“What’s New” Medical Policy Updates February 2026

Listed below are the recent changes made to policies within the Geisinger Health Plan Medical Policy Portfolio during the months of December AND January that will become **effective March 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.

MP205 Advanced Molecular Topographic Genotyping – Revised – Remove Medicare Coverage

~~FOR MEDICARE AND MEDICAID BUSINESS SEGMENT:~~

~~**INDICATIONS:**~~
~~***REQUIRES PRIOR MEDICAL DIRECTOR or DESIGNEE AUTHORIZATION**~~

~~**Consideration for coverage is limited to the Medicare Business Segment, in compliance with CMS directives.**~~

~~Per the Medical intermediary, PathfinderTG® PancraGen™~~

~~Per the Medical intermediary, PathfinderTG® PancraGen™ PancreaSeq® will be considered medically reasonable and necessary when selectively used as an occasional second-line diagnostic supplement:~~

- ~~only where there remains clinical uncertainty as to either the current malignancy or the possible malignant potential of the pancreatic cyst based upon a comprehensive first-line evaluation; **AND**~~
- ~~a decision regarding treatment (e.g. surgery) has NOT already been made based on existing information.~~

~~The specific requirements for medical necessity involve:~~

- ~~Highly concise affirmation, documented in the medical record, that a decision regarding treatment has not already been made and that the results of the molecular evaluation will assist in determining if more aggressive treatment than what is being considered is necessary.~~
- ~~Previous first-line diagnostics, such as, but not restricted to, the following have demonstrated:~~
  - ~~A pancreatic cyst fluid carcinoembryonic antigen (CEA), which is greater than or equal to 200 ng/ml, suggesting a mucinous cyst, but is not diagnostic.~~
  - ~~Cyst cytopathologic or radiographic findings, which raise the index of malignancy suspicion, but where second-line molecular diagnostics is expected to be more compelling in the context of a surgical vs. non-surgical care plan.~~

EXCLUSIONS:

~~**For the Medicare and Medicaid Business Segment**, the Plan does NOT consider the use of advanced molecular topographic genotyping (including but not limited to Interspace Diagnostics Pathfinder TG®, PancraGEN®, PancraSeq®, BarreGEN®) medically necessary when used as a “first-line” pathology analysis.~~

~~Specific criteria of Non-coverage to include either:~~

- ~~Image-guided needle aspiration of the pancreatic cyst or cystic component of a mass lesion or dilated duct demonstrate definitive diagnosis of malignancy by cytology; **OR**~~
- ~~Cytology not showing malignancy but meets AGA guidelines to reach a definitive diagnosis of benign disease. Lesions must be:~~
  - ~~Under 1 cm;~~

- ~~Lack a solid component;~~
- ~~Lack concerning cytology features;~~
- ~~Lack main pancreatic duct dilatation of > 1cm in diameter with absence of abrupt change in duct diameter;~~
- ~~Have fluid CEA level not exceeding 5 ng/ml~~

~~**FOR NON-MEDICARE BUSINESS SEGMENT**:~~

MP273 Gene-based Testing and/or Protein Biomarkers – Revised – Expand Coverage for ExoDx

ExoDx Prostate (IntelliScore) (0005U)

1. The member is age > 50 years of age; and
2. The test will be performed prior to an initial prostate biopsy; or
3. The individual has had a prior negative prostate biopsy; and
4. There is continued clinical suspicion of prostate cancer based on elevation of prostate specific antigen (PSA) >3 ng/mL, and for whom an initial prostate biopsy or repeat prostate biopsy would be recommended by a urologist based on current standard of care.

MP307 Gender Dysphoria and Gender Confirmation Treatment – Revised – Add non-coverage for certain contracts

Note: Effective Jan 1, 2026, and after, some contracts will no longer offer coverage for chemical or surgical sex-trait modification. Contractual exclusions supersede this policy. FEHB members impacted by this exclusion who are in mid-treatment may request an exception for services through the prior authorization process and will be considered on a per-case basis.

MP308 Wireless Pulmonary Artery Pressure Monitoring – Revised – Add Medicare Cross Reference

MEDICARE BUSINESS SEGMENT: See also National Coverage Determination 20.36: Implantable Pulmonary Artery Pressure Sensors for Heart Failure Management

MP334 Genetic Testing for ~~Macular Degeneration~~ Ocular Diseases – Revised – Revise Title; Add Indications; Add Exclusions

INDICATIONS:
Inherited Retinal Dystrophies panel (81404, 81406, 81408, 81434, 81479)
For individuals with clinical signs of an inherited retinal degeneration, single gene or multi-gene panel testing is considered medically necessary. The American Academy of Ophthalmology recommends genetic diagnostic testing for the four major types of inherited retinal degenerations:

- Rod-cone degenerations (e.g., retinitis pigmentosa)
- Cone-rod degenerations (e.g., achromatopsia)
- Chorioretinal degenerations (e.g., CHM-associated retinal degenerations [choroideremia])
- Inherited dystrophies that involve the macula (e.g., ABCA4-associated macular degeneration [Stargardt disease]).

