“What’s New” Medical Policy Updates November 2025

Listed below are the recent changes made to policies within the Geisinger Health Plan Medical Policy Portfolio during the month of October that will become **effective December 15, 2025** (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.

MP023 Keratoplasty – Revised – Update Indication; Update Unproven Language

DESCRIPTION:
Keratoplasty (corneal transplantation) is a surgical procedure in which all or part of the cornea is replaced by healthy corneal tissue from a donor.

INDICATIONS:
Corneal opacification
Microbial /viral keratitis
Non-infectious ulcerative keratitis
Keratoconus
Corneal scarring
Chemical injury or mechanical trauma of the cornea
Corneal degeneration
Corneal dystrophy

MP091 Sacral Nerve Stimulation – Revised – Add Exclusion

EXCLUSIONS:
There is insufficient evidence in the peer-reviewed, published medical literature to support the use of sacral nerve stimulation as a treatment of stress incontinence, urinary obstruction, and specific neurologic diseases (e.g., diabetes with peripheral nerve involvement) which are associated with secondary manifestations of the above three indications. These applications are considered ~~**Experimental, Investigational, or**~~ **Unproven** and are **NOT COVERED.**

The Innova Feminine Incontinence Treatment System is considered ~~**Experimental, investigational or**~~ **Unproven** and is **NOT COVERED.**

Sacral nerve stimulation for the treatment of constipation and chronic pelvic pain is considered unproven and is **NOT COVERED.** There is insufficient support in the peer-reviewed published literature to show clinical benefit compared in these conditions.

MP112 Wireless Capsule Endoscopy – Revised – Add Medicare Cross Reference

Colon Capsule Endoscopy:

For Medicare Business Segment: See Also Novitas LCD L35089/A57753 Wireless Capsule Endoscopy

MP197 Janus Kinase 2 (JAK 2) Gene Mutation Analysis – Revised – Add Indication

INDICATIONS:

JAK 2^{V617F} mutation analysis is considered medically necessary in the evaluation of:

- Members presenting with clinical, laboratory or pathological findings suggesting classic forms of MPD/MPN/PMF
- Adults, age 21 or older, presenting with clinical, laboratory, or pathological findings suggesting classic forms of polycythemia vera; or
- Adults with isolated idiopathic erythrocytosis, AND a serum erythropoietin level <10.
- members diagnosed with Budd-Chiari Syndrome.

MP280 Exome and Genome Sequencing – Revised – Clarify Exclusion

EXCLUSIONS:
The Plan does NOT provide coverage for the use of exome sequencing for indications other than those listed above because it is considered experimental, investigational or unproven. There is currently insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of ES/GS on health outcomes for indications not specifically listed when compared to established tests or technologies for the following applications~~:~~

Exome or genome sequencing in the general population is considered unproven and not medically necessary, and therefore **NOT COVERED.**

Testing using exome or genome sequencing is considered unproven and not medically necessary, and therefore **NOT COVERED** for ANY of the following indications:

- Any testing using cell-free DNA
- Preimplantation testing of an embryo (0335U, 0336U)
- Carrier screening
- Diagnosis or prognosis of cancer

MP306 Tumor Treatment Fields – Revised – Add Medicare cross reference; Update LOB

~~COMMERCIAL AND MEDICARE~~ ALL BUSINESS SEGMENTS:

FOR MEDICARE BUSINESS SEGMENT: See Also: Noridian Healthcare Solutions, LLC Tumor Treatment Field Therapy (TTFT) L33803 and A52711

MP336 Genetic Testing For Inherited Thrombophilia/ Hypercoagulability – Revised – Add Cross Reference to Avalon Policy MPA M2041

INDICATIONS: See Also: MPA M2041 Venous and Arterial Thrombosis Risk Testing

MP378 Genetic Testing for Neuromuscular Disorders – Revised – Add Indications; Add Exclusion

INDICATIONS:

TARGETED VARIANT ANALYSIS

Targeted mutation analysis for a known familial variant associated with a neurodegenerative or neuromuscular disease is considered medically necessary when the member has a close blood relative with a known pathogenic variant for the disease.

COMPREHENSIVE NEUROMUSCULAR DISORDERS PANEL (81161, 81404, 81405, 81406)

Comprehensive neuromuscular panel testing is considered medically necessary to establish a diagnosis when the following criteria are met:
At least one of the following conditions are present:

- Neonatal stridor, respiratory insufficiency and episodic cyanotic and/or apneic episodes; **OR**
- Neonatal feeding difficulties, poor suck or choking; **OR**
- Neonatal generalized weakness, bulbar palsy, facial weakness or ptosis; **OR**
- Generalized or focal motor weakness; **OR**
- Muscle fatigability and/or atrophy with evidence of neuromuscular transmission defect(s) on electromyography: **OR**
- Ptosis or extraocular muscle weakness;

AND

- The member has undergone targeted analysis with non-diagnostic results; **OR**
- The member's presentation is inconsistent with a neuromuscular disorder for which a targeted gene analysis is considered to be the standard of care.

