“What’s New” Medical Policy Updates December 2019

Listed below are the recent changes made to policies within the Geisinger Health Plan Medical Policy Portfolio during the month of November that will become effective January 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.

MP051 Vagus Nerve Stimulation – (Revised) – Added Medicare CED for Depression

For DEPRESSION
FOR MEDICARE BUSINESS SEGMENT:

On February 15, 2019 CMS issued an NCD that covers FDA approved vagus nerve stimulation (VNS) devices for treatment resistant depression (TRD) through Coverage with Evidence Development (CED) when offered in a CMS approved, double-blind, randomized, placebo-controlled trial with a follow-up duration of at least one year with the possibility of extending the study to a prospective longitudinal study when the CMS approved, double-blind, randomized placebo-controlled trial has completed enrollment, and there are positive interim findings.

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.

EXCLUSIONS:
At this time, published, peer-reviewed, medical literature to support the long-term efficacy of this treatment for Refractory Depression is limited. With the exception of Medicare CED program coverage, the Plan currently considers the use of vagus nerve stimulation in the treatment of recurrent or chronic major depression refractory to multiple maximized antidepressant therapeutic antidepressant treatment modalities to be experimental, investigational or unproven and NOT COVERED.

MP260 Canaloplasty and Viscocanalostomy – (Revised) – Refined Exclusion Language

EXCLUSIONS:
The Plan does NOT provide coverage for canaloplasty for any other indication because it is considered experimental, investigational or unproven.

The Plan does NOT provide coverage for viscocanalostomy or combined phacoemulsification and viscocanalostomy for any indication because it is considered experimental, investigational or unproven. The Geisinger Technology Assessment Committee determined there is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of these treatments on health outcomes when compared to established treatments or technologies.

MP261 Aqueous Drainage Shunt – (Revised) – Added Approved Devices

DESCRIPTION: Aqueous drainage shunts are implantable devices that are intended to reduce intraocular pressure (IOP) in the anterior chamber of the eye in individuals with neovascular glaucoma or with glaucoma that has not responded to medical and conventional surgical treatments. Tube-shunt surgery is also frequently used to treat glaucoma when a person has:
There are several devices that have been approved by the US Food and Drug Administration to facilitate the inflow/outflow balance of aqueous humor in the eye. Examples of devices that are FDA-approved for insertion by an external approach are Ex-PRESS™ Mini Glaucoma Shunt, iSTENT Trabecular Micro-Bypass, Baerveldt glaucoma drainage devices, Krupin eye valves, Molteno implants, Schocket shunt, and Ahmed Glaucoma Valve and AquaFlow collagen shunt. The basic design of these devices is similar -- a silicone tube shunts aqueous humor from the anterior chamber to a fibrous capsule surrounding a synthetic plate or band positioned at the equatorial region of the globe. The capsule serves as a reservoir for aqueous drainage.

Minimally invasive glaucoma surgery (MIGS) devices, or micro-stents, such as iStent, iStent inject, Hydras are FDA-approved for use in the treatment of mild to moderate open-angle glaucoma in conjunction with cataract surgery where optimal intraocular pressure has not been achieved with medication. XEN micro stent is FDA-approved for use in the treatment of mild to moderate open-angle glaucoma either with or without cataract surgery when optimal intraocular pressure has not been achieved with medication.

MP301 Sacroiliac Joint Fusion – (Revised) – Refined Criteria

INDICATIONS: REQUIRES PRIOR MEDICAL DIRECTOR or DESIGNEE AUTHORIZATION (For lines of business in which coverage is not explicitly excluded).

Sacroiliac joint fusion is considered to be medically necessary for any of the following indications:
1. As an adjunct to sacrectomy or partial sacrectomy related to tumors involving the sacrum; OR
2. As an adjunct to the medical treatment of sacroiliac joint infection/sepsis; OR
3. Severe traumatic injuries associated with pelvic ring fracture; OR
4. During multi-segment spinal deformity correction spinal constructs (for example, correction of deformity in scoliosis or kyphosis surgery) extending to the ilium.

