of treating physicians.

Summary of recommendations from ACS (last revised Oct 2015)

American Cancer Society (ACS) Breast Cancer Screening Guidelines *JAMA October 2015;314(15):1599-1614*

The ACS recommends that women with an average risk of breast cancer should undergo regular screening mammography starting at age 45 years (strong recommendation).

Women aged 45 to 54 years should be screened annually.

Women 55 years and older should transition to biennial screening or have the opportunity to continue screening annually.

Women should have the opportunity to begin annual screening between the ages of 40 and 44 years.

Women should continue screening mammography as long as their overall health is good and they have a life expectancy of 10 years or longer.

The ACS does not recommend clinical breast examination for breast cancer screening among average-risk women at any age

Rationale: Screening mammography in women aged 40 to 69 years is associated with a reduction in breast cancer deaths across a range of study designs, and inferential evidence supports breast cancer screening for women 70 years and older who are in good health. Estimates of the cumulative lifetime risk of false-positive examination results are greater if screening begins at younger ages because of the greater number of mammograms, as well as the higher recall rate in younger women. The quality of the evidence for over diagnosis is not sufficient to estimate a lifetime risk with confidence. Analysis examining the screening interval demonstrates more favorable tumor characteristics when premenopausal women are screened annually vs biennially.

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Evidence does not support routine clinical breast examination as a screening method for women at average risk.

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USPSTF: Breast cancer screening guidelines Ann Intern Med 2016; 164: 279-296

Annals of Internal Medicine



Primary Screening for Breast Cancer With Conventional Mammography

Population	Women aged 40 to 49 y	Women aged 50 to 74 y	Women aged ≥75 y
Recommendation	The decision to start screening should be an individual one. Grade: C	Screen every 2 years. Grade: B	No recommendation. Grade: I statement (Insufficient evidence)

Risk Assessment	These recommendations apply to asymptomatic women aged ≥40 y who do not have preexisting breast cancer or a previously diagnosed high-risk breast lesion and who are not at high risk for breast cancer because of a known underlying genetic mutation (such as <i>BRCA1</i> or <i>BRCA2</i> gene mutation or other familial breast cancer syndrome) or a history of chest radiation at a young age. Increasing age is the most important risk factor for most women.		
Screening Tests	Conventional digital mammography has essentially replaced film mammography as the primary method for breast cancer screening in the United States. Conventional digital screening mammography has about the same diagnostic accuracy as film overall, although digital screening seems to have comparatively higher sensitivity but the same or lower specificity in women age <50 y.		
Starting and Stopping Ages	For women who are at average risk for breast cancer, most of the benefit of mammography results from biennial screening during ages 50 to 74 y. While screening mammography in women aged 40 to 49 y may reduce the risk for breast cancer death, the number of deaths averted is smaller than that in older women and the number of false-positive results and unnecessary biopsies is larger. The balance of benefits and harms is likely to improve as women move from their early to late 40s.		
Screening Interval	For most women, biennial mammography screening provides the best overall balance of benefit and harms.		
Balance of Benefits and Harms	The net benefit of screening mammography in women aged 40 to 49 y, while positive, is small.	The net benefit of screening mammography in women aged 50 to 74 y is moderate.	Evidence on mammography screening in women aged ≥75 y is insufficient, and the balance of benefits and harms cannot be determined.
Other Relevant USPSTF Recommendations	The USPSTF has made recommendations about the use of medications to reduce women's risk for breast cancer, as well as risk assessment, genetic counseling, and genetic testing for <i>BRCA1</i> - or <i>BRCA2</i> -related cancer (including breast cancer). These recommendations are available on the USPSTF Web site (www.uspreventiveservicestaskforce.org).		

Screening for Breast Cancer With Methods Other Than Conventional Mammography

Screening Method	Primary screening with DBT	Adjunctive screening with breast ultrasonography, MRI, DBT, or other methods in women who have dense breasts
Recommendation	No recommendation. Grade: I statement (Insufficient evidence)	No recommendation. Grade: I statement (Insufficient evidence)

Benefits	From the limited data available, DBT seems to reduce recall rates (i.e., follow-up for additional imaging or testing) and increase cancer detection rates compared with conventional digital mammography alone.	Limited data suggests that ultrasonography or MRI will detect additional breast cancer in women who have dense breasts. DBT also detects additional breast cancer in the short term.
Harms	As currently practiced in most settings, DBT exposes women to about twice the amount of radiation as conventional digital mammography. Current study designs cannot determine the degree to which the additional cases of cancer detected would have become clinically significant (i.e., the degree of overdiagnosis).	Most positive adjunctive breast cancer screening test results are false positive.
Balance of Benefits and Harms	Evidence is insufficient, and the balance of benefits and harms cannot be determined.	Evidence is insufficient, and the balance of benefits and harms cannot be determined.

For a summary of the evidence systematically reviewed in making this recommendation, the full recommendation statement, and supporting documents, please go to www.uspreventiveservicestaskforce.org.

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- These recommendations apply to asymptomatic women aged ≥ 40 years
- No history of breast cancer/high-risk breast lesion
- No high risk for breast cancer because of a genetic mutation
(*BRCA1* or *BRCA2* or other familial breast cancer syndrome)
- No history of chest radiation at a young age)
- DBT (digital breast tomosynthesis) as primary screening: insufficient evidence
- Adding other methods (ultrasound, MRI) in women with dense breasts and negative mammogram: insufficient evidence
- false positive results are common and more frequent in younger women, women with dense breasts (use of DBT may reduce false positives)
- Biennial screening 50-74 avoids 7 BC deaths
- Annual screening 50-74 avoids 10 BC deaths and yields 11 more over diagnoses per 1,000 women screened

Women age 40-49:

- "C" recommendation is not a recommendation *against* mammography screening; it signifies moderate certainty of a small net benefit for screening
- The decision to screen should be an individual one, made after a woman weighs the potential benefit against the possible harms
- Women with a first-degree relative (parent, child, or sibling) with breast cancer may potentially benefit more than average-risk women
- False positives and recommendations for additional imaging (125/1,000) are highest in women 40-49 (Ann Intern Med 2016; 164:226-235)

All Women The USPSTF recommends against *teaching* breast self-examination (BSE). D

Women ≥ 40 Years The USPSTF concludes that the current evidence is insufficient to assess the additional benefits and harms of clinical breast examination (CBE) beyond screening mammography in women 40 years or older. I

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All Women The USPSTF concludes that the current evidence is insufficient to assess the additional benefits and harms of either digital mammography or magnetic resonance imaging (MRI) instead of film mammography as screening modalities for breast cancer.

REVISION / REVIEW HISTORY

<u>Date</u>	<u>Action</u>	<u>Reason</u>
9/3/2021	Revision of Guideline provided the SM UR committee	Page 2, added update language: There is no evidence-based standard of care for a woman with dense breast tissue, thus the decision to add ultrasound should be based on the breast imaging radiologist’s recommendation. Tomosynthesis is consider appropriate for breast screening.