

Medicare Advantage Medical Policy



Nonprofit corporations and independent licensees
of the Blue Cross and Blue Shield Association

Multimarker Serum-Based Testing Related to Ovarian Cancer (e.g., OVA1®, Overa™, OvaWatch, GlycoKnow Ovarian, and ROMA™ Testing) - Medicare Advantage

Medicare Advantage Plan

- ☒ Medicare Plus BlueSM
- ☒ BCN AdvantageSM

UM Committee Approval Date: 7/15/2026

Effective Date: 8/15/2026

Description

A variety of serum biomarkers have been studied for their association with ovarian cancer. Of particular interest have been tests that integrate results from multiple analytes into a risk score to predict the presence of disease. Three tests based on this principle, OVA1, Overa (the second-generation OVA1 test), and Risk of Ovarian Malignancy Algorithm (ROMA) have been cleared by the US Food and Drug Administration. The intended use of OVA1 and Overa as an aid to further assess whether malignancy is present in an individual with an ovarian adnexal mass who has not yet been referred to an oncologist, even when the physician's independent clinical and radiologic evaluation does not indicate malignancy. The intended use of ROMA is as an aid, in conjunction with clinical assessment, to assess whether a premenopausal or a postmenopausal woman who presents with an ovarian adnexal mass and has not yet been referred to an oncologist, is at high likelihood or low likelihood of finding malignancy on surgery.

Related Medical Coverage Policies

- Germline and Somatic Biomarker Testing (Including Liquid Biopsy) for Targeted Treatment in Ovarian Cancer (BRCA1, BRCA2, Homologous Recombination Deficiency) – Medicare Advantage
 - Germline Genetic Testing for BRCA1, BRCA2, and PALB2 for Hereditary Breast/Ovarian Cancer Syndrome and Other High-Risk Cancers – Medicare Advantage
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Policy Guidelines

Blue Cross Blue Shield of Michigan (BCBSM) and Blue Care Network of Michigan (BCN) adhere to guidance from the Centers for Medicare and Medicaid Services (CMS), including when performing organization determinations for Medicare Advantage plan members. CMS Medicare statutes, regulations, manuals, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and other sub-regulatory

guidance provide the clinical guidelines for coverage determinations, payment integrity functions, and all other uses by CMS regulations. When CMS Medicare guidance is silent, incomplete, or insufficient, CMS permits BCBSM/BCN to utilize “internal coverage criteria”, such as independent criteria, health plan policy research, LCD/LCAs outside the services area or research from independent medical research repositories (i.e., Hayes) for coverage policies consistent with 42 CFR § 422.101. BCBSM/BCN internal medical coverage policies are developed and based on current evidence in widely accepted treatment guidelines or clinical literature; in addition, they address how clinical benefits may or may not outweigh member harm.

Clinical review follows guidance provided in the BCBSM Medicare Advantage Coverage Determination Hierarchy policy, which may be found at <https://www.bcbsm.com/providers/mpradmin/> by entering the policy name.

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

Apart from durable medical equipment (DME), Medicare Administrative Contractor (MAC) jurisdiction for the purpose of clinical determination is based upon place of service. The place of service for laboratory testing is defined as the geographic location of the reference laboratory. Non-jurisdictional LCD/LCAs may not be utilized for a determination unless they have been specifically identified as internal coverage criteria by the policy. Alternatively, jurisdiction for DME MAC is determined by the member place of residence. Please see CMS Medicare Administrative Contractors (MAC) table for state MAC assignments below.

CMS Guidance	Additional Guidance
National Coverage Determinations 310.1 - Routine Costs in Clinical Trials For additional information related to clinical trials related to prognostic and predictive biomarkers in ovarian cancers. Please refer to this URL: https://clinicaltrials.gov Local Coverage Determinations and Articles WPS L36807, A57772 – MoDx: Molecular Diagnostic Tests (MDT)* A59649 – MoDx: Proteomics Testing* CGS L36021, A56973 – MoDx: Molecular Diagnostic Tests (MDT)* A59646 – MoDx: Proteomics Testing* First Coast A58918 – Molecular Pathology and Genetic Testing Noridian JE & JF L35160, A57526 – MoDx: Molecular Diagnostic Tests (MDT)*	BCBSM/BCN will follow CMS guidance as the primary source for coverage determinations. However, in instances where CMS guidance is silent, incomplete, or insufficient for a particular code, BCBSM/BCN internal coverage criteria will be applied to ensure consistent and informed decision-making. In such cases, please refer to the relevant BCBSM/BCN policy for guidance: <i>Multimarker Serum Testing Related to Ovarian Cancer (e.g., OVA1®, Overa™, OvaWatch®, GlycoKnow Ovarian, and ROMA® testing)</i> To access this policy, please visit the BCBSM Medical Policy Router Search page at https://www.bcbsm.com/providers/mpradmin/ and enter the policy name in the search field.

