“What’s New” Medical Policy Updates April 2026

Listed below are the recent changes made to policies within the Geisinger Health Plan Medical Policy Portfolio during the month of March that will become **effective May 15, 2026** (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.

MP090 Inj. Bulking Agents/Incontinence – Revised – Add Exclusion Language; Update Unproven Language

EXCLUSIONS:
There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of other agents, as periurethral bulking agents, including but not limited to Teflon®, autologous fat, or autologous ear chondrocytes. The Plan does **NOT** provide coverage of these agents because they are considered ~~**experimental, investigational or**~~ **unproven.**

There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of implantable, volume-adjustable balloon devices including but not limited to ProACT Adjustable Continence Therapy.
These technologies are considered to be **unproven** and therefore **NOT COVERED**

MP104 Continuous Subcutaneous Insulin Infusion Pump – Revised – Add Exclusion Language; Update Unproven Language

EXCLUSIONS:
Replacement of a currently functioning Continuous Subcutaneous Insulin Infusion pumps for the sole purpose of expired warranty, upgrade in model or use with a non-covered monitoring device **is not** considered **medically necessary**. Replacement due to slight damage to the pump without causing the pump to malfunction is also considered **not medically necessary**.

Equipment failure requires detailed documentation and must include the pump serial number. The vendor must provide the member’s equipment serial number with request for repair or replacement.

Equipment upgrades or accessories whose sole purpose is to integrate (with wireless communication technology) an insulin pump and interstitial glucose monitor are considered **not medically necessary.**

Additional software or hardware required for downloading data to a personal computer to aid in self-management of diabetes mellitus is considered a convenience item and **not medically necessary**.

Use of an artificial pancreas system is considered investigational, experimental or unproven and **NOT COVERED**

Disposable external insulin pump with no wireless communication capability (e.g., V-Go™ Disposable Insulin Delivery Device) is considered ~~**experimental, investigational or**~~ **unproven** and is **NOT COVERED. (Commercial Business Segment only).** For **Medicare Business Segment,** disposable insulin delivery devices are covered under the Medicare Part D pharmacy benefit.

Unless otherwise specified or mandated, the Plan does **NOT** provide coverage for Prescription Digital Therapeutics **(see MP367)**, including but not limited to d-Nav Insulin Management Program to evaluate, diagnose, manage symptoms, or treat an illness, injury, or disease because this technology is considered **unproven** and is **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 these digital applications on health outcomes when compared to established tests or technologies.

MP219 Implantable Percutaneous Electrical Nerve Stimulation (PENS) and Neuromodulation Therapy (PTN) – Revised – Add Exclusion Language

EXCLUSIONS:
The Plan does **NOT** provide coverage for Implantable Percutaneous Electrical Nerve Stimulation (PENS) or Neuromodulation Therapy (PTN) for any indication because it is considered **unproven** and not medically necessary, and therefore **NOT COVERED.** 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

The Plan does **NOT** provide coverage for restorative neurostimulation (e.g., ReActiv8, StimRouter PNS System, StimQ, Nalu) for any indication including but not limited to chronic low back pain is considered **Unproven** and not medically necessary and therefore **NOT COVERED**. 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.

The Plan does **NOT** provide coverage for implanted neurostimulation devices designed to normalize the function of the lower esophageal sphincter through neuromodulation (e.g., Endostim neurostimulation therapy). The Endostim device is implanted under the skin of the abdomen and a bipolar lead delivers electrical stimulation therapy to the esophageal sphincter. It is considered **Unproven** and not medically necessary, and therefore **NOT COVERED.** 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

MP239 Pharmacogenetic Testing – Revised – Add Indications

Examples include, but are not limited to any of the following:

- ABCD1 for elivaldogene autotemcel (Skysona)
- ABCG2 for rosuvastatin (Crestor)
- ALK for crizotinib (Xalkori), alectinib (Alecensa) or ceritinib (Zykadia) for the treatment of non-small cell lung cancer (NSCLC).
- BCR/ABL1 for dasatnib, imatinib, nilotinib, ponatinib and/or bosutinib
- BRAF and NRAS for cetuximab (Erbitux) or panitumumab (Vectibix).
- BRAF for vemurafenib (Zelboraf), dabrafenib (Tafinlar), pembrolizumab (Keytruda) or encorafenib (Braftovi)
- BRCA1, BRCA2, PALB2, and other HRR genes for olaparib (Lynparza), rucaparib (Rubraca) or niraparib (Zejula)
- CACNA1S for volatile anesthetics
- CTFR for ivacaftor (Kalydeco) or lumacaftor/ivacaftor (Orkambi)
- CYP2B6 for efanvirenz (Sustiva)
- CYP2C19 for clopidogrel (Plavix) {**May be considered for program exception for the Medicaid business segment for this indication** Antidepressants, Barbiturates, Proton pump inhibitors, Mephenytoin
- CYP2C9 for warfarin metabolism, Celebrex, Marinol, Balversa, Ansaid, Cerebyx, Mobic, Dilantin, Feldene, Mayzent
- CYP2D6 for tetrabenazine (Xenazine) greater than 50 mg per day, eliglustat (Cerdelga), deutetrabenazine

