“What’s New” Medical Policy Updates June 2024

Listed below are the recent changes made to policies within the Geisinger Health Plan Medical Policy Portfolio during the month of May that will become **effective July 15, 2024** (unless otherwise specified). The Plan uses medical policies as guidelines for coverage decisions made within members written benefit documents. Coverage may vary by line of business and providers and members are encouraged to verify benefit questions regarding eligibility before applying the terms of the policy.

MP021 Dorsal Column Stimulation – Revised – Revised Authorization Requirement

INDICATIONS: REQUIRES PRIOR PLAN AUTHORIZATION. The authorization must be requested and approved prior to the implantation of the electrodes for the trial period.

Relief of chronic intractable lumbar or thoracic pain under the following circumstances:

- Lumbosacral arachnoiditis that has not responded to medical management including physical therapy. (Presence of arachnoiditis is usually documented by presence of high levels of proteins in the CSF and/or by myelography or MRI.)
- Nerve root injuries, post-surgical or post traumatic including that of post laminectomy syndrome (failed back syndrome)
- Complex regional pain syndrome I & II
- Diabetic peripheral neuropathy (DPN)
- Phantom limb syndrome that has not responded to medical management
- End stage peripheral vascular disease, when the member cannot undergo revascularization or when revascularization has failed to relieve painful symptoms and the pain has not responded to medical management
- Post- herpetic neuralgia
- Plexopathy
- Intercostal neuralgia that did not respond to medical management and nerve blocks
- Cauda equina injury
- Incomplete spinal cord injury.

~~NOTE: Services related to component reimplantation or replacement in members previously approved for the implantation, or members having had the implantation prior to enrollment in the Plan, and who otherwise meet criteria for coverage, do not require prior authorization.~~

MP040 Somnoplasty/ Coblation – Revised – Refine Title; Revised Exclusion Language

Somnoplasty™, Coblation™ [Radiofrequency volumetric tissue reduction (RFVTR)], ~~Ablation~~)

Somnoplasty / coblation for the treatment of obstructive sleep apnea is considered **~~experimental, investigational or~~ Unproven** and is **NOT COVERED.** There is inconclusive evidence in the published, peer-reviewed medical literature that the service has a beneficial effect on health outcomes.

Somnoplasty /coblation of the inferior turbinates for treatment of chronic nasal obstruction is considered **~~experimental, investigational or~~ unproven** and is **NOT COVERED.** There is insufficient evidence in the peer-reviewed published medical literature directly comparing somnoplasty to the established alternatives of electrocautery or submucosal surgical resection of the turbinates. In addition, there are no published clinical studies reporting on the long-term outcomes of individuals with mucosal hypertrophy that have been treated with radiofrequency volumetric tissue reduction.

Coblation tenotomy for the treatment of musculoskeletal conditions is considered ~~**experimental, investigational or**~~ **unproven** and is **NOT COVERED**. There is insufficient evidence in the peer-reviewed published medical literature directly comparing coblation tenotomy to the established alternatives.

Coblation adenoidectomy is considered ~~**experimental, investigational or**~~ **unproven** and is **NOT COVERED**. There is insufficient evidence in the peer-reviewed published medical literature directly comparing coblation to the established alternatives

Videolaryngoscope-assisted Coblation for the treatment of epiglottic cysts is considered ~~**experimental, investigational or**~~ **unproven** and is **NOT COVERED**. There is insufficient evidence in the peer-reviewed published medical literature directly comparing coblation to the established alternatives

Coblation for the treatment of laryngopharyngeal vascular lesions is considered ~~**experimental, investigational or**~~ **unproven** and is **NOT COVERED**. There is insufficient evidence in the peer-reviewed published medical literature directly comparing coblation to the established alternatives

Coblation for the treatment of glottis cancer or laryngeal cancer is considered ~~**experimental, investigational or**~~ **unproven** and is **NOT COVERED**. There is insufficient evidence in the peer-reviewed published medical literature directly comparing coblation to the established alternatives

Computed tomography (CT)-guided percutaneous Coblation of the thoracic nerve root for the treatment of post-herpetic neuralgia is considered ~~experimental, investigational or~~ **unproven** and is **NOT COVERED**. There is insufficient evidence in the peer-reviewed published medical literature directly comparing coblation to the established alternatives.

Coblation for the treatment of headache and/or nerve pain is ~~considered **experimental, investigational or**~~ **unproven** and is **NOT COVERED**. There is insufficient evidence in the peer-reviewed published medical literature directly comparing coblation tenotomy to the established alternatives.

