2.04.62	Multimarker Serum Testing Related to Ovarian Cancer		
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Section:	2.0 Medicine	**Page:**	Page 1 of 22

Policy Statement

I. All uses of the OVA1, Overa, and ROMA tests are considered **investigational**, including but not limited to:
   A. Preoperative evaluation of adnexal masses to triage for malignancy
   B. Screening for ovarian cancer
   C. Selecting individuals for surgery for an adnexal mass
   D. Evaluation of individuals with clinical or radiologic evidence of malignancy
   E. Evaluation of individuals with nonspecific signs or symptoms suggesting possible malignancy
   F. Postoperative testing and monitoring to assess surgical outcome and/or to detect recurrent malignant disease following treatment

NOTE: Refer to Appendix A to see the policy statement changes (if any) from the previous version.

Policy Guidelines

OVA1, Overa, and ROMA tests are combinations of several separate lab tests and involve proprietary algorithms for determining risk (i.e., what American Medical Association's CPT calls multianalyte assays with algorithmic analyses [MAAAs]).

Coding

The following CPT category I MAAA code is specific for ROMA test:

- **81500**: Oncology (ovarian), biochemical assays of two proteins (CA-125 and HE4), utilizing serum, with menopausal status, algorithm reported as a risk score

The following CPT category I MAAA code is specific for OVA1:

- **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

CPT instructs that these codes cannot be reported with the component tests (i.e., codes 86304 and 86305 cannot be reported with 81500, and codes 82172, 82232, 83695, 83700, 84134, 84466, and 86304 cannot be reported with 81503).

The following code is specific to Overa:

- **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

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 the Risk of Ovarian Malignancy Algorithm (ROMA) have been cleared by the U.S. Food and Drug Administration. The intended use of OVA1 and Overa is as an aid to further assess whether malignancy is present 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 is at a high or low likelihood of finding malignancy on surgery.

Related Policies

- Serum Biomarker Human Epididymis Protein 4

Benefit Application

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

Regulatory Status

In July 2009, the OVA1® test (Aspira Labs [Austin, TX]) was cleared for marketing by the FDA through the 510(k) process. OVA1® was designed as a tool to further assess the likelihood that malignancy is present when the physician's independent clinical and radiologic evaluation does not indicate malignancy.

In September 2011, the Risk of Ovarian Malignancy Algorithm (ROMA™ test; Fujirebio Diagnostics [Sequin, TX]) was cleared for marketing by the FDA through the 510(k) process. The intended use of ROMA™ is as an aid, in conjunction with clinical assessment, in assessing whether a premenopausal or postmenopausal woman who presents with an ovarian adnexal mass is at a high or low likelihood of finding malignancy on surgery.

In March 2016, a second-generation test called Overa™ (also referred to as next-generation OVA1®), in which 2 of the 5 biomarkers in OVA1® are replaced with human epididymis secretory protein 4 and follicle-stimulating hormone, was cleared for marketing by the FDA through the 510(k) process. Similar to OVA1®, Overa™ generates a low- or high-risk of malignancy on a scale from 0 to 10.

Black Box Warning

In December 2011, the FDA amended its regulation for classifying ovarian adnexal mass assessment score test systems. The change required that off-label risks be highlighted using a black box warning. The warning is intended to mitigate the risk to health associated with off-label use as a screening test, stand-alone diagnostic test, or as a test to determine whether to proceed with surgery. Considering the history and currently unmet medical needs for ovarian cancer testing, the FDA concluded that there is a risk of off-label use of this device.[7] To address this risk, the FDA requires that manufacturers provide notice concerning the risks of off-label uses in the labeling, advertising, and promotional material of ovarian adnexal mass assessment score test systems. Manufacturers must address the following risks:

- Women without adnexal pelvic masses (i.e., for cancer "screening") are not part of the intended use population for the ovarian adnexal mass assessment score test systems. Public health risks associated with false-positive results for ovarian cancer screening tests are well described in the medical literature and include morbidity or mortality associated with

unneeded testing and surgery. The risk from false-negative screening results also includes morbidity and mortality due to failure to detect and treat ovarian malignancy.

- Analogous risks, adjusted for prevalence and types of disease, arise if test results are used to determine the need for surgery in patients who are known to have ovarian adnexal masses.
- If used outside the "OR" rule that is described in this special control guidance, results from ovarian adnexal mass assessment score test systems pose a risk for morbidity and mortality due to nonreferral for oncologic evaluation and treatment.

Rationale

Background

Epithelial Ovarian Cancer

The term *epithelial ovarian cancer* collectively includes high-grade serous epithelial ovarian, fallopian tubal, and peritoneal carcinomas due to their shared pathogenesis, clinical presentation, and treatment. We use epithelial ovarian cancer to refer to this group of malignancies in the discussion that follows. There is currently no serum biomarker that can distinguish between these types of carcinoma. An estimated 21,410 women in the U.S. were estimated to be diagnosed in 2021 with ovarian cancer, and approximately 13,770 were expected to die of the disease.[1] The mortality rate depends on 3 variables: (1) patient characteristics; (2) tumor biology (grade, stage, type); and (3) treatment quality (nature of staging, surgery, and chemotherapy used).[2] In particular, comprehensive staging and completeness of tumor resection appear to have a positive impact on patient outcomes.

Adult women presenting with an adnexal mass have an estimated 68% likelihood of having a benign lesion.[3] About 6% of women with masses have borderline tumors; 22% possess invasive malignant lesions, and 3% have metastatic disease. Surgery is the only way to diagnose ovarian cancer; this is because a biopsy of an ovary with suspected ovarian cancer is usually not performed due to the risk of spreading cancer cells. Most clinicians agree that women with masses that have a high likelihood of malignancy should undergo surgical staging by a gynecologic oncologist. However, women with clearly benign masses do *not* require a referral to see a specialist. Therefore, criteria and tests that help differentiate benign from malignant pelvic masses are desirable.

In 2016, the American College of Obstetricians and Gynecologists updated a practice bulletin that addressed criteria for referring women with adnexal masses to gynecologic oncologists.[4] Separate criteria were developed for premenopausal and postmenopausal women because the specificity and positive predictive value of cancer antigen 125 (CA 125) are higher in postmenopausal women. Prior guidance, which was based on expert opinion, recommended a CA 125 >200 U/mL for referring premenopausal women with an adnexal mass to a gynecologic oncologist. The current guidance advises using very elevated CA 125 levels with other clinical factors such as ultrasound findings, ascites, a nodular or fixed pelvic mass, or evidence of abdominal or distant metastasis for referral. The referral criteria for postmenopausal women are similar, except that a lower threshold for an elevated CA 125 test is used (35 U/mL). The practice bulletin states that serum biomarker panels are alternatives to CA 125 levels when deciding about a gynecologic oncologist referral.

