"What's New" Medical Policy Updates June 2020

Listed below are the recent changes made to policies within the Geisinger Health Plan Medical Policy Portfolio during the months of May that will become **effective July 15, 2020** (unless otherwise specified). The Plan uses medical policies as guidelines for coverage decisions made within the insured individuals 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.

MP040 Somnoplasty/ Coblation – (Revised) – Added Exclusion

EXCLUSIONS:
Somnoplasty/coblation for the treatment of socially disruptive snoring is considered **not medically necessary** and is **NOT COVERED.**

Somnoplasty / coblation for the treatment of obstructive sleep apnea is considered **experimental, investigational or Unproven** and is **NOT COVERED.** There is inconclusive evidence in the published, peer-reviewed medical literature that the service has a beneficial effect on health outcomes.

Somnoplasty /coblation of the inferior turbinates for treatment of chronic nasal obstruction ~~due to mucosal hypertrophy of the inferior turbinates~~ is considered **experimental, investigational or unproven** and is **NOT COVERED.** There is insufficient evidence in the peer-reviewed published medical literature directly comparing somnoplasty to the established alternatives of electrocautery or submucosal surgical resection of the turbinates. In addition, there are no published clinical studies reporting on the long-term outcomes of individuals with mucosal hypertrophy that have been treated with radiofrequency volumetric tissue reduction.

Coblaton tenotomy for the treatment of musculoskeletal conditions is considered **experimental, investigational or unproven** and is **NOT COVERED**. There is insufficient evidence in the peer-reviewed published medical literature directly comparing coblation tenotomy to the established alternatives.

MP071 Continuous Subcutaneous Glucose Monitor – (Revised) – Added Medicaid/Medicare Language

For Commercial and Medicaid Business Segment:

INDICATIONS:

I. Continuous subcutaneous glucose monitors with a device provided from an endocrinologist office or clinic will be covered for a maximum of 3 consecutive days, twice per calendar year when all of the following criteria are met:

- Medical documentation of a diagnosis of Type 1 diabetes, Type 2 diabetes or gestational diabetes; **and**
- Suspected hypo- (<50mg/dl) and hyperglycemia excursions; **or**
- Suspected episodes of hypoglycemia unawareness including symptoms, consequences, frequency, and patterns identified; **and**
- Poor blood glucose control as evidenced by two HbA1C values greater than 7.0 within previous 6 months

This device is intended for one-time or occasional 1-3 day time period. The devices provided for this service are supplied by the clinician. It is not meant to replace the traditional (fingerstick) self-monitoring measurements, but rather, serve as a short-term adjunct to these measurements.

A maximum of two CGMS monitoring periods are considered medically necessary within a 12-month period.

II. **Personal continuous subcutaneous glucose monitor may be considered for pediatric and adult members with diabetes mellitus (Type 1 or 2) treated with insulin who meet all of the following criteria:**
    1. Documentation of a diagnosis of diabetes; **and**
    2. Documentation of daily insulin therapy

The "flash" continuous glucose monitoring system (e.g., Flash Glucose Monitoring System) is considered to be an acceptable alternative to other continuous glucose monitoring systems for medically necessary indications in members 18 years of age and older with diabetes.

The Freestyle Libre device may be considered for members with diabetes mellitus (Type 1 or 2) who meet all of the following criteria:

Age 18 years or older; and at least one of the following:

- Current insulin therapy; or
- Functional barriers to finger stick blood glucose monitoring; or
- History of recurrent hypoglycemic episodes; or
- Medical record documentation of HbA1c of 9 or greater

FOR MEDICARE BUSINESS SEGMENT:

Per CMS, Therapeutic CGM may be covered by Medicare when all of the following criteria are met:

- The beneficiary has diabetes mellitus; and,
- The beneficiary has been using a home blood glucose monitor (BGM) and performing frequent (four or more times a day) BGM testing; and,
- The beneficiary is insulin-treated with multiple daily injections (MDI) of insulin or a continuous subcutaneous insulin infusion (CSII) pump; and,
- The beneficiary's insulin treatment regimen requires frequent adjustment by the beneficiary on the basis of therapeutic CGM testing results.

The Freestyle Libre device may be considered for members with diabetes mellitus (Type 1 or 2) who meet all of the following criteria:

Age 18 years or older; and at least one of the following:

- Current insulin therapy; or
- Functional barriers to finger stick blood glucose monitoring; or
- History of recurrent hypoglycemic episodes; or
- Medical record documentation of HbA1c of 9 or greater

MP135 Osseointegrated Hearing Device – (Revised) – Added Replacement Criteria

REPLACEMENT OF COMPONENTS

Replacement of components or upgrades to existing osseointegrated hearing devices are covered when all of the following criteria are met:

- The current component or processor was being used daily until the malfunction occurred; and
- The current component or processor is no longer functional and cannot be repaired; and
- There is no evidence to suggest that the device has been lost, abused or neglected; and
- The replacement is not being requested solely for better technology or improved aesthetics

*NOTE: PA Medical Assistance will cover technology replacement in scenarios of equipment loss, abuse or neglect, if otherwise medically necessary.

EXCLUSIONS:
Osseointegrated hearing devices are excluded from coverage when qualifying criteria are not met.

The Plan does **NOT** provide coverage for the use of Intra-oral bone conduction hearing aids (e.g., the SoundBite hearing system) for the treatment of hearing loss 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 replacement of a functional osseointegrated hearing device based on age of the device or current state of technology. The processor must be non-functional. Age of the device alone does not meet medical necessity for replacement of the processor or components

MP213 Computerized Corneal Topography – (Revised) – Added Indication

INDICATIONS: Computerized Corneal Topography may be considered medically necessary for ANY of the following indications:

- Diagnosis and management of keratoconus, bullous keratopathy, corneal scarring, or corneal dystrophy;
- Complications post-corneal transplant
- Central corneal ulcer
- Post-operative management of penetrating keratoplasty or cataract surgery;
- pterygium and/or corneal ectasia

MP218 Serum Antibodies for the Diagnosis of Inflammatory Bowel Disease – (Revised) – Clarified Exclusion

EXCLUSIONS:
The Plan does not cover the use of anti-neutrophil cytoplasmic antibody (ANCA) and/or anti-Saccharomyces cerevisiae antibody (ASCA) (e.g., Prometheus IBD Serology Testing) for the diagnosis of IBD because it is considered **experimental, investigational or unproven** and **NOT COVERED.** Although the specificity of these tests are relatively high (82-100%), the sensitivity is low (32 -50%), which indicates that a negative result will not be clinically helpful. There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this test on health outcomes when compared to established tests or technologies.

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.

MP049 Visual Field Testing
MP054 Prophylactic Mastectomy
MP057 Prophylactic Oophorectomy
MP072 Perc disc Decomp. Nucleoplasty
MP093 Uroleume
MP101 Gliasite Radiation Therapy
MP129 Total Parenteral Nutrition
MP131 VitalStim NMES
MP146 Sympathetic Therapy
MP150 Carotid Artery Stent

MP154 Transanal Radiofrequency Therapy for Fecal Incontinence (Secca)
MP193 Microvolt T-wave Alternans
MP199 Corneal Pachymetry
MP204 Nasal and Sinus Surgery
MP228 HPV DNA Testing
MP229 Prolozone Therapy
MP232 Autism Spectrum Disorder Evaluation and Medical Management
MP259 Phototherapy for the Treatment of Dermatological Conditions
MP277 Vision Therapy/ Orthoptics
MP289 Dry Eye Syndrome
MP290 Fecal Microbiota Transplantation
MP294 Intercostal Nerve Block