"What's New" Medical Policy Updates June 2022

Listed below are the recent changes made to policies within the Geisinger Health Plan Medical Policy Portfolio during the month of May that will become **effective July 15, 2022** (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.

MP040 Somnoplasty/Coblation – (Revised) – Add Exclusions

EXCLUSIONS:
Somnoplasty/coblation for the treatment of socially disruptive snoring is considered **not medically necessary** and is **NOT COVERED.**

Somnoplasty / coblation for the treatment of obstructive sleep apnea is considered **experimental, investigational or Unproven** and is **NOT COVERED.** There is inconclusive evidence in the published, peer-reviewed medical literature that the service has a beneficial effect on health outcomes.

Somnoplasty /coblation of the inferior turbinates for treatment of chronic nasal obstruction is considered **experimental, investigational or unproven** and is **NOT COVERED.** There is insufficient evidence in the peer-reviewed published medical literature directly comparing somnoplasty to the established alternatives of electrocautery or submucosal surgical resection of the turbinates. In addition, there are no published clinical studies reporting on the long-term outcomes of individuals with mucosal hypertrophy that have been treated with radiofrequency volumetric tissue reduction.

Coblation tenotomy for the treatment of musculoskeletal conditions is considered **experimental, investigational or unproven** and is **NOT COVERED**. There is insufficient evidence in the peer-reviewed published medical literature directly comparing coblation tenotomy to the established alternatives.

Coblation adenoidectomy is considered **experimental, investigational or unproven** and is **NOT COVERED**. There is insufficient evidence in the peer-reviewed published medical literature directly comparing coblation to the established alternatives

Videolaryngoscope-assisted Coblation for the treatment of epiglottic cysts is **considered experimental, investigational or unproven** and is **NOT COVERED**. There is insufficient evidence in the peer-reviewed published medical literature directly comparing coblation to the established alternatives

Coblation for the treatment of laryngopharyngeal vascular lesions is considered **experimental, investigational or unproven** and is **NOT COVERED**. There is insufficient evidence in the peer-reviewed published medical literature directly comparing coblation to the established alternatives

Coblation for the treatment of glottis cancer or laryngeal cancer is considered **experimental, investigational or unproven** and is **NOT COVERED**. There is insufficient evidence in the peer-reviewed published medical literature directly comparing coblation to the established alternatives

MP049 Visual Field Testing – (Revised) – Add Exclusion

EXCLUSIONS:
Visual Field testing is not considered medically necessary and is **NOT COVERED** for any of the following:

- Pretreatment for a previous diagnosis of retinal detachment
- Previous diagnosis of cataracts unless other presenting symptomology is documented

- As a screening test prior to cataract extraction in the absence of glaucoma or other presenting symptomatology
- Repeated testing for macular degeneration or central vision loss unless visual changes have occurred

Screening visual fields in the absence of associated signs, symptoms or complaints are not considered medically necessary and are **NOT COVERED.**

The use of electronic home visual field monitoring is considered **experimental, investigational or unproven** and **NOT COVERED** for all indications. There is insufficient evidence in the peer-reviewed published medical literature directly comparing home visual field monitoring devices to the established in-office alternatives.

MP259 Phototherapy for the Treatment of Dermatological Conditions – (Revised) – Remove Prior Authorization

Home Light Therapy Units: ~~**Requires Prior Authorization by a Plan Medical Director or Designee**~~

MP280 Whole Exome and Whole Genome Sequencing – (Revised) – Clarify Medicaid Program Exception Requirement

MEDICAID Business Segment:

Requests for WES requires a Program Exception for the Medicaid Business segment.
Any requests for services, that do not meet criteria set in the PARP, will be evaluated on a case by case basis.