Three multimarker serum-based tests specific to ovarian cancer have been cleared by the U.S. Food and Drug Administration (FDA) with the intended use of triaging patients with adnexal masses (see Regulatory Status section). These tests are summarized in Table 1. The proposed use of the tests is to identify women with a substantial likelihood of malignant disease who may benefit from referral to a gynecologic oncology specialist. Patients with positive results may be considered candidates for referral to a gynecologic oncologist for treatment. The tests have been developed and evaluated only in patients with adnexal masses and planned surgeries. Other potential uses, such as selecting patients to have surgery, screening asymptomatic patients, and monitoring treatment, have not been investigated. Furthermore, the tests are not intended to be used as stand-alone tests, but in conjunction with clinical assessment.

Other multimarker panels and longitudinal screening algorithms are under development; however, these are not yet commercially available.[5,6]

Table 1. Summary of FDA-Cleared Multimarker Serum-Based Tests Specific to Ovarian Cancer

Variables	OVA1	Overa	ROMA
Cleared	2009	2016	2011
Manufacturer	Quest Diagnostics	Vermillion	Roche Diagnostics
Biomarkers used			
CA 125 II	X	X	X
b_2-microglobulin	X		
Transferrin	X	X	
Transthyretin	X		
Apolipoprotein AI	X	X	
HE4		X	X
FSH		X	
Score range	0 to 10	0 to 10	0 to 10
Risk categorization			
Premenopausal	<5.0: low ≥5.0: high	<5.0: low ≥5.0: high	≥1.3: high
Postmenopausal	<4.4: low ≥4.4: high		≥2.77: high

CA 125: cancer antigen 125; FDA: U.S. Food and Drug Administration; FSH: follicle-stimulating hormone; HE4: human epididymis secretory protein 4; ROMA: Risk of Ovarian Malignancy Algorithm.

Literature Review

Evidence reviews assess whether a medical test is clinically useful. A useful test provides information to make a clinical management decision that improves the net health outcome. That is, the balance of benefits and harms is better when the test is used to manage the condition than when another test or no test is used to manage the condition.

The first step in assessing a medical test is to formulate the clinical context and purpose of the test. The test must be technically reliable, clinically valid, and clinically useful for that purpose. Evidence reviews assess the evidence on whether a test is clinically valid and clinically useful. Technical reliability is outside the scope of these reviews, and credible information on technical reliability is available from other sources.

Multimarker Serum Testing Related to Ovarian Cancer

Clinical Context and Test Purpose

The purpose of multimarker serum testing of individuals over age 18 with an ovarian adnexal mass for which surgery is planned and not yet referred to an oncologist is to use the test as an aid to further assess the probability that malignancy is present, even when the physician's independent clinical and radiologic evaluation does not indicate malignancy.

The questions addressed in this evidence review are: (1) Is there evidence that multimarker serum testing of individuals described above has clinical validity?; and (2) Does multimarker serum testing of such individuals change patient management in a way that improves outcomes as a result of testing?

The following PICO was used to select literature to inform this review.

Populations

The relevant population of interest is individuals who:

- Are over age 18
- Have ovarian adnexal mass for which surgery is planned
- Have not yet been referred to an oncologist

- A physician's independent clinical and radiologic evaluation does not indicate malignancy.

Interventions

The relevant interventions are 3 U.S. Food and Drug Administration cleared commercial multimarker serum genetic tests (e.g., OVA1, Overa, Risk of Ovarian Malignancy Algorithm [ROMA]). Multimarker serum testing related to ovarian cancer may be performed at any point when an individual presents with an ovarian adnexal mass for which surgery is planned, in conjunction with a physician's independent clinical and radiologic evaluation to assess the probability that malignancy is present, and aid in the decision of whether a referral to an oncologist is indicated.

Comparators

The comparator of interest is a standard clinical assessment.

Outcomes

The potential beneficial outcomes of primary interest in the case of a true-negative would be the avoidance of unnecessary surgery and its associated consequences (e.g., morbidity, mortality, resource utilization, patient anxiety). The potential harms from a false-positive could be inappropriate assessment and improper management of patients with ovarian malignancies, which could result in the following: inappropriate surgical decisions, high frequency of unnecessary further testing, and unnecessary patient anxiety. The potential harms from a false-negative could be a determination that the patient does not have ovarian malignancy, which would lead to a delay in surgery and tumor diagnosis.

Off-label use of the test (e.g., in patients who have not already been identified as needing surgery for pelvic mass, or patients without reference to an independent clinical and radiologic evaluation), might lead to a high frequency of unnecessary testing and surgery due to false-positive results, or to a delay in tumor diagnosis due to false-negative results.

Study Selection Criteria

For the evaluation of clinical validity of the tests within this review, studies that meet the following eligibility criteria were considered:

- Reported on the accuracy of the marketed version of the technology
- Included a suitable reference standard
- Patient/sample characteristics were described
- Patient/sample selection criteria were described.

Clinically Valid

A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

Review of Evidence

OVA1 Test

Descriptions of the developmental process for the OVA1 test have been published in U.S. Food and Drug Administration (FDA) documents and in a perspective by Fung (2010).[17,] Candidate biomarkers were selected based on initial studies using mass spectroscopy but were converted to standard immunoassays to improve analytic performance. Seven final markers were evaluated, none of which individually appeared to be highly specific for malignant ovarian disease. However, the choice of 5 of these (cancer antigen 125 [CA 125], prealbumin, apo AI, b_2-microglobulin, transferrin) produced a composite profile that did appear to have the discriminatory ability. The test, as cleared by the FDA, is performed on a blood sample, which is sent to a reference laboratory for testing using the 5 immunoassays previously described. Results of the 5 determinations are entered manually into an Excel spreadsheet used by the OvaCalc software. This software contains an algorithm that combines the 5 discrete values into a single unitless numeric score from 0.0 to 10.0.