MP054 Prophylactic Mastectomy – Revised – Revise Criteria

INDICATIONS:
Prophylactic mastectomy for cancer risk reduction may be considered medically necessary for members with a high risk of hereditary breast cancer who meet the following criteria:

High Risk Criteria - the member must meet **at least one** of these criteria:

- Members with a strong family history of breast cancer such as:
  - A family history of breast cancer in multiple first-degree relatives and/or multiple successive generations of family members with breast and/or ovarian cancer (family cancer syndrome); **and**
  - The member's risk of breast cancer is elevated based on a validated assessment tool such as the Breast Cancer Risk Calculator, Gail Model, or Tyrer-Cuzick Risk Calculator; **and**
  - The member has undergone counseling from an appropriate provider such as gynecologist, breast surgeon or genetic counselor to quantitate their risk;

or

- The member has tested positive for BRCA1, BRCA2, TP53, PTEN, PALB2 or other gene variants that strongly predispose susceptibility to breast cancer ~~gene mutations;~~ **or**
- The member has a high-risk histology: Atypical ductal or lobular hyperplasia, or lobular carcinoma in situ confirmed on biopsy; **or**
- Members with such extensive mammographic abnormalities e.g., calcifications), cystic/dense breast tissue) that adequate biopsy is impossible; **or**

- Members with a personal history of breast cancer making it more likely to develop a new cancer in the opposite breast; **or**
- Members who received radiation therapy to the thoracic region before the age of 30. (e.g. radiation to treat Hodgkin's disease).

MP129 Total Parenteral Nutrition – Revised – Added Language to NCD

Medicare Business Segment:

For Medicare business segment, please refer to:
Centers for Medicare & Medicaid Services. National Coverage Determination (NCD) Enteral and Parenteral Nutritional Therapy 180.2 NCD - Enteral and Parenteral Nutritional Therapy (180.2) (cms.gov)

MP150 Carotid Artery Stent – Revised – Expanded Criteria

INDICATIONS:
Coverage is limited to the use of FDA approved carotid stents for FDA approved indications when the following criteria are met:

- Documented evidence of a reference vessel diameter within the range of 4.0mm and 9.0mm; **and one of the following:**
    - Member is at high risk* for carotid endarterectomy (CEA) with one of the following:
        - symptomatic (e.g., transient ischemic attack or monocular blindness) carotid stenosis greater than 50% or more by angiogram or 70% or more by ultrasound; **or**
        - asymptomatic carotid artery stenosis of 60% or more by angiogram or 70% or more by ultrasound

        and

        - anatomic contraindication for carotid endarterectomy (e.g., prior radiotherapy or neck surgery, surgically inaccessible lesions, spinal immobility, or tracheostomy).

        or
    - Members who are at high risk for CEA and have asymptomatic carotid artery stenosis ≥ 80%, in accordance with the Category B IDE clinical trials regulation (42 CFR 405.201)

MP232 Autism Spectrum Disorder Evaluation and Medical Management – Revised – Added Exclusions

EXCLUSIONS:
Therapies or services for which the Plan, the Geisinger Technology Assessment Committee, or national specialty guidelines have determined that insufficient evidence exists in the peer-reviewed, published medical literature to establish the safety and/or a therapeutic benefit in the treatment of Autism Spectrum Disorder, will be considered Experimental, Investigational or Unproven, and therefore NOT COVERED unless otherwise mandated under Act 62 or other State or Federal mandate. These services include, but are not limited to:

- Interactive Metronome Training – MP74
- Massage Therapy – MP126
- Hippotherapy – MP116
- Suit Therapy – MP181
- Chelation Therapy – MP81

- Therapeutic Listening – MP119
- Vibroacoustic Therapy – MP137
- Alternative or Complimentary Medicine Therapies – MP136
    - (eg. Art therapy, music therapy, therapeutic touch, elimination diets, nutritional supplements, etc.)
- IVIG – MBP4.0
- Routine neuroimaging – AAN Guideline
- Hair analysis, celiac antibodies, allergy testing (particularly food allergies for gluten, casein, candida, and other molds), immunologic or neurochemical abnormalities, micronutrients such as vitamin levels, intestinal permeability studies, stool analysis, urinary peptides, mitochondrial disorders (including lactate and pyruvate), thyroid function tests, or erythrocyte glutathione peroxidase studies – AAN Guideline

Services performed and provided by unlicensed practitioners and/or services which do not require licensure to perform, (e.g., breathing exercises, guided visualization, meditation, etc) are considered to be unproven and not medically necessary, and therefore **NOT COVERED**.

Educational and training services related to vocational or academic performance including, but not limited to, Intelligence Quotient testing, achievement testing and classroom environment interventions (e.g. Theory of Mind training) are considered to be unproven and not medically necessary, and therefore **NOT COVERED**.

