"What's New" Medical Policy Updates August 2026

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

MP048 Surgical and Minimally Invasive Therapies for the Treatment of BPH – Revised – Add Indication; Update Unproven Language

INDICATIONS:
Transurethral Microwave Thermotherapy (TUMT), Transurethral Radiofrequency Thermotherapy (TUNA), Transurethral incision of the prostate (TUIP), Transurethral water vaporization of the prostate [e.g. Rezum™] (TUVP), Transurethral waterjet ablation (e.g., Aquablation), Transurethral enucleation of the prostate (TUEP), Laser Prostatectomy (Holmium laser ablation of the prostate [HoLAP]) , Holmium laser enucleation of the prostate [HoLEP] , Holmium laser resection of the prostate [(HoLRP]), transurethral ultrasound-guided laser induced prostatectomy (TULIP), visually-guided laser ablation of the prostate (VLAP), and Water Induced Thermotherapy (WIT) are outpatient ablation treatments for symptomatic benign prostatic hypertrophy (BPH). These procedures are non-surgical alternatives to transurethral resection of the prostate (TURP). The desired outcome is to relieve urinary symptoms and improve urinary function by reducing urinary obstruction caused by BPH. A urethral probe is used to apply thermal energy to the prostate, causing damage and eventual necrosis of excess prostatic tissue. These procedures are considered to be medically necessary when the following criteria are met:

EXCLUSIONS:
The Plan does **NOT** provide coverage for *transurethral balloon dilation or Drug-coated balloon catheter systems (e.g., Optilume®)* of the prostatic urethra because it is considered **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 **52284**

The Plan does **NOT** provide coverage for *Transurethral ethanol ablation of the prostate (TEAP)* used in the treatment of prostatic hypertrophy 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.

The Plan does **NOT** provide coverage for High-intensity focused ultrasound (HIFU) ablation used in the treatment of prostatic hypertrophy 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

MP051 Vagus and Trigeminal Nerve Stimulation – Revised – Add VNS Indication Clarification

INDICATIONS: Requires Prior Authorization by a Plan Medical Director or Designee

For EPILEPSY:

FOR COMMERCIAL AND MEDICAID BUSINESS SEGMENT:

Conventional implantable (open-loop) vagus nerve stimulator, may be considered medically necessary in members with a diagnosis of medically refractory partial-onset seizures*, for which surgery is not recommended or surgery has failed to control the events, and in which pharmacologic therapy has been maximized

*Partial onset seizures are divided into 3 subtypes:

a. Simple partial seizures: No alteration of consciousness, but may exhibit observable motor components, or may be solely a subjective sensory or emotional phenomenon.
b. Complex partial seizures: Involves an alteration of consciousness and may include automatisms, movements and staring, followed by a period of confusion, occasional amnesia and fatigue.
c. Complex partial seizures, secondarily generalized: Partial onset seizures that progress to involve both sides of the brain and result in complete loss of consciousness. These patients may continue on to experience a generalized tonic/clonic seizure. The presence of an aura prior to the generalized seizure, the observation of a focal symptom at the seizure onset, or a postictal focal deficit indicates the focal nature of the seizure.

Electronic analysis of an implanted neurostimulator pulse generator system for vagus nerve stimulation is considered medically necessary when the implantation has met the criteria for coverage.

FOR MEDICARE BUSINESS SEGMENT: See: NCD160.18 Vagus Nerve Stimulation (VNS)

For DEPRESSION:

FOR COMMERCIAL AND MEDICAID BUSINESS SEGMENT:

Consideration for coverage will default to the Behavioral Health department policies and/or applicable behavioral health vendor's policies.

