

Medicare Advantage Medical Policy



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Germline and Somatic Biomarker Testing (Including Liquid Biopsy) for Targeted Treatment in Prostate Cancer (BRCA1/2, Homologous Recombination Repair Gene Alterations) – Medicare Advantage

Medicare Advantage Plan

- ☒ Medicare Plus BlueSM
- ☒ BCN AdvantageSM

UM Committee Approval Date: 3/18/2026

Effective Date: 4/18/2026

Description

Germline and somatic biomarker testing can help identify patients with prostate cancer who may benefit from targeted therapies. Germline testing refers to the analysis of inherited genetic mutations that are present in all cells of the body. In the context of prostate cancer, germline testing is used to identify individuals with inherited mutations that increase their risk of developing aggressive prostate cancer. The most relevant germline mutations associated with prostate cancer include: BRCA1, BRCA2, HOXB13, and DNA repair genes (e.g., ATM, CHEK2, and PALB2).

Somatic testing analyzes genetic mutations that are acquired during a person's lifetime and are specific to the tumor cells. In prostate cancer, somatic testing is used to identify genetic alterations that can inform treatment decisions. Relevant somatic biomarkers in prostate cancer include: TMPRSS2-ERG fusion, PTEN loss, AR-V7, and genomic instability (e.g., tumor mutational burden or TMB).

The results of germline and somatic biomarker testing can inform the use of targeted therapies in prostate cancer, including PARP inhibitors, PI3K/AKT/mTOR pathway inhibitors, Androgen receptor-targeting therapies, and Immunotherapies.

Related Medical Coverage Policies

- Germline and Somatic Biomarker Testing (Including Liquid Biopsy) For Targeted Treatment in Ovarian Cancer (BRCA 1, BRCA2, Homologous Recombination Deficiency, NTRK) – Medicare Advantage
- Circulating Tumor DNA and Circulating Tumor Cells for Selecting targeted therapy for advanced solid Cancers (Liquid Biopsy) – Medicare Advantage

- Genetic Testing-Somatic Biomarker Testing (Including Liquid Biopsy) for Targeted Treatment and Immunotherapy in Non-Small-Cell Lung Cancer (EGFR, ALK, BRAF, ROS1, RET, MET, KRAS, HER2, PD-L1, TMB) – Medicare Advantage
- Circulating Tumor DNA for Management of Non-Small-Cell Lung Cancer (Liquid Biopsy)
- Genetic Testing—BRAF/NTRK Mutation in Selecting Melanoma Patients for Targeted Therapy Including Liquid Biopsy – Medicare Advantage
- Somatic Biomarker Testing (including Liquid Biopsy) for Targeted Treatment and Immunotherapy in Metastatic Colorectal Cancer (KRAS, NRAS, BRAF, NTRK and HER2 – Medicare Advantage
- Genetic Testing – NGS (NEXT-GENERATION SEQUENCING) Testing of Multiple Genes (Panel) for Solid and Hematolymphoid Malignant Conditions - Medicare Advantage

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.

CMS Guidance	Additional Guidance
National Coverage Determinations 90.2 Next Generation Sequencing 310.1 Routine Costs in Clinical Trials For additional information related to clinical trials related to GT germline and somatic biomarking treatments Please refer to this URL: https://clinicaltrials.gov Local Coverage Determinations and Articles WPS L39040/A58756 - MoIDX: Lab-Developed Tests for Inherited Cancer Syndromes in Patients with Cancer* A55224 - MoIDX: Germline testing for use of PARP inhibitors* L36807/A57772 - MoIDX: Molecular Diagnostic Tests (MDT)* L38429/A57100 - MoIDX: Repeat Germline Testing* L39709/A59549 - MoIDX: Gene Expression Profile Tests for Decision-Making in Castration Resistant and Metastatic Prostate Cancers* CGS L39017/A58734 - MoIDX: Lab-Developed Tests for Inherited Cancer Syndromes in Patients with Cancer* A54689 - Germline testing for use of PARP inhibitors* L36021/A56973 - MoIDX: Molecular Diagnostic Tests (MDT)* L38288/A57141 - MoIDX: Repeat Germline Testing L39648/A59472 - MoIDX: Gene Expression Profile Tests for Decision-Making in Castration Resistant and Metastatic Prostate Cancers* First Coast L36449/A57449 - BRCA1 and BRCA2 Genetic Testing L39367/A59123 - Genetic Testing for Oncology L34519/A57451- Molecular Pathology Procedures A58918 - Molecular Pathology and Genetic Testing NGS L35000/A56199 - Molecular Pathology Procedures A56609 - Biomarker Testing for Prostate Cancer Diagnosis	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>Germline and Somatic Biomarker Testing (Including Liquid Biopsy) for Targeted Treatment in Prostate Cancer (BRCA1/2, Homologous Recombination Repair Gene Alterations)</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.

