

“What’s New” Medical Policy Updates May 2026

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

MP033 Varicose Vein Treatments – Revised – Add Exclusion

EXCLUSIONS:

Sclerotherapy and/or surgical interventions for the treatment of varicose veins less than 3 mm are considered cosmetic and are **NOT COVERED**. Sclerotherapy for treatment of telangiectasias and/or surgical intervention for treatment of varicose veins, performed primarily for cosmetic purposes from which no significantly improved physiologic function could be reasonably expected are **Excluded** per the line of business specific benefit documents for commercial lines of business and LCD L27539 for GOLD, and is **NOT COVERED**.

Sclerotherapy is considered **unproven** for treatment of the saphenofemoral junction or the saphenous veins because sclerotherapy has not been proven to be effective for treatment of these large veins. Sclerotherapy alone has not been shown to be effective for persons with reflux at the saphenofemoral or saphenopopliteal junctions; under established guidelines, individuals with reflux should also be treated with endovenous ablation, ligation or division of the junction to reduce the risk of varicose vein recurrence.

Photothermal sclerosis (ie. Photoderm Vasculight) is considered **unproven** and is **NOT COVERED**. The effectiveness of this procedure has not been established in the current peer-reviewed published medical literature.

Laser treatment of telangiectasias is considered cosmetic and **NOT COVERED**.

Echosclerotherapy is considered unproven and is NOT COVERED

MP232 Autism Spectrum Disorder – Evaluation and Medical Management – Revised – Revise requirements for parity

MANAGEMENT SERVICES:

Physical Therapy, Speech Therapy and/or Occupational Therapy (limitations may be based on individual contract, or by state mandate).

Coverage for any of these therapies is considered medically necessary when all of the following criteria are met

- Physician provided documentation of a diagnosis of ASD according to the DSM-5; **and**
- Physician provided documentation of a physical, social or communicative impairment; **and**
- The therapy is provided by a healthcare provider who is appropriately licensed and is eligible to provide the service under the terms of the member’s contract; **and**
- The member’s progress is measured on an ongoing basis to assure that the objectives of the treatment plan are being met and refinements to that plan are made as appropriate; **and**
- The member’s parent(s) or caregiver is fully engaged in participation and providing the support required by the treatment plan.

Physical Therapy, Speech Therapy and/or Occupational Therapy may be deemed to be not medically necessary if:

- The treatment plan results in a consistently negative impact on function or behavior; or
- The member exhibits documented improvements in function and/or behavior that can be appropriately maintained in a less intensive or less structured program.

Applied Behavior Analysis

- Criteria for coverage will be in accordance with the OMHSAS Bulletin Medical Necessity Guideline for ABA using BSC-ASD & TSS Services for Children & Adolescents with ASD issued Jan 13th 2017.

DOCUMENTATION GUIDANCE REQUIREMENTS:

Treatment plans for individuals with autism spectrum disorder should at a minimum, include all of the following information:

- Physician's orders
- History
- Past services or therapies and the resultant outcomes
- Diagnosis and rationale for services requested
- Contraindications
- Specific treatment goals that are individualized and objectively measurable
- Service type
- Planned duration of frequency of service
- Parent(s) and/or caregiver(s) role in treatment plan
- Plan or schedule for goal updates based on progress
- Rationale for continued services (as applicable)
- Physical/occupational and/or speech therapy evaluation
- Detailed, specific short-term and long-term goals
- Specific treatment techniques to be utilized
- Signature of the member ordering physician and therapist

MP277 Vision Therapy/ Orthoptics – Revised – Clarify Indication

INDICATIONS: REQUIRES PRIOR AUTHORIZATION BY A PLAN MEDICAL DIRECTOR OR DESIGNEE unless contractually excluded.

For Medicaid Business Segment

Vision therapy/orthoptics may be considered medically necessary for members under age 21 when ordered by an ophthalmologist or optometrist a practitioner licensed to order for treatment of any of the following indications:

- Convergence insufficiency
- Strabismus
- Amblyopia

Commercial Business Segment:

Most contracts consider vision therapy to be contractually excluded and therefore **NOT COVERED**. Refer to the member specific benefit document. For contracts with no such exclusion, a maximum of 12 office-based orthoptic vision therapy visits or sessions will be considered medically necessary for treatment of convergence insufficiency or amblyopia.

MP321 Gene Expression Profiling for Cutaneous Melanoma – Revised – Update Criteria

COMMERCIAL AND MEDICARE BUSINESS SEGMENT:

DecisionDx-Melanoma (81529)

Gene expression profiling for cutaneous melanoma utilizing the DecisionDx-Melanoma test is considered medically necessary when the following criteria are met:

1. **Patients Members** diagnosed with pathologic stage sentinel lymph node biopsy (SLNB) eligible **T1-T2 T1b and T1a** cutaneous melanoma tumors with clinically negative sentinel nodes **basins and no evidence of metastatic disease** who are being considered for SLNB to determine eligibility for adjuvant therapy. (Per current NCCN and ASCO guidelines, SLNB eligible patients are defined as:
 - Patients with T1a tumors:
 - in whom there is significant uncertainty about the adequacy of microstaging (positive deep margin), or
 - with Breslow depth <0.8 mm and with other adverse features (eg. very high mitotic index [$\geq 2/\text{mm}^2$], lymphovascular invasion, or a combination of these factors); **OR**
 - Patients with T1b tumors (≥ 0.8 mm or < 0.8 mm with ulceration); **OR**
 - Patients with T2 tumors
2. **Members with clinical or pathological stage I-III cutaneous melanoma tumors with a Breslow depth of 0.3 mm or greater in whom the results of testing are necessary to inform subsequent management.**

MP097 Genetic Testing for BRCA – Revised – Update Unproven Language

MP329 Genuicular Nerve Ablation – Retired – Cohere Management

MP371 Intraosseous Basivertebral Nerve Ablation – Retired – Cohere Management

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.

MP037 Home Phlebotomy Program

MP039 Home Uterine Monitoring

MP044 Aquatic Therapy

MP062 TMLR

MP076 HH/DME Hyperbilirubinemia

MP081 Chelation Therapy

MP127 Prolotherapy

MP165 Treatment of Vestibular Disorders

MP179 Photodynamic Therapy for Oncology Applications

MP198 Pulse Oximetry for Pediatric Home Use

MP212 Non-Contact low-frequency Ultrasound Management (MIST Therapy)

MP223 Discography

MP233 Autologous Injectable Platelet and Blood Products

MP299 Measurement of Serum Antibodies to Infliximab and Adalimumab

MP335 Extracorporeal Photopheresis

MP343 Percutaneous Electrical Nerve Field Stimulation (PENFS)
MP351 Myoelectric Upper Extremity Orthotics

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.