A59641 – MoIDx: Proteomics Testing* Novitas A58917 – Molecular Pathology and Genetic Testing L35396, A52986 – Biomarkers for Oncology Palmetto L35025, A56853 – MoIDx: Molecular Diagnostic Tests (MDT)* A59636 – MoIDx: Proteomics Testing* Wellpoint Federal L38371, A57020 – Multimarker Serum Tests Related to Ovarian Cancer Testing L35000, A56199 – Molecular Pathology	
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Code	Description
81500	Oncology (ovarian), biochemical assays of two proteins (CA-125 and HE4), utilizing serum, with menopausal status, algorithm reported as a risk score
81503	Oncology (ovarian), biochemical assays of five proteins (CA-125, apolipoprotein A1, beta-2 microglobulin, transferrin and pre-albumin), utilizing serum, algorithm reported as a risk score
84999	Unlisted Chemistry Procedure
0003U	Oncology (ovarian) biochemical assays of five proteins (apolipoprotein A-1, CA 125 II, follicle stimulating hormone, human epididymis protein 4, transferrin), utilizing serum, algorithm reported as a likelihood score [Overa (OVA1 Next Generation), Aspira Labs, Inc, Vermillion, Inc, TX]
0375U	Oncology (ovarian), biochemical assays of 7 proteins (follicle stimulating hormone, human epididymis protein 4, apolipoprotein A-1, transferrin, beta-2 macroglobulin, prealbumin [i.e., transthyretin], and cancer antigen 125), algorithm reported as ovarian cancer risk score. [OvaWatchMSM, Aspira Women's HealthSM, Aspira Labs, Inc, TX]

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HCPCS® codes, descriptions and materials are copyrighted by Centers for Medicare and Medicaid Services (CMS).

* CMS MoIDX Program

The MoIDX Program, administered by Palmetto GBA, is a Medicare Molecular Diagnostic Program that aims to identify and establish coverage and reimbursement for molecular diagnostic tests. This program is implemented by several Medicare Administrative Contractors (MACs), including **WPS, CGS, Noridian, and Palmetto**.

The MoIDX Program evaluates genetic and proteomic tests to determine their analytical and clinical validity (AV/CV) and clinical utility (CU), ensuring that each test meets Medicare criteria.

The program's coverage determinations are maintained in the DEX™ Diagnostic Exchange registry. Dex Diagnostic Exchange Registry Coverage Determinations:

1. Not Covered: Not covered tests in the Dex Registry have undergone a review of their clinical utility and analytical validity and have been determined to not meet the requirements for medical necessity under Section 1862(a)(1)(A) of the Social Security Act. As a result, they are not considered medically reasonable or necessary for Medicare coverage.
2. No Determinations: Tests that have not completed the required technical assessment (TA) review are, by default, also considered not medically reasonable or necessary for Medicare under Section 1862(a)(1)(A) until the review is completed.

The MoIDX Program does not provide coverage for tests provided with dates of services prior to the effective date of approval.

3. Covered: Covered Tests in Dex Registry have completed the required TA review and have been determined to be medically reasonable and necessary for Medicare under Section 1862(a)(1)(A). However, coverage is not automatic and is subject to the following conditions:
 - a. The test must meet the applicable criteria outlined in NCDs, LCDs, and LCAs; and
 - b. The patient must exhibit signs or symptoms of a relevant disease or condition, making the test medically necessary for their care.

For specific coding and billing information on covered and excluded tests, please refer to the MoIDX website at <https://www.palmettogba.com/MoIDX>. This website provides up-to-date information on the program's coverage determinations and guidelines.

NOTE: Per § 2.3.3. of the Molecular Diagnostic Program [MoIDX®] Manual, the MoIDX Program does not provide coverage for tests that have not been reviewed and approved through the MoIDX process or for tests provided with dates of services prior to the effective date of approval. For additional information regarding what tests will fall into a Medicare benefit category or which tests are statutory excluded (e.g., predictive, prenatal, and carrier testing and tests considered screening in the absence of clinical signs and symptoms of disease that are not specifically identified by the law) please refer to <https://www.palmettogba.com/palmetto/moldxv2.nsf/DID/DPR5GEM991>

** Status Indicator Code: The National Physician Fee Schedule Relative Value File (NPF SRVF), which is published by Medicare, indicates HCPCS codes starting with “S” or “H” have been assigned a Status Indicator code of “I” - Not valid for Medicare purposes.

The above information is current as of the review date for this policy. However, the coverage issues and policies maintained by CMS are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document.

