MEDICAL COVERAGE POLICY

SERVICE: Biochemical Markers of Alzheimer's Disease

Policy Number: 029
Effective Date: 08/01/2018
Last Review: 05/29/2018
Next Review Date: 05/29/2019

Important note
Even though this policy may indicate that a particular service or supply may be considered covered, this conclusion is not based upon the terms of your particular benefit plan. Each benefit plan contains its own specific provisions for coverage and exclusions. Not all benefits that are determined to be medically necessary will be covered benefits under the terms of your benefit plan. You need to consult the Evidence of Coverage to determine if there are any exclusions or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and your plan of benefits, the provisions of your benefits plan will govern. However, applicable state mandates will take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, Federal mandates will apply to all plans. With respect to Senior Care members, this policy will apply unless Medicare policies extend coverage beyond this Medical Policy & Criteria Statement. Senior Care policies will only apply to benefits paid for under Medicare rules, and not to any other health benefit plan benefits. CMS's Coverage Issues Manual can be found on the CMS website.

SERVICE: Biochemical Markers of Alzheimer's Disease

PRIOR AUTHORIZATION: Not applicable.

POLICY: SWHP considers the use of biomarkers in the diagnosis and management of Alzheimer's Disease to be experimental and investigational and NOT medically necessary.

OVERVIEW:
Alzheimer's disease (AD) is an irreversible, progressive brain disorder that occurs gradually and results in memory loss, unusual behavior, personality changes, and a decline in thinking ability. The Alzheimer's Foundation of America (AFA) reports that there are between 4.2 and 5.8 million people affected with AD. The incidence of AD is expected to climb as the population ages. Additionally, the Alzheimer’s Association (AA) reports that there are between 200,000 and 500,000 people with early onset disease occurring before the age of 65. The mean duration from the onset of clinical symptoms to the death of the patient has been reported to be approximately 8.5 years.

Currently the diagnosis of AD is a clinical diagnosis, focusing on the exclusion of other causes of senile dementia. The United States Preventative task force continues to support the use of clinical findings in diagnosis. Psycho-behavioral instruments such as the Mini-Mental State Examination (MMSE) and the Functional Activities Questionnaire are in current use. The MMSE has a sensitivity that ranges from 71 to 96 percent and a specificity range from 56 to 72 percent for dementia. The task force also concluded that current therapies, primarily medication, could only slow AD progression two to seven months and had limited effects on activities of daily living. The benefits of early screening will not be fully realized until better treatment modalities are developed.

In 1988, the National Institute of Neurological and Communicative Disorders and Stroke (NINCDS) and the Alzheimer's and Related Disorders Association (ADRDA) published clinical criteria for the diagnosis of AD. These organizations defined three categories: Possible AD, Probable AD and Definite AD.

The only difference between Probable and Definite AD is that the Definite AD category requires a brain biopsy confirming the presence of characteristic neurofibrillary tangles. While Definite AD is invariably only confirmed at autopsy, in approximately 85% of those with a diagnosis of Probable AD, pathological findings are found to be consistent.

The clinical criteria currently used for AD in patients with probable AD provide a sensitivity of approximately 85% when compared to autopsy confirmed cases (Definite AD). Therefore, a
A biomarker should have a sensitivity approaching or exceeding this value. A biomarker should have a specificity of 75% to 85% or greater, and the positive predictive value should be 80% or more.

There are currently no biomarkers that meet the above criteria. To date, all studies have focused on the use of biomarkers with Probable AD. The clinical utility of biomarkers may be greatest in patients with Possible AD, where the diagnosis is more uncertain. Few studies have focused on the use of biomarkers in patients with Possible AD with any follow up to determine the sensitivity and specificity of these markers in earlier stages of the disease.

The use of biomarkers will continue to be of interest to distinguish early AD from other causes of mild cognitive impairment, such as normal aging, vascular dementia or alcohol-related cognitive disorders. Research in patients with incipient AD is challenging because of the long follow-up required, and the possibility that any control group will also have patients with unrecognized incipient AD. There are inadequate data to determine how the results of these tests could be used to improve patient management, particularly given the limited treatment options. If ongoing research developing drugs targeting early stages of AD comes to fruition, then biomarkers to identify treatment candidates may have an impact on patient management.

The Alzheimer's Association and the National Institute on Aging (NIA), an agency of the U.S. National Institutes of Health (NIH), agree there are currently no validated biomarkers for Alzheimer's disease. They have jointly issued four new criteria and guidelines to diagnose Alzheimer's disease. Three of the four new criteria and guidelines that came out as a result of the research that the Alzheimer's Association and the National Institute on Aging (NIA) completed in April 2011 focus on three stages of Alzheimer's disease: 1) dementia due to Alzheimer’s, 2) mild cognitive impairment (MCI) due to Alzheimer’s, and 3) preclinical (presymptomatic) Alzheimer’s. The 4th guideline updates criteria for documenting and reporting Alzheimer’s related changes observed during an autopsy.

According to the research completed by these two agencies in 2011 “In the future, biomarker evidence may provide additional diagnostic certainty, but much more research is needed to identify the most accurate biomarkers and confirm their usefulness. “ Please see http://www.alz.org/research/diagnostic_criteria/ for more information.

MANDATES: None

CODES:

Important note:
CODES: Due to the wide range of applicable diagnosis codes and potential changes to codes, an inclusive list may not be presented, but the following codes may apply. Inclusion of a code in this section does not guarantee that it will be reimbursed, and patient must meet the criteria set forth in the policy language.

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CMS: No NCDs or LCDs have been issued.

POLICY HISTORY:
Biochemical Markers of Alzheimers Disease
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REFERENCES:
The following scientific references were utilized in the formulation of this medical policy. SWHP will continue to review clinical evidence related to this policy and may modify it at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available and they are not included in the list, please forward the reference(s) to SWHP so the information can be reviewed by the Medical Coverage Policy Committee (MCPC) and the Quality Improvement Committee (QIC) to determine if a modification of the policy is in order.

52. Schoonenboom, N.S.M., Van De Flier, W.M., et al. CSF and MRI markers independently contribute to the diagnosis of Alzheimer’s disease. Neurobiology of Aging 2008 May; 29(5); 669-675