“What’s New” Medical Policy Updates March 2026

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

MP192 Intensity Modulated Radiation Therapy – Revised – Add Indication; Update Unproven Language

INDICATIONS:
It is not possible to preclude the use of IMRT for tumors based solely on their primary site of origin. Therefore, there is no definitive list of approved indications for IMRT. The following list of indications are supported by current literature; however, this list may not be all inclusive:

IMRT may be considered medically necessary for the following indications when qualifying criteria are met:

- Prostate carcinoma when a radiation dosing/fractions guidelines per current NCCN/ASTRO guidelines are met **or**
- Primary radiosensitive benign or malignant tumors of the central nervous system (e.g., brain, head, neck, spine or paraspinal regions)
- Primary benign or malignant lesions of the head and neck
- Mediastinal tumors, thymoma, tracheal cancer
- Abdominal, pelvic or retroperitoneal tumors when:
  The planned target area has been previously radiated; **or**
  A critical structure is located in the planned radiation field; **or**
  The function or capacity of the targeted organ is significantly limited
- Squamous cell cancer of the anus or anal canal
- Esophageal or tracheal cancer
- Pancreatic cancer
- Cervical, uterine, vulvar cancer
- Primary bone tumors
- Lung cancer when:
  The planned target area has been previously radiated
  A critical structure is located in the planned radiation field; or
  Pulmonary function or capacity is significantly limited
- Breast cancer when:
  There has been prior radiation treatment of the chest wall; or
  The planned treatment field includes the heart; or
  When treatment with 3-D conformal radiation results in focal regions with dose variation greater than 10% of target (i.e. “hot spots”) and can be avoided with IMRT

EXCLUSIONS:
IMRT for the treatment of abdominal or pelvic tumors not meeting the criteria listed is considered to be ~~experimental, investigational or~~ unproven and is **NOT COVERED.**

MP245 Helicobacter pylori Testing – Revised – Add Indication

INDICATIONS:
Based on guidelines of the American Gastroenterological Association (2005) and the American College of Gastroenterology (2007), carbon isotope urea breath testing (^{13}C or ^{14}C) or stool antigen testing is considered to be medically necessary in insured individuals who meet any of the following conditions:

- Active peptic ulcer disease (gastric or duodenal ulcer) or symptoms consistent with peptic ulcer disease
- Confirmed history of peptic ulcer disease and not previously treated for *H. pylori*
- Low-grade mucosa-associated lymphoid tissue (MALT) lymphoma
- Post resection of early gastric cancer
- Gastric intestinal metaplasia
- Evaluation of individuals with chronic immune thrombocytopenic purpura (ITP) and suspected H. pylori infection
- Insured individuals less than 55 years of age who have persistent dyspepsia without alarm symptoms
- To confirm eradication prior to cessation of treatment if recurrent or refractory peptic ulcer disease is present
- Pre-operative assessment prior to bariatric surgery

Individuals initiating chronic treatment with non-steroidal anti-inflammatory drugs

MP281 Bone Morphogenetic Protein – Revised – Remove Indications

DESCRIPTION:
Bone morphogenetic protein is naturally occurring protein found in human bone which plays an active role in bone formation. There are several bone morphogenetic proteins (BMPs) that have been identified. Additionally, there are several recombinant human bone morphogenetic proteins (rhBMPs). ~~However, at present, there are only two which have been developed for use: rhBMP-2 and rhBMP-7.~~

INDICATIONS:
Use of recombinant human bone morphogenetic protein-2 (rhBMP-2, InFUSE, etc.) is considered medically necessary for any of the following indications:

- anterior spinal interbody fusion, in conjunction with an FDA-approved interbody fusion device, at one or more levels in skeletally mature patients with degenerative disc disease from L2-S1. Patients should have failed at least 6 months of conservative treatment.
- use with spine implants made of polyetheretherketone (PEEK) in oblique lateral interbody fusion (OLIF) and anterior lumbar interbody fusion (ALIF) procedures as follows:
    - •OLIF with certain sizes of the PEEK Perimeter Implant at a single level from L5 to S1.
    - •OLIF with certain sizes of the PEEK Clydesdale Implant at a single level from L2 to L5.
    - •ALIF with certain sizes of the PEEK Perimeter Implant at a single level from L2 to S1
- instrumented posterolateral intertransverse spinal fusion procedures, in conjunction with an FDA-approved device, at one or more levels in skeletally mature patients with degenerative disc disease from L2-S1. Patients should have failed at least 6 months of conservative treatment.
- treatment of acute, open fracture of the tibial shaft
- localized alveolar ridge augmentation for defects associated with extraction sockets and sinus augmentation

~~Use of recombinant human bone morphogenetic protein-7 (rhBMP-7, OP-1) is considered medically necessary for any of the following indications:~~

