MEDICAL POLICY

POLICY TITLE	MULTICANCER EARLY DETECTION TESTING
POLICY NUMBER	MP 2.387

CLINICAL BENEFIT	☐ MINIMIZE SAFETY RISK OR CONCERN. ☒ MINIMIZE HARMFUL OR INEFFECTIVE INTERVENTIONS. ☐ ASSURE APPROPRIATE LEVEL OF CARE. ☐ ASSURE APPROPRIATE DURATION OF SERVICE FOR INTERVENTIONS. ☐ ASSURE THAT RECOMMENDED MEDICAL PREREQUISITES HAVE BEEN MET. ☐ ASSURE APPROPRIATE SITE OF TREATMENT OR SERVICE.
Effective Date:	**RETIRED 7/1/2026**

I. POLICY

The use of multicancer early detection (MCED) tests (e.g., Galleri) is considered **investigational** for cancer screening. There is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with the above procedures .

Policy Guidelines

The Galleri test is the only commercially available MCED test in the US at this time.

II. PRODUCT VARIATIONS TOP

This policy is only applicable to certain programs and products administered by Capital Blue Cross and subject to benefit variations as discussed in Section VI. Please see additional information below.

FEP PPO: Refer to FEP Medical Policy Manual. The FEP Medical Policy manual can be found at: https://www.fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies.

III. DESCRIPTION/BACKGROUND TOP

Many cancers appear to have a better prognosis if diagnosed early in their natural history. This has led to efforts to detect preclinical cancers in asymptomatic individuals through screening. Cancer screening tests such as 'liquid biopsies' that are minimally invasive and can simultaneously detect multiple types of cancer have been called multicancer early detection (MCED) tests.

Cancer is the second leading cause of death in the United States following heart disease, causing 1 in every 6 deaths.1, Excluding non-melanoma skin cancers, over 2 million new cancer cases are expected to be diagnosed in the US in 2025 and more than 618,000 people will die from the

disease. Many cancers appear to have a better prognosis if diagnosed early in their natural history. This has led to efforts to detect preclinical cancers in asymptomatic persons through screening. However, screening tests have associated benefits and harms that must be considered when evaluating whether a test should be used in a population. Many cancers appear to have a better prognosis if diagnosed early in their natural history. This has led to efforts to detect preclinical cancers in asymptomatic persons through screening. However, screening tests have associated benefits and harms that must be considered when evaluating whether a test should be used in a population.

Early detection of cancer has 2 components: early diagnosis and screening. Early diagnosis is the early identification of cancer in *symptomatic* individuals with the aim of reducing the proportion of individuals diagnosed at a late stage. Screening is the identification of preclinical cancer or precursor lesions in apparently healthy, *asymptomatic* populations by tests that can be applied rapidly and widely in the target population. This review focuses on tests for screening indications.

Cancer screening tests such as 'liquid biopsies' that are minimally invasive have been called multicancer early detection (MCED) tests. MCED tests are distinct from traditional cancer screening tests due to two main factors. Firstly, they employ a single blood test rather than x-rays, imaging tests like mammography, or procedures like colonoscopy. Secondly, they simultaneously screen for multiple types of cancer from various organs, including those not checked by existing methods. MCED tests predict the presence of cancer, rather than diagnose it. Depending on the biological signals measured, they may screen for multiple cancer types. Current development focuses on measuring signals in blood plasma, such as changes in DNA/RNA sequences, DNA methylation patterns, DNA fragmentation patterns, protein biomarker levels, and antibodies against cancer cell components. Researchers are continually developing new technological approaches to expand the range of measurable biological signals, such as those identified by immune cells.

Regulatory Status

No MCED tests have been approved or cleared by the U.S. Food and Drug Administration (FDA). Several tests, including Galleri® (GRAIL), CanScan™ (Geneseeq), OverC™ Multi-Cancer Detection Blood Test (Burning Rock) have been granted breakthrough device designation by the FDA.