MP289 Dry Eye Syndrome – Revised – Added Exclusion

EXCLUSIONS:
The Plan considers the use of any of the following for the treatment of dry eyes **unproven** and therefore **NOT COVERED**:

- Intense Pulsed Light therapy
- Laser occlusion of the tear duct opening
- Tear film imaging (e.g., the Tear Stability Analysis System)
- Tear film biomarkers (e.g., goblet cell-specific MUC5AC and interleukin-8)
- Acupuncture
- Mechanical eyelid cleaning devices
- Eyelid thermal pulsation (e.g., MiBo Thermoflo; iLux, Systane iLux2, LipiFlow® Thermal Pulsation System)
- Intranasal Neurostimulation (e.g., TrueTear, iTEAR100)

~~a laser to occlude the tear duct opening, tear film imaging (e.g., the Tear Stability Analysis System), tear film biomarkers (e.g., goblet cell-specific MUC5AC and interleukin-8), acupuncture, mechanical eyelid cleaning devices, intense pulsed light therapy, and for the treatment of dry eyes **unproven** and therefore **NOT COVERED.**~~

MP356 Genetic Testing for Mitochondrial Disorders – Revised – Added Description Language; Revised Criteria

DESCRIPTION:
Mitochondrial disorders may be caused by mutation of a mitochondrial DNA (mtDNA) gene or mutation of a nuclear gene (nDNA).

Mitochondrial dysfunction should be considered in the differential diagnosis of any progressive multisystem disorder. A full evaluation for a mitochondrial disorder is often warranted in individuals with a complex neurologic picture or a single neurologic manifestation and other system involvement. Mitochondrial disorders can affect most organ systems, but a particular emphasis on the neuromuscular system and cardiovascular system is important.

Determining the molecular etiology of primary mitochondrial disease in an affected individual can be particularly challenging given the extensive heterogeneity of clinical symptoms, poorly understood genotype-phenotype correlations, and non-specific nature of many symptoms with significant clinical overlap for other conditions.

Inconsistencies exist among clinical diagnostic laboratories in the pathogenicity interpretation and reporting of mtDNA variants, as a potentially disease-causing mtDNA variant may be reported as pathogenic by one laboratory but benign by another due to differing variant classification algorithms or practices, therefore the rationale for testing once per lifetime does not apply to mitochondrial DNA. Benign variants may not be reported at one laboratory generating a negative report, so prior negative testing is not an exclusionary criterion for this testing.

Mitochondria diseases can present across the lifespan, as such, there are no age restrictions on this testing given the potential impact on symptom management, prognosis, and heritability.

CRITERIA FOR COVERAGE: REQUIRES PRIOR AUTHORIZATION BY A PLAN MEDICAL DIRECTOR OR DESIGNEE

Genetic testing (whole mtDNA sequencing and deletion/duplication analysis) for mitochondrial disorders (e.g, Alpers' syndrome; Leigh syndrome; Leber's hereditary optic neuropathy (LHON); mitochondrial encephalopathy, lactic acidosis and stroke-like episodes (MELAS); Myoclonic Epilepsy and Ragged-Red Fibers (MERRF); Chronic Progressive External Ophthalmoplegia (CPEO); Kearns-Sayre syndrome) will be considered medically necessary when the following criteria are met:

- Genetic counseling by a ~~genetics~~ qualified professional has been completed; **and**
- ~~Relevant biochemical testing for the suspected disorder has been complete (examples: plasma or CSF lactic acid, ketone bodies, acylcarnitine, or urine organic acids); **and**~~
- Whole mtDNA testing has either not been ~~previously~~ performed **OR** mtDNA results from a different laboratory indicate a negative or uninformative result.
- Member's clinical presentation does not fit a well-described mendelian disorder or genetic syndrome for which single-gene or targeted nDNA panel testing is available; ~~**or**~~

  AND

  Any one of the following criteria are met:
- Member is being concurrently tested through whole exome sequencing; **or**
- Member has one or more of the following clinical features: progressive wasting, milestone regression, ataxia, encephalopathy, seizures, developmental regression, lactic acidosis, and stroke-like episodes (MELAS), pigmentary retinopathy (NARP), mitochondrial myopathy, diabetes mellitus, sensorineural hearing loss or bilateral deafness, early-onset peripheral neuropathy, optic neuropathy, optic atrophy, ophthalmoplegia, ptosis, cardiomyopathy, heart block; **or**
- Family history is strongly suggestive mitochondrial inheritance (e.g. paternal transmission has been ruled out); ~~and~~ or
- A mtDNA variant has been reported in a maternal blood relative.

The following policies have been reviewed with no change to the policy section. Additional references or background information was added to support the current policy.

MP049 Visual Field Testing

MP057 Prophylactic Oophorectomy
MP060 Lung Volume Reduction
MP071 Continuous Subcutaneous Glucose Monitor
MP093 Uroleume
MP101 Gliasite Radiation Therapy
MP131 VitalStim NMES
MP135 Osseointegrated Hearing Device
MP146 Sympathetic Therapy
MP154 Transanal Radiofrequency Therapy for Fecal Incontinence (Secca)
MP193 Microvolt T-wave Alternans
MP199 Corneal Pachymetry
MP213 Computerized Corneal Topography
MP229 Prolozone Therapy
MP259 Phototherapy for the Treatment of Dermatological Conditions
MP290 Fecal Microbiota Transplantation
MP342 Non-Wearable AED
MP354 Breast Pump
MP370 Endobronchial Valve
MP375 Technology Assessment