“What's New” Medical Policy Updates November 2021

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

MP187 Cryoablation – (Revised) – Add Indication

INDICATIONS: The following indications have been evaluated by the Geisinger Technology Assessment Committee and are considered to be medically necessary.

IV. Cryoablation for the treatment of nerve pain is considered medically necessary.

MP214 Iontophoresis – (Revised) – Clarified Indication

INDICATIONS:
Transdermal local drug delivery utilizing iontophoresis for the treatment of musculoskeletal inflammation resulting in pain and/or edema is considered to be medically necessary only when used as part of an overall treatment protocol in any of the following conditions:

- Epicondylitis
- Patellofemoral syndrome
- Tendonitis (except Achilles tendonitis)
- Rotator cuff syndrome
- Plantar fasciitis

Iontophoresis for the treatment of Primary Focal hyperhidrosis is considered to be medically necessary when insured individual is unresponsive to topicals and pharmacologics (e.g. Topical chloride, anti-cholinergics, beta-blockers, benzodiazapines) (see MP258 Hyperhidrosis).

Iontophoresis for the administration of local anesthesia prior to a venipuncture or dermatological procedures is considered to be medically necessary for pain reduction.

MP258 Hyperhidrosis – (Revised) – Add RF Exclusions

Endoscopic transthoracic sympathectomy and/or Surgical excision of axillary sweat glands:
Endoscopic transthoracic sympathectomy and/or surgical excision of axillary sweat glands: for the treatment of severe primary hyperhidrosis may be considered medically necessary when:

1. Physician provided documentation of failure, contraindication or intolerance of a 6-month trial of non-surgical treatments with topical dermatologics (e.g., aluminum chloride, tannic acid, gluteraldehyde, anti-cholinergics), systemic anti-cholinergics, beta-blockers, benzodiazapines, anti-inflammatory drugs; AND
2. Physician provided documentation of failure, contraindication or intolerance to treatment with botulinum toxin A (Botox A) AND one of the following:
a. the member has medical complications secondary to hyperhidrosis such as, dermatitis, fungal condition, skin maceration, or secondary microbial condition; OR
b. the member is experiencing a significant impact on activities of daily living as a result of hyperhidrosis;

**Iontophoresis**

Iontophoresis for the treatment of primary focal hyperhidrosis may be considered medically necessary when the following criteria are met:

- Physician provided documentation of failure of a 6 month trial of non-surgical treatments with topical dermatologics (e.g., aluminum chloride, tannic acid, gluteraldehyde, anticholinergics), systemic anticholinergics, beta-blockers, benzodiazipines, anti-inflammatory drugs, and the member is experiencing a significant impact on activities of daily living as a result of hyperhidrosis (See MP214 Iontophoresis)

**EXCLUSIONS:**
The Plan does not cover surgical treatment of secondary hyperhidrosis. Appropriate therapy involves treatment of the underlying condition.

The Plan does **NOT** provide coverage for the use of any of the following treatments of hyperhidrosis because they are considered experimental, investigational or unproven for that indication:

- alternative therapies, including but not limited to, homeopathy, massage, acupuncture and herbal drugs (see MP136)
- axillary liposuction, including ultrasound-assisted lipoplasty, retrodermal curettage and tumescent suction curettage
- acupuncture (see MP63)
- biofeedback (see MP04)
- hypnosis
- subdermal Nd-YAG laser
- percutaneous thoracic phenol sympatholysis
- psychotherapy
- repeat/reversal of ETS
- sympathectomy for craniofacial hyperhidrosis
- sympathectomy for plantar hyperhidrosis
- microwave therapy
- Pulsed radiofrequency
- Radiofrequency ablation

**MP292 Sympathetic Nerve Block – (Revised) – Frequency Limitations**

**LIMITATIONS:**
If the medical necessity for intercostal nerve block is met, **no more than two (2) injections may be performed at a single level, 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.
MP294 Intercostal Nerve Block – (Revised) – Frequency Limitations

LIMITATIONS:
If the medical necessity for intercostal nerve block is met, no more than two (2) injections may be performed at a single level, 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.

MP296 Occipital Nerve Block – (Revised) – Frequency 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.

MP297 Suprascapular Nerve Block – (Revised) – Frequency Limitations

LIMITATIONS:
If the medical necessity for sympathetic 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.

