“What’s New” Medical Policy Updates May 2018

Listed below are the recent changes made to policies within the Geisinger Health Plan Medical Policy Portfolio during the month of April that will become **effective June 15, 2018** (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.

MP033 Varicose Vein Therapy – REVISED – (Added Indication; Removed Exclusion)

INDICATIONS: The following treatments must be pre-authorized by a Geisinger Health Plan Medical Director or designee

Liquid or Foam Sclerotherapy (including Varithena™), Mechanochemical Ablation (MOCA (e.g. ClariVein®) or Stab Phlebectomy, or a combination of both may be considered medically necessary for the treatment of symptomatic varicose tributaries, accessory, and perforator veins when the following criteria are met:

EXCLUSIONS:
~~The Plan does **NOT** provide coverage for Subfascial Endoscopic Perforator Surgery for the treatment of post-thrombotic syndrome or varicose veins because it is considered **experimental, investigational and unproven**. The effectiveness of this procedure for these indications has not been established in the current peer-reviewed published medical literature.~~

MP165 Treatment of Vestibular Disorders REVISED – (Added Exclusion)

EXCLUSIONS:
The Plan does **NOT** provide coverage for use of an aural low-pulse pressure generator (i.e. Meniett™ Device) as a treatment for Meniere’s disease because it is considered **experimental, investigational or unproven**. Although the device is FDA approved, 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. **See MP176 Meniett™ Device.**

MP233 Injectable Blood Products for Orthopedic Conditions – REVISED – (Modified Title; Added Exclusion)

I. Policy: Autologous Injectable Platelet and Blood Products ~~for Orthopedic Conditions~~

EXCLUSIONS: The Plan does **NOT** provide coverage for Autologous Platelet-Derived Growth Factor for any indication including but not limited to surgical wounds, chronic non-healing wounds, Epicondylitis, Plantar Fasciitis, Dupuytren’s Contracture, bone healing and fusion, tendinopathy and sinus surgery because it 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 other tests or technologies.

MP217 Polysomnography and Sleep Studies – REVISED – (Removed Exclusion)

EXCLUSIONS:
Devices /Procedures related to diagnosis sleep apnea – The Plan does **NOT** provide coverage for the following devices/procedures for the diagnosis of OSA or other sleep disorders because they are considered **experimental, investigational or unproven**. The current body of evidence in the peer-reviewed, published medical literature supporting the use of these devices/procedures for patients with sleep disorders is insufficient to allow adequate conclusions regarding their efficacy. (This list may not be all inclusive):

- SNAP™ Testing
- ~~Watch PAT™~~

MP265 Proteomic Serum Analysis – REVISED – (clarified Medicare Business Segment)

Medicare Business Segment:

In compliance with Novitas LCD L35396 (~~A52986~~) the OVA1 proteomic assay will be covered according to the FDA label. OVA1 is intended only for members, 18 years and older, who are already selected for surgery because of their pelvic mass. It is not intended for ovarian cancer screening or for a definitive diagnosis of ovarian cancer.

In compliance with Novitas LCD L35396 the Risk of Ovarian Malignancy Algorithm (ROMA™) serum test will be covered to aid in assessing whether a premenopausal or postmenopausal woman who presents with an ovarian adnexal mass is at high or low likelihood of finding malignancy at surgery. ROMA™ will be considered reasonable and necessary for women who meet the following FDA labeling criteria:

- Over age 18;
- Ovarian adnexal mass present for which surgery is planned; and,
- Not yet referred to an oncologist.

In compliance with Novitas LCD L35396 ~~(A52986)~~ the Veristrat proteomic assay will be covered to predict the benefit of single-agent chemotherapy or EGFR Tyrosine Kinase Inhibitor treatment in patients with non-small cell lung cancer with an unknown or wild-type variant of EGFR, or to identify patients with particularly aggressive disease.

MP273 Gene-based Testing and/or Protein Biomarkers for Diagnosis and Management of Prostate Cancer – REVISED – (Title change)

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.

MP037 Home Phlebotomy Program
MP039 Home Uterine Monitoring
MP044 Aquatic Therapy
MP046 Progressive Stretch Devices
MP062 TMLR
MP076 HH/DME Hyperbilirubinemia
MP081 Chelation Therapy
MP097 Genetic Testing for BRCA

MP127 Prolotherapy
MP133 Meniscal Allograft
MP198 Pulse Oximetry for Pediatric Home Use
MP212 Non-Contact low-frequency Ultrasound Management (MIST Therapy)
MP263 Minimally Invasive Lumbar Decompression (MILD)
MP293 Intrathecal Infusion Pump
MP315 Esophageal Sphincter Augmentation