FOR MEDICARE BUSINESS SEGMENT: See: NCD160.18 Vagus Nerve Stimulation (VNS)

On February 15, 2019 CMS issued an NCD that covers FDA approved vagus nerve stimulation (VNS) devices for treatment resistant depression (TRD) through Coverage with Evidence Development (CED) when offered in a CMS approved, double-blind, randomized, placebo-controlled trial with a follow-up duration of at least one year with the possibility of extending the study to a prospective longitudinal study when the CMS approved, double-blind, randomized placebo-controlled trial has completed enrollment, and there are positive interim findings.

For POST-STROKE REHABILITATION:

FOR COMMERCIAL AND MEDICAID BUSINESS SEGMENT:

The Plan considers the use of Vagus Nerve Stimulation as an adjunctive therapy during post-stroke upper limb rehabilitation (e.g., Vivistim® System) to be **unproven** and **NOT COVERED.** Although promising, the evidence is insufficient to determine whether the technology results in an improvement in the net health outcomes.

Although generally non-covered, consideration for in-system "per-case" provisional approval may be considered in those specific cases that meet all of the following:

- Post ischemic stroke (minimum of 6 months)
- Moderate to severe upper extremity deficit
- Residual hand/wrist functionality is intact
- Traditional therapy has plateaued

• Cognitive and physical ability to allow shared decision-making, follow command and actively participate in focused rehab program.

FOR MEDICARE BUSINESS SEGMENT: See: NCD160.18 Vagus Nerve Stimulation (VNS)
Per the CMS NCD16.18, VNS for this indication is **NOT COVERED**. All applications of VNS other than refractory partial onset seizures for whom surgery is not recommended or for whom surgery has failed, or for treatment resistant depression (TRD) through Coverage with Evidence Development (CED) is **NOT COVERED.**

MP056 Management of Excessive Skin and Subcutaneous Tissue – Revised – Added Headers for Clarity

INDICATIONS: REQUIRES PRIOR MEDICAL DIRECTOR or DESIGNEE AUTHORIZATION (For lines of business in which coverage is not explicitly excluded).

Abdominoplasty or Panniculectomy:

A member enrolled in a contract in which coverage is not explicitly excluded, may be eligible for an abdominoplasty or panniculectomy when **ALL** the following are met:

1. The pannus hangs below the level of the pubis; **AND**
2. One of the following:
   a. medical documentation of recurrent or chronic rashes, infections, chronic or recurrent intertrigo, candidiasis, cellulitis or tissue necrosis with inpatient or outpatient follow-up required; **OR**
   b. medical documentation of difficulty with ambulation and interference with the activities of daily living; **AND**
3. Symptoms or functional impairment persists despite significant weight loss defined as at least a 100 lb. weight loss or a weight loss which is 40% or greater of the excess body weight that was present prior to the member's weight loss program or surgical intervention, which has been stable for at least 3 months; **AND**
4. If the member has had bariatric surgery, they are at least 12 months post-operative and have documented stable weight for at least 3 months.

For areas other than the abdomen:
A member, enrolled in a contract in which coverage is not explicitly excluded, may be eligible for surgical management of excessive skin and subcutaneous tissue when ALL the following are met:

One of the following:
   a. medical documentation of recurrent or chronic rashes, infections, chronic or recurrent intertrigo, candidiasis, cellulitis or tissue necrosis with inpatient or outpatient follow-up required; **OR**
   b. medical documentation of difficulty with ambulation and/or interference with the activities of daily living; **AND**

If the member has had bariatric surgery, they are at least 12 months post-operative and have documented stable weight for at least 3 months

Lipedema:
Suction lipectomy (15876 – 15879) may be considered medically necessary for treatment of pain and disability from lipedema who have failed to respond to six or more months of conservative management (compression or manual therapy) lipedema when all of the following criteria are met:

- documentation of pain and hypersensitivity to touch in lipedema affected areas;
- functional impairments due to pain and/or mechanical restriction due to increased lipedema tissue;
- history of bruising without apparent cause in lipedema affected areas;
- lack of effect of weight loss on lipedema affected areas;
- tenderness and nodularity of fat deposits in lipedema affected areas