MP336 Genetic Testing for Inherited Thrombophilia/ Hypercoagulability – (Revised) – Add Medicare Non-Coverage

INDICATIONS:

COMMERCIAL AND MEDICAID BUSINESS SEGMENT:
Genetic testing for Factor V and/or Factor II Blood Clotting Protein mutations may be considered medically necessary for any of the following conditions in members without recurrent VTE risk factors (e.g., recent surgery, prolonged immobilization, collagen vascular disease, malignancy, certain hematologic disorders):

- Age less than 50, any venous thrombosis; or
- Myocardial infarction in female smokers less than age of 50; or
- Recurrent venous thrombosis; or
- First or second degree relative of individuals with venous thrombosis less than age of 50; or
- Relative with confirmed Factor V or Factor II mutation; or
- Venous thrombosis and a first or second degree relative with venous thrombosis; or
- Venous thrombosis in pregnant women or women taking oral contraceptives; or
- Venous thrombosis in unusual sites (such as hepatic, mesenteric and cerebral veins)
- Prior to administration of oral contraceptives in women with a personal or family history of venous thrombosis
- Preeclampsia or hemolysis, elevated liver enzymes, low platelets (HELLP) syndrome

**MEDICARE BUSINESS SEGMENT**

MolDx issued a non-coverage LCD (L36089) for genetic testing for thrombophilia testing for the Factor V Leiden (FVL) variant in the F5 gene, the G20210G>A (G20210A) variant in the F2 gene, and the MTHFR gene which encodes the 5,10-methylenetetrahydrofolate reductase enzyme. Genetic testing for these genes for all risk factors, signs, symptoms, diseases, or conditions, including cardiovascular risk assessment, are non-covered except for pregnant patients. However, Medicare will not add coverage of thrombophilia testing for pregnant women because they likely represent a very small group of potential Medicare (disabled) patients. Claims submitted on this limited Medicare population will deny per the policy but should be appealed for coverage with submission of medical records supporting the necessity for testing, and specify how testing changed anticoagulant prophylaxis management for the patient.

**MP348 LTAC – (NEW)**

**DESCRIPTION:** Long-term acute care (LTAC) is a recognized designation (by the Centers for Medicare and Medicaid Services) for acute care hospitals designed for extended stay patients with chronic conditions. Patients are admitted to LTAC hospitals following treatment in a traditional acute care hospital, but who no longer require intensive diagnostic procedures. The care provided is more individualized and resource-intensive than is provided in a skilled nursing facility or nursing home. LTAC hospitals provide specialized care services to manage medical conditions in patients with catastrophic or acute illnesses/injuries.

**CRITERIA FOR COVERAGE:**

**GENERAL LTAC CRITERIA:**

All of the following must be met

- The member’s clinical needs cannot be adequately met in lower level of care (e.g. home health, SNF, IP rehab)
- The member’s clinical needs will be better met in an LTAC as opposed to the current or alternate level of care
- There are no unstable co-morbidities in evaluation/work-up phase, and do not require active therapy
- There is no hospice/end of life plan of care in place
- There is no chronic ventilator dependence
• Placement is not being sought due to social issues (e.g. family not willing or able to care for member at home, refuses alternate level of care, etc)
• There is a reasonable expectation for clinical/functional improvement
• Member can tolerate oral fluids or has alternate nutritional routes established (e.g. NG or J tube, IV, TPN)
• There is an expected complicated course of recovery requiring prolonged hospitalization
• Member requires chest tube or more intensive services that are available in LTAC setting
• Have 2 or more medically active conditions requiring ALL of the following:
  o Have 3 or more of the following:
    ▪ IV medications
    ▪ continuous IV fluids greater than KVO rate
    ▪ TPN or PPN
    ▪ blood products
  o At least one physician visit daily
  o Frequent diagnostic services
  o Active participation in PT and/or OT five or more days/week
• One of the following must be met
  o There is no tracheostomy
  o All of the following are met
    ▪ LTAC facility can support the current maturity of the stoma
    ▪ LTAC facility can provide the appropriate level of care (e.g. first trach change, etc)
    ▪ transport agency can manage emergency trach care (accidental removal during transport)

LTAC VENT CRITERIA:

