# "What's New" Medical Policy Updates October 2026

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

## MP048 Surgical and Minimally Invasive Therapies for the Treatment of Benign Prostatic Hypertrophy – Revised – Add Indication

**INDICATIONS:**
Transurethral Microwave Thermotherapy (TUMT), Transurethral Radiofrequency Thermotherapy (TUNA), Transurethral incision of the prostate (TUIP), Transurethral water vaporization of the prostate [e.g. Rezum™] (TUVP), Transurethral waterjet ablation (e.g., Aquablation), Transurethral enucleation of the prostate (TUEP), Laser Prostatectomy (Holmium laser ablation of the prostate [HoLAP]) , Holmium laser enucleation of the prostate [HoLEP] , Holmium laser resection of the prostate [(HoLRP] ), transurethral ultrasound-guided laser induced prostatectomy (TULIP), visually-guided laser ablation of the prostate (VLAP), Prostatic arterial embolization and Water Induced Thermotherapy (WIT) are outpatient ablation treatments for symptomatic benign prostatic hypertrophy (BPH). These procedures are non-surgical alternatives to transurethral resection of the prostate (TURP). The desired outcome is to relieve urinary symptoms and improve urinary function by reducing urinary obstruction caused by BPH. A urethral probe is used to apply thermal energy to the prostate, causing damage and eventual necrosis of excess prostatic tissue. These procedures are considered to be medically necessary when the following criteria are met:

**EXCLUSIONS:**
~~The Plan does **NOT** provide coverage for Prostatic arterial embolization (PAE) for the treatment of BPH hypertrophy because it is considered experimental, investigational or **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~~.

## MP053 Cochlear Implant – Revised – Add Replacement Language

Replacement of a Cochlear Implant or Auditory Brainstem Implant or their components not under warranty will be considered medically necessary when EITHER of the following criteria are met:

- The device is no longer functional and has been determined to be either non-repairable or the repair cost is in excess of the replacement cost; or
- Documentation that a change in the member's condition makes the present unit non-functional and improvement is expected with a replacement unit.

## MP168 Non-invasive Testing for Organ transplant Rejection – Revised – Updated Unproven Language; Add Coding

# Heart Transplant Testing

**AlloMap and AlloSure Heart Transplant Testing (81595, 86849, 0540U)**

# Renal Transplant Testing

**For COMMERCIAL and MEDICARE BUSINESS SEGMENTS:**

**AlloSure Kidney Transplant (0540U)**
**OmniGraf Kidney Transplant (81479)**
**Prospera Renal Transplant Testing (0493U)**

**For MEDICAID BUSINESS SEGMENT:**
**TruGraf Blood Gene Expression Test (81479, 30876)**

# Lung Transplant Testing

**FOR MEDICARE BUSINESS SEGMENT:**

**AlloSure Lung (0540U)**

**EXCLUSIONS:**
The Plan does **NOT** provide coverage for Heartsbreath breathing test for heart transplant rejection detection because it is considered ~~**experimental, investigational or**~~ **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 the use of peripheral blood measurement of donor-derived cell-free DNA in the management of patients after heart transplantation (e.g., myTAIHEART), **0055U** including but not limited to the detection of acute transplant rejection because it is considered ~~experimental, investigational or~~ **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.

Unless otherwise mandated, the Plan does **NOT** provide coverage for the use of peripheral blood measurement of donor-derived cell-free DNA in the management of patients after lung transplantation, including but not limited to the detection of acute transplant rejection or transplant graft dysfunction because it is considered ~~experimental, investigational or~~ **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 the use of CXCL10 Urine Test **(0526U)** 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 the use of any peripheral blood measurement of donor-derived cell-free DNA in the management of patients after transplantation not specifically outlined in this policy because it is considered **unproven.** There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of these treatments on health outcomes when compared to established treatments or technologies. **(0087U, 0088U, 0118U, 0319U, 0320U, 0508U, 0509U, 0544U, 0575U)**

