

“What’s New” Medical Policy Updates December 2021

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, 2021** (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 and Trigeminal Nerve Stimulation – (Revised) – Revised Title; Added Description; Added Exclusions

Vagus **and Trigeminal** Nerve Stimulation

DESCRIPTION:

The vagus nerve (10th cranial nerve) is a mixed nerve carrying both somatic and visceral afferent and efferent signals. The basic premise of vagus nerve stimulation in the treatment of epilepsy is that the vagal visceral afferents have a diffuse central nervous system projection, and activation of these pathways has a widespread effect upon neuronal excitability and synchronization. Besides activation of well-defined reflexes, vagal stimulation produces evoked potentials recorded from the cerebral cortex, hippocampus, thalamus, and the cerebellum. Stimulation of the vagus nerve has been shown to decrease seizure frequency and severity.

Vagus nerve stimulation has also been recently purported to provide some degree of long-term adjunctive benefit in the treatment of chronic or recurrent depression refractory to multiple therapeutic antidepressant treatment modalities.

The vagus nerve stimulation system is comprised of an implantable pulse generator and lead, and an external programming system used to change stimulation settings.

The trigeminal nerve (5th cranial nerve) is responsible for sensation in the face and motor functions such as biting and chewing. It is the largest, and most complex of the cranial nerves. Electrical stimulation of the nerve branch has been used to treat trigeminal neuropathic pain, trigeminal neuralgia, supraorbital neuralgia, postherpetic neuralgia, and other facial pain syndromes. Investigators have also studied the potential of trigeminal nerve stimulation to reduce symptoms of treatment-resistant epilepsy, depression, post-traumatic stress disorder and attention-deficit hyperactivity disorder.

For DEPRESSION:

FOR COMMERCIAL AND MEDICAID BUSINESS SEGMENT:

Consideration for coverage will default to the Behavioral Health department policies and/or applicable behavioral health vendor’s policies.

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**.

The Plan considers the use of Vagus Nerve Stimulation for the treatment of all other conditions, including but not limited to treatment of obesity, heart failure, seizure types other than partial onset, etc. to be **experimental, investigational or unproven** and **NOT COVERED**.

The Plan considers the use of vagus nerve electrical stimulators that utilize the detection and stimulation of heart rate including but not limited to the AspireSR and SenTiva Model 1000 for the treatment of epilepsy to be **experimental, investigational or unproven** and **NOT COVERED**.

The Plan considers the use of vagus nerve electrical stimulators and transcutaneous vagus nerve stimulation (e.g., gammaCore-S®) for the prevention of chronic migraine and/or cluster headache to be **experimental, investigational or unproven** and **NOT COVERED**

The Plan considers the use of external or transcutaneous (non-implantable) trigeminal nerve stimulation devices (e.g., Monarch® eTNS System, Cefaly®) for the treatment of epilepsy and headache to be **experimental, investigational or unproven** and **NOT COVERED**.

The Plan considers the use of distal transcutaneous electrical peripheral nerve stimulation (e.g., Nerivo), for the treatment of episodic and chronic migraine headache to be **experimental, investigational or unproven** and **NOT COVERED**.

MP164 Light-based Therapies for Acne – (Revised) – Revised Title; Added Exclusion

~~Laser Treatment of~~ Light-based Therapies for Acne

EXCLUSIONS:

The Plan does **NOT** provide coverage for pulsed dye laser as a treatment for Acne Vulgaris 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 photodynamic therapy for the treatment of Acne Vulgaris 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 home-based devices including those that deliver the following: light or pulsed light therapy; ultraviolet (UV) therapy; laser therapy; heat (radiant or pulsed) therapy; suction; or any combination of the aforementioned for the treatment of acne because they are 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.

MP168 Non-invasive Testing for Organ transplant Rejection – (Revised) – Added Coverage

Renal Transplant Testing

AlloSure Kidney Transplant

For **COMMERCIAL and MEDICARE BUSINESS SEGMENTS**:

AlloSure Kidney [donor-derived cell-free DNA (dd-cfDNA)] is covered to assess the probability of allograft rejection in kidney transplant recipients with clinical suspicion of rejection and to inform clinical decision-

making about the necessity of renal biopsy in such patients at least 2 weeks post-transplant in conjunction with standard clinical assessment.

