

<b>Subject:</b>	Surgical Pathology		
<b>Policy Number:</b>	PO-RE-100v2		
<b>Effective Date:</b>	05/01/2024	<b>Last Approval Date:</b>	06/10/2026

## I. Policy Description

Healthfirst has established a policy regarding the number of units payable for surgical pathology services. This policy ensures appropriate reimbursement and encourages the provision of medically necessary surgical pathology services. This policy outlines the maximum number of units that Healthfirst will reimburse for surgical pathology procedures.

The information below applies to the following lines of business.

• Child Health Plus (CHP)	• Essential Plan (EP)
• Integrated Benefit Dual Plan (IB-Dual)	• Medicaid Advantage Plus/MAP (CompleteCare)
• Medicaid Managed Care (MMC)	• Qualified Health Plan (QHP)
• Medicare Advantage HMO	• Personal Wellness Plan (HARP)
• Medicare PPO	

### Policy Scope

Healthfirst reimburses a maximum of four (4) units of surgical pathology services reported with CPT code 88305.

Exceptions include:

- Up to eight (8) units for gastrointestinal (GI) related diagnoses.
- Up to sixteen (16) units for prostate-related diagnoses.

Claims submitted with units exceeding these limits may be subject to medical record review and validation of supporting clinical documentation.

### Rationale

CPT code 88305 represents a gross and microscopic examination of tissue specimens by a pathologist.

For billing purposes, each specimen is considered one unit. A specimen is defined as tissue or tissues submitted for individual and separate examination requiring a distinct pathological evaluation and diagnosis.

Although reporting more than four units may be clinically appropriate in certain circumstances, claims exceeding established unit thresholds require documentation supporting medical necessity and the number of specimens examined.

## Adjudication and Appeal Process

1. Reimbursement for surgical pathology services will be determined based on the provider's scope of services and the reimbursement rates outlined in the provider's contract with Healthfirst.
2. Claims submitted by providers that do not adhere to this policy will be denied or rejected. It is the responsibility of the provider to ensure claims are coded accurately.
3. This policy applies only to the line(s) of business (LOB) identified at the beginning of the policy and does not apply to other LOBs. For policies applicable to other lines of business, please visit [www.hfproviders.org](http://www.hfproviders.org).
4. This policy is a provider resource for understanding Healthfirst's reimbursement guidelines. It does not guarantee coverage or payment. Final reimbursement decisions depend on benefit coverage, state/federal mandates, medical necessity, and provider contract.
5. Claims submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. *Refer to: Healthfirst Provider Manual Subsection 17, "Billing & Claims Processing"*.

## II. Applicable Codes

Code	Description	Comment
88305	Surgical pathology, gross and microscopic examination Abortion - spontaneous/missed Artery, biopsy Bone marrow, biopsy Bone exostosis Brain/meninges, other than for tumor resection Breast, biopsy, not requiring microscopic evaluation of surgical margins Breast, reduction mammoplasty Bronchus, biopsy Cell block, any source Cervix, biopsy Colon, biopsy Duodenum, biopsy Endocervix, curettings/biopsy Endometrium, curettings/biopsy Esophagus, biopsy Extremity, amputation, traumatic Fallopian tube, biopsy Fallopian tube, ectopic pregnancy Femoral head, fracture Fingers/toes, amputation, non-traumatic Gingiva/oral	

	mucosa, biopsy Heart valve Joint, resection Kidney, biopsy Larynx, biopsy Leiomyoma(s), uterine myomectomy - without uterus Lip, biopsy/wedge resection Lung, transbronchial biopsy Lymph node, biopsy Muscle, biopsy Nasal mucosa, biopsy Nasopharynx/oropharynx, biopsy Nerve, biopsy Odontogenic/dental cyst Omentum, biopsy Ovary with or without tube, non-neoplastic Ovary, biopsy/wedge resection Parathyroid gland Peritoneum, biopsy Pituitary tumor Placenta, other than third trimester Pleura/pericardium - biopsy/tissue Polyp, cervical/endometrial Polyp, colorectal Polyp, stomach/small intestine Prostate, needle biopsy Prostate, TUR Salivary gland, biopsy Sinus, paranasal biopsy Skin, other than cyst/tag/debridement/plastic repair Small intestine, biopsy Soft tissue, other than tumor/mass/lipoma/debridement Spleen Stomach, biopsy Synovium Testis, other than tumor/biopsy/castration Thyroglossal duct/brachial cleft cyst Tongue, biopsy Tonsil, biopsy Trachea, biopsy Ureter, biopsy Urethra, biopsy Urinary bladder, biopsy Uterus, with or without tubes and ovaries, for prolapse Vagina, biopsy Vulva/labia, biopsy	
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### III. Definitions

Term	Meaning

### IV. Related Policies

Policy Number	Policy Description
N/A	N/A

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*Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.*

### V. Reference Materials

[NCCI for Medicare | CMS](#)

American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services

## VI. Revision History

Revision Date	Summary of Changes
6/10/2026	<ul style="list-style-type: none"> <li>Annual review completed. No changes were made to the reimbursement criteria, applicable codes, or unit limitations.</li> <li>Added and clarified the Adjudication and Appeal Process section to improve policy transparency and provide guidance regarding reimbursement determinations, claim submissions, policy applicability, reimbursement limitations, and timely filing requirements.</li> </ul>
2/20/2024	<ul style="list-style-type: none"> <li>Changes have been implemented to include gastrointestinal (GI) related diagnoses and prostate related diagnoses:               <ul style="list-style-type: none"> <li>Expanded the number of units to eight (8) units for gastrointestinal (GI) related diagnoses.</li> <li>Expanded the number of units to sixteen (16) units for prostate related diagnoses.</li> </ul> </li> </ul>

### Disclaimer

Healthfirst's claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.