Details of the algorithm appear proprietary, but the development is described as an empirical process. It is a process based on several different factors: the use of banked samples from academic partners; a small prospective study of samples from Europe; and a designated subset of samples from the clinical study used to support the submission to the FDA. It appears that at an undisclosed point in the developmental process, as a result of interaction with the FDA, separate cut points were developed for premenopausal and postmenopausal women.

The clinical validity was evaluated in a prospective, double-blind, clinical study using 27 enrollment sites.[18,] The study was supported by the commercial sponsor of the test. Patients underwent a complete clinical evaluation before surgical intervention, and only patients with adnexal masses who had a planned surgical intervention were included. The study enrolled 743 patients, with 146 subjects used in the training set and 516 in the testing set. Seventy-four patients were excluded because of missing information or samples. The final prevalence of cancer in the population was 27%.
Using pathologic diagnosis as the criterion standard, OVA1 test performance, when combined with a clinical assessment by nongynecologic oncologists, was as follows (Table 2). The method used for combining clinical assessment and OVA1 results was to consider the test positive if *either* clinical assessment or OVA1 test was positive. Thus, in practice, OVA1 testing would not be necessary if clinical assessment alone indicated cancer. Using OVA1 testing in this manner guarantees that OVA1 testing will be more sensitive and less specific than clinical assessment alone, even if it has no better than the chance capability of detecting ovarian cancer. Sensitivity improved from 72% to 92%, and specificity decreased from 83% to 42%.

Table 2. Clinical Validity of the OVA1 Test[a] Among 269 Patients Evaluated by Nongynecologic Oncologists

Diagnostic Characteristics	Clinical Assessment Alone, %	Clinical Assessment With OVA1 Test, %
Sensitivity	72	92
Specificity	83	42
Positive predictive value	61	37
Negative predictive value	89	93

Adapted from the FDA. 510(k) Substantial Equivalence Determination Decision Summary: OVA1™ Test (K081754) n.d.; http://www.accessdata.fda.gov/cdrh_docs/reviews/K081754.pdf. Accessed Novemer 26, 2021.
[a] Confidence intervals not provided.

One additional study (by Grenache et al [2015]) was identified; it evaluated the diagnostic performance of the OVA1 test.[19,] However, it did not evaluate diagnostic performance in conjunction with clinical assessment, as the test was intended to be used. By itself, OVA1 was 97% sensitive and 55% specific. This means that with clinical assessment (as intended to be used), the test would be no worse than 97% sensitive and no better than 55% specific, but these characteristics cannot be determined from the study.

Table 3. Summary of Key Study Characteristics

Study; Trial	Countries	Dates	Participants	Interventions	
				Active	Comparator
Grenache (2015)[19,]	U.S.	2009-2011	Women with an adnexal mass (n=146)	OVA1	ROMA

ROMA: Risk of Ovarian Malignancy Algorithm.

Table 4. Summary of Key Study Results

Study	Sensitivity (95% CI)	Specificity (95% CI)	PPV (95% CI)	NPV (95% CI)
Grenache (2015)[19,]				
OVA1	96.8% (83.3 to 99.9)	54.8% (45.2 to 64.1)	36.6% (26.2 to 48.0)	98.4% (91.6 to 99.9)
ROMA	83.9% (66.3 to 94.6)	83.5% (75.4 to 89.8)	57.8% (42.2 to 72.3)	95.1% (88.8 to 98.4)

CI: confidence interval; NPV: negative predictive value; PPV: positive predictive value; ROMA: Risk of Ovarian Malignancy Algorithm.

The purpose of the limitations tables (Tables 5 and 6) is to display notable limitations identified in each study. This information is synthesized as a summary of the body of evidence following each table and provides the conclusions on the sufficiency of the evidence supporting the position statement.

Table 5. Study Relevance Limitations

Study	Population[a]	Intervention[b]	Comparator[c]	Outcomes[d]	Follow-Up[e]
FDA(k) OVA1 Test K081754[18],	1. Some patients were not evaluated by a gynecologic oncologist; 2. Unclear how patients were recruited; 3. Enrollment was limited to patients with planned surgical intervention 4. Test sample demographics not described; reference values were determined in a sample that was 81.3% White				
Grenache et al (2015)[19],	1. Patients were not evaluated by a gynecologic oncologist; 2. Enrollment included only patients with planned surgical intervention, due to the small number of women with malignant adnexal masses, the strength of conclusions was limited 4. Sample demographics not described				

FDA: U.S. Food and Drug Administration.
The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.
[a] Population key: 1. Intended use population unclear; 2. Clinical context is unclear; 3. Study population is unclear; 4. Study population not representative of intended use.
[b] Intervention key: 1. Not clearly defined; 2. Version used unclear; 3. Delivery not similar intensity as comparator; 4. Not the intervention of interest.
[c] Comparator key: 1. Not clearly defined; 2. Not standard or optimal; 3.Delivery not similar intensity as intervention; 4. Not delivered effectively.
[d] Outcomes key: 1. Key health outcomes not addressed; 2. Physiologic measures, not validated surrogates; 3. No CONSORT reporting of harms; 4. Not establish and validated measurements; 5. Clinical significant difference not prespecified; 6. Clinical significant difference not supported.
[e] Follow-Up key: 1. Not sufficient duration for benefit; 2. Not sufficient duration for harms.

Table 6. Study Design and Conduct Limitations

Study	Selection[a]	Blinding[b]	Delivery of Test[c]	Selective Reporting[d]	Data Completeness[e]	Statistical[f]
FDA(k) OVA1 Test K081754[18],	None	None	1. Not described	1. Registration not described	1. 10% of subjects were eliminated due to missing information or lack of sample	None
Grenache et al (2015)[19],	None	1,2. Treatment assignment and outcome assessment were not blinded	None	None	1. Inadequate description of indeterminate and missing samples	None

FDA: U.S. Food and Drug Administration.

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.
[a] Selection key: 1. Selection not described; 2. Selection not random or consecutive (ie, convenience).
[b] Blinding key: 1. Not blinded to results of reference or other comparator tests.
[c] Test Delivery key: 1. Timing of delivery of index or reference test not described; 2. Timing of index and comparator tests not same; 3. Procedure for interpreting tests not described; 4. Expertise of evaluators not described.
[d] Selective Reporting key: 1. Not registered; 2. Evidence of selective reporting; 3. Evidence of selective publication.
[e] Data Completeness key: 1. Inadequate description of indeterminate and missing samples; 2. High number of samples excluded; 3. High loss to follow-up or missing data.
[f] Statistical key: 1. Confidence intervals and/or p values not reported; 2. Comparison with other tests not reported.

