"What's New" Medical Policy Updates November 2026

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, 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.

MP020 Solid Organ Transplant Services – Revised – Add CMS Cross Reference

For Medicare Business Segment See : NCD 260.9 Heart Transplant; NCD 260.1 Liver Transplant; NCD 260.3 Pancreas Transplant; NCD 260.5 Intestinal and Multi-visceral Transplantation

MP098 Genetic Testing Related to Colorectal Cancer – Revised – Add ColoSense and Simple Screen Criteria

ColoSense (0421U) (Medicare Business Segment)
A non-invasive stool-based RNA test intended for the qualitative detection of colorectal neoplasia-associated RNA markers and for the presence of occult hemoglobin in human stool is covered as a preventive screening methodology once every 3 years according to the following criteria:

- Age 45 to 85 years; and
- Asymptomatic (no signs/symptoms including but not limited to, lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test, or fecal immunochemical test); and
- There has been no documentation of a normal colonoscopy in the previous 10 years; and
- At average risk of developing CRC defined as:
    - no personal history of adenomatous polyps, colorectal cancer, or inflammatory bowel disease including Crohn's disease and ulcerative colitis; and
    - no family history of colorectal cancer, adenomatous polyps, familial adenomatous polyposis (FAP / MAP), neurofibromatosis type 1, or Lynch syndrome

MP159 Voice Therapy – Revised – Add and Clarify Indications/Exclusions

INDICATIONS:
Voice therapy may be considered medically necessary for the restoration of the ability to produce speech from the larynx for any of the following conditions, which are refractory to a 2 week period of voice rest.

- Post-surgical or post traumatic injury to the vocal cords
- Post laryngeal carcinoma; or
- Vocal cord paralysis and paresis; or
- Vocal cord nodules, cysts, or polyps; or
- Muscle tension dysphonia; or
- Spastic dysphonia; or
- Post-laryngectomy (esophageal speech production); or
- Essential voice tremor; or
- As part of gender confirmation treatment (Please reference MP307 - Gender Dysphoria and Gender Confirmation Treatment)

From initial evaluation through the entire course of treatment, all of the following must be met:

- The presence of a clinically documented functional speech disorder resulting in an inability to perform at the previous functional level
- Documentation supports an expectation by the prescribing physician that measurable improvement is anticipated in a reasonable and predictable period of time for the particular diagnosis and phase of recovery.

EXCLUSIONS:
Voice therapy for the following conditions is considered to be **Unproven** and **Not Medically Necessary,** and therefore **NOT COVERED:**

- Voice therapy for the purpose of accent reduction or acquisition; or
- Voice therapy solely for vocational or recreational purposes in the absence of pathology; or
- Laryngitis due to viral infection or vocal abuse; or
- Maintenance program performed to maintain a level of function (**EXCEPTION:** within the Medicaid business segment coverage to maintain a current level of function will be considered for coverage if determined to be medically necessary)

MP258 Hyperhidrosis – Revised – Add Exclusion

EXCLUSIONS:
The Plan does not cover surgical treatment of secondary hyperhidrosis. Appropriate therapy involves treatment of the underlying condition.

The Plan does **NOT** provide coverage for the use of any of the following treatments of hyperhidrosis because they are considered **unproven** for that indication:

- alternative therapies, including but not limited to, homeopathy, massage, acupuncture and herbal drugs **(see MP136)**
- axillary liposuction, including ultrasound-assisted lipoplasty, retrodermal curettage and tumescent suction curettage
- acupuncture **(see MP63)**
- biofeedback **(see MP04)**
- hypnosis
- subdermal Nd-YAG laser
- percutaneous thoracic phenol sympathicolysis
- psychotherapy
- repeat/reversal of ETS
- sympathectomy for craniofacial hyperhidrosis
- sympathectomy for plantar hyperhidrosis
- microwave therapy (miraDry procedure)
- Pulsed radiofrequency
- Radiofrequency ablation

MP360 Minimal Residual Disease NGS Testing – Revised – Add Indications

Signatera (Natera) 0340U The Signatera test is personalized and tumor-informed, tailored to fit the unique signature of clonal mutations found in that individual's tumor. Signatera is offered for bladder, breast, colorectal, lung, melanoma, ovarian, and malignancies of unknown origin. This test can be performed as a standalone test, or as a tumor-informed test.

INDICATIONS:

Colorectal Cancer:

- Stage II-IV and oligometastatic colorectal cancer (CRC) in the adjuvant and recurrence monitoring setting

Breast Cancer:

- Stage II-IV breast cancer in the neoadjuvant setting, regardless of subtype
- Stage IIb and higher breast cancer in the adjuvant and recurrence monitoring settings

Lung Cancer:

- stage I-III non-small cell lung cancer (NSCLC) in the surveillance setting

ClonoSeq 0364U

INDICATIONS:
MRD testing (e.g., clonoSEQ) is considered to be medically necessary when performed in members with:

Multiple myeloma:

- During surveillance after response to primary treatment
- After each treatment phase (e.g. after induction therapy, high-dose therapy/autologous stem-cell transplantation,
  consolidation, and maintenance)

Acute myeloid leukemia:

- At completion of initial induction therapy
- Prior to allogeneic transplantation
- Periodic retesting guided by the regimen used

Acute lymphoblastic leukemia:

- At completion of initial induction therapy
- Periodic retesting guided by the regimen used
- Serial monitoring in members with molecular relapse or persistent low-level disease burden

Chronic lymphocytic leukemia or small lymphocytic lymphoma

- After completion of treatment
- For consideration of therapy with lenalidomide for high-risk patients after first-line therapy

B-Cell Acute Lymphoblastic Leukemia (B-ALL)

- At completion of initial induction therapy
- Periodic retesting guided by the regimen used

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

TruSight Oncology Comprehensive (0543U)

TruSight Oncology Comprehensive is considered medically necessary for the following indications:

- Members with solid malignant tumors that have specific RNA changes in the NTRK1, NTRK2, and NTRK3 genes detected by the test may benefit from personalized treatment with VITRAKVI (larotrectinib).
- Members with non-small cell lung cancer who have certain RNA mutations in the RET gene may benefit from personalized treatment with RETEVMO (selpercatinib).

RaDaR ST (81479)

RaDaR is considered medically necessary for the following indications:

- assess recurrence risk following curative-intent surgery.
- recurrence monitoring during surveillance.
- longitudinal testing to monitor treatment response in members with late-stage solid tumors

FoundationOne MRD (81479)

FoundationOne MRD is considered medically necessary for the following indications:

- recurrence monitoring in Stage II-III breast cancer across all subtypes
- neoadjuvant use to guide treatment choice in Stage II-III Breast Cancer across all subtypes

MP374 Genetic Testing for Inheritable Diseases – Revised – Add Indications

Familial Hyperaldosteronism:

Genetic testing for hereditary causes of excessive aldosterone production by the adrenal glands leading to hypertension is considered medically necessary for a member in the following scenarios:

- Diagnosis of primary hyperaldosteronism and one of the following:
    - Onset <20y; or
    - At least one first-degree relative has also been diagnosed with primary hyperaldosteronism; or
    - Family history of hypertension or stroke with onset <40y

Malignant Hyperthermia:

Genetic testing for malignant hyperthermia susceptibility (preferably with a full RYR1/CACNA1S/STAC3 panel) is medically necessary for either of the following indications:

- Diagnostic testing for members who are clinically confirmed to have had or there is strong clinical suspicion of an episode of malignant hyperthermia during or immediately after anesthesia to facilitate predictive testing in at-risk relatives; or
- Screening at-risk members who have a relative(s) with a variant in the RYR1, CACNA1S, or STAC3 gene that is considered causative for malignant hyperthermia susceptibility

MP378 Genetic and Biomarker Testing for Neuromuscular Disorders – Revised – Title Change; Add Exclusions

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.

Serum biomarker testing for multiple sclerosis including, but not limited to the gMS Dx,gMS Pro EDSS, and the Octave MSDA test is considered to be **Unproven** and therefore **NOT COVERED**. There is insufficient evidence in the published literature to support the efficacy and clinical utility of blood-based biomarker tests to either assist in the diagnosis of MS or measure the risk for rapid progression of disability.

MP393 Category III New Technology CPT codes – NEW

DESCRIPTION:

Category III CPT codes (T codes) are temporary CPT codes for emerging technologies, services, and procedures, used to support data collection and to substantiate widespread use and/or provide documentation for the Food and Drug Administration (FDA) approval process. Many of the services represented by these codes have not been proven medically necessary and are considered to be investigational or unproven based on a lack of peer-reviewed medical literature.
The inclusion of a code in this policy does not imply any right to reimbursement or guarantee claims payment. Claims filed for services using Category III codes will be denied unless the code is addressed as a covered service in a Geisinger Health Plan Medical Coverage Policy.

Services meeting **ANY** of the following criteria are considered experimental/investigational or unproven:

- The intervention does not have Food and Drug Administration (FDA) approval to be marketed for the specific relevant indication(s) - **experimental/investigational**
- The intervention is not proven to be applicable outside the research setting - **experimental/investigational**
- Available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes - **Unproven**
- The intervention is not proven to be as safe or effective in achieving an outcome equal to or exceeding the outcome of alternative therapies - **Unproven**
- The intervention does not improve health outcomes - **Unproven**

EXCLUSIONS:

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.

Procedure codes identified in this policy are considered non-covered because the safety and/or effectiveness of these services cannot be established by the available published peer-reviewed literature.

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.

MP023 Keratoplasty
MP047 Hyperbaric Oxygen Therapy
MP050 Surgical Correction of Chest Wall Deformities
MP058 Negative Pressure Wound Therapy
MP091 Sacral Nerve Stimulation
MP112 Wireless Capsule Endoscopy
MP197 Janus Kinase 2 (JAK 2) Gene Mutation Analysis
MP214 Iontophoresis
MP243 Anorectal Fistula Repair Using an Acellular Plug
MP244 Pelvic Floor Stimulation
MP278 Hyperthermia in Cancer Therapy
MP280 Exome and Genome Sequencing
MP282 Termination of Pregnancy
MP292 Sympathetic Nerve Block
MP294 Intercostal Nerve Block
MP306 Tumor Treatment Fields
MP311 Genotyping or Phenotyping for Thiopurine Methyltransferase
MP322 Drug Testing in Substance Abuse Treatment
MP336 Genetic Testing For Inherited Thrombophilia/ Hypercoagulability
MP348 LTAC
MP355 Plasma-based Proteomic Testing in the Management of Pulmonary Nodules

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.