Minimally invasive fusion of the SI joint is considered to be medically necessary for the treatment of SI joint syndrome and SI joint mediated mechanical low back pain when all of the following criteria as recommended by the International Society for the Advancement of Spine Surgery (ISASS) are met:

- Significant SIJ pain (e.g., pain rating at least 5 on the 0-10 numeric rating scale where 0 represents no pain and 10 represents worst imaginable pain) or significant limitations in activities of daily living; and
- SIJ pain confirmed with at least 3 physical examination maneuvers that stress the SI joint (e.g., distraction test, compression test, thigh thrust, FABER (Patrick’s) test, Gaenslen’s maneuver, sacral sulcus tenderness) and cause the patient’s typical pain; and
- Confirmation of the SIJ as a pain generator with a 75% or greater acute decrease in pain upon fluoroscopically guided diagnostic intra-articular SI joint block using local anesthetic; and
- Failure to respond to at least 6 months of non-surgical treatment consisting of non-steroidal anti-inflammatory drugs and/or opioids (if not contraindicated) and one or more of the following: rest, physical therapy, SI joint steroid injection. Failure to respond means continued pain that interferes with activities of daily living and/or results in functional disability; and
- Additional or alternative diagnoses that could be responsible for the patient’s ongoing pain or disability have been ruled out (e.g., L5/S1 compression, hip osteoarthritis).

The procedure is performed by a physician trained in either neurosurgery or orthopedic spine surgery; and
• The provider performing the surgery has either completed procedure-specific training or has been granted hospital privileges to perform minimally invasive sacroiliac joint surgery.

MP331 Inpatient Rehabilitation – (NEW)

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

To be considered for admission to an inpatient rehabilitation facility, **ALL MUST BE MET:**

- The member has had a recent acute event resulting in a significant function decline requiring an interdisciplinary team approach that includes:
  - Weekly rehabilitation team assessment, intervention, and conferences due to the potential risk of significant change in physical or medical status; and
  - 24-hour per day access to a rehabilitative registered nurse; and
  - Supervision or active intervention by a rehabilitation physician at least 3 times per week; and
  - The planned rehabilitation services require an intensity, frequency and duration as to make it impractical for the services to be delivered in a less intense setting
- The member must be clinically stable enough to follow commands, and be able to tolerate and willing to participate in an intensive therapy program for a minimum of 3 hours/day, 5 days/week
- The member must require at least 2 therapy disciplines (PT, OT, ST, orthotics/prosthetics), one of which must be PT or OT
- The rehabilitative program is individualized and defines quantifiable outcome goals; and
- There is a reasonable expectation of significant therapeutic improvement as a result of the rehabilitative program over a clearly defined timeframe, and reasonable expectation of discharge to home or other community setting

EXCLUSIONS:
Inpatient rehabilitation will be considered to be not medically necessary and therefore **NOT COVERED** when any of the following apply:

- The medical record documentation does not support the need for intensive inpatient rehabilitation
- The member’s condition is such that the medically necessary services could be adequately provided in a less intensive setting
- A program of coordinated interdisciplinary care is either not required or not provided
- A significant meaningful therapeutic improvement is not expected
- The treatment is intended to maintain the current physical state, or to prevent or slow progressive deterioration of the current state.

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.

MP015 Experimental/Investigational
MP021 Dorsal Column Stimulation
MP056 Management of Excessive Skin and Subcutaneous Tissue
MP060 Lung Volume Reduction
MP157 Prothrombin Time Home Testing
MP162 Salivary Hormone Testing for Menopause and Aging
MP164 Laser Treatment for Acne
MP177 Sensory Integration Therapy
MP194 Rhinophototherapy
MP219 Percutaneous Neuromodulation Therapy
MP270 Ocular Photoscreening
MP300 Digital Breast Tomosynthesis
MP308 Wireless Pulmonary Artery Pressure Monitoring