MP289 Dry Eye Syndrome – (Revised) – Add Exclusions

EXCLUSIONS:
The Plan considers the use of a laser to occlude the tear duct opening, tear film imaging (e.g., the Tear Stability Analysis System), tear film biomarkers (e.g., goblet cell-specific MUC5AC and interleukin-8), acupuncture, mechanical eyelid cleaning devices, intense pulsed light therapy, and eyelid thermal pulsation (e.g., MiBo Thermoflo; iLux, Systane iLux2, LipiFlow® Thermal Pulsation System) for the treatment of dry eyes unproven and therefore **NOT COVERED.**

MP354 Breast Pump – (NEW)

CRITERIA FOR COVERAGE:
Breast pumps are considered to be medically necessary during the 3rd trimester or postpartum period for breastfeeding when any of the following criteria are met:

- Normal pregnancy and/or delivery of a healthy baby; or
- The mother is unable to nurse or unable to provide breast milk adequately for her infant(s); or
- The infant has a medical condition or congenital disorder that interferes with feeding; or
- Expression of milk after delivering a stillborn infant; or
- While the mother takes medications that can be found in breast milk and would pose a risk to her infant(s).

A new set of breast pump supplies (i.e., initial tubing, shields, and bottles) are necessary with each subsequent pregnancy

A replacement manual or standard electrical breast pump is considered medically necessary for each subsequent pregnancy, for initiation or continuation of breastfeeding during pregnancy or following delivery.

LIMITATIONS:
Coverage for breast pump will be limited to the standard manual or personal-use, double-electric breast pump.

A member may request a heavy duty electrical (hospital grade) or deluxe pump, but the member will be responsible for any cost over and above that of the standard breast pump.

EXCLUSIONS:
The following items are considered to be disposable or are otherwise non-covered:

- Pump cleaning supplies including but not limited to antibacterial soap, sprays, wipes, or steam cleaning bags
- Nursing bras, bra pads, breast shells, and other products or garments to allow hands-free pump operation

MP356 Genetic Testing for Mitochondrial Disorders – (NEW)

DESCRIPTION: Genetic Testing for Mitochondrial Disorders

CRITERIA FOR COVERAGE: REQUIRES PRIORAUTHORIZATION BY A PLAN MEDICAL DIRECTOR OR DESIGNEE

Genetic testing (whole mtDNA sequencing and deletion/duplication analysis) for mitochondrial disorders (e.g, Alpers' syndrome; Leigh syndrome; Leber's hereditary optic neuropathy (LHON); mitochondrial encephalopathy, lactic acidosis and stroke-like episodes (MELAS); Myoclonic Epilepsy and Ragged-Red Fibers (MERRF); Chronic Progressive External Ophthalmoplegia (CPEO); Kearns-Sayre syndrome) will be considered medically necessary when the following criteria are met:

- Genetic counseling by an appropriate provider has been completed; and
- Appropriate biochemical testing for the suspected disorder is not confirmatory of a diagnosis of a specific mitochondrial condition; and
- Member's clinical presentation does not fit a well-described syndrome for which single-gene or targeted panel testing is available; and
- Member has altered function in two or more organ systems, and
- Member has one or more of the following clinical features: ataxia, encephalopathy, seizures, developmental regression, lactic acidosis, and stroke-like episodes (MELAS), pigmentary retinopathy (NARP), mitochondrial myopathy, diabetes mellitus, sensorineural hearing loss, optic neuropathy, optic atrophy, ophthalmoplegia, ptosis, cardiomyopathy, heart block
  and
- Family history strongly suggests mitochondrial inheritance (e.g. paternal transmission has been ruled out); and
- Whole mtDNA sequencing has not been previously performed

EXCLUSIONS:
Requests for mitochondrial DNA sequencing and deletion/duplication analysis not meeting the criteria outlined above will be considered **unproven** and therefore **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.

MP054 Prophylactic Mastectomy
MP057 Prophylactic Oophorectomy
MP093 Uroleume
MP101 Gliasite Radiation Therapy
MP129 Total Parenteral Nutrition
MP131 VitalStim NMES
MP135 Osseointegrated Hearing Device
MP146 Sympathetic Therapy
MP150 Carotid Artery Stent
MP154 Transanal Radiofrequency Therapy for Fecal Incontinence (Secca)
MP193 Microvolt T-wave Alternans
MP199 Corneal Pachymetry
MP213 Computerized Corneal Topography
MP228 HPV DNA Testing
MP229 Prolozone Therapy
MP232 Autism Spectrum Disorder Evaluation and Medical Management
MP290 Fecal Microbiota Transplantation
MP342 Non-Wearable AED