

EFFECTIVE DATE: 11/25/02. Prior dates of service, refer to previous LMRP titled Tumor Markers.

National Coverage Determinations (NCDs)
Tumor Antigen by Immunoassay CA 15-3/CA 27.29
(Breast Cancer Antigen)

CPT/HCPCS Codes

86300

IMMUNOASSAY FOR TUMOR ANTIGEN, QUANTITATIVE;
CA 15-3 (27.29) (BREAST CANCER ANTIGEN)

Publication Number

6

Effective Date of this Version

10-1-06

Implementation Date

1/1/2003

Item/Service Description

Description: Immunoassay determinations of the serum levels of certain proteins or carbohydrates serve as tumor markers. When elevated, serum concentration of these markers may reflect tumor size and grade.

This policy specifically addresses the following tumor antigens: CA 15-3 & CA 27.29

Limitations of Coverage

Limitations:

These services are not covered for the evaluation of patients with signs or symptoms suggestive of malignancy. The service may be ordered at times necessary to assess either the presence of recurrent disease or the patient's response to treatment with subsequent treatment cycles.

ICD-9 Codes Covered

<u>174.0 - 174.9</u>	MALIGNANT NEOPLASM OF NIPPLE AND AREOLA OF FEMALE BREAST
<u>175.0 - 175.9</u>	MALIGNANT NEOPLASM OF NIPPLE AND AREOLA OF MALE BREAST
198.2	SECONDARY MALIGNANT NEOPLASM OF SKIN
198.81	SECONDARY MALIGNANT NEOPLASM OF BREAST
338.3	NEOPLASM RELATED PAIN (ACUTE) (CHRONIC)
795.89	OTHER ABNORMAL TUMOR MARKERS
V10.3	PERSONAL HISTORY OF MALIGNANT NEOPLASM OF BREAST

Reasons for Denial

Tests for screening purposes that are performed in the absence of signs, symptoms, complaints, or personal history of disease or injury are not covered except as explicitly authorized by statute. These include exams required by insurance companies, business establishments, government agencies, or other third parties. Tests that are not reasonable and necessary for the diagnosis or treatment of an illness or injury are not covered according to the statute. Failure to provide documentation of the medical necessity of tests may result in denial of claims. The documentation may include notes documenting relevant signs, symptoms, or abnormal findings that substantiate the medical necessity for ordering the tests. In addition, failure to provide independent verification that the test was ordered by the treating physician (or qualified nonphysician practitioner) through documentation in the physician's office may result in denial. A claim for a test for which there is a national coverage or local medical review policy will be denied as not reasonable and necessary if it is submitted without an ICD-9-CM code or narrative diagnosis listed as covered in the policy unless other medical documentation justifying the necessity is submitted with the claim. If a national or local policy identifies a frequency expectation, a claim for a test that exceeds that expectation may be denied as not reasonable and necessary, unless it is submitted with documentation justifying increased frequency.

ICD-9 Codes That Do Not Support Medical Necessity or That Will Be Denied:

Any ICD-9 code not listed above. ICD-9 codes that do not support medical necessity are open for review with Medicare. ICD-9 codes that are denied will not be open for review with Medicare. A list of denied codes is available at HGSA.com under Medical Policy-Nat'l Clinical Lab Policies.

Revised: 1/03, 9-06