“What’s New” Medical Policy Updates June 2026

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

MP040 Somnoplasty/Coblation – Revised – Add Exclusion

EXCLUSIONS:
Submucosal cryolysis is considered **unproven** and **NOT COVERED.** There is insufficient evidence in the peer-reviewed published medical literature directly comparing submucosal cryolysis to the established alternatives. **(See also: MP187 Cryoablation)**

MP075 Tissue Engineered Skin Substitutes – Revised – Add Breast Reconstruction Section

Breast Reconstruction:

Acellular dermal matrix products listed below are covered for post mastectomy breast reconstruction:

AlloDerm Regenerative Tissue Matrix **(Q4416)** (aseptic or sterile)
Cortiva **(A4100)**
DermACELL **(Q4122)**
DermaMatrix **(A4100)**
FlexHD **(Q4128)**
SimpliDerm **(Q4100)**
Strattice **(Q4130)**
SurgiMend **(C9358) (C9360)**

EXCLUSIONS:

The use of tissue engineered skin equivalents and wound products not specifically listed under Indications is considered **unproven** and is **NOT COVERED.**

Repliform®	Conexa™	Hyalomatrix®	Repriza™
Puros® Dermis	CorMatrix®	InteguPly™	Restore® Orthobiologic
AlloMend™	CRXa™	Jaloskin®	Seamguard®
Puracol®	CryoSkin®	LiquidGen™	SportMesh™
Alloskin™	Cuffpatch™	MariGen Omega3	SS Matrix™
Alloskin RT™	Cymetra	Matriderm®	Stimulen™ Collagen
AlloWrap®	DeNovo® NT Graft	Matristem®	StrataGraft®
AmnioCare®		Matrix HD™	Strattice™
AmnioExcel™	Dermadapt™ Wound Dressing	MediHoney®	Suprathel®
AmnioFix™	DermaMatrix™	Medeor™	SurgiMend®

Amniomatrix™	DermaSpan™	Mediskin®	Surgisis® (including Surgisis® AFP™ Anal Fistula Plug, Surgisis® Gold™ Hernia Repair Grafts, and Surgisis™)
AmnioMTM™	DressSkin™	Memoderm™	Talymed™
AmnioShield®	Duraform™	Menaflex™	TenoGlide™
Aongen™ Collagen Matrix	Duragen® XS	Meso BioMatrix™	TenSIX™
Architect Extracellular Matrix™	Duragen™ Plus		TheraForm™ Standard/Sheet
ArthroFlex®	DuraMatrix™	NEOX® 100 Quick-Peel	TissueMend®
Atlas Wound Matrix	Durepair® Regeneration Matrix	NEOX® 1k Wound Matrix	TranzGraft®
Avance® Nerve Graft	Endobon® Xenograft Granules	NEOX® FLO NuCel™	Unite™
Avaulta Plus™	Endoform™	Neuragen®	Veritas® Collagen Matrix
AxoGuard® nerve connector	ENDURAgen™	NeuraWrap™	X-Repair
AxoGuard® nerve protector	Inforce®	Neuroflex™	XCM Biologic™
CollaFix™	EpiDex®	NeuroMatrix™	Xelma®
BioDDryFlex®		NeuroMend™	XenMatrix™
Biodesign	Excellagen®	NuCel®	Xwrap™ (Hydro, DRY, and ECM)
BioDExCel™	EZ Derm™	Collamend™	hMatrix®
BioDfactor™	CollaWound™	CollaSorb™	Amniply
BioDfence®	FloGraft™	OrthADAPT™	Reguard
BioDOptix™	FortaDerm™ Wound Dressing	OsseoGuard®	Cortiva
BioFiber™	Gammagraft™	Ovation®	AllopatchHD **Requires Program Exception for Medicaid**
Biovance®		Puraply	
C-QUR™	GORE®Bio –A	Pelvicol®	Guardian **Requires Program Exception for Medicaid**
Celaderm	Grafix® CORE	Pelvisoft®	PTFE felt
CellerateRX®	Grafix® PRIME	Peri-Guard® Repair Patch	Helicoll
CelluTome™	GraftJacket™	Peri-Strips Dry®	CLARIX™ FLO
CLARIX™ 100 Quick-Peel	Graftjacket™ Xpress injectable	Permacol™	Promogran™
CLARIX™ 1k	HA Absorbent Wound Dressing	Via Matrix	Microlyte painguard
Foundation drs+ solo and duo	Novashield or novogen wound matrix	Biolab membrane wrap flow,lite flow and solo	Biolab tri-membrane wrap flow

