“What’s New” Medical Policy Updates September 2018

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

MP148 Ambulatory Cardiac Event Monitors – (Revised) – (Added Exclusions)

EXCLUSIONS:
MCOT is considered experimental, investigational or unproven when used as a screening tool, and is NOT COVERED.

MCOT in excess of one unit (one to 30 consecutive days) is NOT COVERED.

The following cardiac monitoring systems including but not limited to:

- BIOTRONIK biomonitor
- smartphone ECG systems (eg, AliveCor, ViSi Mobile Monitoring System, Kardia Mobile, HEART, ect.)

are considered experimental, investigational or unproven because their therapeutic value has not been established due to a lack of published evidence, and are NOT COVERED.

MP247 Nutritional Supplements – (Revised) – (Added Exclusions)

EXCLUSIONS:

Commercial Business Segment:

Oral nutrition products and/or supplements not used to treat inborn errors of metabolism are NOT COVERED including, but not limited to:

- Formula or Supplements to treat a deficient diet or to provide an alternative source of nutrition in conditions such as, but not limited to, allergies, obesity, hypo- or hyper-glycemia and gastrointestinal disorders; or
- Lactose-free foods; or
- Banked breast milk; or
- Standardized or specialized infant formulas (including over-the-counter infant formulas (such as Similac, Enfamil, etc.))

Grocery items and food additives as defined under section V. Additional Definitions or medical food products are NOT COVERED.

Enteral products for the diagnosis of “failure to thrive” are NOT COVERED.

Enteral products for the purpose of augmenting normal dietary sources of nutrition are NOT COVERED.

Digestive enzyme cartridges (e.g. Relizorb) used in conjunction with enteral nutrition therapy is considered to be of unproven benefit and therefore not medically necessary and NOT COVERED.
NOTE: May be considered on a per-case basis through the Program Exception process for Medicaid Business segment members ages 5 years and older with exocrine pancreatic insufficiency who are partially or completely unable to hydrolyze fats in enteral formula.

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.

MP102 Morphometric Tumor Analysis
MP151 Epidural Steroid Injection
MP163 Thermography
MP175 Trigger Point Injections
MP183 Cranial Electrotherapy Stimulation
MP185 Chemosensitivity and Chemoresistance Assays
MP200 Osteochondral Autograft Transplant
MP202 Interferential Stimulation
MP206 Electrocardiographic Body Surface Mapping
MP208 Selective Internal Radiation Therapy
MP221 Suprachoroidal Delivery of Pharmacologic Agents
MP234 Occipital Nerve Stimulation
MP246 Multigene Expression Assay for predicting Recurrence in Colon Cancer
MP267 Amniotic Membrane Transplantation
MP283 Facet Injections
MP287 Shift Care
MP291 TX1 Tissue Removal System for Ablating and Removing Tissue
MP292 Sympathetic Nerve Block
MP295 Sacroiliac Joint Injection
MP297 Suprascapular Nerve Block