“What’s New” Medical Policy Updates September 2017

Listed below are the recent changes made to policies within the Geisinger Health Plan Medical Policy Portfolio during the month of August that will become effective October 15, 2017 (unless otherwise specified). The Plan uses medical policies as guidelines for coverage decisions made within the insured individuals 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.

MP104 Subcutaneous Insulin Pump - REVISED – (Age restriction change)
Sensor-augmented insulin pump therapy with the low glucose threshold suspend

Sensor-augmented insulin pump therapy with the low glucose threshold suspend will be considered for coverage for members 16 years and older with Type 1 diabetes when the current criteria for both external insulin pumps and the additional criteria for continuous glucose monitors listed below have been met:

1. Documentation of three (3) months active participation in either the Plan Diabetes Management program or an American Diabetes Association recognized program with continuing diabetes education; AND  
2. Documentation by either a certified diabetic educator (CDE) or Plan Case Manager of compliance with self-monitoring testing, diet or other recommendations to improve glycemic control; AND
3. Documentation of insulin injections three or more times a day, or use of an insulin pump; and
   - Documented episodes of recurrent severe hypoglycemia (less than 50 mg/dL) or physician documented evidence of severe ketosis, suspected postprandial hyperglycemia, or hypoglycemic unawareness including symptoms, consequences, frequency, and patterns identified; and
   - Documentation of insulin regimen modification and compliance with frequent finger-stick self-monitoring (at least four times per day)

EXCLUSIONS:
Sensor augmented insulin pump therapy with the low glucose threshold suspend feature is considered investigational in member younger than 16 years.

MP151 Epidural Steroid Injections - REVISED – (Revise Drug Requirement)

4. Documented failure or contraindication to pharmacologic therapy. There must be documentation of the use of at least three (3) or two (2) classes of medications from the following list of medication classes must be submitted for review: NSAIDs, opiates, non-opioid analgesics, anti-epileptic medications used for treatment of chronic pain, antidepressant medications used for treatment of chronic pain, ASA or ASA derivatives, muscle relaxants, steroids, such as prednisone or Medrol or documented contraindication to each of these drug classes.

MP175 Trigger Point Injections - REVISED – (Revise Drug Requirement)

- Documented failure or contraindication to pharmacologic therapy. There must be documentation of the use of at least three (3) or two (2) classes of medications from the following list of medication classes must be submitted for review: NSAIDs, opiates, non-opioid analgesics, anti-epileptic medications used for treatment of chronic pain, antidepressant medications used for treatment of chronic pain, ASA or ASA derivatives, muscle relaxants, steroids, such as prednisone or Medrol or documented contraindication to each of these drug classes.
MP247 Nutritional Supplements - REVISED – (Added Human Donor Breast Milk)
Medicaid Business Segment:

Oral or enteral nutrition products or supplements used for the treatment of members with an established diagnosis of inborn error of metabolism (eg, phenylketonuria (PKU) homocystinuria, branch chain ketonuria, galactosemia, etc) with documentation of failure of conservative dietary interventions are covered as mandated by Act 191

Oral Nutritional Products:

For members under age 21 years:
Each case will be determined based on medical necessity. Physician documentation must provide all of the following:

• a description of the member’s clinical condition that clearly outlines why the nutritional needs cannot be met through dietary modification to increase caloric intake (snacks, higher calorie/protein foods)
• A description of the member’s current nutritional status (eg, height, weight, percentiles for pediatric members)
• A prescription or order including the product, administration route and rate of intake
• An estimated duration of therapy
• For oral nutritional supplementation expected to be required long term (months), documentation of a nutritional assessment needs to be provided that includes an assessment of current caloric intake, caloric needs, and why dietary modification cannot meet those needs.