All of the following must be met
• The clinical needs cannot be adequately met in lower level of care (e.g. home health, SNF, IP rehab)
• The clinical needs will be better met in an LTAC as opposed to the current or alternate level of care
• There are no unstable co-morbidities in evaluation/work-up phase, and do not require active therapy
• There is no hospice/end of life plan of care in place
• There is no chronic ventilator dependence (prior to hospitalization)
• Placement is not being sought due to social issues (e.g. family not willing or able to care for member at home, refuses alternate level of care, etc.)
• There is a reasonable expectation for clinical/functional improvement
• Member can tolerate oral fluids or has alternate nutritional routes established (e.g. NG or J tube, IV, TPN)
• There is an expected complicated course of recovery requiring prolonged hospitalization
• Expectation of ventilator support for one week or greater in an acute setting
• There are no sophisticated vent modes
• PEEP requirements < 10cm H2O
• Member has not been breathing spontaneously for 72 consecutive hours
• There is continued prolonged mechanical vent support and all of the following must be met
  o More than 2 failed vent weaning attempts documented as failing established vent weaning protocol
  o There is an expected prolonged vent weaning period
  o ALL of the following must be met:
    ▪ Stable cardiovascular system (HR < 140, stable BP, none or minimal vasopressors)
- Temp < 100.4 F or 38.0 C
- No significant respiratory acidosis
- Adequate Hgb (e.g. > 8 g/dL)
- Adequate mentation (e.g. arousable, Glasgow coma scale > 13 and no continuous sedative or paralytic infusions)
- Adequate cough
- Stable metabolic status (e.g. acceptable electrolytes)
- Resolution of acute disease phase
- Co-morbid conditions which preclude weaning have been ruled out
- Physician believes that discontinuance is possible
- Demonstrated spontaneous respiratory effort during weaning trial
- Oxygenation stable during suctioning and repositioning
- No evidence of terminal disease
- No evidence of irreversible neuro-muscular process

- One of the following must be met
  - There is no tracheostomy; or
  - All of the following must be met
    - LTAC facility can support the current maturity of the stoma
    - LTAC facility can provide the appropriate level of care (e.g. first trach change, etc)
    - Transport agency can manage emergency trach care (accidental removal during transport)

**LTAC WOUND AND SKIN CRITERIA**

**All of the following must be met**

- The member’s clinical needs cannot be adequately met in lower level of care (e.g. home health, SNF, IP rehab)
- The member’s clinical needs will be better met in an LTAC as opposed to the current or alternate level of care
- There are no unstable co-morbidities in evaluation/work-up phase, and do not require active therapy
- There is no hospice/end of life plan of care in place
- There is no chronic ventilator dependence
- There is no placement being sought for social issues (e.g. family not willing or able to care for member at home, refuses alternate level of care, etc)
- There is a reasonable expectation for clinical/functional improvement
- Tolerating po fluids or have alternate nutritional routes established (e.g. NG or J tube, IV, TPN)
- Expected complicated course of recovery requiring prolonged hospitalization
- Complex wound that meets AT LEAST ONE of the following:
  - slow healing stage 4 pressure ulcer(s)
  - large draining wound(s) or 3rd degree burns (estimated >100 sq cm surface area)
  - extensive undermining or tunneling including high output fistula (>200mL in 24 hrs)
  - risk of limb loss
  - necrotic wound requiring multiple aggressive sharp wound debridements
  - post skin flap/graft with risk of flap/graft loss
  - traumatic wound without wound closure after 1 week
  - wounds/burns > 15% BSA
  - parenteral analgesia required for dressing changes which cannot be delivered in an alternate setting
- Must also meet one of the following:
  - intensive treatment as defined by > 4 hrs/24 hrs nursing care specifically related to the prescribed wound care treatment
have an active co-morbid medical condition that creates risk for additional complications or non-healing that meets AT LEAST ONE of the following:

- Diabetes
- Movement restricted to 2 or less turning surfaces
- NYHA class III/IV CHF
- BMI > 40
- quadriplegia/paraplegia/hemiplegia
- stage II/III hepatic insufficiency
- infection with systemic manifestations (active)
- Immunocompromised host
- malignancy/end stage disease
- malnutrition (Albumin < 3.5, weight loss of > 10% in < 10 mos and sub optimal intake > 1 week)
- end stage renal disease
- ventilator dependency

- One of the following must be met
  - There is no tracheostomy, OR
  - All of the following must be met
    - LTAC facility can support the current maturity of the stoma, AND
    - LTAC facility can provide the appropriate level of care (e.g. first trach change, etc), AND
    - transport agency can manage emergency trach care (accidental removal during transport)

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.

MP020 Solid Organ Transplant Services
MP023 Keratoplasty
MP047 Hyperbaric Oxygen Therapy
MP050 Surgical Correction of Chest Wall Deformities
MP058 Negative Pressure Wound Therapy
MP071 Subcutaneous Glucose Monitor
MP091 Sacral Nerve Stimulation
MP104 Subcutaneous Insulin Pump
MP159 Voice Therapy
MP197 Janus Kinase 2 (JAK 2) Gene Mutation Analysis
MP243 Anorectal Fistula Repair Using an Acellular Plug
MP244 Pelvic Floor Stimulation
MP278 Hyperthermia in Cancer Therapy
MP311 Genotyping or Phenotyping for Thiopurine Methyltransferase