Please refer to the Medicare Coverage Database website at <https://www.cms.gov/medicare-coverage-database/search.aspx> for the most current applicable NCD, LCD, LCA, and CMS Online Manual System Transmittals. For any code associated with a product or service determined to be noncovered by policy (either CMS or health plan policy if CMS is silent) medical record review, including prior authorization, will not be required.

CMS Medicare Administrative Contractors (MAC) Jurisdictions Guidance

Part A and Part B MAC Jurisdictions	
Wisconsin Physicians Service Insurance Corporation (WPS)	IA, IN, KS, MI, MO, NE
CGS Administrators, LLC	KY, OH
First Coast Service Options, Inc	FL, PR, US VI
Noridian Healthcare Solutions, LLC Jurisdiction JE	CA, HI, NV, American Samoa, Guam, Northern Mariana Islands
Noridian Healthcare Solutions, LLC Jurisdiction JF	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
Novitas Solutions Inc.	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX,
Palmetto GBA	AL, GA, TN NC, SC, VA, WV

Wellpoint Federal - Previously known as National Government Services, Inc. (NGS)	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI,
DME MAC Jurisdictions	
CGS Administrators, LLC, Jurisdictions JB and JC	AL, AR, CO, FL, GA, IL, IN, KY, LA, MI, MN, MS, NM, NC, OH, OK, Puerto Rico, SC, TN, TX, VA, Virgin Island, WI, WV
Noridian Healthcare Solutions, LLC, Jurisdictions JA and JD	AK, American Soamoa, AZ, CA, CT, DE, DC, Guam, HI, ID, IA, KS, MA, MD, ME, MO, MT, ND, NE, NH, NJ, NV, NY, Northern Mariana Islands, OR, PA, RI, SD, UT, VT, WA, WY

Important Reminder

BCBSM and BCN follow CMS Medicare coverage guidance to limit coverage to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. Medicare Advantage Medical Policies list the criteria BCBSM and BCN use to decide which medical services are considered “reasonable and necessary” when Medicare coverage rules are not fully developed, or as otherwise permitted by CMS Medicare regulations. Individual member benefit plan documents, such as the Evidence of Coverage and Annual Notice of Change, as well as applicable laws govern benefit coverage, including any inclusion, exclusion, and/or other restrictions.

Medicare Advantage Medical policies are created when permitted by CMS Medicare regulations, reviewed regularly, and may be revised periodically. BCBSM/BCN Medical Policies are proprietary and should not be copied or disseminated without the express, prior written approval of BCBSM. All providers are required to review applicable BCBSM reimbursement policies prior to claim submission and bill for covered services in accordance with those policies. Additionally, providers contracted with BCBSM or BCN’s Medicare Advantage network(s) should review the provider manual for any additional claim submission requirements. Providers not contracted with BCBSM or BCN’s Medicare Advantage network may be required to submit documentation to BCBSM, BCN, or its delegated entity supporting billed claims, including but not limited to applicable medical records.

Note: U.S. Food and Drug Administration (FDA) approval for a specific indication or the issuance of a CPT code is not sufficient for a procedure to be considered medically reasonable and necessary. Similarly, the presence of a procedure/device code or payment amount for the service in the Medicare fee schedule does not necessarily indicate coverage. If a service is deemed not reasonable and necessary, to treat illness or injury for any reason (including lack of safety and efficacy because it is an experimental procedure, etc.), the procedure is considered not covered.

Disclaimer: This medical policy is not an authorization, certification, explanation of benefits, or a contract for the services, devices, or drugs that is referenced in the medical policy. Medical policies do not constitute medical advice and do not guarantee any results or outcomes or guarantee payment. The medical policy is not intended to replace independent medical judgment for the treatment of individuals. Treating physicians and health care providers are solely responsible for determining what care to provide for their patients. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test, or procedure over another.

Pursuant to Section 1557 and Section 504, Blue Cross does not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes). This includes our rules, benefit designs and medical policies.

BCBSM/BCN Medicare Advantage Policy History

Policy Effective Date	UM Committee Approval Date	Comments
08/17/2024	07/17/2024	Medicare Advantage policy established
08/16/2025	07/16/2025	Annual Review: MA Policy Foundational Language updated. Adopted JUMP policy Updates
02/28/2026	01/28/2026	Off-Cycle Review: Reformatted guidance and code tables. Added related policies. Adopted JUMP policy updates including the addition of code 0577U.
08/15/2026	07/15/2026	Annual Review: Adopted JUMP policy updates including addition of code 84999, deletion of code 0577U and title change. Previous title: <i>Multimarker Serum Testing Related to Ovarian Cancer (e.g., OVA1®, OVERA, OvaWatch and ROMA testing) - Medicare Advantage.</i>