Overa Test

Descriptions of the developmental process for the Overa test have been published in FDA documents.[U.S. Food and Drug Administration (FDA). 510(k) Su.... df. Accessed November 5, 2022.] The FDA documents do not provide details on how biomarkers were selected. The test, as cleared by the FDA, is performed on a blood sample, which is to be sent to a reference laboratory for testing using the 5 immunoassays previously described. Results of the 5 determinations are entered into a proprietary algorithm, called OvaCalc software (v4.0.0), which combines the 5 discrete values into a single unitless numeric score from 0.0 to 10.0.

Clinical validity was evaluated in a nonconcurrent prospective study of 493 preoperatively collected serum specimens from premenopausal and postmenopausal women presenting with an adnexal mass requiring surgical intervention.[18,] Overa test scores were determined based on the analysis of archived serum specimens from a previous study,[20,] and the patient was stratified into a low- or high-risk group for finding malignancy on surgery. The analysis examined whether patient referral to a gynecologic oncologist was supported when a dual assessment was determined to be positive (either Overa or clinical assessment was positive, or both were positive). A dual assessment was considered negative when both Overa and clinical assessment were negative.

Using pathologic diagnosis as the criterion standard, Overa test performance, when combined with clinical assessment by nongynecologic oncologists, was as follows (Table 7). The method used for combining clinical assessment and Overa test results was to consider the test positive if *either* clinical assessment or Overa test was positive. Thus, in practice, Overa testing would not be necessary if clinical assessment alone indicated cancer. Using Overa testing in this manner guarantees that Overa testing will be more sensitive and less specific than clinical assessment alone, even if it has no better than the chance capability of detecting ovarian cancer. Sensitivity improved from 74% to 94%, and specificity decreased from 93% to 65%.

Table 7. Clinical Validity of the Overa Test Among 493 Patients Evaluated by Nongynecologic Oncologists

Diagnostic Characteristics	Clinical Assessment Alone, %	Dual Assessment With Overa Test, %
Sensitivity (95% CI)	74 (64 to 82)	94 (87 to 97)
Specificity (95% CI)	93 (90 to 95)	65 (60 to 70)
Positive predictive value (95% CI)	70 (62 to 77)	38 (35 to 41)
Negative predictive value (95% CI)	94 (92 to 96)	98 (95 to 99)
Prevalence	19 (92/493)	

Adapted from the FDA. 510(k) Substantial Equivalence Determination Decision Summary: OVA1™ Next Generation Test (K150588).
CI: confidence interval.

The purpose of the limitations tables (Tables 8 and 9) is to display notable limitations identified in each study. This information is synthesized as a summary of the body of evidence following each

table and provides the conclusions on the sufficiency of the evidence supporting the position statement.

Table 8. Study Relevance Limitations

Study	Population[a]	Intervention[b]	Comparator[c]	Outcomes[d]	Follow-Up[e]
FDA 510(k) OVA1 Next Generation K150588[18],	4. 70.3% of subjects were white				

FDA: U.S. Food and Drug Administration.
The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.
[a] Population key: 1. Intended use population unclear; 2. Clinical context is unclear; 3. Study population is unclear; 4. Study population not representative of intended use.
[b] Intervention key: 1. Not clearly defined; 2. Version used unclear; 3. Delivery not similar intensity as comparator; 4. Not the intervention of interest.
[c] Comparator key: 1. Not clearly defined; 2. Not standard or optimal; 3.Delivery not similar intensity as intervention; 4. Not delivered effectively.
[d] Outcomes key: 1. Key health outcomes not addressed; 2. Physiologic measures, not validated surrogates; 3. No CONSORT reporting of harms; 4. Not establish and validated measurements; 5. Clinical significant difference not prespecified; 6. Clinical significant difference not supported.
[e] Follow-Up key: 1. Not sufficient duration for benefit; 2. Not sufficient duration for harms.

Table 9. Study Design and Conduct Limitations

Study	Selection[a]	Blinding[b]	Delivery of Test[c]	Selective Reporting[d]	Data Completeness[e]	Statistical[f]
FDA 510(k) OVA1 Next Generation K150588[18],	1. Not described	1. Not described	1. Not described	1. Registration not described	1. Inadequate description of indeterminate and missing samples	None

FDA: U.S. Food and Drug Administration.
The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.
[a] Selection key: 1. Selection not described; 2. Selection not random or consecutive (ie, convenience).
[b] Blinding key: 1. Not blinded to results of reference or other comparator tests.
[c] Test Delivery key: 1. Timing of delivery of index or reference test not described; 2. Timing of index and comparator tests not same; 3. Procedure for interpreting tests not described; 4. Expertise of evaluators not described.
[d] Selective Reporting key: 1. Not registered; 2. Evidence of selective reporting; 3. Evidence of selective publication.
[e] Data Completeness key: 1. Inadequate description of indeterminate and missing samples; 2. High number of samples excluded; 3. High loss to follow-up or missing data.
[f] Statistical key: 1. Confidence intervals and/or p values not reported; 2. Comparison with other tests not reported.

ROMA Test

Moore et al (2008) described the development of the ROMA test.[21,] The authors studied 9 biomarkers and chose human epididymis secretory protein 4 (HE4) and CA 125 because these markers in tandem produced the best performance. The algorithm developed was subsequently modified to include a menopausal status and was independently validated.[22,] Again, separate cutoffs were used for premenopausal and postmenopausal women.

ROMA compared with CA 125 and HE4

Three systematic reviews have assessed the diagnostic accuracy of ROMA in comparison with CA 125 and HE4 through meta analysis.[23,24,25,] Study characteristics are summarized in Table 10. Across analyses, there was little variability in estimates of sensitivity and specificity, and the area under the receiver operating characteristic (AUROC) (Table 11). ROMA sensitivities (range 85.3% to 87.3%) were higher than those for CA 125 (range 76.3% to 84.0%) and HE4 (range 68.2% to 76.3%). HE4 was associated with higher specificities (range 85.1% to 93.6%) than both ROMA (range 79.0% to 85.5%)

and CA 125 (range 73.0% to 82.5%). ROMA, CA 125, and HE4 all showed excellent discrimination, based on AUROCs of 0.91 to 0.92 for ROMA, 0.86 to 0.89 for CA 125, and 0.87 to 0.91 for HE4. A sensitivity analysis conducted by Suri et al (2021)[23], found ROMA had better diagnostic accuracy in postmenopausal women (sensitivity 88%, specificity 83%) than premenopausal women (sensitivity 80%, specificity 80%), and better discrimination (AUROC 0.94 [SE 0.01) and 0.88 [SE 0.01], respectively). The review found no evidence of publication bias, nor did it find differential results when analyses were limited to blinded studies.

