“What’s New” Medical Policy Updates November 2022

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, 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.

MP187 Cryoablation – (Revised) – Add Indication

IV. Cryoablation may be considered medically necessary to treat lung cancer when either of the following criteria is met:
The member has early-stage non-small cell lung cancer and is a poor surgical candidate;
or
The member requires palliation for a central airway obstructing lesion.

MP307 Gender Dysphoria and Gender Confirmation Treatment – (Revised) – Revise Indication; Add Exclusion

1. Surgical Treatment

Gender confirming services may be considered medically necessary when supporting documentation is provided by the clinicians (physicians and mental health professionals) confirms **ALL** of the following:

- The member is 18 years of age or older *; and
- The member has been diagnosed with Gender Dysphoria; and
- The member has expressed a desire to transition his/her body to the preferred gender through surgery and hormone replacement therapy** (if not otherwise contraindicated); and
- The member has completed a psychological assessment (psychotherapy may be recommended, but is not required) by a mental health professional who works with adults presenting with gender dysphoria:
  1. A master’s degree or its equivalent in a clinical behavioral science field. This degree, or a more advanced one, should be granted by an institution accredited by the appropriate national or regional accrediting board. The mental health professional should have documented credentials from a relevant licensing board or equivalent for that country.~~” behavioral health professional with a doctoral degree (Ph.D., M.D., Ed.D., D.Sc., D.S.W., or Psy.D) who is capable of adequately evaluating if the candidate has any co-morbid psychiatric conditions~~; and
- If considering vaginoplasty or phalloplasty, the member has completed a twelve (12) month period of full-time experience functioning in the desired gender role; and
- A medical evaluation has been completed by a MD/DO; and
- The gender confirming surgery has been recommended by:
  - “One referral from a qualified mental health professional is needed for breast/chest surgery (e.g., mastectomy, chest reconstruction, or augmentation mammoplasty)”; or
  - “Two referrals—from qualified mental health professionals who have independently assessed the patient—are needed for genital surgery (i.e., hysterectomy/salpingo-oophorectomy, orchiectomy, genital reconstructive surgeries). If the first referral is from the patient’s psychotherapist, the second referral should be from a person who has only had an evaluative role with the patient”.

WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender- Nonconforming People v. 7

*Note: Per WPATH guidelines, “Chest surgery in FtM patients could be carried out earlier, preferably after ample time of living in the desired gender role and after one year of testosterone treatment. The intent of this suggested sequence is to give adolescents sufficient opportunity to experience and socially adjust in a more masculine gender role, before undergoing irreversible surgery. However, different approaches may be more suitable, depending on an adolescent’s specific clinical situation and goals for gender identity expression.”

**Note: hormone therapy is not required when the requested surgery is solely a mastectomy for purposes of female to male gender confirmation.

The following surgical services are considered medically necessary for gender transition:

Male to female transition	**Female to male transition**
Penectomy	Mastectomy (subcutaneous mastectomy or simple/total mastectomy)
Orchiectomy	Nipple/areola reconstruction related to mastectomy
Vaginoplasty	Penile prostheses
Labiaplasty	Salpingo-oophorectomy
Clitoroplasty	Scrotoplasty
Breast augmentation	Testicular prostheses
Colovaginoplasty	Urethroplasty
Voice therapy	Vaginectomy
Electrolysis of vaginoplasty donor site	Metoidoplasty
Laryngoplasty	Colpectomy
Voice modification surgery	Hysterectomy
Voice/speech therapy	Phalloplasty
Urethroplasty	Electrolysis of phalloplasty donor site

EXCLUSIONS: The following procedures are considered to be cosmetic and not medically necessary to complete gender transition:

- Blepharoplasty (unless criteria per MP10 are met apart from gender reassignment)
- Rhinoplasty (unless criteria per MP204 are met apart from gender reassignment)
- Collagen injections
- Electrolysis (other than noted above)
- Rhytidectomy (i.e. face lift)
- Facial implants, injections, or bone reduction (may be considered on a per-case basis with appropriate clinical documentation)
- Hair removal (except as noted in the MtF indication tables)
- Hair transplantation
- Medication to promote hair growth
- Lip reduction or enhancement
- Liposuction
- Removal of redundant skin (unless criteria per MP56 are met apart from gender reassignment)
- Silicone injections
- Body sculpting (e.g., masculinization or feminization of torso, body contouring, gluteal augmentation, etc.)

