"What's New" Medical Policy Updates July 2026

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, 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.

MP003 Ocular Photodynamic Therapy (revision) – Add Indication

INDICATIONS:

1. Age-related macular degeneration (AMD) with predominately classic subfoveal choroidal neovascularization (CNV) lesions (where the area of classic CNV occupies greater than 50% of the area of the entire lesion) at the initial visit as determined by a fluorescein angiogram; **or**

2. Subfoveal occult lesions with no classic CNV associated with AMD; **or**

3. Subfoveal minimally classic CNV (where the area of classic CNV occupies less than 50% of the area of the entire lesion) associated with AMD; **or**

   NOTE: Indications 2 and 3 are considered medically necessary only when:
   a) The lesions are small (4 disk areas or less in size) at the time of initial treatment or within the 3 months prior to initial treatment; and
   b) The lesions have shown evidence of progression within the 3 months prior to initial treatment. Evidence of progression must be documented by deterioration of visual acuity (at least 5 letters on a standard eye examination chart), lesion growth (an increase in at least 1 disk area), or the appearance of blood associated with the lesion.

4. Subfoveal CNV secondary to Infection by Histoplasma capsulatum, retinitis; **or**
5. Subfoveal CNV secondary to Progressive high (degenerative) myopia; **or**
6. Chronic central serous chorioretinopathy

MP045 Chest Percussion Vest (revision) – Add Medicare Cross Reference

MEDICARE BUSINESS SEGMENT: See Also: A52494 High Frequency Chest Wall Oscillation Devices - Policy Article

MP134 Gastric Electrical Stimulation (revision) – Add Criteria

DESCRIPTION:

Gastric electrical stimulation has been proposed for use in patients with gastroparesis who are refractory to medical treatment. This implanted device delivers high-frequency electrical stimulation at four times the basal rate to the stomach. The proposed use of this device is believed to reduce the symptoms of gastroparesis such as nausea and vomiting and is thought to improve gastric emptying. The Enterra Therapy System is a Class III medical device regulated under the Humanitarian Device Exemption (HDE) pathway (HDE Number: H990014).

Revision or Replacement

Revision or replacement of a gastric electrical stimulator is considered medically necessary when all of the following criteria are met:

- The member demonstrated clinical benefit from gastric electrical stimulation; and
- The device has malfunctioned.

Removal of a gastric electrical stimulator (does NOT require prior authorization)

Removal of a gastric electrical stimulator is considered medically necessary when any of the following criteria are met:

- Complications including, but not limited to infection, obstruction, gastric perforation, lead migration or malfunction, **or**
- When gastric stimulation is unsuccessful after an adequate trial period (at least one year)

MP136 Alternative Medicine Therapies (revision) – Add 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:

Antineoplaston therapy
Apitherapy
Aromatherapy
Art therapy *
Ayurveda
Bee sting therapy
Bioidentical hormone therapy
Biomagnetic therapy
Biometric collection devices (eg, Oura ring)
Body wraps
Brainspotting
Chinese herbal medicine
Colonic irrigation
Cupping
Dance/Movement therapy
Di Bella Cancer Therapy
Electrodermal stress analysis
Emotional Freedom Technique (aka, EFT, Tapping)
Exercise With Oxygen Therapy (EWOT)
Faith healing
Gemstone therapy
Gerson therapy
Greek cancer cure
Guided imagery
Herbal medicine
Hippotherapy
Homeopathy
Hoxsey method
Humor therapy
Hydrazine sulfate
Hydrogen peroxide therapy
Hydrotherapy* (eg, spa therapy, water cure, etc.)
Insulin potentiation therapy
Intravenous micronutrient therapy (Myers' Cocktail)
Intravenous vitamin C infusion
Inversion therapy
Kambo Cleanse Therapy
Livingston-Wheeler therapy
Magnet therapy
Micronutrient testing
Mistletoe extract
Moxibustion
Music therapy*
OTC Supplements
Ozone therapy
PFAS (forever chemical) Testing
Pilates
Placentophagy
Polarity therapy
Polarity therapy
Primal therapy
Psychodrama
Purging
Qigong
Reflexology
Reiki
Revici's guided chemotherapy
Rolfing
Sauna
ScoliSmart Program and Suit
Shark cartilage products