Table 10. Characteristics of Systematic Reviews That Compared ROMA With CA 125 and HE4

Study	Tests evaluated (No. Studies)	Reference Standard	Study Populations Included	Study Designs Included
Suri et al (2021)[23]	CA 125 (26), HE4 (25), and ROMA (22)	Pathologic diagnosis	Women with ovarian cancer or benign ovarian mass	Blinded and unblinded; sensitivity analysis limited to blinded studies
Dayyani et al (2016)[24]	CA 125 (6), HE4 (6), and ROMA (6)	Pathologic diagnosis	Women with ovarian cancer	All
Wang et al (2014)[25]	CA 125 (28), HE4 (28), and ROMA (14)	Pathologic diagnosis	Women with ovarian cancer and benign gynecologic disease	Blinded and unblinded

CA 125: cancer antigen 125; HE4: human epididymis secretory protein 4; ROMA: Risk of Ovarian Malignancy Algorithm.

Table 11. Meta-Analytic Findings for Diagnostic Performance of the ROMA Test Compared With CA 125 and HE4

Test	Study	No. Studies	Sensitivity (95% CI)	Specificity (95% CI)	AUROC (95% CI)
ROMA					
	Suri 2021[23]	22	86.0 (84.0 to 87.0)	79.0 (78.0 to 80.0)	0.91 (95% CI NR; SE 0.01)
	Dayyani 2016[24]	6	87.3 (75.2 to 94.0)	85.5 (71.9 to 93.2)	0.92 (0.86 to 0.96)
	Wang 2014[25]	14	85.3 (81.2 to 88.6)	82.4 (77.4 to 86.5)	0.91 (0.88 to 0.93)
CA 125					
	Suri 2021[23]	26	84.0 (82.0 to 85.0)	73.0 (72.0 to 74.0)	0.86 (95% CI NR; SE 0.02)
	Dayyani 2016[24]	6	79.6 (66.3 to 88.5)	82.5 (82.5 to 91.9)	0.88 (0.77 to 0.95)
	Wang 2014[25]	28	76.3 (72.0 to 80.1)	82.1 (76.6 to 86.5)	0.89 (0.86-0.92)
HE4					
	Suri 2021[23]	25	73.0 (71.0 to 75.0)	90.0 (89.0 to 91.0)	0.91 (95% CI NR; SE 0.01)
	Dayyani 2016[24]	6	68.2 (69.3 to 90.1)	85.1 (71.6 to 92.8)	0.90 (0.84 to 0.94)
	Wang 2014[25]	28	76.3 (72.0 to 80.1)	93.6 (90.0 to 95.9)	0.87 (0.84-0.90)

AUROC: area under the receiver operating characteristic; CA 125: cancer antigen 125; HE4: human epididymis secretory protein 4; NR: not reported; ROMA: Risk of Ovarian Malignancy Algorithm; SE: standard error.

Since the Wang et al (2014) and Dayyani et al (2016) meta-analyses, multiple individual studies have compared the use of the ROMA test to HE4 and CA 125 in various subgroups based on menopausal status, the cutoff value used, and different racial/ethnic backgrounds.[26,27,28,29,30,31,32,33] These studies demonstrate that ROMA's sensitivity (range, 54.5% to 93%) and specificity (range, 75% to 96%) can vary importantly depending on variation in these factors. For example, in a few recent studies of racial/ethnic subpopulations, ROMA's sensitivity dramatically declined and was lowest when used in a sample of 274 African American women (54.5%; 95% CI 33.7 to 75.3)[31], and when distinguishing

between malignant/borderline versus benign or between malignant and borderline/benign in a sample of 177 premenopausal Korean women (46.4% and 52.6%, respectively).[30,] On the other hand, specificity was highest (95.9%) in a subgroup of 104 postmenopausal women when using a "new optimal cutoff value" of 33.4% instead of 29.9%.[28,]

ROMA compared with Other Risk Indices

Two systematic reviews have compared ROMA to other tests for detection of ovarian cancer (Table 12).[34,35,] Chacon et al (2019) conducted a meta-analysis comparing ROMA with Risk Malignancy Index (RMI, a model incorporating menopausal status, ultrasound findings, and serum CA 125 level) for detecting ovarian cancer.[34,] Among the 2662 women included in the meta-analysis, 50 percent were premenopausal and 50 percent were postmenopausal. Mean ovarian cancer prevalence was 29% in premenopausal women and 51% in postmenopausal women. The majority of studies were conducted at a single-center. Although pooled sensitivities for ROMA (Table 13) were similar to those reported in previous systematic reviews that compared ROMA to HE4 and CA 125, specificities for ROMA were somewhat lower in this meta-analysis (range of 82 to 85% in Wang et al 2014 and the Dayyani et al 2016 meta-analyses, compared with 75 to 78%). However, findings from this meta-analysis should be interpreted with caution due to important limitations including a high-risk of selection bias in most studies and significant unexplained statistical heterogeneity.

Davenport et al (2022) conducted a meta-analysis comparing commonly-used tests, including ROMA, RMI, International Ovarian Tumor Analysis Logistic Regression Model 2 (LR2, a model incorporating menopausal status and ultrasound findings), and Assessment of Different NEoplasias in the adneXa (ADNEX), a model incorporating menopausal status, CA 125, type of center (referral center for gynecologic oncology vs. other), and ultrasound findings).[35,] The analysis included 59 studies, 42 of which evaluated ROMA; 32,059 patients (9545 cases of ovarian cancer) were included. Mean ovarian cancer prevalence ranged from 16% to 27% in premenopausal patients and 38% to 55% in postmenopausal women. In general, ROMA and other tests had higher sensitivity than RMI, but carried lower specificity, particularly in premenopausal women (Table 13). This analysis carries important limitations, including high risk of selection bias, index test- and reference standard-related biases, and heterogeneity.

