



# **Health Evidence Review Commission**

**April 12, 2012**

**Meridian Park Hospital  
Community Health Education Center, Room 117B&C  
19300 SW 65th Avenue, Tualatin, OR 97062**



## AGENDA

### HEALTH EVIDENCE REVIEW COMMISSION

Meridian Park Hospital  
Health Education Center, Room 117B&C  
April 12, 2012 from 1:30-4:00 pm

*(All agenda items are subject to change and times listed are approximate)*

#	Time	Item	Presenter	Action Item
1	1:00 PM	Call to Order	Som Saha	
2	1:05 PM	Approval of Minutes ( Feb 9, 2012)	Som Saha	X
3	1:10 PM	Director's Report	Darren Coffman	
4	1:15 PM	Subcommittee Structure	Darren Coffman	X
5	1:20 PM	Conflict of Interest	Cat Livingston	
6	1.40 PM	Report of Value-based Benefits Subcommittee	Lisa Dodson Ariel Smits	X
7	2:00 PM	Report of Health Technology and Assessment Subcommittee	Alissa Craft Dave Lenar	
8	2:10 PM	Report of Evidence-based Guidelines Subcommittee a. Guideline on Advanced Imaging for Low Back Pain	Wiley Chan Cat Livingston Alison Little	X
9	2:30 PM	Public input process discussion	Darren Coffman	X
10	3:15 PM	Trusted evidence sources for future coverage guidances	Alison Little	X
11	3:30 PM	Potential additional EbGS and HTAS Topics and forecasted schedule of current topics	Cat Livingston	X
12	3:45 PM	Next Steps <ul style="list-style-type: none"><li>Schedule next meeting - June 14, 2012</li></ul>	Som Saha	
13	3:50 PM	Public Comment		
14	4:00 PM	Adjournment	Som Saha	

## Minutes

**HEALTH EVIDENCE REVIEW COMMISSION**  
**Portland State Office Building, Room 1D**  
**800 NE Oregon St., Portland, Oregon**  
*February 9, 2012*

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**Members Present:** Som Saha, MD, MPH, Chair; Gerald Ahmann, MD; Wiley Chan, MD; Alissa Craft, DO, MBA; Irene Croswell, RPh; Lisa Dodson, MD; Leda Garside, RN; Mark Gibson; Vern Saboe, DC; James Tyack, DMD; Kathryn Weit; Beth Westbrook, PsyD.

**Staff Present:** Darren Coffman; Ariel Smits, MD, MPH; Cat Livingston, MD, MPH; Dave Lenar; Margie Fernando.

**Also Attending:** Jeanene Smith, MD, MPH (OHP), Kristine Andrews; Anne Marie Licos, MedImmune; Paul Nielsen, MedImmune; Denise Taray, DMAP; Larry Burnett, DDS; Joanie Cosgrave, Medtronic; Allison Little, OHSU; Shannon Vandergriff, OHSU

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### I. Call to Order and Introductions

Som Saha, Chair of the Health Evidence Review Commission (HERC), called the meeting to order at 1:15 pm and welcomed the Commission.

### 2. Approval of Minutes

**MOTION: To approve the minutes of the January 12, 2012 meeting as presented.**  
**CARRIES 12-0.**

### 3. Director's Report

Darren Coffman reported that Carla McKelvey has officially resigned from her position on the HERC because she has been nominated to the Health Policy Board. Her place will not be filled until later in the spring because her replacement has to be appointed by the Governor and then go through the vetting process before Senate confirmation can take place.

Coffman gave an update on subcommittee membership. – He reported that the following are willing to appointments as follows:

- Laura Ocker, LAc as complimentary and alternative medicine representative on the Value-based Benefits Subcommittee
- Bob Joondeph, JD, a former Health Services Commission member as a consumer representative on the Evidence-based Guidelines Subcommittee
- Timothy Keenen, MD, an orthopedist and former member of the Health Resources Technology Subcommittee as a member of the Health Technology Assessment Subcommittee.
- A few more have expressed interest and they will officially let us know soon.

Coffman also explained that reports from the Subcommittee's to the Commission will be high level summaries and if members want more detail, it will be available in the minutes.