Reversal of genital surgery is **NOT COVERED**.

Reversal of surgery to revise secondary sex characteristics is **NOT COVERED.**

Revision of surgical procedures in the absence of evidence of physiologic dysfunction is **NOT COVERED**.

In the absence of contract-specific benefits, procedures for the preservation of fertility (e.g., procurement, cryopreservation and storage of sperm, oocytes or embryos) is **NOT COVERED**.

MP322 Drug Testing in Substance Abuse Treatment – (Revised) – Revise frequency limits

DESCRIPTION: Drug Testing in Substance Abuse Treatment is divided into two categories: Qualitative (also known as Presumptive) and Quantitative (also known as Confirmatory) immunoassay.

Presumptive (Qualitative) Testing: For baseline screening before initiating treatment or at the time treatment is initiated: All criteria must be met:

1. Clinical assessment of the member's history and risk of substance abuse is performed; and
2. The diagnosis, physical examination or exhibited behavior of the insured individual support the need for urine drug testing; and
3. There is a plan of care outlining how to the test results will be used clinically

Note:
Presumptive UDT testing may be ordered as a panel but will be considered as a single test or single member encounter, regardless of the number of analytes tested. Medical and surgical procedures should be reported with the Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT®) codes that most comprehensively describe the services performed. Providers must not unbundle the services described by a HCPCS/CPT® code. Services that are integral to a more comprehensive service are not eligible for separate reimbursement when reported by the same provider for the same member on the same date of service.

Presumptive UDT orders should be individualized based on clinical history and risk assessment, and must be documented in the medical record.

Confirmatory (Quantitative) testing: At least one of the criteria are met.

1. The presumptive test results are positive AND the confirmatory testing is limited to substances identified as present or positive on the presumptive test; AND
    a. The confirmatory test is ordered within 24 hours of a presumptive test; OR
    b. The presumptive test result is negative and the result is inconsistent with the member's history or presenting behavior AND the confirmatory test is ordered within 24 hours of the presumptive test.

OR

2. The criteria for presumptive testing are met, but there is no presumptive test available (e.g., some synthetic or semi-synthetic opioids); or
3. Immunoassays for the relevant drug(s) are not commercially available; or
4. definitive drug levels are required for clinical decision making.

At the current time, physician-directed definitive profile testing is reasonable and necessary when ordered for a particular member based upon historical use and community trends. However, the same physician-defined profile is not reasonable and necessary for every member in a physician's practice.

Definitive UDT orders should be individualized based on clinical history and risk assessment, and must be documented in the medical record.

FOR COMMERCIAL AND MEDICAID BUSINESS SEGMENTS:

INDICATIONS: The following drug testing is covered when criteria are met:

Diagnosis and treatment for substance abuse or dependence is a covered indication for urine drug testing. Ordered tests and testing methods (presumptive or definitive) should match the member's stage of screening, treatment, or recovery, the member's documented history and diagnoses. For members with a diagnosed SUD, the clinician should perform random UDT, at random intervals in order to properly monitor the member. Testing should be determined by the clinician based on member history, physical examination, and previous laboratory findings, stage of treatment or recovery, suspected abused substance(s), and substances that may present high risk for additive or synergistic interactions with prescribed medication (e.g., benzodiazepines, alcohol).

The member's medical record should include an appropriate testing frequency based on the stage of screening, treatment, or recovery; the rationale for the drugs/drug classes ordered; and the results must be documented in the medical record and used to direct care.

Blanket orders (a test request that is not for a specific patient; rather, it is an identical order for all patients in a clinician's practice without individualized decision making at every visit) and routine standing orders for all members in a physician's practice are not medically necessary.

Quantity limits for presumptive and definitive tests are represented by codes 80305-80307 and G0480 - G0483, and G0659, are limited to

- 1-2 presumptive UDT dates of service per week and no more than 1 per day for members with 0-30 consecutive days of abstinence.
- For members with 31 to 90 consecutive days of abstinence, presumptive UDT are limited to 1 per week.
- For members with more than 90 consecutive days of abstinence, presumptive UDT is limited to a frequency of one UDT date of service per month.

