"What's New" Medical Policy Updates July 2017

Listed below are the recent changes made to policies within the Geisinger Health Plan Medical Policy Portfolio during the month of June that will become **effective August 15, 2017** (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.

MP45 Chest Percussion Vest – REVISED – (Revised Indications)

INDICATIONS: Requires Prior Medical Director or designee Authorization

~~The following indication will be case managed by the Plan's Medical Management Department. Approval of coverage will be dependent upon the following criteria. Insured individuals must meet criteria 1 or 2 or 3, and both 4 and 5.~~

High frequency chest compression systems (HFCWS)

HFCWS will be considered medically necessary when the following criteria are met:

A diagnosis of:

1. ~~Diagnosis of~~ cystic fibrosis; or
2. ~~Diagnosis of~~ bronchiectasis, characterized by daily productive cough for at least 6 continuous months, or frequent (more than 2/year) exacerbations requiring antibiotic therapy and confirmed by high resolution, spiral or standard CT scan; or
3. ~~Diagnosis of~~ one of the following neuromuscular diseases: Post-polio, Acid maltase deficiency, Anterior horn cell diseases, Multiple sclerosis, Quadriplegia, Hereditary muscular dystrophy, Myotonic disorders, other myopathies affecting respiratory clearance, or Paralysis of the diaphragm.

and

4. Well documented failure of standard treatments to adequately mobilize retained secretions; and
5. Must be recommended by an Adult or Pediatric Pulmonologist or upon exception, approved by a Medical Director

Oscillating positive expiratory pressure (PEP) devices:

Oscillating PEP device will be considered medically necessary for members with hypersecretory lung disease with documented difficulty clearing secretions which is causing recurrent exacerbations.

MP136 Alternative Medicine Therapies – REVISED – (Revised Exclusions)

EXCLUSIONS:

In general, complementary and alternative therapies are considered to be **experimental, investigational or unproven** and are **NOT COVERED** (unless otherwise mandated under Act 62) because there is insufficient evidence in the published, peer-reviewed medical literature to support their safety and/or effectiveness. The list of such interventions includes, but is not limited to:

Hippotherapy	Yoga
Homeopathy	Exercise With Oxygen Therapy (EWOT)
Hoxsey method	Transcendental meditation
Humor therapy	Electrodermal stress analysis
Sauna	Primal therapy
Psychodrama	Pilates
Polarity therapy	Ozone therapy
Whole body vibration therapy	Insulin potentiation therapy
Inversion therapy	Intravenous micronutrient therapy (Myers' Cocktail)
Intravenous vitamin C infusion	Bee sting therapy
Body wraps	
Livingston-Wheeler Therapy	

MP174 Exhaled Nitric Oxide – REVISED – (Added Indications; Revised Exclusions)

DESCRIPTION:

Nitric Oxide (NO) is an important endogenous regulatory molecule widely distributed throughout the body that is a messenger in many different biological processes. In biological tissue, nitric oxide is highly reactive making a determination of the amount of NO very difficult. However, in the gas phase nitric oxide is relatively stable, permitting its measurement in exhaled air. Of greatest clinical interest is the role of NO as an inflammatory mediator, particularly in the management of eosinophilic asthma to determine the likelihood of steroid responsiveness in individuals with chronic symptoms suggestive of airway inflammation

INDICATIONS:

The measurement of exhaled nitric oxide may be considered medically necessary for the management of when all of the following criteria are met:

- Utilization is limited to Pulmonary or Allergy/Immunology specialists; and
- Diagnosis of esosinophilic asthma has been established or highly suspected

EXCLUSIONS:

~~The Plan does **NOT** provide coverage for~~ The use of exhaled nitric oxide outside of the indications outlined in this policy ~~for the diagnosis and management of asthma because it~~ is considered **experimental, investigational or unproven**, and therefore **NOT COVERED.** 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 test on health outcomes for use outside of the indications outlined in this document, when compared to established tests or technologies.

MP201 Obstructive Sleep Apnea – REVISED – (Revised Criteria; Added Exclusions)

A. *Oral appliances*

Mandibular advancement appliances and/or tongue-retaining devices are considered to be medically necessary for members who have a sleep study documenting one of the following:

a AHI/RDI greater than 15 events per hour; or
b AHI/RDI greater than 5 and less than 14 with documented symptoms of one of the following:
(i) Symptomatic excessive daytime sleepiness (EDS) as in an elevated Epworth sleepiness scale score of 11 or more; or
(ii) Documented evidence of impaired cognition or mood disorders or insomnia; or
(iii) Documented hypertension, cor pulmonale, ischemic heart disease; or
(iv) Documented evidence of non-arteritic anterior ischemic optic neuropathy (NAION); or
(v) Body mass index of 35 or greater; or
(vi) History of stroke

c AHI/RDI greater than 30 and:
(i) the member cannot tolerate a positive pressure device; or
(ii) a positive pressure device is medically contraindicated