**MOTION: To approve the new members noted above.**  
**CARRIES 12-0.**

#### **4. Development of HERC Policies/Rules**

##### Conflict of Interest

Saha gave a brief outline of the conflict of interest issues. It is generally accepted that conflict of interest is framed not just as what you perceive is a conflict of interest but also how it is perceived by the outside. Mark Gibson added that conflict of interests can also be issues that you are not aware of. It is therefore wiser to err on the side of more disclosure than less. With that in mind, the documents attached in the packet are those that were used by the HRC and others considered by the HSC and they give a good indication of what should and should not be disclosed.

Coffman provided clarification on the question raised by Mark Gibson at the last meeting on whether his work at the Center for Evidence-based Policy at OHSU is a potential conflict of interest with the guideline and technology assessment that will be conducted by the commission. He confirmed that the Department of Justice determined that it would not be a conflict of interest because OHSU is a non-profit organization and is not seen as a business under State regulations and thus there is no potential financial benefit to Gibson.

##### Action

Based on the discussions above, Jeanene Smith and Cat Livingston will formulate a draft conflict of interest form/document for disclosure that they will present to the commission at the next meeting. They will also look at what is available in other states in drafting this form.

##### Submission of Evidence and Acceptance of Testimony

Saha talked about the process for submitting evidence to the Commission. The documents provided in the packet were policies that were used by the HSC. There are basically three situations in which topics can be brought to the Commission for consideration at a future meeting for making a change to the Prioritized List:

- 1) A new health technology is available with credible evidence as to its effectiveness
- 2) There has been a change in practice supported by systematic reviews or evidence-based guidelines
- 3) Only expert opinion alone can indicate a more cost effective or cost-effective treatment exists than what is paired on the Prioritized List

All the evidence must be submitted six weeks in advance of a meeting, and, if meriting placement on a HERC or subcommittee, the presentation will be no longer than 10 minutes in length, with unsolicited testimony totaling no more than five minutes per topic.

##### Posting of Materials

Coffman added that every effort will be made to post meeting materials no later than the Friday before the meeting (at least six days ahead of time). A public notice will be posted 30 days in advance of a meeting (or within two business days if the next meeting is less than 30 days away) on the website listing the major agenda topics.

**MOTION: To adopt:1) the HSC Policy on Acceptance of Testimony and Guidelines for Speakers & Presenters and 2) the Criteria for Topic Review used by the Health Services Commission as HERC policy also.**  
**CARRIES 12-0.**

## **5. Report of Value-based Benefit Subcommittee**

Staff reported that there is one topic that was not resolved before the Health Services Commission disbanded. Advocates for transgender services provided testimony to the HSC in August 2011 on a request to review the placement of hormone therapy for those with gender identity disorder, particularly for purpose of suppressing puberty in gender questioning children. The HSC had delegated this topic to its Mental Health Care and Chemical Dependency Subcommittee for further consideration, but the advocates requested more time before this occurred. Coffman indicated that the advocates would still prefer that this topic not be considered further, but he is concerned that putting it off any longer will not leave enough time to give it adequate consideration before the biennial list must be finalized in June. The subcommittee agreed that discussion should begin with splitting out gender identity disorder into a new line item at the March meeting.

Ariel Smits summarized four topics that were discussed at the Value-based Benefits Subcommittee:

1. Avascular Necrosis of the Hip and Vascular Bone Grafting – patient advocate testified and staff will invite a surgeon who performs surgery and one who doesn't to a future meeting.
2. Chemodenervation for Dystonias – recommend pairing this condition/treatment with a coding specification.
3. Continuous Glucose Monitoring in Diabetes – will acquire MED Report for further discussion.
4. Concussion NOS – recommend adding code to funded head trauma line.

Smits also reported that the VbBS reviewed the following ICD-10/Biennial Review speciality group recommendations:

1. Cardiothoracic Surgery - All recommendations were accepted except for a request to switch the ranking of RHEUMATIC MULTIPLE VALVULAR DISEASE with AORTIC VALVULAR DISEASE.
2. Neonatology – All recommendations accept, with the scoring of a new line for “Feeding Problems in Newborn” ranking it around line 21.
3. Rheumatology – Accepted all recommendations with scoring of the following new lines resulting in the approximate ranking given: SARCOIDOSIS (~Line 380), RAYNAUDS (~Line 525), CALCIUM PYROPHOSPHATE DEPOSITION DISEASE (CPPD) AND HYDROXYAPETITE DEPOSITION DISEASE (~Line 525), PANNICULITIS (~Line 545),

4. Pediatrics – Accepted recommendation to combine all viral pneumonias into currently funded line.

They did not have time to do the straightforward issues and had decided to make it into a consent agenda to send out ahead of the meetings in future.

