“What’s New” Medical Policy Updates August 2024

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, 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.

MP005 Medical Policy Process – Revised – Process Revision

2. The Director reviews the requests for medical policy development with a Health Plan Medical Director on an ad hoc basis 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 Health Plan Technology Assessment Committee (TAC) for determination for appropriateness of TAC evaluation. Recommendation of approval or disapproval of a procedure, device or therapy by the Geisinger Health Plan 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 through #6).

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 is gathered from contracted technology assessment vendors and system subject matter experts ~~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 monthly via TEAMS virtual meeting. 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 Benefit Review Team.
f. Policies showing the proposed changes that are approved by MMC are forwarded to the Plan’s current vendor for UM platform and condition management along with applicable CPT/HCPCS coding.

g. Review and 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.
h. Review and final approval of finalized medical policies is also completed by the Medicare Advantage UM Committee on a periodic basis to assure compliance with CMS coverage position for the Medicare Advantage business segment.

MP048 Surgical and Minimally Invasive Therapies for the Treatment of BPH – Revised – Add Exclusions

EXCLUSIONS:
The Plan does **NOT** provide coverage for *transurethral balloon dilation or Drug-coated balloon catheter systems (e.g., Optilume®)* of the prostatic urethra 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 **52284**

The Plan does **NOT** provide coverage for *Transurethral ethanol ablation of the prostate (TEAP)* used in the treatment of prostatic hypertrophy 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 High-intensity focused ultrasound (HIFU) ablation used in the treatment of prostatic hypertrophy 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 Prostatic arterial embolization (PAE) for the treatment of BPH hypertrophy 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 Transperineal laser ablation (TPLA) for the treatment of BPH hypertrophy because it is considered 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. **0655T, 0714T, 0867T**

The Plan does **NOT** provide coverage for temporarily implanted nitinol devices (e.g., iTind) as a minimally invasive alternative to transurethral resection of the prostate (TURP) to treat symptomatic benign prostatic hyperplasia because it is considered 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. **C9769**

MP100 Electrical Bioimpedance – Revised – Add NCD

DEFINITION:
Thoracic Electrical Bioimpedance (TEB) is a non-invasive method of measuring cardiac output based on detection of changes in impedance caused by the electrical conductivity of blood that occurs as blood is pumped into the aorta. The procedure is intended as an alternative to invasive cardiac output measurement techniques.

MEDICARE/MEDICAID BUSINESS SEGMENTS (NCD 20.16)

MP304 Genetic Testing for Inherited Cardiomyopathies and Channelopathies – Revised – Add Exclusion

EXCLUSIONS:
Per MolDx A54685, Arrhythmogenic Right Ventricular Dysplasia/Cardiomyopathy (ARVD/C) genetic testing (CPT Code 81439) may be performed in panels of 5-7 of these genes and disease-causing mutation is expected to be identified in 42-55% of cases. Testing would be performed to confirm an established diagnosis or on individuals already diagnosed with ARVD/C to identify family members at risk. Therefore, MolDX has determined that testing for ARVD/C is a statutorily excluded test for the Medicare/Medicaid population.

MP325 Genetic Testing for Familial Hypercholesterolemia – Revised – Revise Criteria

DESCRIPTION:
Familial hypercholesterolemia is an inherited genetic condition that results in a >20-fold increase in risk for premature or "early-onset" atherosclerotic cardiovascular disease events (ASCVD) due to lifelong exposure to elevated low-density lipoprotein cholesterol (LDL-C). The condition encompasses a spectrum of clinical phenotypes with a broad range of pathogenic variants.

A 2024 review of >21K individuals, across six prospective cohorts, identified a causative FH variant was found in individuals across all ages in the following LDL-C categories: 2.2% positive rate with >190mg/dL, 0.6% positive rate in 160-189mg/dL, 0.2% positive rate in 130-159mg/dL, and 0.1% <130mg/dL.

Disease-specific panels may change from ~~form~~ year to year based on available evidence and technological advancements. Germline multigene panel testing (MGPT) for moderate and high-penetrance familial hypercholesterolemia susceptibility genes should include LDLR, APOB, and PCSK9. Test methodology should include sequencing and full deletion and duplication analysis (i.e., detection of large genomic rearrangements) with a benefit of once per lifetime, dependent upon advances in testing technology.

INDICATIONS:
Genetic Testing for Familial Hypercholesterolemia or inherited dyslipidemias will be considered medically necessary in a member when any of the following criteria are met:

1. The member meets diagnostic criteria per MedPed, Simon Broome, or Dutch Lipid Clinic tools (below)

OR

2. Elevated LDL-C level, defined as:
   - **1** An LDL-C level of >160mg/dL in a member at any age ~~<18y,~~ without an apparent secondary cause, **OR**
   - 2 ~~A pre-treatment LDL-C level of >190mg/dL without an apparent secondary cause, in a member >18y,~~ **OR** A post-treatment LDL-C level of >130mg/dl with no pre-treatment LDL-C available at any age, **OR**
   - 3 Failure to achieve LDL-C goal with at least one line of acceptable therapy
   - 4 An LDL-C level of >130mg/dL at any age, with ≥1 close relative(s) with known or suspected FH.

MP343 Percutaneous Electrical Nerve Field Stimulation (PENFS) – Revised – Add Prior Authorization for Commerical Lines of Business

Commercial Business Segment: Requires Prior Authorization by a Plan Medical Director or designee

Percutaneous electrical nerve field stimulation (PENFS) with an FDA approved device (e.g., IB-STIM®) is considered to be medically necessary in children and adolescents when **ALL** of the following are met:

- Member is age 11-18; and
- Diagnosed with a ROME IV criteria* defined-functional gastrointestinal disorder (functional abdominal pain, functional abdominal pain syndrome, irritable bowel syndrome, functional dyspepsia, or abdominal migraine) with symptoms present for at least 9 months; and
- No evidence of organic gastrointestinal disease (e.g., neoplasm, infection, etc.); and
- Failure or intolerance to treatment with diet modification and probiotics; and
- Failure or intolerance to at least 3 months of treatment with acid suppressors, antispasmodics, and neuromodulators
- The device is prescribed by a pediatric gastroenterologist; and
- The device will be used up to 120 hours per week, up to 3 consecutive weeks, not to exceed 4 weeks

* Rome Foundation. Rome IV Diagnostic Criteria for FGIDs (2019). https://theromefoundation.org/wp-content/uploads/Rome-Foundation-Diagnostic-Criteria-Booklet-2019.pdf.

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.

MP001 Neuromuscular Electrical Stim
MP063 Acupuncture
MP071 Continuous Subcutaneous Glucose Monitor
MP125 Cranial Remodeling Orthotic
MP137 Vibroacoustic Therapy
MP227 Spaced Retrieval Training
MP240 Dermal Injections for Treatment of Facial LDS
MP241 Non-invasive Measurement of Advanced Glycation Endproducts
MP266 Magnetoencephalography and Magnetic Source Imaging
MP279 Gene Expression Testing to Predict Coronary Artery Disease
MP309 Computerized Dynamic Posturography
MP313 Environmental Lead Testing
MP346 Intraoperative Neurophysiologic Monitoring
MP376 Gene Testing to Predict Opioid Use Disorder Risk