SHP Contrast-Enhanced Spectral Mammography

AUTH: SHP Imaging 54 v4 (AC)

MCG Health
Ambulatory Care
26th Edition

Link to Codes

Coverage

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See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.

Application to Products

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- Policy is applicable to all products.

Authorization Requirements

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Pre-certification by the Plan is required.

Description of Item or Service

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Contrast-Enhanced Spectral Mammography uses two different X-rays; one with contrast and one without that are taken at about the same time. The combined view can show increased areas of concern.

Exceptions and Limitations

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There is insufficient scientific evidence to support the medical necessity of this service as it is not shown to improve health outcomes upon technology review.

Clinical Indications for Procedure

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- NA

Document History

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- Revised Dates:
- Reviewed Dates:
  - 2023: February
  - 2022: March
  - 2021: March
  - 2020: March
- Effective Date: March 2017

Coding Information

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- CPT/HCPCS codes covered if policy criteria is met:
  - None

- CPT/HCPCS codes considered not medically necessary per this Policy:
  - CPT 76499 - Unlisted diagnostic radiographic procedure

References

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References used include but are not limited to the following:

Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; Uptodate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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Codes

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CPT® : 76499