Smits also talked about the public testimony on the topic of home deliveries that came up at their meeting. The HERC staff will discuss this internally and will bring this matter back to the subcommittee to decide where this issue needs to go.

## **6. Evidence-based Guidelines & Health Technology Assessment Development**

Coffman summarized the process used for the State of Oregon Evidence-based Guidelines Project used to complete the first guideline on the evaluation and management of low back pain. It took nearly a year to finish the process and the desire is to streamline it going forward.

Cat Livingston recapped that the HERC had agreed to carry over the topics chosen by the Health Services Commission for potential guideline and technology assessment at their January meeting. The Commission further agreed that the criteria for choosing additional topics as discussed at the meeting are as follows:

- a) Represents a significant burden of disease
- b) Represents important uncertainty with regard to efficacy or harms
- c) Represents important variation or controversy in clinical care
- d) Represents high costs, significant economic impact
- e) Represents high public interest or policy urgency/diffusion concern

Alison Little, from the Center for Evidence-based Policy, walked through three proposed processes for the development of: 1) evidence-based guidelines, 2) health technology assessments, and 3) coverage guidance. The guideline development process would be reduced to 4-5 months by eliminating the initial public comment period prior to conducting an evidence search, which had not been producing much in the way of useful testimony, and by concurrently running the 30-day public comment period on the draft guideline and the peer review process. She also listed some of the primary sources of evidence that they use, but said that the list is not exhaustive.

There was a lengthy discussion about the development of coverage guidance vs. guidelines or technology assessments for topics. If an evidence report exists from a trusted source, the HERC will skip to developing coverage guidance based on that report – with the guidance representing the Commission's direction to OHA programs on the coverage or non-coverage of health care services based on the evidence. Private payers will hopefully incorporate this guidance into their plans in working towards a statewide approach.

After much deliberation by the group Alyssa Craft suggested that Cat Livingston and Ariel Smits should choose the next topics for working on because they are more familiar with the background and would be able to make a more informed decision on which topics HERC should prioritize the highest.

## 7. Identification and Prioritization of Additional Topics for Evidence-based Guideline Development and Health Technology Assessment

A list of additional potential future topics was supplied by the CeBP as those with existing evidence reports produced through the MED Project, AHRQ or the Washington Health Technology Assessment program. The following topics were identified by Commissioners as some of the more obvious topics to begin working on.

- Elective induction of labor
- Cesarean section on maternal request
- PET scans
- Imaging for headache
- Hip resurfacing
- Prophylactic mastectomy
- Breast MRI
- Upper GI

It was decided to include all of the topics brought forth by staff as potential future topics, as they all met most if not all of the selection criteria they had established. Those topics having public evidence-reports available from these trusted sources to be focused on initially. Once APAC (All-Payer, All Claims) data is available, sometime in April, there may be more data to direct the Commission on what topics are priorities.

**MOTION: To add topics as presented for potential guideline/technology assessment/guidance development, with priority given to those with public evidence reports available. CARRIES 12-0.**

## 8. Next Steps

The first meetings of the Evidence-based Guidelines Subcommittee and Health Technology Subcommittee will be held prior to the April Commission meeting to begin working on coverage guidance on the highest priority topics.

## 9. Public Comment

Larry Burnett, DDS, appealed to the HERC committee on the topic of dental decay in children. He wants to give HERC a 20 minute presentation on his findings on how to reverse or eliminate early signs of dental decay starting at age 1. He has medical evidence to show that if a child has the proper care at an early age, there can be a drastic reduction in dental problems in the future. He would like to know how to incorporate this evidence, perhaps into the upcoming CCO benefits. Livingston gave him her contact details so that he can send his evidence to her. HERC can then decide if this evidence meets its criteria to include on a future agenda.

## 10. Adjournment

Meeting was adjourned at 4:00pm. Next meeting will be on Thursday, April 12, 2012 at the Legacy Meridian Hospital Community Health Education Center in Conference Room 117B&C.

## **Conflict of Interest Summary**

Question: What type of conflict of interest disclosure form should HERC and HERC subcommittee members be required to complete?

Question Source: HERC Staff

Issue: At the February 9, 2012 HERC meeting, there was a discussion about the use of conflict of interest disclosure forms. It was agreed that these are important for both committee and subcommittee members. It was discussed that Staff would research and present sample COI forms for discussion.