## MP209 Medical Error "Never Events" and Hospital Acquired Conditions – Revised – Revise Title; Remove Readmission Criteria

**Policy:** Medical Error "Never Events" and Hospital Acquired Conditions~~, and Hospital Readmission Review~~

~~**HOSPITAL READMISSION REVIEW**~~

~~Geisinger Health Plans reserves the right to review hospital readmissions - defined as any admission occurring within 30 days of the date of discharge from the same hospital or hospital system for the same or similar diagnosis or a related diagnosis – to determine if the readmission could have reasonably been prevented by optimization of any of the following factors:~~

- ~~Provision of care during the initial admission~~
- ~~Discharge planning~~
- ~~Post-discharge follow-up~~
- ~~Coordination of care between inpatient and outpatient care teams~~

~~A readmission may be considered to be clinically related to the initial admission if any of the following scenarios are supported in the medical record:~~

- ~~Recurrence or continuation of the condition responsible for the initial admission; or~~
- ~~Surgical procedures required to treat the recurrence or continuation of the condition responsible for the initial admission; or~~
- ~~Medical complications caused by, or for which the quality of care during the initial admission is implicated; or~~
- ~~Surgical procedures resulting from a medical complications caused by or for which the quality of care during the initial admission is implicated; or~~
- ~~Exacerbation or decompensation of a chronic medical condition for which there is a reasonable expectation that optimal care during or immediately following the initial admission could have prevented.~~

~~**Readmissions that are determined to be clinically related to the initial admission and preventable will not be reimbursed.**~~

~~The following readmission types are not considered to be preventable, and therefore are not subject to non-payment rules:~~

- ~~Planned readmissions for repetitive or ongoing treatment~~
- ~~Initial discharge was against medical advice that is documented in the medical record.~~
- ~~Readmissions caused by end-stage disease processes~~
- ~~Readmissions that occur more than 30 days after the initial admission.~~
- ~~Readmissions for planned elective surgery~~

## MP284 Bone Mineral Density Measurement – Revised – Add Exclusions

**EXCLUSIONS:**
**Vertebral Fracture Assessment:**
Screening for vertebral fractures as an adjunct to bone mineral density measurement is considered not medically necessary and is therefore NOT COVERED. There is insufficient evidence in the published peer reviewed scientific literature regarding the clinical utility using DEXA for evaluation of vertebral fractures.

The following ~~two~~ studies are not covered because they are **unproven** and not considered reasonable and necessary

- single photon absorptiometry **(78350)**
- dual photon absorptiometry **(78351)**
- Pulse-echo ultrasound bone density measurement of the tibia **(0508T)**
- Ultrasound-based radiofrequency echographic multi-spectrometry (REMS) **(0815T)**

## MP302 Percutaneous Tibial Nerve Stimulation – Revised – Add Exclusion

**EXCLUSIONS:**

Transcutaneous tibial nerve stimulation {e.g., Vivally system, Zida, etc.} is considered **unproven** and **NOT COVERED** for the treatment of urinary incontinence and urinary urgency. There is insufficient evidence in the published peer-reviewed medical literature to show this technology imparts improved outcomes compared to current standard technologies.

## MP345 Peroral Endoscopic Myotomy (POEM) – Revised – Add Indication

**INDICATIONS:**

### Commercial and Medicare Business Segments

Peroral endoscopic myotomy (POEM) is considered medically necessary when all the following criteria are met:

- The member is 18 years of age or older; and
- Member has a diagnosis of primary achalasia; or
- recurrent achalasia following prior surgical Heller myotomy; and
- Eckardt symptom score is greater than 3; and
- POEM is being proposed as an alternative to pneumatic dilation or myotomy (open or laparoscopic)

## MP363 Urinary Tumor Markers for Bladder Cancer – Revised – Add Indications; Clarified Exclusions

### General Coverage: 0363U, 0420U

Urine-based biomarker testing (e.g, Cxbladder Triage, Cxbladder Detect) in members with microhematuria and are suspected of having a malignancy may be considered medically necessary when the following criteria are met:

- The member has a clinical presentation of microhematuria; and
- Other potential causes have been ruled out; and
- Has not received a cystoscopy in the previous 6 months; and
- Has been appropriately counseled and intends to forgo a cystoscopy contingent on test results

Urinary biomarkers **(86294, 86316, 86386, 88346, 88120)** (bladder tumor antigen (BTA) test, nuclear matrix protein (NMP22) test, or fluorescence
in situ hybridization (FISH) {*UroVysion Bladder Cancer* test} may be covered when used as:

a. An adjunct in the diagnosis of bladder cancer for members who have an atypical or equivocal cytology

b. An adjunct in the monitoring of high-risk, non-muscle invasive bladder cancer

The use of fluorescence immunocytology {*ImmunoCyt/uCyt*} **(88346)** may be covered as an adjunct to cystoscopy or cytology in the monitoring of members with bladder cancer.

### See Also: AHS G2125 Urinary Tumor Markers For Bladder Cancer

## Medicare Business Segment: please see: L40378 Urine-based Biomarkers in Patients with Microhematuria and A60424 Billing and Coding: Urine-based Biomarkers in Patients with Microhematuria

In compliance with Response to Comments: Bladder/Urothelial Tumor Markers A55457-As a laboratory-developed test (LDT), the analytical validation, clinical validation and the clinical utility for Cxbladder™ has not been assessed by MolDX. Cxbladder™ is considered investigational and not covered by Medicare.
Response to Comments: Genetic Testing for Oncology A59417 Regarding CxBladder testing: "In summary, these tests do not have sufficient evidence to warrant coverage in Medicare patients."
**0021M, 0013M**

**EXCLUSIONS:**
There is insufficient evidence in the peer-reviewed, published medical literature to support the use of urinary biomarkers (bladder tumor antigen (BTA) test, nuclear matrix protein (NMP22) test, fluorescence in situ hybridization (FISH) UroVysion Bladder Cancer test) or fluorescence immunocytology (ImmunoCyt/uCyt) as mechanisms for bladder cancer population screening ~~evaluation of hematuria~~, or diagnosing bladder cancer in symptomatic members. These tests are considered to be **Unproven** for those indications and are therefore **NOT COVERED**.

~~There is insufficient evidence in the peer-reviewed, published medical literature to support the use of gene expression profiling by real-time quantitative PCR {Cxbladder Detect, Cxbladder Monitor}. The Plan does **NOT** provide coverage for Proteomic Serum analysis to bladder cancer. These tests are considered to be **Unproven** for those indications and are therefore **NOT COVERED.**~~

There is insufficient evidence in the peer-reviewed, published medical literature to support the use of any urinary tumor markers for bladder cancer not specifically identified as covered in this policy. These tests are considered to be **Unproven** for those indications and are therefore **NOT COVERED.**

## MP380 Prenatal and Preimplantation Genetic Testing – Revised – Revise Criteria; Add Exclusion

**DESCRIPTION:**
PGT-P (polygenic conditions) refers to testing of embryos to screen for those at higher risk for common multifactorial disorders (e.g. cardiovascular disease, cancer, type II diabetes, neuropsychiatric disorders) based on their polygenic risk score (PRS). PRS are derived from genome-wide association studies, in which thousands of genetic markers across the genome of participants are evaluated by how likely or unlikely they are to be found in a person affected by the condition of interest. The sum total of the effects of these markers is then used to calculate a PRS, providing an overall risk score for a person to develop the condition during their lifetime. There are currently no clinical guidelines for the use of PRS in clinical settings, and testing embryos by PGT-P has limited clinical utility at this time.