Table 12. Characteristics of Systematic Reviews of ROMA compared with Other Risk Indices

Study	Dates	Studies	Participants	N (Range)	Design	Risk of bias
Chacon et al (2019)[34,]	2011-2018	8	Patients in whom both ROMA and RMI were calculated for predicting malignancy in adnexal masses	2662 (50-1061)	Prospective (7) and retrospective (1) cohort studies	Based on QUADAS-2 assessment, risk of bias was “high in most studies”, due to “selection bias in that they had selected only women who underwent surgery”
Davenport et al (2022)[35,]	2009-2019	59	Patients with signs or symptoms suspicious for ovarian cancer in whom 1 or more of ROMA, RMI, LR2, or ADNEX were calculated	32,059 (36-2403)	Prospective (28), retrospective (21), or unclear (9)	Based on QUADAS-2 assessment, risk of bias was: *Participant selection domain*: high or unclear for applicability in 92% of studies "because study participants did not obviously represent symptomatic women" *Index test domain:* low risk in 79% of ROMA studies "either because of the prospective nature of studies, or the objective nature of the index test", but high risk for applicability in 100% of studies "because ultrasound was

Study	Dates	Studies	Participants N (Range)	Design	Risk of bias
					conducted by specialist sonographers or their level of specialization was unclear" *Reference standard and target condition domain*: unclear (46% of studies) or high risk (3% of studies) of bias "either because minimum length of follow-up for index negatives was not reported at 6 months, or because there was concern that the reference standard outcome was ascertained with knowledge of the index test result", and high or unclear risk for applicability in 85% of studies "because borderline tumors had been excluded from analysis or classification of borderline tumors for estimation of test accuracy was unclear" *Flow and timing domain*: unclear risk in 54% of studies "most commonly because of no information about the interval between the index test and the reference standard" and high risk in 22% of studies "because not all participants receiving an index test received a reference standard"

ADNEX, Assessment of Different NEoplasias in the adneXa; LR2, International Ovarian Tumor Analysis Logistic Regression Model 2; QUADAS-2: Quality Assessment of Diagnostic Accuracy Studies 2; ROMA: Risk of Ovarian Malignancy Algorithm; RMI: risk malignancy index.

Table 13. Diagnostic Performance of ROMA compared with Other Risk Indices

Test	Sensitivity (95% CI), %		Specificity (95% CI), %	
Chacon et al (2019)[34],	*Premenopausal*	*Postmenopausal*	*Premenopausal*	*Postmenopausal*
ROMA	80% (70 to 88%)	87% (78 to 93%)	78% (69 to 85%)	75% (66 to 83%)
RMI	73% (62 to 81%)	77% (65 to 86%)	89% (83 to 93%)	85% (73 to 92%)
Davenport et al (2022)[35],	*Premenopausal*	*Postmenopausal*	*Premenopausal*	*Postmenopausal*
ROMA	77.4% (72.7 to 81.5%)	90.3% (87.5 to 92.6%)	84.3% (81.2 to 87.0%)	81.5% (76.5 to 85.5%)
RMI	57.2% (50.3 to 63.8%)	78.4% (74.6 to 81.7%)	92.5% (90.3 to 94.2%)	85.4% (82.0 to 88.2%)
LR2	83.3% (74.7 to 89.5%)	94.8% (92.3 to 96.6%)	90.4% (84.6 to 94.1%)	60.6% (50.5 to 69.9%)
ADNEX	95.5% (91.0 to 97.8%)	97.6% (95.6 to 98.7%)	77.8% (67.4 to 85.5%)	55.0% (42.8 to 66.6%)

ADNEX, Assessment of Different NEoplasias in the adneXa; CI: confidence interval; LR2, International Ovarian Tumor Analysis Logistic Regression Model 2; RMI: risk malignancy index; ROMA: Risk of Ovarian Malignancy Algorithm.

ROMA in Conjunction with Clinical Assessment

The FDA labeling for ROMA, unlike that for OVA1, does not indicate how ROMA is to be used in conjunction with clinical assessment. All previously cited literature assessed ROMA as a stand-alone test for ovarian cancer and did not provide a comparison with clinical assessment alone. The study by Moore et al (2014) evaluated ROMA in conjunction with clinical assessment, using either a positive clinical assessment or a positive ROMA as a positive test (similar to the recommended usage for OVA1).[36,] Using this method of combining tests guarantees a higher sensitivity and lower specificity for the combined test than for either test alone. Used in this way, ROMA would only need to be given to patients with a negative clinical assessment. In this study, 461 women were enrolled, of whom 86

(19%) had a malignancy. Combined assessment improved sensitivity from 77.9% to 89.7%, but specificity worsened from 84.3% to 67.2% (Table 14).

Table 14. Summary of Key Study Characteristics

Study; Trial	Countries	Sites	Dates	Participants	Comparison	
					ROMA Group	Comparator
Moore (2014)[36,]	U.S.	13	2009-2010	Women with an ovarian cyst or pelvic mass (n=461)	ICRA + ROMA	ICRA

ICRA: Initial Cancer Risk Assessment; ROMA: Risk of Ovarian Malignancy Algorithm.

Table 15. Diagnostic Performance of the ROMA Test for All Malignancy

Diagnostic Characteristics	Clinical Assessment Alone (95% CI), %	Clinical Assessment With ROMA (95% CI), %
Sensitivity	77.9 (66.2 to 87.1)	89.7 (79.9 to 95.8)
Specificity	84.3 (80.2 to 87.8)	67.2 (62.2 to 71.9)
Positive predictive value	47.3 (37.8 to 57.0)	33.2 (26.4 to 40.5)
Negative predictive value	95.5 (92.6 to 97.4)	97.3 (94.5 to 98.9)

Adapted from Moore et al (2014).[36,]
CI: confidence interval; ROMA: Risk of Ovarian Malignancy Algorithm.

The purpose of the limitations tables (Tables 16 and 17) is to display notable limitations identified in each study. This information is synthesized as a summary of the body of evidence following each table and provides the conclusions on the sufficiency of the evidence supporting the position statement.