HSC Staff recommendation:

- 1) Choose COI form
- 2) Decide if testimony conflict interest form is important for this group, or if verbal declaration is adequate



## Health Evidence Review Commission

### CONFLICT OF INTEREST FORM

The Oregon Health Authority asks that you complete this Conflict of Interest form to help us in the decision making process for appointments to the Health Evidence Review Commission or any of its subcommittees.

**If you are selected to serve on the Health Evidence Review Commission or its subcommittees, you will be subject to Conflict of Interest disclosure requirements in ORS Chapter 244 as a public official.**

This form is due on an annual basis, although you should update the form with the HERC Commission within 15 days of a material change in the information provided to the Commission. You may wish to retain a copy of this form.

A relationship is considered as:

1. Receipt or potential receipt of anything of monetary value, including but not limited to, salary or other payments for services such as consulting fees or honoraria in excess of \$10,000.
2. Equity interests such as stocks, stock options or other ownership interests in excess of \$10,000 or 5% ownership, excluding mutual funds and blinded trusts.
3. Status of position as an officer, board member, trustee, owner or employee of a company or organization representing a company, association or interest group.
4. Loan or debt interest; or intellectual property rights such as patents, copyrights and royalties from such rights.
5. Manufacturer or industry support of research in which you are participating.
6. Any other relationship that could reasonably be considered a financial, intellectual, or professional conflict of interest.
7. Representation: if representing a person or organization, include the organization's name, purpose, and funding sources (e.g. member dues, governmental/taxes, commercial products or services, grants from industry or government).

\_\_\_\_\_  
**Your Name (Please Print)**

\_\_\_\_\_  
**(Date signed)**

**I have no relationships to disclose.**

## Disclosure

Any unmarked topic will be considered a "Yes"

	Potential Conflict Type	Yes	No
1.	Salary or payments such as consulting fees or honoraria in excess of \$10,000		
2.	Equity interests such as stocks, stock options or other ownership interests		
3.	Status of position as an officer, board member, trustee, owner		
4.	Loan or intellectual property rights		
5.	Research funding		
6.	Any other relationship*		

\*6. If yes, Provide Description: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

	Potential Conflict Type	Yes	No
7.	Representation: if representing a person or organization, include the name and funding sources (e.g. member dues, governmental/taxes, commercial products or services, grants from industry or government).		

7. If yes, Provide Name and Funding Sources: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If you believe that you do not have a conflict but are concerned that it may appear that you do, you may **attach additional sheets** explaining why you believe that you should not be excluded. The department will evaluate this justification.

**I certify that I have read and understand this Conflict of Interest Form and that the information I have provided is true, complete, and correct as of this date.**

X

\_\_\_\_\_

*Signature*

\_\_\_\_\_

*Date*

\_\_\_\_\_

*Print Name*

**Please return by mail, or email or fax to:**

**Health Evidence Review Commission**

**1225 Ferry Street SE, 1<sup>st</sup> Floor**

**Salem, OR 97301 Phone: 503-3731779; Fax: 503-3785511**

**[HERC.info@state.or.us](mailto:HERC.info@state.or.us)**



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3. Status of position as an officer, board member, trustee, owner or employee of a company<sup>1</sup> or organization representing a company, association or interest group.
4. Loan or debt interest; or intellectual property rights such as patents, copyrights and royalties from such rights.
5. Manufacturer or industry support of research in which you are participating.
6. Any other relationship that could reasonably be considered a financial, intellectual, or professional conflict of interest.
7. Representation: if representing a person or organization, include the organization's name, purpose, and funding sources (e.g. member dues, governmental/taxes, commercial products or services, grants from industry or government).

\_\_\_\_\_  
**Your Name (Please Print)**

\_\_\_\_\_  
**(Date signed)**

**I have no relationships to disclose.**

**The disclosure requests information including whether the responsible official or any immediate family member (spouse or dependent children -check all that apply) have any of the relationships listed below. In each category, the responsible official should disclose *both* the existence of a relationship and the amount of any financial arrangement. Such disclosure should indicate whether the amount of financial support received within any year of the prior 3 years falls into specific categories: \$10-50,000 and >\$50,000**

<sup>1</sup> "Company" is a for-profit entity (other than the individual's primary employer) that develops, produces, markets, or distributes drugs, devices, services or therapies used to diagnose, treat, monitor, manage and alleviate health conditions.