**Genetic Testing for Infertility and/or Multiple Miscarriages:**

Karyotype testing, also called “chromosome analysis,” to evaluate for a chromosomal rearrangement, is covered for a male or female member in the following scenarios:

- When a member or their reproductive partner has had two or more miscarriages, consecutive or non-consecutive, occurring at any gestational age; OR
- A diagnosis of primary infertility, without an otherwise apparent cause, such as a structural uterine anomaly, thyroid dysfunction, or an autoimmune disorder.

**PGT-A** is covered for members in the following scenarios:

- If the member or egg donor is 39 years of age or older at the time of embryo implantation; OR
- There is a family history of a genetic condition that is associated with a sex-dependent disorder (eg: Fragile X syndrome); OR
- If the member has had one or more miscarriages confirmed to be caused by aneuploidy, as determined by karyotype or chromosomal microarray testing; OR
- PGT-M is being performed concurrently and the member meets the coverage criteria listed below

**PGT-M** for evaluation of an embryo is covered for members in the following scenarios:

- To diagnose an autosomal dominant or X-linked condition for which a parent or sperm/egg donor has a confirmed molecular diagnosis, (eg: Fragile X syndrome); OR
- To diagnose an autosomal recessive condition for which both parents are known to be carriers, (eg: Cystic Fibrosis); OR
- One biological parent is a known carrier of an early-onset, autosomal recessive disorder and together, the biological parents have produced previous offspring affected with the disorder AND both variants are known or confirmed in the affected child,

**AND**

- The genetic condition is associated with clinically significant symptoms or disability; AND
- ~~The PGT-M procedure will eliminate the need for invasive testing during the pregnancy (eg: chorionic villus sampling or amniocentesis); AND~~

**EXCLUSIONS:**

PGT-P is considered to be **Unproven** and **NOT COVERED.**

## MP385 Pediatric Specialty Bed and Safety Equipment – Revised –

**EXCLUSIONS:**

The following are considered not medically necessary and therefore **NOT COVERED.**

- Vehicle ramps (permanent or portable), vehicle lifts, or structural van modifications

## MP392 Hospital Readmission Review (NEW)

**DESCRIPTION:**

This policy outlines Geisinger Health Plan's payer requirements and review methodology for hospital readmissions occurring within 30 days of discharge. The policy establishes standards for determining clinical relatedness between admissions, evaluating whether a readmission was reasonably preventable based on information available at the time of discharge, and applying reimbursement determinations consistent with quality improvement, patient safety, and care transition objectives.

**PROCESS:**
Geisinger Health Plan reserves the right to review hospital readmissions - defined as any admission occurring within 30 days of the date of discharge from the same hospital or hospital system for the same or similar diagnosis or a related diagnosis – to determine if the readmission could have reasonably been prevented by optimization of any of the following factors:

- Provision of care during the initial admission
- Discharge planning
- Transition of care planning
- Post-discharge follow-up
- Medication reconciliation
- Provider communication

A readmission may be considered to be clinically related to the initial admission if any of the following scenarios are supported in the medical record:

- Readmission is for continuation, recurrence, or progression of the condition responsible for the initial admission; or
- The readmission is for the treatment of an acute medical complication clinically attributable to care delivered during the initial admission; or
- An unplanned surgery or procedure(s) required to treat the recurrence and/or continuation or complication of treatment of the original condition responsible for the initial admission; or
- Exacerbation or decompensation of a chronic medical condition for which there is a reasonable expectation that optimal care during or immediately following the initial admission could have prevented a subsequent admission; or
- Acute decompensation of a chronic condition where documentation demonstrates a reasonable relationship to care provided during or immediately after the initial admission; or
- The medical record demonstrates a direct clinical relationship between the initial admission and the subsequent admission; or
- An acute medical complication that is clinically attributable to care rendered during the initial admission and supported by medical record documentation.

Readmissions that are determined to be clinically related to the initial admission and preventable will not be reimbursed. Determinations shall be based on information reasonably available to the treating provider at the time of discharge and shall not rely solely on retrospective knowledge of subsequent events.