COMPREHENSIVE ATAXIA PANEL (0216U, 0217U 81185, 81189, 81286,81403, 81404)

Comprehensive ataxia panel testing is considered to be medically necessary in members who exhibit any of the following:

- Progressive dysarthria; **OR**
- Eye muscle weakness; **OR**
- Eye movement abnormalities; **OR**
- Progressive coordination difficulties with hand and/or finger movement; **OR**
- Progressive gait disturbance

AND

Non-genetic etiologies such as paraneoplastic disease, vascular disorders, alcoholism, nutritional deficiencies, and multiple sclerosis have been ruled out.

PARKINSON DISEASE

Multigene panel testing for Parkinson disease is considered to be medically necessary when:

- The member exhibits clinical symptoms of Parkinson disease before age 50; **OR**
- The member exhibits clinical symptoms pf Parkinson disease**; AND**
    - The member has a family history of at least one relative with Parkinson disease, movement disorder or dementia

CSF testing for biomarkers for detection of misfolded α-synuclein protein by qualitative seed amplification assay is considered to be **Unproven** and therefore **NOT COVERED**. **(0393U)**

MYOTONIC DYSTROPHY

CNBP repeat analysis and/or DMPK repeat expansion analysis is considered to be medically necessary in the following circumstances:

1. Members at any age with evidence of myotonic discharges on electromyography (EMG);

OR

2. Members at any age with evidence of grip myotonia

OR

3. Members at any age with at least one of the following:

- Distal extremity weakness; **OR**
- Face and neck weakness

AND at least one of the following

- Insulin insensitivity; **OR**
- Hypogammaglobulinemia; **OR**
- Posterior subcapsular cataracts; **OR**
- Cardiomyopathy or conduction defects

4. Neonates with at least two of the following presentations:
   - Respiratory insufficiency
   - Generalized weakness
   - Hypotonia
   - Facial weakness
   - Positional malformations (e.g., clubfoot deformity, etc)

5. Asymptomatic adult members with a close blood relative with known myotonic dystrophy

INHERITED PERIPHERAL NEUROPATHIES (e.g. Charcot-Marie-Tooth, etc) (81324, 81325, 81448)

Multigene panel testing for inherited peripheral neuropathies is considered to be medically necessary when the member exhibits one or more of the following:

- Distal muscle weakness and atrophy; **OR**
- Diminished tendon reflexes; **OR**
- Diminished ankle dorsiflexion (foot drop); **OR**
- Pes cavus deformity of the foot; **OR**
- Recurrent acute focal sensory and/or motor neuropathies; **OR**
- Painless nerve palsy after minor trauma or compression; **OR**
- Distal sensory loss

FRIEDREICH'S ATAXIA (0233U, 81284, 81285)

Testing for FXN repeat analysis or sequencing analysis is considered to be medically necessary the:

1. The member is at least 18 years of age, is asymptomatic and has biological sibling diagnosed with Friedreich's ataxia

OR

2. The member exhibits at least two of the following:
   - Progressive ataxia; **OR**
   - Dysarthria; **OR**
   - Diminished sense of position and/or vibration in the lower extremities; **OR**
   - Pyramidal weakness of the lower extremities; **OR**
   - Muscle weakness; **OR**
   - Optic atrophy or deafness; **OR**
   - Extensor plantar signs (Babinski sign); **OR**
   - Pes cavus deformity of the foot; **OR**
   - Diabetes or glucose intolerance; **OR**
   - Hypertrophic nonobstructive cardiomyopathy

AND

Non-genetic etiologies such as paraneoplastic disease, vascular disorders, alcoholism, nutritional deficiencies, and multiple sclerosis have been ruled out.

