“What’s New” Medical Policy Updates August 2019

Listed below are the recent changes made to policies within the Geisinger Health Plan Medical Policy Portfolio during the month of July that will become effective September 15, 2019 (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.

MP005 Medical Policy Process – (Revised) – (Revised Process)

Process

1. A request for medical policy development or revision is received via paper or electronic submission to the Director, Medical Policy (Director) by a Plan Provider, Plan Administrator, Plan Medical Director, through communication of governmental regulation, or Technology Assessment Committee recommendation. Topics considered for medical policy may also be gathered from routine periodic review of industry standards and emerging published, peer reviewed medical literature. The Director or the Medical Policy Research Coordinator(s) logs requests for medical policy on the tracking module.

2. The Director reviews the requests for medical policy development with a Health Plan Medical Director on an ad hoc basis (with the exception of urgent requests as outlined in section 3) and requests are evaluated to determine priority, approach and need for specialty input. Requests for policy related to new technology or new applications of existing technologies are also reviewed with the chairperson of the Geisinger Clinic Technology Assessment Committee (TAC) for determination of appropriateness of TAC evaluation. Recommendation of approval or disapproval of a procedure, device or therapy by the Geisinger Clinic Technology Assessment Committee (TAC) or the Technology Assessment Committee Triage Group (TACt) is followed by assignment of a numeric identifier for the draft policy and the development of a draft medical benefit policy. The draft policy follows the review and implementation process.

3. The Director or Medical Policy Research Coordinator(s) meets with the Medical Director as necessary. Routine requests for medical policy development are reviewed and the following process is followed.

   a. The Director or Medical Policy Research Coordinator conducts a literature search, and obtains medical specialty input as needed.
   b. A draft policy or draft revision of an existing document is written, and input gathered from the Physician Advisory Group(s) as applicable.
   c. The proposed draft policy is submitted to the Plan’s Medical Management Committee (MMC) for review, discussion and recommendation as soon as the agenda permits. Copies of the proposed policy are distributed to the participants of the Medical Management Committee prior to the meeting. The Medical Management Committee meets twice a month. Recommendation for approval of the medical policy can be made by a quorum vote of 1/3 of the committee membership which must include at least one (1) Plan Medical Director.
   d. Policies recommended for approval by MMC are forwarded to the PA Department of Human Services (DHS) Prior Authorization Review Process (PARP). Policies must be submitted electronically by the assigned PARP submission dates. The PARP review is held during the last week of each month. Policies requiring revision applicable to the GHP Family (Medicaid) business segment are revised and resubmitted for approval by DHS. The criteria revision may be applied across all business segments at the Plan’s discretion or limited to the GHP Family business segment. If proposed that the revision is applicable across all business
segments, MMC must be notified and must recommend approval of the proposal to apply the revision across all business segments.

e. As deemed necessary by the Director, new or revised policies having impact to the Plan’s benefit design or potential impact for regulatory filings will be scheduled for review by the Medical Services Review Group and/or Benefit Review Team.

f. Review and final approval of medical benefit policy recommendation is the responsibility of the Plan’s Medical Management Administrative Committee (MMAC). Approval is acquired via electronic vote by the MMAC membership.

g. The new or revised policy is signed by the Geisinger Health Plan’s Vice President, Chief Medical Officer and entered into the medical policy manual located in the Health Services Department.

MP048 Surgical and Minimally Invasive Therapies for the Treatment of BPH – (Revised) – (Added Covered Therapies; Reformat Criteria)