1. If you are employed as staff by a company that produces health care goods or services

Organization Name & Address	Self or Family	Amount
		<p>ρ <b>I have no relationships to disclose.</b></p> <p>ρ <b>\$10-50,000</b></p> <p>ρ <b>&gt;\$50,000</b></p>

2. Own stock, options or a similar interest in a company that produces health care goods or services (excluding mutual funds or trust fund income)

Organization Name & Address	Self or Family	Amount
		<p>ρ <b>I have no relationships to disclose.</b></p> <p>ρ <b>\$10-50,000</b></p> <p>ρ <b>&gt;\$50,000</b></p>

3. Serve as a consultant for a pharmaceutical company, medical device maker or other company that produces health care goods or services

Organization Name & Address	Self or Family	Amount
		<p>ρ <b>I have no relationships to disclose.</b></p> <p>ρ <b>\$10-50,000</b></p> <p>ρ <b>&gt;\$50,000</b></p>

4. Serve as a member of a speakers bureau for a pharmaceutical company, medical device maker or other company that produces health care goods or services

Organization Name & Address	Self or Family	Amount
		<p>ρ <b>I have no relationships to disclose.</b></p> <p>ρ <b>\$10-50,000</b></p> <p>ρ <b>&gt;\$50,000</b></p>

5. Receive grant money from a pharmaceutical company, medical device maker or other company that produces health care goods or services

Organization Name & Address	Self or Family	Amount
		ρ <b>I have no relationships to disclose.</b> ρ <b>\$10-50,000</b> ρ <b>&gt;\$50,000</b>

6. Receive licensing fees, royalties or other similar income from a pharmaceutical company, medical device maker or other company that produces health care goods or services

Organization Name & Address	Self or Family	Amount
		ρ <b>I have no relationships to disclose.</b> ρ <b>\$10-50,000</b> ρ <b>&gt;\$50,000</b>

7. Hold patents, copyrights or other intellectual property rights with a company that produces health care goods or services

Organization Name & Address	Self or Family	Amount
		ρ <b>I have no relationships to disclose.</b> ρ <b>\$10-50,000</b> ρ <b>&gt;\$50,000</b>

8. Received a gift from a company that produces health care goods or services

Organization Name & Address	Self or Family	Amount
		ρ <b>I have no relationships to disclose.</b> ρ <b>\$10-50,000</b> ρ <b>&gt;\$50,000</b>

9. Served as expert witness in which you were paid for expert testimony on behalf of a company that produces health care goods and services

Organization Name & Address	Self or Family	Amount
		<p>ρ <b>I have no relationships to disclose.</b></p> <p>ρ <b>\$10-50,000</b></p> <p>ρ <b>&gt;\$50,000</b></p>

10. Receive reimbursement for travel and lodgings from a company that produces health care goods or services

Organization Name & Address	Self or Family	Amount
		<p>ρ <b>I have no relationships to disclose.</b></p> <p>ρ <b>\$10-50,000</b></p> <p>ρ <b>&gt;\$50,000</b></p>

If you believe that you do not have a conflict but are concerned that it may appear that you do, you may **attach additional sheets** explaining why you believe that you should not be excluded. The department will evaluate this justification.

**I certify that I have read and understand this Conflict of Interest Form and that the information I have provided is true, complete, and correct as of this date.**

X

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Print Name*

**Please return by mail, or email or fax to:**

**Health Evidence Review Commission  
1225 Ferry Street SE, 1<sup>st</sup> Floor  
Salem, OR 97301 Phone: 503-3731779; Fax: 503-3785511  
[HERC.info@state.or.us](mailto:HERC.info@state.or.us)**



## Drug Use Review / Pharmacy & Therapeutics Committee

### Declaration of Compensation for Public Comment or Testimony

The P & T Committee will allow opportunity for public testimony at every meeting and accept testimony, in writing when submitted at least one week in advance of the scheduled meeting or in-person, prior to deliberating on any recommendations regarding a drug or a class of drugs. Persons offering either written or in-person testimony shall be required to state in writing and disclose publicly, prior to their testimony, if they are being compensated by any other interested party or entity including the nature or amount of the compensation being given in exchange for offering testimony.