In February 2024, the National Cancer Institute (NCI) launched the Cancer Screening Research Network (CSRN) to evaluate emerging technologies for cancer screening. As part of this initiative, the CSRN began the Vanguard Study, which aims to enroll up to 24,000 participants to evaluate the feasibility and benefits of MCED tests. This study will focus on diverse populations across eight US sites led by the Fred Hutchinson Cancer Center, with further participation from the US Department of Defense and the Department of Veterans Affairs. Participants will be randomly assigned to a control group or one of two MCED test groups. The control group will have blood drawn without further testing, while the MCED test groups will receive assays - Avantect® from

ClearNote Health and Shield™ from Guardant Health - at no cost. The study objectives include assessing participant willingness, adherence to testing, diagnostic follow-up, and evaluating the feasibility of diagnostic processes.

Clinical laboratories may develop and validate tests in-house and market them as a laboratory service; laboratory-developed tests must meet the general regulatory standards of the Clinical Laboratory Improvement Amendments. Galleri is available under the auspices of the Clinical Laboratory Improvement Amendments.

Laboratories that offer laboratory-developed tests must be licensed by the Clinical Laboratory Improvement Amendments for high-complexity testing. To date, the FDA has chosen not to require any regulatory review of this test.

IV. RATIONALE

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For individuals who are being screened for cancer who receive multicancer early detection (MCED) testing, the relevant published evidence includes a systematic review, and one US-based prospective study. Relevant outcomes are overall survival, disease-specific survival, functional outcomes, quality of life, treatment-related mortality, and treatment-related morbidity. A systematic review of 36 studies on MCED tests highlighted variability in diagnostic accuracy. Evidence was limited, with no completed RCTs. While the tests exhibited high specificity, sensitivity varied depending on study design, population, reference tests, and follow-up duration. Insufficient follow-up for negative results led to high risk of bias across studies. Currently, the Galleri test is the only commercially available MCED test in the United States. One prospective study of the Galleri test reported a positive predictive value of 38% (95% CI, 29 to 48) and specificity and negative predictive value of approximately 99%. The specifics regarding the practical application of the test, including the appropriate at-risk target populations, frequency of testing, and follow-up for positive and negative results, have not been fully described. There is a need for performance characteristics for both the prediction of overall cancer likelihood and the tissue of origin. No clinical utility studies have been published to date, and estimates of changes in cancer-specific mortality, quality of life, functional outcomes, and rates of overdiagnosis and overtreatment remain unknown. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

V. DEFINITIONS

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N/A

VI. DISCLAIMER

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Capital Blue Cross' medical policies are used to determine coverage for specific medical technologies, procedures, equipment, and services. These medical policies do not constitute medical advice and are subject to change as required by law or applicable clinical evidence from independent treatment guidelines. Treating providers are solely responsible for medical

advice and treatment of members. These polices are not a guarantee of coverage or payment. Payment of claims is subject to a determination regarding the member's benefit program and eligibility on the date of service, and a determination that the services are medically necessary and appropriate. Final processing of a claim is based upon the terms of contract that applies to the members' benefit program, including benefit limitations and exclusions. If a provider or a member has a question concerning this medical policy, please contact Capital Blue Cross' Provider Services or Member Services.

VII. CODING INFORMATION

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Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

Investigational; therefore, not covered:

Procedure Codes							
81479	81599						

VIII. REFERENCES

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IX. POLICY HISTORY

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MP 2.387	**06/09/2023 New Policy adoption.**

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	01/19/2024 Administrative Update. Clinical benefit added.
	08/06/2024 Consensus Review. References updated and code 81599 added
	07/17/2025 Consensus Review. NCCN statement removed. Background and Rationale updated. References added.
	10/07/2025 Administrative Update. Removed Benefit Variations Section and updated Disclaimer.
	03/06/2026 Retirement Review. Service to be managed by the vendor Evicore.

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