Revive ft and tl	DermaBind DL N; DermaBind DL +; DermaBind DL X	Dermabind tl + or dermabind tl x	Dermabind sl n or dermabind sl + or dermabind sl x
Renati membrane	Renati ac membrane	Revival ac	Dermabind ch n or dermabind ch x
Pretect	Instagraft	Curamatrix	

EXCLUSIONS:
The use of tissue engineered skin equivalents not specifically listed in this policy for use in diabetic foot ulcers or venous leg ulcers or in any application outside of the current FDA approvals is considered **unproven** and is **NOT COVERED**.

When the skin substitute grafts/CTP HCPCS code is determined to be unproven and not medically necessary, the related application code(s) will also be non-covered as not medically necessary.

MP135 Osseointegrated Hearing Device – Revised – Add Exclusion

EXCLUSIONS:
Osseointegrated hearing devices are excluded from coverage when qualifying criteria are not met.

The Plan does **NOT** provide coverage for the use of Intra-oral bone conduction hearing aids (e.g., the SoundBite hearing system) for the treatment of hearing loss 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.

The Plan does **NOT** provide coverage for replacement of a functional osseointegrated hearing device based on age of the device or current state of technology. The processor must be non-functional. Age of the device alone does not meet medical necessity for replacement of the processor or components.

Semi-implantable and fully implantable middle ear hearing aids (e.g., Vibrant Sound Bridge, Maxum System, and Esteem device) are considered **unproven** and **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.

MP187 Cryoablation – Revised – Add Exclusion

EXCLUSIONS:
Cryoablation of benign or malignant breast lesions is considered **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 technology on health outcomes when compared to established tests or technologies.

For the Medicaid Business Segment cryoablation of breast fibroadenoma may be considered as a program exception.

Cryoablation for the treatment of plantar fasciitis or plantar fibroma is considered **unproven** and therefore **NOT COVERED.** There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this technology on health outcomes when compared to established tests or technologies.

Cryoablation for the treatment of chronic rhinitis is considered **unproven** and therefore **NOT COVERED**. There is insufficient evidence in the peer-reviewed published medical literature to establish the

effectiveness of this technology on health outcomes when compared to established tests or technologies. **Please also see MP 204 Nasal and Sinus Surgery**

Submucosal cryolysis is considered **unproven** and **NOT COVERED**. There is insufficient evidence in the peer-reviewed published medical literature directly comparing submucosal cryolysis to the established alternatives.

MP199 Corneal Pachymetry – Revised – Add Indication

INDICATIONS:
Corneal pachymetry may be considered medically necessary for **any** of the following conditions:

- To assist in the diagnosis of corneal thinning disorders; **or**
- To assess corneal edema; **or**
- To assess corneal ectasia; **or**

MP213 Computerized Corneal Topography – Revised – Add Indications

INDICATIONS:
Computerized Corneal Topography may be considered medically necessary for ANY of the following indications:

- Diagnosis and management of keratoconus, bullous keratopathy, corneal scarring, or corneal dystrophy;
- Complications post-corneal transplant
- Central corneal ulcer
- Monocular diplopia
- Post-operative management of penetrating keratoplasty or cataract surgery;
- pterygium and/or corneal ectasia
- evaluation of post-surgical or post-traumatic astigmatism

MP259 Phototherapy for the Treatment of Dermatological Conditions – Revised – Add Exclusion; Add Medicare Cross Reference

MEDICARE BUSINESS SEGMENT: See also; National Coverage Determination (NCD) Treatment of Actinic Keratosis 250.4

EXCLUSIONS:
Phototherapy as a first line of therapy for any dermatological condition is considered **not medically necessary.**

Home tanning beds for any use is **NOT COVERED.**

Phototherapy is considered COSMETIC when used to alter one's appearance, including but not limited to Vitiligo (except as noted above), Alopecia Areata, and therefore is **NOT COVERED.**

The Plan does NOT routinely provide coverage for Phototherapy as a treatment for hair removal or rejuvenation of skin tone because it is considered **unproven** 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.

