

“What’s New” Medical Policy Updates September 2026

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

MP001 Neuromuscular Electrical Stim – Revised – Added Cross References

For other related policies please see:

- MP 113 – Electrical and Electromagnetic Stimulation to Promote Wound Healing
- MP 146 – Sympathetic Therapy
- MP 219 – Implantable Percutaneous Electrical Nerve Stimulation (PENS) and Neuromodulation Therapy (PTN)
- MP 244 – Pelvic Floor Stimulation
- MP343 – Percutaneous Electrical Nerve Field Stimulation (PENFS)
- MP302 – Percutaneous Posterior Tibial Nerve Stimulation (PTNS)

The Plan does **NOT** provide coverage for the use of the Cala Trio nerve stimulating device for the treatment of essential tremors 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. **NOTE: This exclusion does not apply to Medicare. Please see L39591 External Upper Limb Tremor Stimulator Therapy**

MP170 Gene Expression Profiling for Breast Cancer Treatment – Revised – Clarified Exclusion; Updated Unproven Language

EXCLUSIONS:

Unless coverage is mandated, the Plan does NOT provide coverage for any other assays of genetic expression in breast tumor tissue **not specifically identified in this policy** (e.g. Blueprint™, TargetPrint®, Mammostrat® Breast Cancer Test, BreastOncPx™, NexCourse® Breast IHC4, PreciseDx™ Breast Cancer Test, BreastPRS™, **GeneStrat® ESR1** and the Rotterdam Signature 76-Panel) because they are considered **experimental, investigational or unproven**.

MP175 Trigger Point Injections – Revised – Added Medicare Cross Reference

MEDICARE BUSINESS SEGMENT: See Novitas LCD L35010 Trigger Point Injections and A57751 Billing and Coding: Trigger Point Injections

MP201 Obstructive Sleep Apnea – Revised – Removed Exclusion; Updated Unproven Language

EXCLUSIONS:

The **Plan** does not provide coverage for ANY of the following procedures or services for the treatment of OSA because they are considered **experimental, investigational or unproven**:
(This list may not be all inclusive):

- Radiofrequency Volumetric Tissue Reduction (Somnoplasty™) (**See Also MP40 – Somnoplasty/Coblation**)
- Coblation (**See Also MP40 – Somnoplasty/Coblation**)
- Cautery-assisted Palatal Stiffening Operation (CAPSO)
- Pillar™ Palatal Implant System
- Repose Bone Screw System
- AIRvance Tongue Suspension Advance System (adjustable tongue advancement device)
- Winx therapy system/oral pressure therapy
- NMES tongue muscle (eXciteOSA)
- Injection Snoreplasty™
- Flexible Positive Airway Pressure
- Intranasal expiratory resistance valve
- Electronic positional OSA treatment devices
- **SleepEase Pro**

The Plan **does NOT provide coverage** for the use of NMES to the tongue base as a treatment for obstructive sleep apnea 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 use of oral appliances for the treatment of socially disruptive snoring in the absence of documented OSA is considered to be not medically necessary, and **NOT COVERED**.

The use of oral appliances for the treatment of upper airway resistance syndrome is considered to be **experimental, investigational or** unproven, and **NOT COVERED**.

The use of implantable neurostimulation (aka Phrenic Nerve Stimulation) devices for the treatment of Central Sleep Apnea (CSA) is considered to be unproven and **NOT COVERED**. There is insufficient evidence of safety and/or efficacy in the published peer-reviewed medical literature.

MP221 Suprachoroidal Delivery of Pharmacologic Agents – Revised – Added Indication

INDICATIONS:

Suprachoroidal injection of FDA approved triamcinolone acetonide injectable suspension (Xipere) may be considered to be medically necessary when the following criteria are met:

- The member is 18 years of age or older, and
- The member has diagnosis of macular edema associated with uveitis

MP391 Phrenic Nerve and Diaphragmatic Stimulation – NEW

DESCRIPTION:

Diaphragmatic/phrenic nerve stimulation, also referred to as phrenic pacing, phrenic nerve stimulation, diaphragm pacing, or electrophrenic respiration, is the electrical stimulation of the diaphragm via the phrenic nerve. The phrenic nerve is the major nerve supply to the diaphragm that controls breathing and stimulation of this nerve is considered a treatment for several conditions including central sleep apnea (CSA), central alveolar hypoventilation syndrome/congenital central hypoventilation syndrome, and ventilatory failure secondary to high spinal cord injury at or above C-3.

CRITERIA FOR COVERAGE:

Diaphragmatic/Phrenic Stimulation

Diaphragmatic/phrenic nerve stimulation with an FDA-approved device (i.e. NeuRx DPS, Mark IV) is considered medically necessary as an alternative to invasive mechanical ventilation for members who are 18 years of age or older when **ALL** of the following criteria are met:

The member has been

- diagnosed with ventilatory failure as a result of either :
 - high spinal cord injury
 - central alveolar hypoventilation syndrome; and
- cannot spontaneously breathe for a minimum of 4 continuous hours without use of a mechanical ventilator; and
- Diaphragmic movement with stimulation has been visualized under fluoroscopy or ultrasound; and
- Bilateral phrenic nerve function is demonstrated with electromyography recordings and nerve conduction times
- Stimulation of the diaphragm either directly or through the phrenic nerve results in sufficient muscle activity to accommodate independent breathing without the support of a ventilator for at least 4 continuous hours a day; and
- Member has normal chest anatomy, a normal level of consciousness, and has the ability to participate in and complete the training and rehabilitation associated with the use of the device

Phrenic nerve stimulation

Phrenic nerve stimulation for the treatment of adult central sleep apnea is considered medically necessary when the use of an FDA-approved device (remedē system) is considered in members who meet the following criteria:

- Age 18 years and older
- Diagnosed with central sleep apnea evidenced by polysomnography and sleep study
- Failure or suboptimal response to conventional treatment of central sleep apnea
- Diaphragmic movement with stimulation has been visualized under fluoroscopy or ultrasound; and
- Bilateral phrenic nerve function is demonstrated with electromyography recordings and nerve conduction times
- Member has normal chest anatomy, a normal level of consciousness, and has the ability to participate in and complete the training and rehabilitation associated with the use of the device

MEDICARE BUSINESS SEGMENT: See NCD160.19 Phrenic Nerve Stimulator

EXCLUSIONS: The use of any phrenic nerve or diaphragmatic stimulation device not meeting the criteria outlined in this policy will be considered **Unproven** and therefore **NOT COVERED**.

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.

MP102 Morphometric Tumor Analysis

MP163 Thermography

MP183 Cranial Electrotherapy Stimulation

MP185 Chemosensitivity and Chemoresistance Assays

MP202 Interferential Stimulation

MP206 Electrocardiographic Body Surface Mapping

MP208 Selective Internal Radiation Therapy

MP234 Occipital Nerve Stimulation
MP246 Multigene Expression Assay for predicting Recurrence in Colon Cancer
MP267 Amniotic Membrane Transplantation
MP289 Dry Eye Syndrome
MP291 Percutaneous Ultrasonic or Radiofrequency Coblation Tenotomy
MP316 High Intensity Focused Ultrasound and Laser
MP324 Genetic Testing for Disease Carrier Status
MP327 Autonomic Testing
MP339 Irreversible Electroporation
MP357 Predictive Classifiers for Early-Stage Non-Small Cell Lung Cancer

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.