Therapeutic touch
Transcendental meditation
Visceral manipulation therapy
Whitcomb Technique
Whole body vibration therapy
Wilderness Therapy
Yoga

MP282 Termination of Pregnancy (revision) – Revise Medicaid Coverage

For Medicaid Business Segment: NO PRIOR AUTHORIZATION REQUIRED
Per the directive issued by the Pennsylvania Medical Assistance Program, abortion services must be covered in all legal instances and is no longer limited to coverage only in cases of rape, incest, or a threat to the life of the mother. The PA Department of Human Services Physician Certification for an Abortion form must be completed and submitted. ~~with the prior authorization request.~~

EXCLUSIONS:
Unless otherwise specified, elective abortion not meeting the criteria set forth in this policy is contractually excluded from most plans and therefore **NOT COVERED.**

MP314 Molecular Testing - General Guidelines (revision) – Add Policy Title

Diagnostic testing (non-cancer): identifies, confirms or rules out specific conditions of chromosomal or genetic etiology. Specific policies may apply. See also: *HPV DNA Testing; Janus Kinase 2 Gene Mutation Analysis; Gene Expression Testing to Predict Coronary Artery Disease; Genetic Testing For Inherited Thrombophilia/ Hypercoagulability; Genetic Testing for Familial Hypercholesterolemia; Whole Exome Sequencing; Genetic Testing For Inherited Thrombophilia/ Hypercoagulability, Genetic and Biochemical Testing for Alzheimer's Disease and Dementia; Genetic Testing for Mitochondrial Disorders; Genetic Testing for Monogenic and Syndromic Obesity; Genetic Testing for Neuromuscular Disorders, Genetic Testing for Sensorineural Hearing Loss*

MP350 Genetic and Biochemical Testing for Alzheimer's Disease and Dementia (revision) – Revise Medicare Coverage Position

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, 82233, 82234, 84394 (Note: 82233, 82234 and 94394 NOT COVERED for Medicare)**

MP390 Unproven Molecular and Genetic Tests (NEW)

DESCRIPTION:
There are commercially available genetic and molecular tests that come to market routinely throughout the year. Many are marketed with very limited published evidence regarding the clinical utility and/or the clinical and analytical validity. Tests included in this policy may prove to be valuable as diagnostic, prognostic, or therapeutic tests once the evidence base matures, but at present the evidence is insufficient to determine that the test results in an improvement in health outcomes.

The following genetic and molecular tests are considered to be of **unproven** value and are therefore **NOT COVERED. This is not an all-inclusive list.**