Prospera Renal Transplant Testing

For MEDICARE BUSINESS SEGMENTS:

The Prospera assay is covered only when the following clinical conditions are met:

- First time renal allograft recipients; and
- Physician-assessed pretest need to further evaluate the member for the probability of active renal allograft rejection

TruGraf Blood Gene Expression Test

For MEDICARE BUSINESS SEGMENTS:

The TruGraf Blood Gene Expression Test is covered only when the following clinical conditions are met:

- The member is at least 18 years of age.
- Recipient of a primary or subsequent deceased-donor or living-donor kidney transplantation.
- Stable serum creatinine (current serum creatinine <2.3 mg/dl, <20% increase compared to the average of the previous 3 serum creatinine levels).
- Kidney transplant patients who are more than 90 days post-transplant.
- The member is being managed in a facility that utilizes surveillance biopsies

MP204 Nasal and Sinus Surgery – (Revised) – Added Exclusion

EXCLUSIONS:

Septoplasty/Rhinoplasty:

Rhinoplasty is considered a cosmetic procedure when performed to alter the external appearance of the nose in the absence of trauma or disease. Cosmetic procedures are **NOT COVERED** per the **Exclusions** section of the applicable benefit documents.

Septoplasty performed as part of a cosmetic procedure, or performed solely to improve appearance, or in the absence of the specified medical conditions as listed under INDICATIONS is considered a cosmetic procedure. Cosmetic procedures are **NOT COVERED** per the **Exclusions** section of the applicable benefit documents.

Computer augmented endoscopic sinus surgery:

Computer augmented endoscopic sinus surgery is **not covered** for indications not listed in this policy or if it is determined to be not medically necessary.

Balloon Sinuplasty:

The Plan does **NOT** provide coverage for the use of balloon sinuplasty as a treatment for nasal polyposis, sinusitis with fungal disease, or if the sinus being treated has failed previous balloon dilation use of balloon sinuplasty for these conditions is considered **experimental, investigational or unproven.**

The Geisinger Technology Assessment Committee evaluated this technology and concluded that there is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this technology on health outcomes when compared to established tests or technologies.

Cryoablation for Treatment of Rhinitis

The Plan does **NOT** provide coverage for the use of cryoablation as a treatment for allergic and non-allergic rhinitis as it is considered to be unproven. There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this technology on health outcomes when compared to established tests or technologies.

Latera Absorbable Nasal Implant (Exclusion not applicable to Medicaid)

The Plan does **NOT** provide coverage of the Latera absorbable nasal implant for the treatment of nasal valve obstruction or nasal wall collapse as it is considered to be **unproven**. There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this technology on health outcomes when compared to established tests or technologies.

MP260 Canaloplasty and Viscocanalostomy – (Revised) – Added Exclusion

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.

The Plan does **NOT** provide coverage for canaloplasty and trabeculotomy ab interno with the OMNI System combined with cataract surgery **experimental, investigational or unproven** for the treatment of POAG 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.

MP296 Occipital Nerve Block – (Revised) – Revised Limitations

LIMITATIONS:

If the medical necessity for occipital nerve block is met, **no more than two (2) injections may be performed at a single setting. up to three (3) injections per intercostal nerve level may be approved initially. No more than 3 procedures will be approved in a 12-week period of time per region, with at least 14 days between injections in the initial therapeutic phase.** If there is greater than 50% reduction in symptoms or physical and **functional improvement for at least 2 months, functional status with the initial blocks,** the provider may request **an additional series of repeat injections performed at intervals of at least 2 months, and limited to a maximum total of 4 therapeutic procedures per region per 12 months. up to three blocks per intercostal nerve level not to exceed six (6) per calendar year.**

If special circumstances are documented, then repeat injections are limited to a maximum of 6 procedures in 12 months.

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

MP038 Oral Health

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

MP177 Sensory Integration Therapy

MP194 Rhinophototherapy

MP219 Percutaneous Neuromodulation Therapy

MP261 Aqueous Drainage Shunt

MP270 Ocular Photoscreening

MP297 Suprascapular Nerve Block

MP300 Digital Breast Tomosynthesis

MP321 Gene Expression Profiling for Cutaneous Melanoma

MP331 Inpatient Rehabilitation

MP332 Skilled Nursing Facility

MP341 TissueCypher Barrett's Esophagus Assay