~~***B.*** *Intra-oral prosthesis and for the Treatment of OSA*~~

~~Intra-oral prosthesis may be considered medically necessary when the patient meets **one** of the following criteria:~~

~~1. Patients with mild OSA who do not respond to or are not appropriate candidates for treatment with behavioral measures; **OR**~~

2. ~~Patients with moderate to severe OSA who are intolerant of or refuse treatment with CPAP;~~
   ~~**OR**~~
3. ~~Patients with OSA who refuse or are not candidates for surgical treatments.~~

III. Exclusions

The **Plan** does not provide coverage for ANY of the following procedures or services for the treatment of OSA because they are considered **experimental, investigational or unproven**: (This list may not be all inclusive):

- Radiofrequency Volumetric Tissue Reduction (Somnoplasty™) ***(See Also MP40 – Somnoplasty/Coblation)***
- Coblation ***(See Also MP40 – Somnoplasty/Coblation)***
- Cautery-assisted Palatal Stiffening Operation (CAPSO)
- Pillar ™ Palatal Implant System
- Repose Bone Screw System
- Injection Snoreplasty™
- Flexible Positive Airway Pressure
- Hypoglossal nerve stimulation

The use of oral appliances for the treatment of socially disruptive snoring in the absence of documented OSA is considered to be not medically necessary, and **NOT COVERED.**

The use of oral appliances for the treatment of upper airway resistance syndrome is considered to be experimental, investigational or unproven, and **NOT COVERED.**

MP271 Non-Invasive Testing for Fetal Aneuploidy – REVISED – (Revised Indications; Added Limitations; Added Exclusions)

INDICATIONS:

Non-Invasive Testing for Fetal Aneuploidy may be considered to be medically necessary when all of the following criteria are met:

The testing is ordered by a Maternal Fetal Medicine specialist or an Obstetrician; and
One or more of the following conditions (defined by The American College of Obstetricians and Gynecologists (ACOG) Committee on Genetics and The Society for Maternal-Fetal Medicine (SMFM) Publications Committee) are met:

- ~~Maternal age 35 years or older at delivery; or~~
- Members with a current singleton pregnancy; or
- Fetal ultrasonographic findings indicating an increased risk of aneuploidy; or
- History of a prior pregnancy with a trisomy; or
- Positive test result for aneuploidy, including first trimester, sequential, or integrated screen, or a quadruple screen; or
- Parental balanced Robertsonian translocation with increased risk of fetal trisomy 13 or trisomy 21.

Nucleic acid sequencing–based testing of maternal plasma for trisomy 13 and/or 18 may be considered medically necessary in women who are eligible for and are undergoing nucleic acid sequencing based testing of maternal plasma for trisomy 21

LIMITATION:

Noninvasive prenatal testing (NPIT) using cell free fetal DNA in maternal plasma for trisomy 13 and/or 18 is considered be experimental, investigational or unproven, unless performed with trisomy 21 screening analysis.

EXCLUSIONS:

The use of Non-Invasive Testing for Fetal Aneuploidy for any indication not conforming the criteria listed in this policy is considered to be **experimental, investigational or unproven**, and therefore **NOT COVERED**.

Nucleic acid sequencing–based testing of maternal plasma for fetal sex chromosome aneuploidies is considered to be experimental, investigational or unproven, and therefore **NOT COVERED**.

Nucleic acid sequencing-based testing of maternal plasma for microdeletions is considered to be experimental, investigational or unproven, and therefore **NOT COVERED.** According to the American College of Obstetricians and Gynecologists Practice Bulletin No. 163: Screening for Fetal Aneuploidy: *"Without published clinical validation trials, some laboratories have begun to offer cell-free DNA screening for additional disorders, including two forms of aneuploidy associated with nonviable pregnancies (trisomy 16 and trisomy 22) and five or more microdeletion syndromes. A microdeletion syndrome is caused by a chromosomal deletion encompassing contiguous genes that is too small to be detected by conventional cytogenetics. Given the rarity of these disorders, it is uncertain what a positive or negative screening test result means. Cell-free DNA screening tests for microdeletions have not been validated clinically and are not recommended at this time."*

MP156 Robotic Assisted Prostatectomy – RETIRED POLICY

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.

MP03 Ocular Photodynamic Therapy
MP17 Ambulance Transport
MP30 IDET
MP74 Interactive Metronome Training
MP84 Stereotactic Radiosurgery
MP89 Evaluation of Breast Ductal Lavage
MP110 Uterine Artery Embolization
MP124 Transpupillary Thermotherapy
MP134 Gastric Electrical Stimulation
MP140 Automatic Implanted Defibrillator/CRT-D with Attachment
MP141 Biventricular Pacemaker
MP144 Vitamin B12 Injection Therapy
MP152 Low Level Laser Therapy
MP203 Radiofrequency Ablation Therapy for Barrett's Esophagus
MP216 Quantitative EEG (QEEG)
MP306 Tumor Treatment Fields