HEREDITARY SPASTIC PARAPLEGIA (81448)

Multigene panel testing is considered to be medically necessary to confirm clinical diagnosis in members who exhibit any of the following:

- Lower extremity spasticity; **OR**
- Lower extremity hyperreflexia and Extensor plantar signs (Babinski sign); **OR**
- Diminished sense of vibration in the lower extremities; **OR**
- Weakness of the hamstring, tibialis anterior or iliopsoas

AMYOTROPHIC LATERAL SCLEROSIS (ALS) (81179, 81403, 81404, 81405, 81406, 81407, S3800)

Multigene panel testing is considered to be medically necessary in members meeting the following criteria:

The member is at least 18 years of age and exhibits **ALL** of the following:

- Signs and symptoms of lower motor neuron degeneration; **AND**
- Signs and symptoms of upper motor neuron degeneration; **AND**
- Progressive worsening of symptoms; **AND**
- Absence of other disease states to account for the upper and lower motor neuron degeneration

DUCHENNE and BECKER MUSCULAR DYSTROPHY (0218U, 81161, 81408)

Genetic testing in for variants the DMD gene is considered to be medically necessary in the following circumstances:

- To confirm the diagnosis in member exhibiting signs and symptoms of a dystrophinopathy; or
- To confirm or exclude the need for surveillance in at-risk relatives; or
- For at-risk first and second-degree relative of an individual with a dystrophinopathy and results of testing will allow informed reproductive decision making; or
- Prenatal testing if at least one parent is known to be a carrier or has a close blood relative who has the disease or is a known carrier.
- To inform appropriate gene therapy opportunities if DMD testing was completed greater than one year ago AND was negative or uninformative

HUNTINGTON DISEASE (81271, 81274)

Genetic testing is considered to be medically necessary in members meeting the following criteria:

1. The member is
    - An adult with unexplained progressive choreatic movement disorder and neuropsychiatric disturbance; or
    - An adult with a 1st, 2nd or 3rd degree family member with a confirmed molecular diagnosis of the disease; or
    - A pediatric (<18 yrs) member with either:
        - A known family history of the disease; or
        - Two or more of the following symptoms:
            - Seizures
            - Rigidity
            - Gait disturbance
            - Oral motor dysfunction

    AND
2. The member has a documented assessment by a licensed clinical psychologist or social worker regarding implications of this testing

    AND
3. Informed consent for testing from the member or member's legal guardian has been obtained by the ordering provider or care team

HYPOKALEMIC PERIODIC PARALYSIS (81406, 81479)

Genetic testing of CACNA1S and SCN4A deletion/duplication analysis, or multigene panel to establish a genetic diagnosis of periodic paralysis may be considered medically necessary when:

- The member has had two or more attacks of muscle weakness with documented serum potassium less than 3.5mEq/L, and other causes of hypokalemia (e.g., renal, adrenal, thyroid dysfunction, etc) have been excluded

OR

- The member has experienced one attack of muscle weakness, and has a close relative who has had one attack of muscle weakness with documented serum potassium less than 3.5 mEq/L,

OR

- The member has a history of three or more of the following:
  - Symptomatic onset in the first or second decade, OR
  - Muscle weakness involving at least 1 limb lasting more than two hours, OR
  - The presence of triggers such as symptom onset during rest after exercise, stress, previous carbohydrate rich meal), OR
  - Symptomatic improvement or resolutiFon with potassium intake, OR
  - A positive family history of hypokalemic periodic paralysis in a close relative

SPINAL MUSCLE ATROPHY (see MP374): (81329, 81336, 81401, 81405, 0236U)

RETT SYNDROME (see MP374) (81302, 81304, 0234U)

EXCLUSIONS:
Targeted variant analysis in the absence of signs or symptoms of the disease, or in the absence of a blood relative with a known pathogenic variant is considered to be of **UNPROVEN** values and is therefore **NOT COVERED**.

CSF testing for biomarkers by qualitative seed amplification assay is considered to be **Unproven** and therefore **NOT COVERED.** There is insufficient evidence in the peer reviewed published literature to support the use of this testing at this time.

MP047 Hyperbaric Oxygen Therapy – Revised – Update Unproven Language

MP243 Anorectal Fistula Repair Using an Acellular Plug – 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.

MP020 Solid Organ Transplant Services
MP050 Surgical Correction of Chest Wall Deformities
MP058 Negative Pressure Wound Therapy
MP104 Subcutaneous Insulin Pump
MP159 Voice Therapy
MP187 Cryoablation
MP214 Iontophoresis
MP244 Pelvic Floor Stimulation
MP258 Hyperhidrosis
MP278 Hyperthermia in Cancer Therapy
MP292 Sympathetic Nerve Block

MP294 Intercostal Nerve Block
MP311 Genotyping or Phenotyping for Thiopurine Methyltransferase
MP322 Drug Testing in Substance Abuse Treatment
MP348 LTAC
MP355 Plasma-based Proteomic Testing in the Management of Pulmonary Nodules
MP374 Genetic Testing for Inheritable Diseases