Table 16. Study Relevance Limitations

Study	Population[a]	Intervention[b]	Comparator[c]	Outcomes[d]	Follow-Up[e]
Moore et al (2014)[36,]	4. 84.8% of subjects were white; 60.4% of subjects were EOC grade 3; 66.7% had stage III epithelial ovarian cancer				

EOC: epithelial ovarian cancer.
The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.
[a] Population key: 1. Intended use population unclear; 2. Clinical context is unclear; 3. Study population is unclear; 4. Study population not representative of intended use.
[b] Intervention key: 1. Not clearly defined; 2. Version used unclear; 3. Delivery not similar intensity as comparator; 4. Not the intervention of interest.
[c] Comparator key: 1. Not clearly defined; 2. Not standard or optimal; 3.Delivery not similar intensity as intervention; 4. Not delivered effectively.
[d] Outcomes key: 1. Key health outcomes not addressed; 2. Physiologic measures, not validated surrogates; 3. No CONSORT reporting of harms; 4. Not establish and validated measurements; 5. Clinical significant difference not prespecified; 6. Clinical significant difference not supported.
[e] Follow-Up key: 1. Not sufficient duration for benefit; 2. Not sufficient duration for harms.

Table 17. Study Design and Conduct Limitations

Study	Selection[a]	Blinding[b]	Delivery of Test[c]	Selective Reporting[d]	Data Completeness[e]	Statistical[f]
Moore et al (2014)[36,]	None	None	None	None	1. Inadequate description of indeterminate and missing samples	None

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.
[a] Selection key: 1. Selection not described; 2. Selection not random or consecutive (ie, convenience).
[b] Blinding key: 1. Not blinded to results of reference or other comparator tests.
[c] Test Delivery key: 1. Timing of delivery of index or reference test not described; 2. Timing of index and comparator tests not same; 3. Procedure for interpreting tests not described; 4. Expertise of evaluators not described.
[d] Selective Reporting key: 1. Not registered; 2. Evidence of selective reporting; 3. Evidence of selective publication.
[e] Data Completeness key: 1. Inadequate description of indeterminate and missing samples; 2. High number of samples excluded; 3. High loss to follow-up or missing data.
[f] Statistical key: 1. Confidence intervals and/or p values not reported; 2. Comparison with other tests not reported.

Section Summary: Clinically Valid

Evidence for the clinical validity for the OVA1 and Overa tests include prospective, double-blind studies that have evaluated the clinical validity of these tests in predicting the likelihood of malignancy in women who are planning to have surgery for an adnexal mass. These tests have not been studied for ovarian cancer screening. The prospective studies showed that, in patients with an adnexal mass who had a planned surgical intervention, the use of OVA1 and Overa in conjunction with a clinical assessment by nongynecologic oncologists increased the sensitivity but decreased the specificity compared with clinical assessment alone. When used with clinical assessment in this manner, the sensitivity to ovarian malignancy was 92%, and the specificity was 42%. ROMA is intended for use in conjunction with clinical assessment, but no specific method has been defined. One study, which used clinical assessment and ROMA results, showed a sensitivity of 90% and a specificity of 67%. Multiplemeta-analyseshave reported less than 90% sensitivity and specificity with ROMA testing.

Clinically Useful

A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive correct therapy, more effective therapy, or avoid unnecessary therapy or testing.

The ideal study design to evaluate the clinical utility of a multimarker serum-based test would be a randomized controlled trial comparing health outcomes (e.g., mortality) in patients managed using the tests with those managed according to best current clinical practices. According to the chain of logic, greater numbers of persons with ovarian cancer referred for surgery by a gynecologic oncology specialist should result in improved overall health outcomes. No randomized or nonrandomized studies with these comparisons were identified.

Although OVA1, Overa, and ROMA, when used in conjunction with clinical assessment, improve the sensitivity for detection of malignancy, the specificity declines. In studies using either positive ROMA or clinical assessment as a positive test, sensitivity improved but it was still less than 90%. It is uncertain whether there is meaningful clinical benefit from using a test that avoids a high number of referrals and does not contain sensitive data (even though incrementally better). Because there is no established or recommended method for using ROMA in conjunction with clinical assessment, diagnostic performance characteristics are uncertain because it would vary depending on how it is used.

It is also uncertain whether the incremental yield of malignancy resulting from the use of the tests would result in improved patient outcomes. Although prior studies revealed an improvement of outcomes when women with ovarian cancer were initially managed by gynecologic oncologists, it is uncertain whether improved outcomes would occur in the additional cases detected by the use of these tests. These additional cancer cases may differ from other cases detected by clinical assessment alone. If they tend to be earlier stage cancers or biologically less aggressive cancers, initial treatment by a gynecologic oncologist may not provide incremental benefit.

Section Summary: Clinically Useful

As no trials were identified that have compared health outcomes for patients managed with and without the use of FDA cleared multimarker serum-based tests, there is no direct evidence of clinical usefulness. It is uncertain whether discrimination is sufficient to alter decision-making based on clinical assessment alone, thus offering a meaningful benefit to patients. Therefore, the chain of evidence supporting improved outcomes is incomplete.

Supplemental Information

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the evidence review conclusions.

Clinical Input From Physician Specialty Societies and Academic Medical Centers

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

In response to requests, input was received while this policy was under review in 2012. The input was mixed in support of these tests as a tool for triaging patients with an adnexal mass. Reviewers agreed that the evidence was insufficient to determine the impact of these tests on referral patterns. For indications other than triaging patients with an adnexal mass, there was a lack of support for the use of these tests.

Practice Guidelines and Position Statements

Guidelines or position statements will be considered for inclusion in 'Supplemental Information' if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

American College of Obstetricians and Gynecologists

In 2017, with reaffirmation in 2019 and 2021, the American College of Obstetricians and Gynecologists (ACOG) opinion on the role of the obstetrician-gynecologist in the early detection of epithelial ovarian cancer addressed using multimarker serum testing.[37,] The opinion states that multimarker panels lack strong evidence for use in asymptomatic women without adnexal masses and do not improve early detection and survival rates in average-risk women. The Society for Gynecologic Oncology endorsed this ACOG opinion.

In 2016, an ACOG Practice Bulletin addressing the evaluation and management of adnexal masses made a level B recommendation (based on limited or inconsistent scientific evidence) that consultation with or referral to a gynecologic oncologist is recommended for premenopausal or postmenopausal with an elevated score on a formal risk assessment test such as the multivariate index assay, risk of malignancy index, or the Risk of Ovarian Malignancy Algorithm, or 1 of the ultrasound-based scoring systems from the International Ovarian Tumor Analysis group.[13,] A level C recommendation (based on consensus and expert opinion) was given to using serum biomarker panels as an alternative to cancer antigen 125 (CA 125) level to decide about the referral to a gynecologic oncologist for an adnexal mass requiring surgery.