MP356 Genetic Testing for Mitochondrial Disorders – Revised – Add General Info

CRITERIA FOR COVERAGE: REQUIRES PRIOR AUTHORIZATION BY A PLAN MEDICAL DIRECTOR OR DESIGNEE

Genetic testing (whole mtDNA sequencing and deletion/duplication analysis) for mitochondrial disorders (e.g, Alpers' syndrome; Leigh syndrome; Leber's hereditary optic neuropathy (LHON); mitochondrial encephalopathy, lactic acidosis and stroke-like episodes (MELAS); Myoclonic Epilepsy and Ragged-Red Fibers (MERRF); Chronic Progressive External Ophthalmoplegia (CPEO); Neuropathy, ataxia, and retinitis pigmentosa (NARP); Kearns-Sayre syndrome) will be considered medically necessary when the following criteria are met:

MP389 Genetic Testing for Hereditary Hearing Loss – NEW Policy

DESCRIPTION:
Genetic hearing loss occurs when changes in certain genes affect how the hearing system develops and works. Approximately 50 to 60 percent of all hearing loss has a genetic basis. Several different gene variants have been identified that can disrupt the formation of critical parts of the inner ear or interfere with the functioning of hair cells, which are essential for making sound into signals that the brain can understand. Depending on the specific gene involved hearing loss can be present at birth (congenital) or develop it later in life.

INDICATIONS:
Confirmation testing in members with suspected hearing loss who are in a family with a known deleterious familial hearing loss gene variant, the following testing is considered medically necessary:

- Targeted gene testing restricted to the known familial variant; **(81252, 81253, 81254, 81403)**

In members diagnosed with hearing loss and with pedigree analysis suspicious of familial hearing loss, the following testing is considered medically necessary:

- Comprehensive genetic testing using multi-gene panel testing when the specific familial variant is unknown. (**81430, 81431)**

In members diagnosed with l hearing loss in which non-hereditary causes (e.g., infection, injury, age-related) have been ruled out, the following testing is considered medically necessary:

- Multi-gene panel testing (panel must include GJB2 and GJB6) **(81430, 81431)**

Carrier testing for hereditary hearing loss-related genes (e.g., GJB2, GJB6 and other hereditary hearing loss related genes) in parents may be considered medically necessary when at least one of the following conditions has been met:

- One or both of the parents has a suspected or confirmed hereditary hearing loss; OR
- First or second-degree relative with a known hereditary hearing loss; OR
- Offspring diagnosed with hereditary hearing loss; OR
- First-degree relative with offspring diagnosed with hereditary hearing loss

EXCLUSIONS:
Repeat genetic testing for hereditary hearing loss-related gene variants is considered **Unproven** and is therefore **NOT COVERED.**

Genetic testing for hearing loss in circumstances not listed above is considered **Unproven** and is therefore **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.

MP049 Visual Field Testing
MP054 Prophylactic Mastectomy
MP057 Prophylactic Oophorectomy
MP060 Lung Volume Reduction
MP093 Uroleume
MP101 Intracavitary Balloon Catheter Brain Brachytherapy
MP129 Total Parenteral Nutrition
MP131 VitalStim NMES
MP146 Sympathetic Therapy
MP150 Carotid Artery Stent
MP154 Transanal Radiofrequency Therapy for Fecal Incontinence (Secca)
MP193 Microvolt T-wave Alternans
MP229 Prolozone Therapy
MP290 Fecal Microbiota Transplantation
MP342 Non-Wearable AED
MP370 Endobronchial Valve
MP375 Technology Assessment

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.