**Section 370.90 Medical Records and Mammography Reports**

a) Contents and terminology. Each facility shall prepare a written report of the results of each mammography examination performed under its certificate. The mammography report shall include the following information:

1) The name of the patient and an additional patient identifier;

2) Date of examination;

3) The name of the interpreting physician who interpreted the mammogram;

4) Overall final assessment of findings, classified in one of the following categories:

A) "Negative." Nothing to comment upon (if the interpreting physician is aware of clinical findings or symptoms, despite the negative assessment, these shall be explained);

B) "Benign." Also a negative assessment;

C) "Probably Benign." Finding(s) has a high probability of being benign;

D) "Suspicious." Finding(s) without all the characteristic morphology of breast cancer but indicating a definite probability of being malignant;

E) "Highly suggestive of malignancy." Finding(s) has a high probability of being malignant;

5) In cases where no final assessment category can be assigned due to incomplete work-up, "Incomplete: Need additional imaging evaluation" shall be assigned as an assessment and reasons why no assessment can be made shall be stated by the interpreting physician; and

6) Recommendations made to the health care provider about what additional actions, if any, should be taken. All clinical questions raised by the referring health care provider shall be addressed in the report to the extent possible, even if the assessment is negative or benign.

b) Communication of mammography results to the patient. Each facility shall send each patient a summary of the mammography report written in lay terms within 30 days after the mammographic examination. If assessments are "Suspicious" or "Highly suggestive of malignancy", the facility shall make reasonable attempts to ensure that the results are communicated to the patient as soon as possible.

1) Patients who do not name a health care provider to receive the mammography report shall be sent the report described in subsection (a) of this Section within 30 days, in addition to the written notification of results in lay terms.

2) Each facility that accepts patients who do not have a health care provider shall maintain a system for referring such patients to a health care provider when clinically indicated.

c) Communication of mammography results to health care providers. When the patient has a referring health care provider or the patient has named a health care provider, the facility shall:

1) Provide a written report of the mammography examination, including the items listed in subsection (a) of this Section, to that health care provider as soon as possible, but no later than 30 days after the date of the mammography examination; and

2) If the assessment is "Suspicious" or "Highly suggestive of malignancy," make reasonable attempts to communicate with the health care provider as soon as possible, or if the health care provider is unavailable, to a responsible designee of the health care provider.

d) Recordkeeping. Each facility that performs mammograms:

1) Shall (except as provided in subsection (c)(2) of this Section) maintain mammography films and reports in a permanent medical record of the patient for a period of not less than 5 years, or not less than 10 years if no additional mammograms of the patient are performed at the facility;

2) Shall upon request by, or on behalf of, the patient permanently or temporarily transfer the original mammograms and copies of the patient's reports to a medical institution, or to a physician or health care provider of the patient, or to the patient directly. Any fee charged to the patient for providing the services in this subsection (d) shall not exceed the documented costs associated with this service.

e) Mammographic image identification. Each mammographic image shall have the following information indicated on it in a permanent, legible, and unambiguous manner and placed so as not to obscure anatomic structures:

1) Name of patient and an additional patient identifier.

2) Date of examination.

3) View and laterality. This information shall be placed on the image in a position near the axilla. Standardized codes specified by the accreditation body shall be used to identify view and laterality.

4) Facility name and location. At a minimum, the location shall include the city, state and zip code of the facility.

5) Technologist identification.

6) Cassette/screen identification.

7) Mammography unit identification, if there is more than one unit in the facility.

(Source: Amended at 24 Ill. Reg. 18258, effective December 1, 2000)