Testing for a biallelic RPEL65 variant **(81406)** is considered medically necessary for individuals with vision loss suspected to be due to biallelic RPE65 variant-associated retinal dystrophy and being considered for treatment with Luxturna

Genetic testing to establish or confirm the diagnosis and to guide management may be considered medically necessary when the member demonstrates clinical features consistent any of the following conditions

- Duane Syndrome
- Retinitis Pigmentosa
- Familial Exudative Vitreoretinopathy
- Aniridia
- X-linked Congenital Retinoschisis
- Presenile Cataract

EXCLUSIONS:
The Plan does **NOT** provide coverage for genetic testing for macular degeneration **(0205U)** 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.

The Plan does **NOT** provide coverage for genetic testing for glaucoma **(81404, 81406, 81407, 81408, 81479)** 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.

MP343 Percutaneous Electrical Nerve Field Stimulation (PENFS) – Revised – Add Exclusion

The Plan does **NOT** provide coverage for H-wave electrical stimulation devices for the treatment of pain from diabetic peripheral neuropathy, muscle spasms, temporomandibular joint (TMJ) dysfunction, reflex sympathetic dystrophy, or healing of wounds such as diabetic peripheral ulcers because it is considered **unproven.** There is insufficient evidence in the peer-reviewed medical literature to establish the effectiveness of this treatment on health outcomes when compared to established treatments or technologies for any indication.

MP386 Renal Denervation Technology – NEW

DESCRIPTION:
Renal Denervation technology, also known as renal sympathetic nerve ablation, is a minimally invasive percutaneous procedure that uses ultrasound or a radiofrequency catheter inserted through the femoral artery to selectively ablate the sympathetic nerve fibers surrounding the renal artery. Doing so, interrupts the influence of the sympathetic reflexes on the kidney and systemic hemodynamics. This therapy has been proposed as a non-pharmacologic treatment for members with treatment-resistant hypertension.

MEDICARE BUSINESS SEGMENT:
On October 28, 2025, CMS issued an NCD that covers FDA approved renal denervation (RDN) for uncontrolled hypertension under Coverage with Evidence Development (CED) when furnished in accordance with the coverage criteria specified in the NCD. The complete NCD decision memorandum is available on the CMS website (see link below).

https://www.cms.gov/medicare-coverage-database/view/ncacal-decision-memo.aspx?proposed=N&ncaid=318

COMMERCIAL AND NON-MEDICARE BUSINESS SEGMENTS:

The Plan does **NOT** provide coverage for Renal Denervation technology because it is considered **unproven.** 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 treatment on health outcomes when compared to established treatments or technologies.

EXCLUSIONS:
Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.

MP276 Hearing Aids – Revised – Add Medicare Cross Reference

Medicare Business Segment

Please see Medicare Benefit Policy Manual, Ch 16, Section 100
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c16.pdf

MP282 Termination of Pregnancy – Revised – Revise Criteria

For Geisinger TPA contract:
Termination of pregnancy may be considered only for the following indications:

1. The member's life is in danger due to a condition, illness, or injury, and medical documentation is submitted to support an abortion being necessary to avert the death of the insured individual; or
2. The member is an alleged victim of rape or incest and physician certification attests that
   i. a). the alleged rape or incest was reported to law enforcement or child protective services: or
   ii. b). the member was physically or psychologically unable to report the crime
   or
3. The fetus has been determined to have an anomaly not compatible with life as documented by the treating OB/GYN or MFM specialist

MP333 Coverage for Treatment of Rare Disease – Revised – Add Cross Reference

NOTE: Exome and Genome testing requires Prior Authorization as outlined in MP280 Exome and Genome Sequencing

MP350 Genetic and Biochemical Testing for Alzheimer's Disease and Dementia – Revised – Revise Criteria

INDICATIONS:
Germline testing via panel sequencing as a first line test is covered and considered medically necessary in the in members meeting the following clinical criteria:

1.Diagnosis of Amyotrophic Lateral Sclerosis (ALS) at any age, regardless of family history AND is considering therapy with Tofersen
2. Diagnosis of frontotemporal dementia at any age, regardless of family history, when necessary to aid in establishing a diagnosis.