(austedo) greater than 36mg/day, Antidepressants for treatment of depression (including SSRI's) , Anti-psychotics for treatment of schizophrenia, atomoxetine, codeine, ondansetron, tropisetron, tamoxifen, tramadol, hydrocodone

- CYP3A5 for tacrolimus (Prograf, Protopic)
- CYP4F2 for warfarin
- DYPD ~~gene mutation~~ for capecitabine or 5-fluorouracil
- EGFR for cetuximab (Erbitux), erlotinib (Tarceva) osimertinib (Tagrisso) and/or afatinib dimaleate (Gilotrif)
- ER for fulvestarnt (Faslodex)
- F2
- F5
- FGFR2 for pegaptanib (Pemazyre)
- FGFR3 for erdafitinib (Balversa)
- FTL3 mutation assay for midostaurin (Rydapt), gilternib (Xospata) or sorafenib (Nexavar).
- G6PD for rasburicase (Elitek)
- GBA for velaglucerase alfa
- Genotype 1 chronic hepatits C for teleprevir (Incivik)
- HER2/neu for traztuzumab (Herceptin) and/or lapitinib (Tykerb)
- HLA-A for carbamazepine (Tegretol)
- HLA-B*1502 for persons of Asian ancestry prior to carbamazepine (Tegretol)
- HLA-B*5701 for Abacavir (Ziagen)
- HLA-B*5801 for allopurinol
- IFNL3, IFNL4 for peginterferon (Pegasys, Pegintron, Sylatron)
- K-RAS for cetuximab (Erbitux) and/or panitumumab (vectibix)
- KIT
- MGMT gene methylation assay for temozolomide (Temodar)
- MT-RNR1 for aminoglycosides
- NAT2 for amifampridine or amifampridine phosphate
- NS3 Q80K for simeprevir (Olysio)
- NUDT15 for thiopurines
- PDGFRß for treatment with imatinib mesylate (Gleevec).
- PDL1 for pembrolizumab (Keytruda), durvalumab (Imfinzi).
- PD-L1 for treatment with durvalumab (Imfinzi); atezolizumab (Tecentriq), pembrolilzumab (Keytruda).
- PIK3CA for alpelisib (Piqray)
- ROS1
- RYR1 for inhaled anesthetics
- SLCO1B1 for Statins (class): simvastatin, pravastatin, atorvastatin, lovastatin, rosuvastatin, fluvastatin, pitavastatin
- TPMT gene mutation or phenotypic assay for 6-mercaptopurine or azathioprine therapy (See MP311 for additional information)
- UGT1A1 for irinotecan treatment
- UGT2B17 for belzutifan
- VKORC1 for warfarin metabolism

MP260 Canaloplasty and Viscocanalostomy – Revised – Add Indication

INDICATIONS:
Canaloplasty is considered to be medically necessary for the treatment of primary open-angle glaucoma only when the following criteria are met:

- Maximized medical therapy including medication and laser therapy has failed to control intraocular pressure; and
- The member is not a candidate for trabeculectomy or aqueous shunt due to a high risk for complications

Minimally invasive glaucoma surgery (MIGS) involving canaloplasty and trabeculotomy ab interno to lower intraocular pressure (IOP) in adults with mild to moderate, primary open-angle glaucoma (POAG), either as a standalone device or in combination with cataract surgery is considered medically necessary when the following criteria are met:

- Documented diagnosis of primary open angle glaucoma; and
- Inadequate response, failure or intolerance to non-surgical management

MEDICARE BUSINESS SEGMENT: See also: Novitas Local carrier Determination L38223 and A56633

EXCLUSIONS:
The Plan does **NOT** provide coverage for canaloplasty for any other indication because it is considered **unproven.**

The Plan does **NOT** provide coverage for viscocanalostomy or combined phacoemulsification and viscocanalostomy for any indication because it is considered **unproven.** The Geisinger Technology Assessment Committee determined there is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of these treatments on health outcomes when compared to established treatments or technologies.

~~The Plan does **NOT** provide coverage for canaloplasty and trabeculotomy ab interno with the OMNI System combined with cataract surgery **unproven** for the treatment of POAG because it is considered experimental, investigational or unproven. 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.~~

MP265 Proteomic Serum Analysis – Revised – Add Medicare Cross Reference; Remove Exclusion; Updated Unproven Language

Medicare Business Segment: (See also: LCD L39365/A52986)

EXCLUSIONS: All Business Segments Except as Annotated

PA Dept. of Human Services has determined OVA1 assay may be considered on a per-case basis through the Program Exception process

Unless otherwise mandated (eg, Medicare), the Plan does **NOT** provide coverage for Proteomic Serum analysis to Identify Ovarian Cancer because it is considered ~~**experimental, investigational or**~~ **unproven.** There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this test on health outcomes when compared to established tests or technologies.

Any use of VeriStrat® serum proteomic testing except as noted above is considered **unproven** and **NOT COVERED**.