**DESCRIPTION:** INDICATIONS

Transurethral Microwave Thermotherapy (TUMT), Transurethral Radiofrequency Thermotherapy (TUNA), Transurethral incision of the prostate (TUIP), Transurethral water vaporization of the prostate [e.g. Rezum<sup>™</sup>] (TUVP), Transurethral enucleation of the prostate (TUER), Laser Prostatectomy (Holmium laser ablation of the prostate [HoLAP]), Holmium laser enucleation of the prostate [HoLEP], Holmium laser resection of the prostate ([HoLRP]) and Water Induced Thermotherapy (WIT) are outpatient ablation treatments for symptomatic benign prostatic hypertrophy (BPH). These procedures are non-surgical alternatives to transurethral resection of the prostate (TURP). The desired outcome is to relieve urinary symptoms and improve urinary function by reducing urinary obstruction caused by BPH. A urethral probe is used to apply thermal energy to the prostate, causing damage and eventual necrosis of excess prostatic tissue. Prostatic Urethral Lift (UroLift<sup>®</sup>) is a minimally invasive implant developed to treat lower urinary tract outflow obstruction secondary to BPH in men 50 years of age or older. Permanent implants are delivered trans-prostatically to retract the enlarged lateral lobes of the prostate. These procedures are considered to be medically necessary when the following criteria are met:

**INDICATIONS:**
Outlet obstruction caused by benign prostatic hypertrophy

**CRITERIA FOR COVERAGE:** All must be met

- Diagnosis of symptomatic BPH with duration of symptoms greater than 3 months
- Failed trial or intolerance to medication therapy (alpha-blocker and/or finasteride)
- Recent PSA that resulted in a value of 2.5 ng/ml or less for members up to age 50; 4.0 ng/ml or less for members over age 50
- Peak urine flow rate (Qmax) less than 15 cc on a voided volume of greater than 125cc
- Post void residual (PVR) greater than 50cc or less than 350cc

Prostatic Urethral Lift (UroLift<sup>®</sup>) is a minimally invasive implant developed to treat lower urinary tract outflow obstruction secondary to BPH in men 50 years of age or older. Permanent implants are delivered trans-prostatically to retract the enlarged lateral lobes of the prostate. This procedure is considered to be medically necessary when the following criteria are met:

- Diagnosis of symptomatic BPH with duration of symptoms greater than 3 months
- Prostate gland volume is less than or equal to 80ml
- Prostate anatomy demonstrates normal bladder neck without an obstructive or protruding median lobe
- Therapeutic failure or intolerance to medical therapy (e.g. α1-adrenergic antagonists, 5α-reductase inhibitors)
- Absence of contraindications
MP071 Subcutaneous Glucose Monitor – (Revised) – (Added Coverage; Added Exclusion; Revised Criteria)

For Commercial Business Segment:

INDICATIONS:

I. Continuous subcutaneous glucose monitors with a device provided from an endocrinologist office or clinic will be covered for a maximum of 3 consecutive days, twice per calendar year when all of the following criteria are met:

* Medical documentation of a diagnosis of Type 1 diabetes, Type 2 diabetes or gestational diabetes; and
* Documented daily repeated Suspected hypo- (<50mg/dl) and hyperglycemia excursions each day; or
* Documented Suspected episodes of hypoglycemia unawareness including symptoms, consequences, frequency, and patterns identified; and
* Poor blood glucose control as evidenced by two HgBA1C values greater than 7.0 within previous 6 months

This device is intended for one-time or occasional 1-3 day time period. The devices provided for this service are supplied by the clinician. It is not meant to replace the traditional (fingerstick) self-monitoring measurements, but rather, serve as a short-term adjunct to these measurements.

A maximum of two CGMS monitoring periods are considered medically necessary within a 12-month period.

II. Personal continuous subcutaneous glucose monitor may be considered for pediatric and adult members with diabetes mellitus (Type 1 or 2) treated with insulin who meet all of the following criteria:

1. Documentation of a diagnosis of diabetes, and 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 of daily insulin therapy 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 multiple daily insulin injections, or use of a continuous subcutaneous 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)

The “flash” continuous glucose monitoring system (e.g., Flash Glucose Monitoring System) is considered to be an acceptable alternative to other continuous glucose monitoring systems for medically necessary indications in members 18 years of age and older with diabetes.

For Medicare Business Segment:
Per CMS, Therapeutic CGM may be covered by Medicare when all of the following criteria are met:

* The beneficiary has diabetes mellitus; and,
The beneficiary has been using a home blood glucose monitor (BGM) and performing frequent (four or more times a day) BGM testing; and,
The beneficiary is insulin-treated with multiple daily injections (MDI) of insulin or a continuous subcutaneous insulin infusion (CSII) pump; and,
The beneficiary’s insulin treatment regimen requires frequent adjustment by the beneficiary on the basis of therapeutic CGM testing results.


Documentation of a vendor certificate of medical necessity with physician signature without previous supporting documentation in the medical record is not sufficient to meet criteria for coverage.

AUTHORIZATION DETERMINATION Long-term use of continuous glucose monitoring devices will be initially provided for a three month time period. Members authorized to receive long-term use of continuous glucose monitoring devices must be followed by a Plan disease management or medical home case manager. At the end of the first three months, Health Plan staff will review compliance and health outcomes data provided by the ordering physician. Non-compliance or lack of improvement in glycemic control will result in medical director review to determine continued medical necessity. Extenuating circumstances that affect compliance will be taken into consideration.

EXCLUSIONS:
The GlucoWatch® is an external device worn like a wristwatch that measures glucose every 20 minutes in interstitial fluid extracted through the skin with an electric current (referred to as reverse iontophoresis). Use of a non-implanted, external device (e.g., GlucoWatch®) in the monitoring of glucose levels in the interstitial fluid as a technique of diabetic monitoring, is considered experimental, investigational or unproven because there is insufficient evidence in the peer reviewed medical literature to support its reliability and efficacy. Therefore it is NOT COVERED.

CGM using an implantable glucose sensor (e.g., Eversense) is considered experimental, investigational or unproven because there is insufficient evidence in the peer reviewed medical literature to support its reliability and efficacy. Therefore it is NOT COVERED.

Personal digital assistant-based blood glucose monitoring devices and interface systems (e.g., TheraSense FreeStyle Tracker, Accu-Check Advantage Module, the Dexcom SHARE), and remote glucose monitoring add-on systems (e.g., mySentry) are considered experimental, investigational or unproven because there is insufficient evidence in the peer reviewed medical literature to support its reliability and efficacy. Therefore they are NOT COVERED.

MP269 Elective Spinal Fusion – (Revised) – (Added Indication)

INDICATIONS: Requires Prior Medical Director or designee Authorization (Not applicable to Medicare, Medicaid and TPA business segments with the exception of GHP)

Elective cervical, thoracic, or lumbar spinal fusion is considered medically necessary when the following criteria are met:

1. Image studies confirming the diagnosis of any of the following:
   a. Spinal fracture with instability or neural compression
   b. dislocation, abscess and/or tumor requiring spinal repair
   c. Spinal tuberculosis

OR
2. Completed a spine evaluation and surgical intervention is recommended by the healthcare provider providing and overseeing treatment of the spine, and image studies confirm the diagnosis of any of the following:
   a. Spondylolisthesis or spinal stenosis with one or more of the following
      i. Neurogenic claudication or radicular pain
      ii. Documentation of lateral/central recess or foraminal stenosis
      iii. Functional impairment
   b. Severe degenerative scoliosis causing loss of function with one or more of the following
      i. Persistent axial pain
      ii. Persistent neurogenic symptoms including radicular pain or claudication
   c. Pseudoarthrosis causing one or more of the following
      i. Persistent axial or radicular pain
      ii. Functional impairment

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.

MP010 Blepharoplasty
MP100 Electrical Bioimpedance
MP114 Vertebroplasty and Percutaneous Kyphoplasty
MP125 Cranial Remodeling Orthotic
MP137 Vibroacoustic Therapy
MP201 Obstructive Sleep Apnea
MP227 Spaced Retrieval Testing
MP240 Dermal Injections for Treatment of Facial LDS
MP241 Non-invasive Measurement of Advanced Glycation Endproducts
MP266 Magnetoencephalography and Magnetic Source Imaging
MP268 Elective Laminectomy
MP309 Computerized Dynamic Posturography