Pasteurized Human Donor Breast Milk

Requests for pasteurized human donor breast milk will be reviewed using the American Academy of Pediatrics guidelines: http://pediatrics.aappublications.org/content/pediatrics/139/1/e20163440.full.pdf

• Donor human milk may be used for high-risk infants when the mother’s milk is not available or the mother cannot provide milk. Priority will be given to providing donor human milk to infants <1500 g birth weight.
• The donor must be identified and screened using methods such as those currently used by HMBANA milk banks or other established commercial milk banks.
• The donor milk is pasteurized according to accepted standards.

MP272 PCA3 Assay - REVISED – (Title Change; Added Testing)
DESCRIPTION:
Prostate cancer antigen 3 (PCA3, also referred to as DD3) is a gene that expresses a non-coding RNA. PCA3 is only expressed in human prostate tissue, and the gene is highly overexpressed in prostate cancer. Because of its restricted expression profile, the PCA3 RNA is thought to be useful as a tumor marker. The PROGENSA® PCA3 Assay is an automated molecular assay that helps physicians determine the need for repeat prostate biopsies in members who have had a previous negative biopsy.

In vitro gene expression prognostic assays measure gene expression in tumor tissue samples or from prostate biopsy samples to provide a personalized risk score indicative of a tumor’s aggressiveness and may also provide a long-range prostate cancer -specific mortality risk score.

Epigenetic assays utilize methylation-specific PCR to assess DNA methylation of gene regions that are associated with prostate cancer. The test assesses the methylation status of glutathione s-transferase PI (GSTP1), adenomatous polyposis coli (APC), and RAS association (RalGDS/AF-6) domain family member 1 (RASSF1)

ALL BUSINESS SEGMENTS
ConfirmMDx is covered for members with negative or non-malignant abnormal histopathology findings, such as atypical cell or high-grade prostate intraepithelial neoplasia (HGPIN) on prostate biopsy, yet with high-risk factors (elevated/rising PSA or abnormal digital rectal exam) and are candidates for repeat biopsy.

**MEDICARE BUSINESS SEGMENT:**
The PROGENSA® PCA3 Assay [eg, Progensa] is covered for insured individuals to help determine the need for repeat prostate biopsies in members who have had a previous negative biopsy.

Gene expression prognostic assay (eg, Prolaris, ProMark) is covered for members to help determine which patients with early stage, needle biopsy proven prostate cancer can be conservatively managed rather than treated with definitive surgery or radiation therapy.

**EXCLUSIONS:** The Geisinger Technology Assessment Committee determined that at the present time, there is insufficient evidence in the peer-reviewed, published medical literature to support the use of PCA3 assay to determine the need for repeat biopsy in members who have had a previous negative prostate biopsy. Unless mandated by state or federal regulation, this testing is currently considered to be experimental, investigational or unproven, and therefore NOT COVERED.

There is insufficient evidence in the peer-reviewed, published medical literature to support the use of Gene expression prognostic assay (eg, Prolaris, ProMark) to determine which patients with early stage, needle biopsy proven prostate cancer can be conservatively managed rather than treated with definitive surgery or radiation therapy. Unless mandated by state or federal regulation, this testing is currently considered to be experimental, investigational or unproven, and therefore NOT COVERED.

**MP283 Facet Injections - REVISED – (Revise Drug Requirement)**

4. Documented failure or contraindication to pharmacologic therapy. There must be documentation of the use of at least three (3) classes of medications from the following list of medication classes must be submitted for review: NSAIDs, opiates, non-opioid analgesics, anti-epileptic medications used for treatment of chronic pain, antidepressant medications used for treatment of chronic pain, ASA or ASA derivatives, muscle relaxants, steroids, such as prednisone or Medrol or documented contraindication to each of these drug classes.

**MP287 Shift Care - REVISED – (Edited Language)**

**LIMITATIONS:**
- Activities such as, but not limited to, the administration of eye drops, topical ointments, applying creams, and bathing the skin do not constitute skilled care. Each request for this type of service will be evaluated on an individual basis for determination of medical necessity.

