“What’s New” Medical Policy Updates March 2020

Listed below are the recent changes made to policies within the Geisinger Health Plan Medical Policy Portfolio during the months of February that will become effective April 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.

MP021 Dorsal Column Stimulation – (Revised) – Removed Coverage for DME Statement

**INDICATIONS:** REQUIRES PRIOR PLAN AUTHORIZATION. The authorization must be requested and approved prior to the implantation of the electrodes for the trial period.

Coverage for Durable Medical Equipment is subject to the terms and conditions of the applicable benefit document. Equipment must be obtained through contracted Durable Medical Equipment vendor(s).

MP184 Intracranial Percutaneous Transluminal Angioplasty – (Revised) – Revised Layout

MP236 Immune Cell Function Assay for Transplant Rejection – (Revised) – Add Test Reference Names

86352 Cellular function assay involving stimulation (eg, mitogen or antigen) and detection of biomarker (eg, ATP) note: this code is not covered when used to identify Immuknow™ PleximmuneTM, myTAIHEART or CU Index® testing.

PleximmuneTM, CU Index®

Associated Key Words: Immune Cell Function Assay, Immuknow™, Pleximmune™, myTAIHEART, CU Index®

MP249 Bioimpedance Spectroscopy – (Revised) – Added Technology Examples

**EXCLUSIONS:**
The Plan does NOT provide coverage for the use of bioimpedance spectroscopy (e.g., ImpediMed L-Dex U400; MoistureMeterD, etc.) for the assessment of lymphedema 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 test on health outcomes when compared to established tests or technologies.

MP255 Comparative Genomic Hybridization for Evaluation of Developmental Delay – (Revised) – Title Change; Added Prenatal Criteria

**INDICATIONS:** *Requires Prior Authorization by a Plan Medical Director or designee

Array-based comparative genomic hybridization or chromosomal microarray testing may be considered medically necessary when ordered by a Medical Geneticist*, Certified Genetic Counselor*, Pediatric Neurologist or Developmental Pediatrician for:
Evaluation of chromosomal imbalances in children when all of the following criteria are met:

1. One of the following conditions apply:
   a. Child exhibits symptoms suspected of autism spectrum disorder; or
   b. Child exhibits symptoms of a non-syndromic developmental delay, intellectual disability or loss of developmental milestones; or
   c. Child exhibits congenital malformation(s), anomalies or dysmorphic features that are not specific to a well delineated genetic syndrome

   And

2. Fragile X (FMR1) gene analysis (unless clinically contraindicated) is negative; and
3. The genetic testing results have a reasonable potential to be useful in the clinical management or preventive surveillance strategies of the child; and
4. The parents or legal guardians have participated in in-person genetic counseling with a licensed or certified genetic counselor; Medical Geneticist, Certified Genetic Counselor, Pediatric Neurologist or Developmental Pediatrician who are involved in the child’s care.

**Chromosomal microarray testing** is considered medically necessary for prenatal use when any one of the following criteria is met:

- Diagnostic testing for fetal abnormalities in women undergoing invasive prenatal testing (i.e. amniocentesis, chorionic villus sampling or fetal tissue sampling); or
- Non-invasive prenatal screening results require confirmation; or
- Abnormal fetal ultrasound findings characteristic of a genetic abnormality; or
- Intrauterine fetal demise or third trimester stillbirth; or
- Diagnostic testing for fetal abnormalities when the in vitro embryo is at increased risk of an inherited disorder because one of the following is documented:
   - The parents are carriers of an autosomal recessive disease; or
   - One parent is a carrier of an autosomal dominant, sex-linked, or mitochondrial disorder

**MP264 Ventricular Assist Device (VAD) – (Revised) – Added Indications**

**INDICATIONS:**

Ventricular assist devices that are FDA approved as medically necessary for the following indications when implanted postcardiotomy in an approved facility*:

- acute cardiogenic shock
- acute myocarditis
- individuals who are unable to be weaned from cardiopulmonary bypass following cardiac surgery
- Bridge- to- transplant when the risk of death is imminent from left ventricular heart failure
- Destination therapy when heart transplantation is not an option and when all any of the following criteria are met:
  - New York Heart Association (NYHA)* class IV end-stage left ventricular heart failure for at least 90 days and life expectancy of less than 2 years; or and
  - Class IV heart failure symptoms have failed to respond to optimal medical management (dietary salt restrictions, diuretics, digitalis, beta-blockers, and ACE inhibitors); or
    - HeartMate XVE-LVAS patient has failed the optimal medical therapy for at least 60 of the last 90 days; or
    - HeartMate II patient has failed the optimal medical therapy for 45 of the last 60 day or dependence on an intra-aortic balloon pump for 7 days; and
    - have been balloon pump-dependent for 7 days, or
    - have been IV inotrope-dependent for 14 days; or
  - and,
Left ventricular ejection fraction (LVEF) is less than 25%; and

- Demonstrated functional limitations with a peak oxygen consumption of <14ml/kg/min; or
- The patient has a continued need for intravenous inotropic therapy owing to symptomatic hypotension, decreasing renal function, or worsening pulmonary congestion

MP299 Measurement of Serum Antibodies to Infliximab, Adalimumab and Vedolizumab – (Revised) – Clarified Description and Exclusion

DESCRIPTION: The measurement of serum concentrations and antibodies have 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 such as the Anser™IFX test for infliximab, Anser™ VDZ for vedolizumab, 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), or vedolizumab (Entyvio) either alone or as a combination test which includes the measurement of medication serum levels, 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.

MP316 High Intensity Focused Ultrasound – (Revised) – Added Indication

INDICATIONS: MRI-guided focused ultrasound (MRgFUS) is considered medically necessary if the following are met:

Diagnosis of metastatic bone cancer if ALL the following are met:
- Treatment is for palliation of cancer pain
- Member is eighteen years or older

Diagnosis of medication refractory essential tremor

(Medication refractory essential tremor is defined for the purposes of this policy as being refractory to a minimum of two trials of medical therapy to include the following unless contraindicated: beta blockers, anticonvulsants and/or benzodiazepines)

MP324 Genetic Testing for Non-Cancer Heritable Disease Carrier Status – (Revised) – Added Prior Authorization for Whole Genome Sequencing (WGS)

Whole Genome Sequencing (WGS) - REQUIRES PRIOR AUTHORIZATION BY A PLAN MEDICAL DIRECTOR OR DESIGNEE

Whole Genome Sequencing (WGS) is generally considered to be unproven for the purposes of screening and evaluating genetic disorders. There is currently insufficient evidence to support the efficacy is using WGS for routine evaluations.
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.

MP147 Artificial Intervertebral Disc
MP171 Clinical Guideline Development, Implementation, and Review Process
MP192 Intensity Modulated Radiation Therapy
MP207 Corneal Hysteresis
MP211 Endovascular Repair of Intracranial Aneurysms
MP220 Epiretinal Radiation Therapy
MP222 Intradiscal Biacuplasty
MP223 Functional Anesthetic Discography
MP226 Proton Beam Radiation
MP231 Facet or Sacroiliac Joint Denervation
MP235 Total Facet Arthroplasty
MP237 Transurethral Radiofrequency Tissue Remodeling
MP238 Ocular Blood Flow Tonometer
MP245 Helicobacter pylori Testing
MP248 SNP’s To Predict Risk of Non-Familial Breast CA
MP252 Colon Motility Testing
MP254 Tinnitus Treatment
MP275 Speech Generating Devices
MP281 Bone Morphogenetic Protein
MP282 Termination of Pregnancy
MP285 Tonsillectomy
MP286 Cholecystectomy
MP303 Molecular Markers to Predict Thyroid FNA (Fine-Needle Aspiration)