

Medicare Advantage Medical Policy



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of the Blue Cross and Blue Shield Association

Evaluation of Biomarkers for Alzheimer's Disease – Medicare Advantage

Medicare Advantage Plan

- ☒ Medicare Plus BlueSM
- ☒ BCN AdvantageSM

UM Committee Approval Date: 09/17/2025

Effective Date: 10/17/2025

Description

The evaluation of Alzheimer's Disease (AD) biomarkers is proposed to assist in the management and understanding of the disease. Biomarkers are biological indicators that can be measured to assess the presence or progression of a disease. Biomarkers can be found in blood, other body fluids, organs, and tissues. They have also been proposed to assess the risk of developing AD in individuals who are not yet symptomatic but may have a genetic predisposition for the disease. Potential AD biomarkers can include β -amyloid peptides, tau proteins, and neural thread proteins. Both levels can be measured in cerebrospinal fluid. Decreased levels of amyloid-beta 42 in the CSF can indicate that amyloid plaques are forming in the brain, a hallmark of Alzheimer's disease. While elevated levels of total tau and phosphorylated tau in the CSF can indicate neurodegeneration typical of Alzheimer's disease. While not a direct marker of Alzheimer's, testing for the APOE ϵ 4 allele can indicate increased genetic risk for developing the disease.

Related Medical Coverage Policies

- Genetic Testing for Alzheimer's Disease
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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 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.

Code	Description	CMS Guidance	Additional Guidance
82233	Beta-amyloid; 1-40 (Abeta 40)	National Coverage Determinations None Local Coverage Determinations and Articles WPS L36807, A57772 Moldx: Molecular Diagnostic Tests (MDT)* CGS None First Coast None NGS None Noridian JE None Noridian JF None Novitas L36256, A57527 Moldx: 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>Evaluation of Biomarkers for Alzheimer's Disease</i> To access this policy, please visit the BCBS Michigan Medical Policy Router Search page at https://www.bcbsm.com/providers/mpradmin/ and enter the policy name in the search field.
82234	Beta-amyloid; 1-42 (Abeta 42)		
84393	Tau, phosphorylated (e.g., pTau 181, pTau 217), each		
84394	Tau, total (tTau)		
84999	Unlisted chemistry procedure [When used for Lumipulse G pTau217/β-Amyloid 1-42 Plasma Ratio testing]		
0445U	B-amyloid (Abeta42) and phospho tau (181P) (pTau181), electrochemiluminescent immunoassay (ECLIA), cerebral spinal fluid, ratio reported as positive or negative for amyloid pathology (Elecsys® Total Tau CSF (tTau) and β-Amyloid (1-42) CSF II (Abeta 42) RatioTest)		

Code	Description	CMS Guidance	Additional Guidance
0459U	β -amyloid (Abeta42) and total tau (tTau), electrochemiluminescent immunoassay (ECLIA), cerebral spinal fluid, ratio reported as positive or negative for amyloid pathology	Palmetto L35025, A56853 Moldx: Molecular Diagnostic Tests (MDT)*	
81099	Unlisted urinalysis procedure (e.g., AlzheimerAlert™ when performed on urine)		
83520	Immunoassay, analyte, quantitative, not otherwise specified		
86849	Unlisted immunology procedure (e.g., AlzheimerAlert™ when performed on CSF)		
84999	Unlisted chemistry procedure [when specified as tau protein, amyloid beta peptide or neural thread protein biochemical testing]		
0443U	Neurofilament light chain (NfL), ultra-sensitive immunoassay, serum or cerebrospinal fluid		
0479U	Tau, phosphorylated, pTau217		
0503U	Neurology (Alzheimer disease), beta amyloid (A β 40, A β 42, A β 42/40 ratio) and tau-protein (ptau217, np-tau217, ptau217/nptau217 ratio), blood, immunoprecipitation with quantitation by liquid chromatography with tandem mass spectrometry (LC-MS/MS), algorithm score reported as likelihood of positive or negative for amyloid plaques		
0548U	Glial fibrillary acidic protein (GFAP), chemiluminescent enzyme immunoassay, using plasma		

Code	Description	CMS Guidance	Additional Guidance
0551U	Tau, phosphorylated, pTau217, by single-molecule array (ultrasensitive digital protein detection), using plasma (LucentAD p-Tau 217)		
0568U	Neurology (dementia) beta amyloid (AB40, AB42, AB42/40 ratio), tau-protein phosphorylated at residue (e.g., pTau 217), Neurofilament light chain (Nf-L), and glial fibrillary acidic protein (GFAP), by ultra-high sensitivity molecule array detection, plasma, algorithm reported as positive, intermediate, or negative for Alzheimer pathology (LucentAD™)		

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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 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>

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.

CMS Medicare Administrative Contractors (MAC) Jurisdictions

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
National Government Services, Inc (NGS)	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI,
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
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 may be 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 to 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
10/17/2025	09/17/2025	MA policy foundational language updated. Adoption of JUMP policy updates.