CMS Guidance	Additional Guidance
Noridian JE A55294 - MoIDX: Germline testing for use of PARP inhibitors* L35160/A57526 - MoIDX: Molecular Diagnostic Tests (MDT)* L38351/A57331 - MoIDX: Repeat Germline Testing* L38972/A58679 - MoIDX: Lab-Developed Tests for Inherited Cancer Syndromes in Patients with Cancer * L39686/A59513 - Gene Expression Profile Tests for Decision-Making in Castration Resistant and Metastatic Prostate Cancers* Noridian JF A55295 - MoIDX: Germline testing for use of PARP inhibitors* L36256/A57527 - MoIDX: Molecular Diagnostic Tests (MDT)* L38353/A57332 - MoIDX: Repeat Germline Testing* L38974/A58681 - MoIDX: Lab-Developed Tests for Inherited Cancer Syndromes in Patients with Cancer* L39688/A59515 - Gene Expression Profile Tests for Decision-Making in Castration Resistant and Metastatic Prostate Cancers* Novitas L36715/A56542 - BRCA1 and BRCA2 Genetic Testing L39365/A59125 - Genetic Testing for Oncology L35062 - Biomarkers Overview A58917 - Molecular Pathology and Genetic Testing Palmetto L38966 - MoIDX: Lab-Developed Tests for Inherited Cancer Syndromes in Patients with Cancer* A54338 Billing and Coding: MoIDX: Germline testing for use of PARP inhibitors* L38966/A58652 - MoIDX: Lab-Developed Tests for Inherited Cancer Syndromes in Patients with Cancer* L35025/A56853 – MoIDX: Molecular Diagnostic Tests (MDT)* L38274/A58017 - MoIDX: Repeat Germline Testing* L39636/A59462 - MoIDX: Gene Expression Profile Tests for Decision-Making in Castration Resistant and Metastatic Prostate Cancers*	

Code	Description
81162	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full sequence analysis and full duplication/deletion analysis (i.e., detection of large gene rearrangements) [FoundationFocus CDxBRCA, Foundational Medicine, Inc]
81163	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full sequence analysis
81164	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (i.e., detection of large gene rearrangements)
81165	BRCA1 (BRCA1, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full sequence analysis
81166	BRCA1 (BRCA1, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (i.e., detection of large gene rearrangements)
81167	BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (i.e., detection of large gene rearrangements)
81191	NTRK1 (neurotrophic receptor tyrosine kinase 1) (e.g., solid tumors) translocation analysis
81192	NTRK2 (neurotrophic receptor tyrosine kinase 2) (e.g., solid tumors) translocation analysis
81193	NTRK3 (neurotrophic receptor tyrosine kinase 3) (e.g., solid tumors) translocation analysis
81194	NTRK (neurotrophic receptor tyrosine kinase 1, 2, and 3) (e.g., solid tumors) translocation analysis
81212	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; 185delAG, 5385insC,6174delT variants
81215	BRCA1 (BRCA1, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; known familial variant
81216	BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full sequence analysis
81217	BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; known familial variant
81301	Microsatellite instability analysis (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) of markers for mismatch repair deficiency (e.g., BAT25, BAT26), includes comparison of neoplastic and normal tissue, if performed
81307	PALB2 (partner and localizer of BRCA2) (e.g., breast and pancreatic cancer) gene analysis; full gene sequence
81308	PALB2 (partner and localizer of BRCA2) (e.g., breast and pancreatic cancer) gene analysis; known familial variant
81408	Molecular pathology procedure, Level 9 (e.g., analysis of >50 exons in a single gene by DNA sequence analysis) (ataxia-telangiectasia mutated [ATM])
81432	Hereditary breast cancer-related disorders (e.g., hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer); genomic sequence analysis panel, must include sequencing of at least 10 genes, always including BRCA1, BRCA2, CDH1, MLH1, MSH2, MSH6, PALB2, PTEN, STK11, and TP53
81479*	Unlisted molecular pathology code (e.g., BRAC Analysis CDx)
0037U	Targeted genomic sequence analysis, solid organ neoplasm, DNA analysis of 324genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden

Code	Description
	[FoundationOne CDx™ (F1CDx), Foundation Medicine, Inc]
0129U	Hereditary breast cancer-related disorders (e.g., hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis and deletion/duplication analysis panel (ATM, BRCA1, BRCA2, CDH1, CHEK2, PALB2, PTEN, and TP53) [BRCAplus, Ambry Genetics]
0172U	Oncology (solid tumor as indicated by the label), somatic mutation analysis of BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) and analysis of homologous recombination deficiency pathways, DNA, formalin-fixed paraffin-embedded tissue, algorithm quantifying tumor genomic instability score [myChoice® CDx, Myriad Genetics Laboratories, Inc]
0239U	Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free DNA, analysis of 311 or more genes, interrogation for sequence variants, including substitutions, insertions, deletions, select rearrangements, and copy number variations [FoundationOne® Liquid CDx, Foundation Medicine, Inc]
0475U	Hereditary prostate cancer related disorders, genomic sequence analysis panel using next-generation sequencing (NGS), Sanger sequencing, multiplex ligation-dependent probe amplification (MLPA), and array comparative genomic hybridization (CGH), evaluation of 23 genes and duplications/deletions when indicated, pathologic mutations reported with a genetic risk score for prostate cancer [ProstateNow™ Prostate Germline Panel, GoPath Diagnostics, Inc]

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* 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 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
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
04/19/2025	03/19/2025	Annual Review: MA policy foundational language updated. Adoption of JUMP policy updates.
4/18/2026	03/18/2026	Annual Review: Reformatted coverage and code tables. Adoption of JUMP policy updates.