CPT/PLA Code	Brand Name	CPT/PLA Code	Brand Name
0619U	TruD MDS COPD	0001U	PreciseType® HEA Test
0620U	TruD MDS Hepatocellular Carcinoma	0002U	PolypDX
0621U	TruD MDS Lyme Disease	0007U	ToxProtect
0622U	TruD MDS Major Depressive Disorder	0008U	AmHPR® H. pylori Antibiotic Resistance Panel
0623U	TruD MDS Major Depressive Disorder,	0009U	DEPArray™ HER2
0624U	TruD MDS NASH	0650U	CKM PGxTM Panel
0625U	TruD MDS Osteoporosis	0652U	RenaPGx
0626U	TruD MDS Osteoporosis	0653U	RenaXome
0631U	Northstar Select CH	0618U	TruD MDS Bipolar
0638U	Bartonella ImmunoBlot IgG	0617U	TruD MDS ASCVD
0639U	Bartonella ImmunoBlot IgM	0616U	TruD MDS Alzheimer's & MCI
0634U	GeneStrat® ESR1	0649U	MAP-AD
0635U	AdvanceAD-Tx	0313U	RedPath Pathfinder TG, PancraGen
0636U	Babesia ImmunoBlot IgG	0312U	AVISE Lupus
0637U	Babesia ImmunoBlot IgM	0446U 0447U	AVISE CTD, AVISE SLE Monitor, AVISE SLE
0627U	TruD MDS Schizophrenia	0083U	Onco4D
0628U	RenaDx	0174U	LC-MS/MS Targeted Proteomic Assay
0629U	CRISPR-TB Blood Test	0248U	3D Predict Glioma
0630U	BluePrint® Molecular	0249U	Theralink Reverse Phase Protein Array
0640U	CNSide CSF Tumor Cell Enumeration	0285U	RadTox cfDNA
0641U	PredicineBEACON	0325U	3D Predict Ovarian PARP Panel
0642U	PredicineBEACON MRD	0435U	ChemoID
0643U	PredicineCARE Urine	0525U	3D Predict Ovarian
0644U	FusionMRDTM Monitoring,baseline	0153U	Insight TNBCtype
0645U	FusionMRDTM Monitoring	0259U	DCISionRT
0646U	Plasma Detect Genome MRD – Baseline	0377U	LipoScale
0647U	Plasma Detect Genome MRD Monitor	0415U	SmartHealth Vascular Dx
0648U	Oncomine Dx Express	0439U	Epi+Gen CHD
0649U	MAP-AD	0440U	PrecisionCHD
0578U	Merlin Test	0466U	CardioRisk+
0572U	ProsTAV	0206U	DISCERN
0550U	ClarityDx Prostate	0207U	DISCERN
0534U	PROSTOXTM ultra	0289U	MindX
0205U	Vita Risk	0412U	PrecivityAD
0018M	Pleximark	0584U	RT-QuIC Prion
81560	Pleximmune		
86352	Immuknow, Pleximmune,, myTAIHEART or CU Index,	0560U 0561U	Haystack MRD Baseline Haystack MRD Monitoring
0558U	IGoCheck	0013U	MatePair
0559U	MammoCheck	0014U	MatePair

0319U	Clarava	0050U	MyAML NGS
0320U	Tuteva	0438U	EffectiveRX Comprehensive Panel
0317U	LungLB, LungLife AI	0461U	RightMed
0395U	OncobiotaLUNG	0203U	PredictSURE IBD
0406U	CyPath Lung	0176U	IBSchek
0012M	Cxbladder™ Detect	0164U	ibs-smart
0013M	Cxbladder™ Monitor	0367U	Oncuria Predict
0452U	EarlyTect	0366U	Oncuria Monitor
0256U	Trimethylamine (TMA) and TMA N-Oxide	0365U	Oncuria Detect
0580U	iDart™ Lyme IgG ImmunoBlot Kit	0615U	iDart™ Lyme IgM ImmunoBlot Kit
0614U	Blue Native Polyacrylamide Gel Electrophoresis	0623U	TruD MDS Multiple Sclerosis
0618U	TruD MDS Bipolar	0624U	TruD MDS NASH
0619U	TruD MDS COPD	0625U	TruD MDS Osteoporosis
0622U	TruD MDS Major Depressive Disorder	0626U	TruD MDS Parkinson's
0627U	TruD MDS Schizophrenia	0629U	CRISPR-TB Blood Test™
0635U	AdvanceAD-Tx	0613U	AssureMDx
0549U	BladderCARE		
0365U	Oncuria Detect		
0366U	Oncuria Monitor		
0367U	Oncuria Predict		

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.

MP004 Biofeedback
MP074 Interactive Metronome Training
MP084 Stereotactic Radiosurgery
MP089 Evaluation of Breast Ductal Lavage
MP110 Uterine Artery Embolization
MP124 Transpupillary Thermotherapy
MP144 Vitamin B12 Injection Therapy
MP152 Low Level Laser Therapy
MP174 Exhaled Nitric Oxide for Asthma Management
MP203 Radiofrequency Ablation Therapy for Barrett's Esophagus
MP209 Medical Error Never Events
MP216 Quantitative EEG (QEEG)
MP247 Nutritional Supplements
MP249 Bioimpedance Spectroscopy
MP256 Transoral Incisionless Fundoplication
MP271 Non-Invasive Testing for Fetal Aneuploidy
MP344 Sublingual Immunotherapy
MP358 Home Accessibility Durable Medical Equipment
MP359 Medical Daycare
MP372 Electrodermal and Surface Electromyographic Seizure Detection Devices

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.