- ~~As an alternative to autograft in patients at increased risk of autograft failure (e.g., osteoporosis, tobacco use, or diabetes) requiring non-instrumented revision posterolateral intertransverse~~

~~lumbar spinal fusion, for whom autologous bone and bone marrow harvest are not feasible or are not expected to promote fusion; or~~

- ~~As an alternative to autograft in long bone non-unions where use of autograft is not feasible and alternative conservative treatments have failed~~

EXCLUSIONS:
Bone morphogenetic protein (rhBMP-2 ~~or rhBMP-7~~) is considered ~~**experimental, investigational or**~~ **unproven** for all other indications, including but not limited to:

- Cervical spinal fusion
- Posterior or transforaminal lumbar interbody spinal fusion
- As initial treatment or revision of non-instrumented posterolateral intertransverse spinal fusion that does not meet the criteria listed above
- As an alternative or adjunct to bone grafting in other locations, including craniomaxillofacial surgeries
- Proficient

The rhBMP-7 product is no longer marketed in the United States, and is therefore **NOT COVERED**.

MP354 Breast Pump – Revised – Add Prior Auth Requirement

MEDICAID BUSINESS SEGMENT

Per MA Bulletin (MAB 01-25-41) Hospital-grade breast pumps **(E0604)** will require prior authorization if rented for more than six months.

MP360 Minimal Residual Disease NGS Testing – Revised – Add Indication

NavDx Test 0356U

Oropharyngeal cancer:

NavDx test is considered to be medically necessary for the surveillance of recurrence in members with a personal history of documented HPV-driven oropharyngeal cancer, who presently have no evidence of disease, starting three months following completion of any regimen of curative intent therapy, with a frequency of:

- 0-3 months, one (1) day after surgery or seven (7) days after CRT
- not more often than every three months for the first 24 months thereafter,
- not more often than every six months for the next 36 months thereafter,
- not more often than annually thereafter until if and when a positive test result is detected

Anal cancer:

NavDx test is considered to be medically necessary the surveillance of cancer recurrence in patients with a personal history of documented HPV-driven anal squamous cell cancer, who presently have no evidence of disease, following the completion of any regimen of curative intent therapy with a frequency of:

- not more often than every three months for the first 36 months,
- not more often than every six months for the next 24 months thereafter,
- Until if and when a positive test result is detected

MP387 Brain Computer Interface Rehabilitation Devices – NEW

DESCRIPTION: Brain computer interface (BCI) rehabilitation devices are electronic systems, either implanted in the brain or worn on the head, that allow people to control computers, robots, or other devices by detecting electrical brain signals related to the intent for movement and then using these signals to control a limb, computer or devices such as exoskeletons. The primary potential application of BCI technology is its use as an adjunct aid for motor recovery following a stroke by translating brain waves into signals controlling orthotic devices resulting in movement of paralyzed limbs. One BCI device is currently commercially available. It is used as an aid in post-stroke upper limb rehabilitation. The IpsiHand Upper Extremity Rehabilitation System (Neurosolutions, Inc.) went through the FDA de Novo classification process and was classified as a type II device with the generic name of an electroencephalography (EEG)-driven upper extremity powered exerciser in April 2021. The FDA de Novo classification process does not require that clinical data be submitted demonstrating that the device improves net health outcomes.

EXCLUSIONS:
The use of brain computer interface (BCI) rehabilitation devices is considered **unproven** and therefore **NOT COVERED.** There is insufficient evidence in the published, peer-reviewed medical literature to establish the net outcome benefits of this technology at this time**.**

MP217 Polysomnography and Sleep Studies – Revised – Retire Policy to Cohere Management

MP207 Corneal Hysteresis – Revised – Update Unproven Language

MP220 Epiretinal Radiation Therapy – Revised – Update Unproven Language

MP237 Transurethral Radiofrequency Tissue Remodeling – Revised – Update Unproven Language

MP238 Ocular Blood Flow Tonometer – Revised – Update Unproven Language

MP248 SNP's To Predict Risk of Non-Familial Breast CA – Revised – Update Unproven Language

MP252 Colon Motility Testing – 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.

MP010 Blepharoplasty
MP029 Bone Growth Stim
MP211 Endovascular Repair of Intracranial Aneurysms
MP226 Proton Beam Radiation
MP236 Immune Cell Function Assay for Transplant Rejection
MP254 Tinnitus Treatment
MP255 Comparative Genomic Hybridization or Chromosomal Microarray Analysis
MP262 Microarray Based Gene Expression Testing for Cancer of Unknown Origin
MP285 Tonsillectomy

MP286 Cholecystectomy
MP303 Genomic Analysis to Predict Thyroid Malignancy in FNA (Fine-Needle Aspiration)

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.