~~Unless otherwise mandated (eg, Medicare), the Plan does **NOT** provide coverage for Proteomic Serum analysis to Identify Lung Cancer (Xpresys Lung, BDX-XL2, REVEAL Lung Nodule Characterization) because it is considered **unproven**. There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this test on health outcomes when compared to established tests or technologies.~~

MP326 Biomarker Testing for Rheumatoid Arthritis – Revised – Update Indications and Exclusions

INDICATIONS:

For individuals with signs or symptoms of an autoimmune disease, screening for disease using antinuclear antibodies (ANA) is considered medically necessary for members with signs or symptoms of an autoimmune disease:

a) Once during initial workup.
b) Up to two additional tests per lifetime if new or more severe signs or symptoms of an autoimmune disease develop.

Extractable nuclear antigens (ENA) panel testing of specific autoantibodies is considered medically necessary for members with an abnormal, raised ANA titer and a clinical correlation with the appropriate autoimmune disorder

Rheumatoid factor (RF) and/or anti-cyclic citrullinated peptide (anti-CCP) antibodies testing is considered medically necessary for members with painful and swollen joints suggestive of rheumatoid arthritis (RA),

a) Once during initial workup.
b) If initial testing did not result in a diagnosis of RA, up to two additional tests per lifetime if symptoms persist or additional symptoms of RA develop.

dsDNA testing is considered medically necessary up to four (4) times per year for members with an initial positive ANA test and a diagnosis of systemic autoimmune rheumatic disease.

For members with a negative or low positive ANA test, the following condition specific antibody testing is considered medically necessary:

a) Testing for anti-Jo-1 in a unique clinical subset of myositis.
b) Testing for anti-SSA in the setting of lupus or Sjögren's syndrome.

EXCLUSIONS:

Unless otherwise noted, the Plan does **NOT** provide coverage for Vectra DA or PrismRA because it is considered ~~**experimental, investigational or**~~ **unproven.** There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this test on health outcomes when compared to established measures of disease activity. **(81490)**

Monitoring of disease with ANA testing or ANA titers is considered **unproven** and therefore **NOT COVERED**. There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this test on health outcomes when compared to established measures of disease activity.

For individuals without symptoms suggestive of an autoimmune disorder, ANA and/or ENA testing in the absence of symptoms suggestive of an autoimmune disorder is considered **unproven** and therefore **NOT COVERED.** There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this test on health outcomes when compared to established measures of disease activity.

For the diagnosis of RA, testing for serum biomarkers not discussed above, alone or in a panel (e.g., Seronegative Rheumatoid Arthritis Profile), is considered **unproven** and therefore **NOT COVERED.** There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this test on health outcomes when compared to established measures of disease activity. **(0521U)**

For the diagnosis of systemic lupus erythematosus (SLE), the use of cell-bound complement activation products (e.g., AVISE Lupus) is considered **unproven** and therefore **NOT COVERED.** There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this test on health outcomes when compared to established measures of disease activity**. (0312U)**

For the diagnosis, prognosis, or monitoring of SLE or connective tissue diseases, serum biomarker panel testing with proprietary algorithms and/or index scores (e.g., AVISE CTD, AVISE SLE Monitor, AVISE SLE Prognostic, aisle® DX Disease Activity Index, Early Sjögren's Syndrome Profile) is considered **unproven** and therefore **NOT COVERED.** There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this test on health outcomes when compared to established measures of disease activity. **(0446U, 0447U)**

MP034 Foot Orthotics – Revised – Add Medicaid Guidance Document

MP385 Pediatric Specialty bed and Safety Equipment – Revised – Add Medicaid Guidance Document

MP064 Breast Reconstruction Surgery – Revised – Add Medicaid Guidance Document

MP275 Speech Generating Devices – Revised – Add Medicaid Guidance Document

MP388 Guidelines for Face and Ear Prostheses – NEW

MP066 ESWT – Revised – Update Unproven Language

MP094 Unilateral Pallidotomy – Revised – Update Unproven Language

MP172 MicroVas Vascular Treatment System – Revised – Update Unproven Language

MP196 Convection-Enhanced Drug Delivery – Revised – Update Unproven Language

MP320 Absorbable Hydrogel Spacer – Revised – Update Unproven Language

MP353 Laser Interstitial Thermal Therapy – Revised – Update Unproven Language

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.

MP068 Reduction Mammaplasty
MP078 Sexual Dysfunction Therapies
MP106 Ultrasound/ Pregnancy
MP113 Electrical Stim Wound Healing
MP176 Meniett Device
MP204 Nasal and Sinus Surgery
MP310 Vertical Expandable Titanium Rib
MP328 Genetic Susceptibility Cancer Panels
MP340 Wide Area Transepithelial Sampling (WATS)
MP368 Carotid Sinus Baroreflex Device
MP382 Genetic Testing for Monogenic and Syndromic Obesity

Prior Authorization List

The Prior Authorization list has been revised. Providers are encouraged to refer to the following link:

https://www.geisinger.org/-/media/OneGeisinger/Files/PDFs/Provider/PriorAuthList.pdf?la=en

Sections with revisions are highlighted and updated monthly.