- Skilled nursing is not covered once the member is 21 years of age

- PH-MCOs cannot require a minimum number of specified hours [e.g., four (4) continuous hours] considered to be medically necessary cannot be required in order to authorize services. Each request submitted must be reviewed for medical necessity on its own merit and an appropriate decision rendered.

- A request may not be denied because the service will be provided in a location outside of the child’s home, such as, but not limited to, a school setting. Each request submitted must be reviewed for medical necessity on its own merit and an appropriate decision rendered.

- A request may not be denied because the PH-MCO believes it is believed that the service should be covered as part of a child’s Individualized Education Program (IEP) or Section 504 Plan. Each
request submitted must be reviewed for medical necessity on its own merit and an appropriate decision rendered.

MP292 Sympathetic Nerve Block - REVISED – (Revise Drug Requirement)
Documented failure or contraindication to pharmacologic therapy. There must be documentation of the use of at least three (3) two (2) classes of medications from the following list of medication classes must be submitted for review: NSAIDs, opiates, non-opioid analgesics, anti-epileptic medications used for treatment of chronic pain, antidepressant medications used for treatment of chronic pain, ASA or ASA derivatives, muscle relaxants, steroids, such as prednisone or Medrol or documented contraindication to each of these drug classes.

MP295 Sacroiliac Joint Injection - REVISED – (Revise Drug Requirement)
- Documented failure or contraindication to pharmacologic therapy. There must be documentation of the use of at least three (3) two (2) classes of medications from the following list of medication classes must be submitted for review: NSAIDs, opiates, non-opioid analgesics, anti-epileptic medications used for treatment of chronic pain, antidepressant medications used for treatment of chronic pain, ASA or ASA derivatives, muscle relaxants, steroids, such as prednisone or Medrol or documented contraindication to each of these drug classes.

MP296 Occipital Nerve Block - REVISED – (Revise Drug Requirement)
Occipital nerve block may be considered medically necessary when ALL of the following criteria are met:
- Diagnosis of occipital neuralgia; and
- Documented failure or contraindication to pharmacologic therapy. There must be documentation of the use of at least three (3) two (2) classes of medications from the following list of medication classes must be submitted for review: NSAIDs, opiates, non-opioid analgesics, anti-epileptic medications used for treatment of chronic pain, antidepressant medications used for treatment of chronic pain, ASA or ASA derivatives, muscle relaxants, steroids, such as prednisone or Medrol or documented contraindication to each of these drug classes.

MP297 Suprascapular Nerve Block - REVISED – (Revise Drug Requirement)
Documented failure or contraindication to pharmacologic therapy. There must be documentation of the use of at least three (3) two (2) classes of medications from the following list of medication classes must be submitted for review: NSAIDs, opiates, non-opioid analgesics, anti-epileptic medications used for treatment of chronic pain, antidepressant medications used for treatment of chronic pain, ASA or ASA derivatives, muscle relaxants, steroids, such as prednisone or Medrol or documented contraindication to each of these drug classes.

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.

MP024 External Counterpulsation
MP053 Cochlear Implant
MP059 Fetal Surgery
MP102 Morphometric Tumor Analysis
MP115 Autologous Chondrocyte Implant
MP121 Automated External Defibrillators
MP148 Ambulatory Cardiac Event Monitors
MP163 Thermography
MP183 Cranial Electrotherapy Stimulation
MP185 Chemosensitivity and Chemoresistance Assays
MP200 Osteochondral Autograft Transplant
MP202 Interferential Stimulation
MP206 Electrocardiographic Body Surface Mapping
MP208 Selective Internal Radiation Therapy
MP221 Suprachoroidal Delivery of Pharmacologic Agents
MP234 Occipital Nerve Stimulation
MP246 Multigene Expression Assay for predicting Recurrence in Colon Cancer
MP267 Amniotic Membrane Transplantation
MP291 TX1 Tissue Removal System for Ablating and Removing Tissue