Genoptying of APOE **(0596U)** is covered and considered medically necessary **ONLY** in members meeting the following clinical criteria:

1. Clinical diagnosis of Alzheimer's disease AND
   - 2. Required for eligibility to participate in clinical trial for anti-amyloid therapeutics; **OR**
   - 3. Consideration of initiating Leqembi or Kisunla therapy

Genetic testing for amyloid precursor protein (APP), presenilin-1 (PSEN1), or presenilin-2 (PSEN2) for members with mild cognitive impairment or mild Alzheimer's D dementia who are less than 50 years of age as a companion diagnostic test and are being considered for aducanumab (Aduhelm) or lecanemab-irmb (Leqembi) therapy. **81406**

Cerebrospinal fluid testing for measurement of phosphorylated tau (P-tau) protein and long form amyloid beta (also referred to as Aβ, Aβ1-42, Beta-amyloid [1-42], and Abeta42) is considered medically necessary in individuals when AD is suspected and for whom treatment with amyloid beta targeting therapy is being considered. **0346U, 0358U, 0445U, 0459U, 0568U**

EXCLUSIONS:
The Plan considers testing of genetic markers APOE, TREM2, APP, PSEN1, and/or PSEN2 for the diagnosis of Alzheimer's disease not meeting the criteria listed above to be **unproven** and therefore **NOT COVERED** as a diagnostic technique for individuals in:

- symptoms suggestive of Alzheimer's disease/ early-onset Alzheimer's disease(EOAD), or
- asymptomatic individuals with a family history of Alzheimer's disease/ early onset Alzheimer's disease.

There is insufficient evidence in the peer-reviewed medical literature to support routine APOE genotyping OR panel testing for Alzheimer disease-related gene variants for members with suspected AD. According to the American Academy of Neurology (AAN) there is not sufficient data to support that this testing improves health outcomes and is considered to be Unproven ~~providers meaningful therapeutic opportunities for people diagnosed with Alzheimer's disease, dementia, or mild cognitive impairment~~ unless otherwise specified in this policy.

MP367 Prescription Digital Therapeutics – Revised – Add Exclusion

EXCLUSIONS:
Unless otherwise specified, the Plan does **NOT** provide coverage for Prescription Digital Therapeutics, including but not limited to Freespira, reSET, reSET-o, Insulia, BlueStar, NightWare, CanvasDx, Somryst, d-NAV System, EndeavorRX, CureSight CS 100, Luminopia One, d-Nav Insulin Management Program and Parallel to evaluate, diagnose, manage symptoms, or treat an illness, injury, or disease because this technology is considered **unproven**. 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.

MP379 Wound Imaging and Nonthermal Wound Therapy – Revised – Add Exclusion

EXCLUSIONS:
There is insufficient evidence in the published, peer-reviewed medical literature to support the use of any of the following procedures. They are considered to be **Unproven** and therefore **NOT COVERED**.

- Clarifi Imaging System
- Point-of-care fluorescence imaging of wounds [e.g., *MolecuLight]*
- Noncontact normothermic wound therapy (NNWT) and warming therapy [e.g.,*Warm-Up Active Wound Therapy*]
- Noncontact, nonthermal, low-frequency ultrasound therapy for the treatment of wounds and all other indications [e.g., *AR1000 Ultrasonic Wound Therapy System, AS1000 Ultrasound Wound Therapy System, SonicOne Plus Ultrasonic Wound Care System, SONOCA 180/185 Wound Care System*]

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.

MP055 Mastectomy for Gynecomastia
MP073 Deep Brain Stimulation
MP108 Work Hardening/Conditioning
MP191 Mindstreams Cognitive Health Assessment
MP201 Obstructive Sleep Apnea
MP210 Endometrial Ablation
MP224 Topical Oxygenation
MP230 Outpatient Pulmonary Rehabilitation
MP312 Routine Care in Clinical Trials
MP365 Multi-Cancer Early Detection Testing
MP077 Noninv Mech tx for Back Pain
MP123 HDR Temp Brachytherapy
MP318 Sphenopalatine Gangloin Block for Headache

MP019 Laser Tx of Cutaneous Lesions
MP064 Breast Reconstruction
MP099 Breast Implant Removal
MP126 Massage Therapy
MP130 Automated Amb. BP
MP155 Cooling Devices
MP315 Esophageal Sphincter Augmentation
MP381 Trigeminal Neuralgia
MP006 Nocturnal Enuresis Alarm
MP095 Craniosacral Therapy
MP119 Therapeutic Listening
MP138 Lysis Epidural Adhesions
MP142 Anodyne Infrared Therapy
MP149 Pulsed Electrical Stimulation for Osteoarthritis
MP169 Retinal Prosthesis
MP217 Polysomnography and Sleep Studies
MP250 Bronchial Thermoplasty
MP352 Epidermal Nerve Fiber Density Testing

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.