National Institute for Health and Care Excellence

In 2011, the National Institute for Health and Care Excellence issued guidance on the identification and management of ovarian cancer.[38,] The guideline does not provide any recommendations regarding additional serum marker testing besides testing for serum CA 125 levels in women with symptoms suggestive of ovarian cancer.

National Comprehensive Cancer Network

In 2022, the National Comprehensive Cancer Network (NCCN) guideline on ovarian cancer (v. 5.2022) includes the following statement[39]:

The FDA has approved the use of ROMA, OVA1, and OVERA for estimating the risk for ovarian cancer in women with an adnexal mass for which surgery is planned, and have not been referred to an oncologist. Although the American Congress of Obstetricians and Gynecologists (ACOG) has suggested that ROMA and OVA1 may be useful for deciding which patients to refer to a gynecologic oncologist, other professional organizations have been non-committal. Not all studies have found that multi-biomarker assays improve all metrics (ie, sensitivity, specificity, positive predictive value, negative predictive value) for prediction of malignancy compared with other methods (eg, imaging, single-biomarker tests, symptom index/clinical assessment). Currently, the NCCN Panel does not recommend the use of these biomarker tests for determining the status of an undiagnosed adnexal/pelvic mass.

In addition, the guideline states "based on data documenting increased survival, the NCCN Guidelines Panel recommends that all patients with suspected malignancies (especially those with an adnexal mass) should undergo evaluation by an experienced gynecologic oncologist prior to surgery."

U.S. Preventive Services Task Force Recommendations

In 2018, the U.S. Preventive Services Task Force recommended against screening asymptomatic women for ovarian cancer (D recommendation). [40] The Task Force has not addressed multimarker serum testing related to ovarian cancer.

Medicare National Coverage

There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

Ongoing and Unpublished Clinical Trials

Some currently ongoing and unpublished trials that might influence this review are listed in Table 18.

Table 18. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
Ongoing			
NCT03837327	Clinical Validation of the InterVenn Ovarian CAncer Liquid Biopsy (VOCAL)	1200	Dec 2024
NCT04668521	Multifactorial Risk Assessment for Breast & Ovarian Cancer Risk Detection	1200	Dec 2024
NCT04487405	A Multivariate Index Assay for Ovarian Cancer Risk Assessment in Women With Adnexal Mass and High-Risk Germline Variants	4661	Dec 2030

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Documentation for Clinical Review

- No records required

Coding

This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy.

The following codes are included below for informational purposes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy. Policy Statements are intended to provide member coverage information and may include the use of some codes for clarity. The Policy Guidelines section may also provide additional information for how to interpret the Policy Statements and to provide coding guidance in some cases.

Type	Code	Description
CPT®	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
	81500	Oncology (ovarian), biochemical assays of two proteins (CA-125 and HE4), utilizing serum, with menopausal status, algorithm reported as a risk score
	0375U	Oncology (ovarian), biochemical assays of 7 proteins (follicle stimulating hormone, human epididymis protein 4, apolipoprotein A-1, transferrin, beta-2 macroglobulin, prealbumin [ie, transthyretin], and cancer antigen 125), algorithm reported as ovarian cancer risk score ***(Code effective 4/1/2023)***
	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
HCPCS	None	

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action
10/15/2007	BCBSA Medical Policy adoption
10/01/2010	Policy Revision with title change from Analysis of Proteomic Patterns in Serum to Identify Cancer
03/25/2011	Administrative Review
02/22/2013	Coding Update
09/27/2013	Policy revision with position change effective 12/19/2013
12/19/2013	Policy revision with position change

Effective Date	Action
06/30/2015	Coding update
01/01/2016	Coding update
09/01/2016	Policy title change from Proteomic Pattern Analysis in Serum to Identify Cancer. Policy revision without position change.
02/01/2017	Policy title change from Proteomics-Based Testing Related to Ovarian Cancer. Policy revision without position change.
02/01/2018	Policy revision without position change
03/01/2019	Policy revision without position change
02/01/2020	Annual review. No change to policy statement. Literature review updated.
02/01/2021	Annual review. No change to policy statement. Literature review updated.
02/01/2022	Annual review. No change to policy statement. Literature review updated.
02/01/2023	Annual review. Policy statement and literature review updated.
06/01/2023	Coding update

Definitions of Decision Determinations

Medically Necessary: Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are: (a) consistent with Blue Shield medical policy; (b) consistent with the symptoms or diagnosis; (c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; (d) furnished at the most appropriate level which can be provided safely and effectively to the patient; and (e) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease.

Investigational/Experimental: A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

Split Evaluation: Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

Prior Authorization Requirements and Feedback (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at www.blueshieldca.com/provider.

We are interested in receiving feedback relative to developing, adopting, and reviewing criteria for medical policy. Any licensed practitioner who is contracted with Blue Shield of California or Blue

Shield of California Promise Health Plan is welcome to provide comments, suggestions, or concerns. Our internal policy committees will receive and take your comments into consideration.

For utilization and medical policy feedback, please send comments to: MedPolicy@blueshieldca.com

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.

Appendix A

POLICY STATEMENT (No changes)	
BEFORE	**AFTER**
Multimarker Serum Testing Related to Ovarian Cancer 2.04.62 **Policy Statement:** **I. All uses of the OVA1, Overa, and ROMA tests are considered investigational, including but not limited to:** **A. Preoperative evaluation of adnexal masses to triage for malignancy** **B. Screening for ovarian cancer** **C. Selecting individuals for surgery for an adnexal mass** **D. Evaluation of individuals with clinical or radiologic evidence of malignancy** **E. Evaluation of individuals with nonspecific signs or symptoms suggesting possible malignancy** **F. Postoperative testing and monitoring to assess surgical outcome and/or to detect recurrent malignant disease following treatment**	**Multimarker Serum Testing Related to Ovarian Cancer 2.04.62** **Policy Statement:** I. All uses of the OVA1, Overa, and ROMA tests are considered **investigational**, including but not limited to: A. Preoperative evaluation of adnexal masses to triage for malignancy B. Screening for ovarian cancer C. Selecting individuals for surgery for an adnexal mass D. Evaluation of individuals with clinical or radiologic evidence of malignancy E. Evaluation of individuals with nonspecific signs or symptoms suggesting possible malignancy F. Postoperative testing and monitoring to assess surgical outcome and/or to detect recurrent malignant disease following treatment