MP098 Genetic Testing/Colorectal CA – Revised – Add CMS Reference; Update Unproven Language

MEDICARE BUSINESS SEGMENT: See also NCA CAG-00440R Screening for Colorectal Cancer-Non-Invasive Biomarker Tests

Genetic testing is appropriate only when offered in a setting where a licensed or certified genetic counselor* or adequately trained health care professional is able to provide appropriate pre- and post-test genetic counseling, and medical necessity is supported by ALL of the following criteria:

1. The information is needed to adequately assess risk; and
2. The information will be used in the immediate care plan; and
3. Pedigree analysis establishes a high risk group for the disease; or
4. Clinical presentation of symptomology is evident and diagnosis cannot be established with conventional evaluation testing.

*A genetic counselor is considered by the Plan to be qualified if the following are met:

- M.S. or Ph.D. degree from a genetic counseling program approved/recognized by the American Board of Genetic Counseling or the American Board of Medical Genetics.

or

- Board certified or board qualified/eligible in the orderly process of obtaining board certification by the American Board of Genetic Counseling or American Board of Medical Genetics

and

- Proof of current competence and demonstrated ability (minimum of two years recent and continual experience within the past three years).

EXCLUSIONS:
There is no evidence to support the use of genetic testing for individuals from the general population with average risk. This is considered **NOT MEDICALLY NECESSARY.**

The ColonSentry testing panel is considered ~~**experimental, investigational, or**~~ **unproven** and **is NOT COVERED.** There are no current evidence-based guidelines from medical professional organizations or public health agencies that recommend ColonSentry for colorectal cancer screening and no evidence to support the use of this testing.

For Commercial and Medicaid Business Segments: The Epi proColon test is considered ~~**experimental, investigational, or**~~ **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 this test on health outcomes when compared to established tests or technologies.

MP240 Dermal Injections for Treatment of Facial LDS – Revised – Add CMS Reference and Product Names

DESCRIPTION:
Facial lipodystrophy Syndrome is characterized by facial wasting of fat under the skin of the face resulting in a gaunt or wasted appearance. Dermal fillers comprised of Poly-L-lactic acid and synthetic calcium hydroxylapatite (e.g. Sculptra and Radiesse) can be used to restore a more normal facial.

LIMITATIONS:
Medicare and Medicaid Business Segments: CAG-00412N NCD250.5

MP266 Magnetoencephalography and Magnetic Source Imaging – Revised – Updated Unproven Language

EXCLUSIONS:
MEG or MSI used as a stand-alone test or as the first order of test after clinical and routine electroencephalography (EEG) diagnosis of epilepsy because it is considered ~~**experimental, investigational or**~~ **unproven** and is **NOT COVERED.**

MEG or MSI used for evaluation of any of the following indications is considered ~~**experimental, investigational or**~~ **unproven** and is **NOT COVERED:**

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.

MP005 Medical Policy Process
MP063 Acupuncture
MP100 Electrical Bioimpedance
MP125 Cranial Remodeling Orthotic
MP137 Vibroacoustic Therapy
MP171 Clinical Guideline Development, Implementation, and Review Process
MP227 Spaced Retrieval Training
MP241 Non-invasive Measurement of Advanced Glycation Endproducts
MP279 Gene Expression Testing to Predict Coronary Artery Disease
MP304 Genetic Testing for Inherited Cardiomyopathies and Channelopathies
MP309 Computerized Dynamic Posturography
MP313 Environmental Lead Testing
MP323 Molecular Profiling of Malignant Tumors to Identify Targeted Therapies
MP325 Genetic Testing for Familial Hypercholesterolemia
MP346 Intraoperative Neurophysiologic Monitoring
MP376 Gene Testing to Predict Opioid Use Disorder Risk

Prior Authorization List

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

Prior Authorization Page

Sections with revisions are highlighted and updated monthly.