Readmission determination made at the utilization management level will be offered a peer-to-peer review. The Medical Management readmission determination may be challenged through the claims reconsideration (CRRF) process, after the claim has been adjudicated. Any CRRF submission must include complete chart submission from all relevant admissions.

The following readmission types are not considered to be preventable, and therefore are not subject to non-payment rules:

- Planned readmissions for repetitive or ongoing treatment
- Initial discharge was against medical advice that is documented in the medical record.
- Readmissions caused by end-stage disease processes
- Readmissions that occur more than 30 days after the initial admission.

Readmission review is excluded for the following:

- Skilled nursing facility admissions
- Inpatient rehabilitation admissions
- Long term acute care (LTAC) admissions
- Admissions for mental health or substance use disorders

- Planned admissions, including those for surgeries/procedures, or staged or serial treatments, i.e. chemotherapy
- Transplant services
- Readmission within 30 days to a different Hospital.
- Mental health and substance use disorder admission.

The medical record submitted for GHP review must contain sufficient documentation to support the applicable medical necessity criteria. This includes, but is not limited to, documentation from both the initial/initial admission file and the subsequent readmission file, such as the history and physical, progress notes, physician orders, discharge summary, discharge instructions, medication reconciliation, care coordination or transition planning notes, post-discharge follow-up arrangements, and any records from the receiving or post-acute facility when applicable. All documentation is subject to review and audit by GHP at any time, in accordance with the terms of the provider agreement, applicable facility contract language, member benefit documents, and GHP policies.

## FOR THE MEDICARE LINE OF BUSINESS:

Potentially Preventable Readmission (PPR): A clinically related admission occurring within 30 days of discharge where review of the medical record demonstrates that the readmission may reasonably have been avoided through appropriate inpatient care, discharge planning, care coordination, follow-up care, medication management, or transition planning.

A clinically related readmission may be considered potentially preventable when documentation demonstrates one or more of the following:

- Premature discharge before the member achieved medical stability, based on information the provider would have known, or events that could have been anticipated at the time of discharge.
- Failure to address symptoms or findings identified during the initial admission.
- Failure to complete medically necessary diagnostic evaluation or treatment.
- Inadequate discharge planning.
- Failure to provide appropriate medication reconciliation or medication instructions.
- Failure to arrange medically necessary follow-up care.
- Inadequate coordination of care among providers or care settings.
- Failure to address post-acute placement, rehabilitation, or home-care needs.
- Failed transfers to a Skilled Nursing Facility (SNF), Long Term Acute Care (LTAC), Acute Inpatient Physical Rehabilitation (IPR), or a similar facility can potentially indicate a premature discharge. When a discharge includes an anticipated return to the hospital, the readmission may be treated as a leave of absence rather than a preventable readmission. Readmissions resulting from errors or events at the receiving facility that are unrelated to the transfer orders provided by the discharging hospital, such as falls or failure to deliver treatment, will not result in denial of payment for the readmission.
- Readmission for care that reasonably could have been provided during the initial admission.

**Readmissions that are determined to be clinically related to the initial admission and preventable will not be reimbursed.**

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.

MP024 External Counterpulsation
MP046 Stretch Devices and Continuous Passive Motion Device

MP059 Fetal Surgery
MP069 Ultrafiltration
MP116 Hippotherapy
MP117 Dry Hydrotherapy
MP118 Quantitative Sensory Testing
MP120 Intracavitary Balloon Brachytherapy for Breast Cancer
MP161 Thermal Capsulorraphy
MP181 Suit Therapy
MP218 Serum Antibodies for the Diagnosis of Inflammatory Bowel Disease
MP228 HPV DNA Testing
MP274 Diapers and Incontinence Supplies
MP330 Responsive Neurostimulation
MP347 Central Auditory Processing Disorder
MP364 Fecal Analysis for Diagnosis of Intestinal Dysbiosis
MP373 Medication Assisted Treatment

## 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.