Testing identified by codes 80320-80377, and 83992 are also subject to the same limitations delineated in the three prior bullets and are also limited to 1 per day. Drug testing, by any test method and/or combination, will be considered medically necessary up to a maximum of 28 dates of service in a calendar year when the presumptive and confirmatory testing criteria (delineated in prior sections of MP322) are met. Drug testing utilizing oral fluid analysis is considered on a per-case basis.

Requests for coverage in excess of 28 dates of service REQUIRES PRIOR AUTHORIZATION BY A PLAN MEDICAL DIRECTOR, and may be considered if it is suspected that the member is continuing a pattern of substance abuse as evidenced by either of the following:

- documentation of poor compliance; or
- documentation of deteriorating function or aberrant behavior (e.g., repeated lost prescriptions, repeated early refill requests, prescriptions for controlled substances from multiple providers, unauthorized or self-dosing, unsupervised dose escalation, apparent intoxication.)

FOR MEDICARE BUSINESS SEGMENTS

Please see Novitas Solutions, Inc. L35006 Controlled Substance Monitoring and Drugs of Abuse Testing

Presumptive (Qualitative) Testing: For baseline screening before initiating treatment or at the time treatment is initiated: All criteria must be met:

4. Clinical assessment of the member's history and risk of substance abuse is performed; and
5. The diagnosis, physical examination or exhibited behavior of the insured individual support the need for urine drug testing; and
6. There is a plan of care outlining how to the test results will be used clinically

FREQUENCY OF TESTING DURING SUBSTANCE ABUSE TREATMENT
Stabilization phase: Although variable based on complexity of the individual member's case, the stabilization phase is typically 4 weeks for persons receiving treatment for substance abuse. During this phase, weekly testing is generally considered appropriate.

Maintenance phase: Although variable based on complexity of the individual member's case, targeted presumptive testing once every 1 to 3 months generally considered appropriate

Confirmatory (Quantitative) testing: At least one of the criteria are met.

5. The presumptive test results are positive AND the confirmatory testing is limited to substances identified as present or positive on the presumptive test; AND
    a. The confirmatory test is ordered within 24 hours of a presumptive test; OR
    b. The presumptive test result is negative and the result is inconsistent with the member's history or presenting behavior AND the confirmatory test is ordered within 24 hours of the presumptive test.

    OR
6. The criteria for presumptive testing are met, but there is no presumptive test available (e.g., some synthetic or semi-synthetic opioids); or
7. Immunoassays for the relevant drug(s) are not commercially available; or
8. definitive drug levels are required for clinical decision making.

LIMITATIONS:
Drug testing, by any test method and/or combination, will be considered medically necessary up to a maximum of 24 dates of service in a calendar year when the criteria are met.
Requests for coverage in excess of 24 dates of service **REQUIRES PRIOR AUTHORIZATION BY A PLAN MEDICAL DIRECTOR**, and may be considered if it is suspected that the member is continuing a pattern of substance abuse as evidenced by either of the following:

- documentation of poor compliance; or
- documentation of deteriorating function or aberrant behavior (e.g., repeated lost prescriptions, repeated early refill requests, prescriptions for controlled substances from multiple providers, unauthorized or self-dosing, unsupervised dose escalation, apparent intoxication.)

FOR MEDICAID BUSINESS SEGMENT:

Quantity limits for presumptive and definitive tests are represented by codes 80305-80307 and G0480 - G0483, and G0659, are limited to 1 per day. Testing identified by codes 80320-80377, and 83992 are also limited to 1 per day.
Drug testing utilizing oral fluid analysis is considered on a per-case basis.

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
MP091 Sacral Nerve Stimulation
MP104 Subcutaneous Insulin Pump
MP159 Voice Therapy
MP197 Janus Kinase 2 (JAK 2) Gene Mutation Analysis
MP214 Iontophoresis
MP243 Anorectal Fistula Repair Using an Acellular Plug
MP244 Pelvic Floor Stimulation
MP258 Hyperhidrosis
MP278 Hyperthermia in Cancer Therapy
MP292 Sympathetic Nerve Block
MP294 Intercostal Nerve Block
MP311 Genotyping or Phenotyping for Thiopurine Methyltransferase
MP336 Genetic Testing For Inherited Thrombophilia/ Hypercoagulability
MP348 LTAC