

# Tumor Antigen by Immunoassay CA15-3/CA 27.29



CPT: 86300

## CMS National Coverage Policy

Medically Supportive ICD Codes are listed on subsequent page(s) of this document.

### Coverage Indications, Limitations, and/or Medical Necessity

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

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

### Indications

Multiple tumor markers are available for monitoring the response of certain malignancies to therapy and assessing whether a residual tumor exists post-surgical therapy. CA 15-3 is often medically necessary to aid in the management of patients with breast cancer. Serial testing must be used in conjunction with other clinical methods for monitoring breast cancer. For monitoring, if medically necessary, use consistently either CA 15-3 or CA 27.29, not both. CA 27.29 is equivalent to CA 15-3 in its usage in management of patients with breast cancer.

### 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.

Visit <https://www.synergylaboratories.com/coverageguidance> to view current limited coverage tests, reference guides, and policy information. To view the complete policy and the full list of medically supportive codes, please refer to the CMS website reference

[www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/r17ncd.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/r17ncd.pdf)

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Please refer to the Limitations or Utilization Guidelines section on previous page(s) for frequency information.

The ICD10 codes listed below are the top diagnosis codes currently utilized by ordering physicians for the limited coverage test highlighted above that are also listed as medically supportive under Medicare’s limited coverage policy. **If you are ordering this test for diagnostic reasons that are not covered under Medicare policy, an Advance Beneficiary Notice form is required.**

*\*Note—Bolded diagnoses below have the highest utilization*

Code	Description
C50.011	Malignant neoplasm of nipple and areola, right female breast
C50.012	Malignant neoplasm of nipple and areola, left female breast
C50.111	Malignant neoplasm of central portion of right female breast
C50.112	Malignant neoplasm of central portion of left female breast
C50.211	Malignant neoplasm of upper-inner quadrant of right female breast
C50.212	Malignant neoplasm of upper-inner quadrant of left female breast
C50.312	Malignant neoplasm of lower-inner quadrant of left female breast
<b>C50.411</b>	<b>Malignant neoplasm of upper-outer quadrant of right female breast</b>
<b>C50.412</b>	<b>Malignant neoplasm of upper-outer quadrant of left female breast</b>
C50.419	Malignant neoplasm of upper-outer quadrant of unspecified female breast
C50.511	Malignant neoplasm of lower-outer quadrant of right female breast
C50.512	Malignant neoplasm of lower-outer quadrant of left female breast
C50.811	Malignant neoplasm of overlapping sites of right female breast
C50.812	Malignant neoplasm of overlapping sites of left female breast
C50.819	Malignant neoplasm of overlapping sites of unspecified female breast
<b>C50.911</b>	<b>Malignant neoplasm of unspecified site of right female breast</b>
<b>C50.912</b>	<b>Malignant neoplasm of unspecified site of left female breast</b>
<b>C50.919</b>	<b>Malignant neoplasm of unspecified site of unspecified female breast</b>
R97.8	Other abnormal tumor markers
Z85.3	Personal history of malignant neoplasm of breast

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**Disclaimer:**  
This diagnosis code reference guide is provided as an aid to physicians and office staff in determining when an ABN (Advance Beneficiary Notice) is necessary. Diagnosis codes must be applicable to the patient’s symptoms or conditions and must be consistent with documentation in the patient’s medical record. The Alliance does not recommend any diagnosis codes and will only submit diagnosis information provided to us by the ordering physician or his/her designated staff. The CPT codes provided are based on AMA guidelines and are for informational purposes only. CPT coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed.