“What’s New” Medical Policy Updates August 2020

Listed below are the recent changes made to policies within the Geisinger Health Plan Medical Policy Portfolio during the months of July that will become **effective September 15, 2020** (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.

MP001 Neuromuscular and Functional Electrical Stimulation (NMES)(FES) – (Revised) – Edited Title; Added Exclusion

Subject: Neuromuscular and Functional Electrical Stimulation NMES/FES

EXCLUSIONS:
NMES is considered **experimental, investigational and unproven** for the following applications and is **NOT COVERED**:

- As a muscle strengthening regimen in healthy individuals
- For use in the treatment of scoliosis
- For reduction of spasticity or to facilitate voluntary motor control in cerebral palsy, or other upper motor neuron disorders
- Treatment of denervated muscles
- Treatment of pain

The Plan does **NOT** provide coverage for the use of NMES as a treatment for idiopathic facial palsy (Bell’s palsy) because it is considered **experimental, investigational or unproven.** There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this treatment on health outcomes when compared to established treatments or technologies

The Plan does **NOT** provide coverage for the use of MEDex unit (combined NMES and TENS), and RS4i (combined NMES and interferential therapy) or similar equipment as a treatment for any indication because it is considered **experimental, investigational or unproven.** Although the device is FDA approved, there is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this treatment on health outcomes when compared to established treatments or technologies

The Plan does **NOT** provide coverage for the use of Micro-current Stimulation Devices (MENS) including, but not limited to use in the treatment of migraine headache, fibromyalgia, anxiety, depression, insomnia, cognitive dysfunction and other pain disorders because it is considered **experimental, investigational or unproven.** There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this treatment on health outcomes when compared to established treatments or technologies

The Plan does **NOT** provide coverage for the use of ~~E~~electromyographic impulse generated muscle stimulator (biofeedback device) as a treatment for any indication because it is considered **experimental, investigational or unproven.** There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this treatment on health outcomes when compared to established treatments or technologies

The Plan does **NOT** provide coverage for the use of horizontal therapy as a treatment for any indication because it is considered **experimental, investigational or unproven.** There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this treatment on health outcomes when compared to established treatments or technologies.

The Plan does **NOT** provide coverage for the use of FES of the upper extremities (e.g., NESS H200 Handmaster NMS1 System) to improve muscle strength, treat atrophy or reduce spasticity due to traumatic brain injury, stroke, spinal cord injury or upper motor neuron disorders because it is considered **experimental, investigational or unproven.** There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this treatment on health outcomes when compared to established treatments or technologies.

The Plan does **NOT** provide coverage for the use of Functional Electrical Stimulation (eg, NESS L300, WalkAide™, Bionicare Knee System, Odstock Dropped Foot Stimulator) to improve ambulation in members with a gait disorder such as foot drop or hemiplegia due to multiple sclerosis, stroke or cerebral injury because it is considered **experimental, investigational or unproven**. There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this treatment on health outcomes when compared to established treatments or technologies.

The Plan does **NOT** provide coverage for the use of FES (including but not limited to REGYS/ERGYS and RT300-S/RT300-SP) as in-home physical therapy and exercise equipment to prevent or reverse muscular atrophy and bone demineralization, general rehabilitation, relaxation of muscle spasms, or maintenance of range of motion because it is considered **experimental, investigational or unproven**. There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this treatment on health outcomes when compared to established treatments or technologies.

MP010 Blepharoplasty – (Revised) – Added Canthoplasty/Canthopexy Coverage

Canthoplasty/Canthopexy (21280, 21282)

- Reconstruction of the eyelid following surgical resection of lesions (benign or malignant) of the medial or lateral canthus; **or**
- as an adjunct to a medically necessary ectropion or entropion repair

MP048 Surgical and Minimally Invasive Therapies for the Treatment of BPH – (Revised) – Revised UroLift Criteria

Prostatic Urethral Lift (UroLift ®) is a minimally invasive implant developed to treat lower urinary tract outflow obstruction secondary to BPH in men 45 ~~50~~ years of age or older. ~~Permanent implants are delivered trans-prostatically to retract the enlarged lateral and median lobes of the prostate. This procedure is considered to be medically necessary when the following criteria are met:~~ Permanent implants are delivered via the urethra, deployed, and implanted into each lobe of the prostate to retract the tissue away from the urethral walls to increase the opening of the urethra. This procedure is considered 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 100 ~~80~~ml
- Prostate anatomy demonstrates urinary outflow obstruction secondary to benign prostatic hyperplasia (BPH), including lateral and median lobe hyperplasia ~~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

CONTRAINDICATIONS:
Active urinary tract infection

Prostate malignancy
~~Prostate gland with obstructive median lobe~~
Hyperreflexive neurogenic bladder
Previous prostate surgery
Active cystolithiasis
Gross hematuria
Urethral stricture
Bladder neck contracture
Acute prostatitis
Prior radiation therapy to the pelvic area

MP063 Acupuncture – (Revised) – Added Medicaid Coverage

MEDICARE/MEDICAID BUSINESS SEGMENT

Please see CMS NCD 30.3.3

MP114 Vertebroplasty and Percutaneous Kyphoplasty – (Revised) – Added Medicare Coverage Citation

FOR MEDICARE BUSINESS SEGMENT:
Please see Novitas Solutions, Inc. L35130 Percutaneous Vertebral Augmentation (PVA) for Vertebral Compression Fracture (VCF)

MP268 Elective Laminectomy – (Revised) – Removed Prior Authorization

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

MP269 Elective Spinal Fusion – (Revised) – Removed Prior Authorization

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

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

1. I~~mage~~ Imaging 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~~ A spinal evaluation has been completed and surgical intervention is recommended by the healthcare provider providing and overseeing treatment of the spine, and imaging 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

MP299 Measurement of Serum Antibodies to Infliximab, Adalimumab, Ustekinumab and Vedolizumab – (Revised) – Revised Title; Added Exclusion

Subject: Measurement of Serum Antibodies to Infliximab, Adalimumab, Ustekinumab and Vedolizumab

DESCRIPTION: The measurement of serum concentrations and of antibodies ~~have~~ has been proposed as a way to detect individuals with inadequate response to treatment with monoclonal antibodies and tumor necrosis factor drugs. Several commercial laboratory companies including, but not limited to Prometheus® Laboratories Inc. offers non-radiolabeled fluid-phase HMSA tests (e.g., Anser™IFX test for infliximab, Anser™ VDZ for vedolizumab, Anser UST for ustekinumab and Anser™ADA for adalimumab). These tests measure antidrug antibodies in the presence of detectable drug levels, improving upon a major limitation of the ELISA method. These tests measure serum concentrations and antidrug antibodies. The detection and quantitative measurement of antidrug antibodies has historically been difficult to establish.

EXCLUSIONS: Measurement of serum concentrations and/or antibodies to infliximab (Remicade), adalimumab (Humira), ustekinumab (Stelara), or vedolizumab (Entyvio) either alone or as a combination test is considered experimental, investigational or unproven or is **NOT COVERED.** The clinical value of these measurements for individuals receiving infliximab, vedolizumab or adalimumab therapy has not been established.

MP336 Genetic Testing for Inherited Thrombophilia/ Hypercoagulability – (NEW)

DESCRIPTION: Inherited thrombophilia is a genetic predisposition to develop a group of clinical conditions caused by associated gene variants and defects. Common causes include Factor V Leiden, a prothrombin gene variation, and deficiencies in protein S, protein C, and antithrombin.

INDICATIONS:
Genetic testing for Factor V and/or Factor II Blood Clotting Protein mutations may be considered medically necessary for any of the following conditions in members without recurrent VTE risk factors (e.g., recent surgery, prolonged immobilization, collagen vascular disease, malignancy, certain hematologic disorders):

- Age less than 50, any venous thrombosis; or
- Myocardial infarction in female smokers less than age of 50; or
- Recurrent venous thrombosis; or
- First or second degree relative of individuals with venous thrombosis less than age of 50; or
- Relative with confirmed Factor V or Factor II mutation; or
- Venous thrombosis and a first or second degree relative with venous thrombosis; or
- Venous thrombosis in pregnant women or women taking oral contraceptives; or
- Venous thrombosis in unusual sites (such as hepatic, mesenteric and cerebral veins)
- Prior to administration of oral contraceptives in women with a personal or family history of venous thrombosis

- Preeclampsia or hemolysis, elevated liver enzymes, low platelets (HELLP) syndrome

EXCLUSIONS:
The Plan considers the use of genetic testing for hereditary thrombophilia for ANY of the following indications to be **experimental, investigational or unproven** and **NOT COVERED**:

- General population screening
- Routine initial testing in an individual with arterial thrombosis
- Routine screening of asymptomatic women during pregnancy or prior to the use of oral contraceptives, hormone replacement therapy (HRT), or selective estrogen receptor modulators
- Newborn testing, or routine testing in an asymptomatic child
- Prenatal or preimplantation testing

The Plan considers the use of genetic testing for Factor V and Factor II mutations for all other indications not listed above to be considered **experimental, investigational or unproven** and **NOT COVERED**.

The Plan considers the use of genetic testing for MTHFR for diagnosis or management of all indications, including but not limited to, inherited thrombophilia, infertility, recurrent pregnancy loss, coronary artery disease, vascular disease, congenital heart defects, hepatitis, stroke, Parkinson's, peripheral neuropathy, cancer, migraine headache, Alzheimer's disease, dementia, autism spectrum disorder, depression, or schizophrenia to be considered **experimental, investigational or unproven** and **NOT COVERED.**

MP338 COVID19 Antibody Testing – (NEW)

DESCRIPTION:
COVID19 antibody assays help determine whether someone has ever been infected with SARS-CoV-2 virus, even if they never had symptoms of infection. COVID19 antibody tests detect waning or past SARS-CoV-2 virus infection by measuring the individual's immune response to the virus. At present, the immunologic correlates of immunity from SARS-CoV-2 infection are not well defined. Currently, the Centers for Disease Control and Prevention (CDC) recommendations state:

> "Serologic test results should not be used to make decisions about grouping persons residing in or being admitted to congregate settings, such as schools, dormitories, or correctional facilities. Serologic test results should not be used to make decisions about returning persons to the workplace."

CDC Interim Guidelines for COVID-19 Antibody Testing in Clinical and Public Health Settings
https://www.cdc.gov/coronavirus/2019-ncov/lab/resources/antibody-tests-guidelines.html

FOR COMMERCIAL/MEDICARE BUSINESS SEGMENTS

INDICATIONS:
Currently, the Plan will consider the following indications for COVID19 antibody testing to be medically necessary **only** when ordered by a treating clinician:

- A member with symptoms consistent with COVID19 infection and multiple negative PCR tests to COVID 19; or
- A member who has recovered from a documented COVID19 infection and is now considering plasma donation; or
- A child with suspected Multisystem Inflammatory Syndrome in Children (MIS-C)

LIMITATIONS:
COVID19 antibody testing will be limited to one (1) test per year.

COVID19 antibody testing must be obtained through an in-network lab provider.

Occupational requirements for COVID19 antibody testing established by a member's employer as a benchmark for returning to the workplace are not currently supported by the CDC. Any such required testing will be expected to be provided through the employer's employee health program.

Any state or federally mandated coverage directives will supersede this policy.

EXCLUSIONS:
There is insufficient published peer reviewed medical literature to support the use of COVID19 antibody testing for any indication not listed in this policy. The use of COVID19 antibody testing to diagnose a current COVID 19 infection; to screen the general population; to determine eligibility to return to work; or as a determinant of immunity is considered **experimental, investigational or unproven** and **NOT COVERED.**

There is insufficient published peer reviewed medical literature to support the use of unsupervised "at home" collection devices for COVID19 antibody testing for any indication. The use of these devices is **considered experimental, investigational or unproven** and **NOT COVERED.**

There is insufficient published peer reviewed medical literature to support the use of rapid ~~antigen-detecting rapid diagnostic tests for~~ COVID19 antibody testing for any indication. The use of ~~antigen-detecting~~ rapid antibody ~~diagnostic~~ tests is considered **experimental, investigational or unproven** and **NOT COVERED.**

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.

MP005 Medical Policy Process
MP100 Electrical Bioimpedance
MP125 Cranial Remodeling Orthotic
MP137 Vibroacoustic Therapy
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
MP309 Computerized Dynamic Posturography