

Chapter 6

Section 1.1

General

Issue Date:

Authority: 32 CFR 199.4(a)(1)(i), (b)(2)(ix), (b)(2)(xviii), (b)(3)(vi), (b)(3)(xv), (c)(2)(ix), (c)(2)(x), and (g)(60)

Copyright: CPT only © 2006 American Medical Association (or such other date of publication of CPT).
All Rights Reserved.

Revision:

1.0 CPT PROCEDURE CODES

80048 - 87622, 87640, 87641, 87650 - 87999, 88104 - 89264, 89330 - 89399

2.0 DESCRIPTION

2.1 Pathology is the medical science and specialty practice that deals with all aspects of disease, but with special reference to the essential nature, the causes, and development of abnormal conditions, as well as the structural and functional changes that result from disease processes.

2.2 The surgical pathology services include accession, examination, and reporting for a specimen which is defined as tissue that is submitted for individual and separate attention, requiring individual examination and pathologic diagnosis. These codes require gross and microscopic examination.

3.0 POLICY

3.1 Pathology and laboratory services are covered except as indicated.

3.2 Surgical pathology procedures, billed by a pathologist, are covered services.

3.3 If the operating surgeon bills for surgical pathology procedures, they will be denied as incidental, since the definitive (microscopic) examination will be performed later, after fixation of the specimen, by the pathologist who will bill separately.

3.4 Dermatologists are qualified to perform surgical pathology services. Therefore, if a dermatologist bills for both the surgical procedure (e.g., Current Procedural Terminology (CPT) procedure code 11100, skin biopsy) as well as the surgical pathology, both procedures are covered in full.

3.5 Human papillomavirus testing (CPT procedure codes 87620 - 87622) is covered as a diagnostic test for the assessment of women with Atypical Squamous Cells of Undetermined Significance (ASCUS) detected during a Pap smear.

3.6 The Nuclear magnetic Resonance (NMR) LipoProfile-2 test, used with the NMR Profiler (CPT procedure codes 83701 and 83704) is proven and covered for the management of lipoprotein disorders associated with cardiovascular disease.

3.7 For transfusion services, refer to [Section 2.1](#).

4.0 EXCLUSIONS

4.1 Autopsy and postmortem (CPT procedure codes 88000 - 88099).

4.2 Sperm penetration assay (hamster oocyte penetration test or the zona-free hamster egg test) is excluded for In vitro Fertilization (IVF) (CPT procedure code 89329).

4.3 In-vitro chemoresistance and chemosensitivity assays (stem cell assay, differential staining cytotoxicity assay and thymidine incorporation assay) are unproven.

4.4 Hair analysis to identify mineral deficiencies from the chemical composition of hair is unproven. Hair analysis testing (CPT procedure code 96902) may be reimbursed when necessary to determine lead poisoning.

4.5 Insemination of oocytes (CPT procedure code 89268).

4.6 Extended culture of oocyte(s) embryo(s) four to seven days (CPT procedure code 89272).

4.7 Assisted oocyte fertilization, microtechnique; less than or equal to 10 oocytes (CPT procedure code 89280). Assisted oocyte fertilization, microtechnique; greater than 10 oocytes (CPT procedure code 89281).

4.8 Biopsy oocyte polar body or embryo blastomere (CPT procedure code 89290). Biopsy oocyte polar body or embryo blastomere; greater than four embryos (CPT procedure code 89291).

4.9 Cryopreservation reproductive tissue, testicular (CPT procedure code 89335).

4.10 Storage (per year) embryo(s) (CPT procedure code 89342). Storage (per year) sperm/semen (CPT procedure code 89343). Storage (per year) reproductive tissue, testicular/ovarian (CPT procedure code 89344). Storage (per year) oocyte (CPT procedure code 89346).

4.11 Thawing of cryopreserved, embryo(s) (CPT procedure code 89352). Thawing of cryopreserved, sperm/semen, each aliquot (CPT procedure code 89353). Thawing of cryopreserved, reproductive tissue, testicular/ovarian (CPT procedure code 89354). Thawing of cryopreserved, oocytes, each aliquot (CPT procedure code 89356).

4.12 AlloMap® for molecular testing is unproven for use in cardiac transplant rejection surveillance.

4.13 Oncotype Dx (S3854) is not covered due to the lack of U.S. Food and Drug Administration (FDA) status.

4.14 OVA1™ test for ovarian cancer.

TRICARE Policy Manual 6010.60-M, April 1, 2015

Chapter 6, Section 1.1

General

4.15 The Pathwork® Tissue of Origin Test is unproven to assist in identifying the origin of poorly differentiated, undifferentiated, or metastatic tumors.

5.0 EFFECTIVE DATE

July 23, 2008, for NMR LipoProfile-2 test, used with the NMR Profiler.

- END -