**Have you been compensated for the testimony you plan to provide today?**

No

Yes If yes, please answer the following:

How were you compensated? (e.g. gifts, money, etc.) \_\_\_\_\_

How much were you compensated? \_\_\_\_\_

Who were you compensated by? \_\_\_\_\_

**Print Name** \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## **Value-based Benefits Subcommittee Recommendations Summary**

*For Presentation to:*

Health Evidence Review Commission on February 9, 2012

*For specific coding recommendations and guideline wording, please see the text of the 2/9/12 VbBS highlights.*

### **CODE MOVEMENT**

- Coverage for botulinum toxin injection for blepharospasm and torticollis was added to a covered line with a coding specification.
- The code for unspecified types of concussion was added to a covered line and left on an uncovered line, with coverage to be determined by residual symptoms being present

### **ITEMS CONSIDERED BUT NO CHANGES MADE**

- Coverage of vascularized bone grafting as a treatment for avascular necrosis of the hip was discussed and will be further discussed at a future meeting date dependent on the availability of hip surgeon(s) familiar with the procedure
- Coverage for continuous glucose monitoring for diabetes was discussed and will be further addressed at the March, 2012 VBBS meeting

### **GUIDELINE CHANGES**

- None

### **CHANGES FOR THE OCTOBER 1, 2013 PRIORITIZED LIST AS PART OF THE ICD-10 CONVERSION PROCESS**

- Specialty group recommendations review: Cardiothoracic Surgery, Neonatology, Pediatrics, Rheumatology
- Multiple lines were renamed
- Several lines were deleted
- Several lines were merged
- Guidelines were modified as shown in Appendix A
- New line "Feeding Problems in the Newborn" was created and ranked at approximately line 21
- Line 447 SARCOIDOSIS was rescored to about line 380
- Line 560 RAYNAUD'S was rescored to about line 525

## MEETING HIGHLIGHTS

### VALUE-BASED BENEFITS SUBCOMMITTEE

Portland State Office Building

*February 9, 2012*

*9:00 AM – 1:00 PM*

**Members Present:** Lisa Dodson, MD, chair; Kevin Olson, MD; James Tyack, DMD; Chris Kirk, MD; Mark Gibson; Irene Crowell RPh

**Staff Present:** Darren Coffman; Ariel Smits, MD, MPH; Cat Livingston, MD, MPH; Dorothy Allen; Dave Lenar

**Also Attending:** Wally Shaffer, MD and Denise Taray, DMAP; Ellen Pinney, OHA; Michael Adkins; Kristine Andrews; Ann Neilson, Amgen; Anne Marie Licos, William LaVia and Paul Nielsen, MedImmune; Jennifer Stoll, Allergan; Bill Struyk, Johnson and Johnson.

The meeting was called to order at 9:15 AM. Roll call was done. Introductions of subcommittee members followed. Smits reviewed the goals of the subcommittee, which include reviewing placement of procedures and diagnoses on the Prioritized List, review of new medical procedures (with the Health Technology Assessment Subcommittee), review of the ICD-10 conversion process for the Prioritized List, and discussion of value-based benefits packages based on the Prioritized List for potential use within the Exchange. A vote was then held for a chair and vice chair. Lisa Dodson, MD was elected unanimously as Chair and Kevin Olson, MD was elected unanimously as Vice Chair.

Smits gave a staff report, which included a discussion on what additional members, if any, the subcommittee felt would be appropriate. Suggestions included someone with expertise in addictions, complementary and alternative medicine, and health plan/insurance design. The full HERC will discuss the process for nominating and deciding on additional subcommittee membership.

Smits then brought up an outstanding issue for discussion. The Health Services Commission was asked to discuss coverage of hormone treatment for transgendered individuals. Currently, the diagnosis of gender identity disorder is on the same line as conditions such as pedophilia and bestiality. This diagnosis is inappropriate for such a placement. If this diagnosis is moved to a new line, then the question before the subcommittee will be what procedures and treatments should be included on this new line and where should it be ranked. HERC staff have been working with various advocacy groups in Oregon to develop this topic. However, these groups have not indicated that they are ready to bring testimony yet. If the subcommittee is to have time to adequately examine this issue and make changes which can be included as part of the biennial review for the October 1, 2013 Prioritized List, then the group needs to start discussing this topic. The decision was to place this item on the March, 2012 agenda, and notify the advocacy groups to allow them to participate if they desire.

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Topic: **Vascular bone grafts for avascular necrosis of the hip**

**Discussion:** Smits reviewed a summary document outlining the use of vascularized bone grafting for the treatment of avascular necrosis (AVN) of the hip, the evidence of effectiveness for this treatment, and staff recommendations for coverage.

Testimony was heard from Mr. Michael Adkins, who also provided written materials for the subcommittee. He testified about his frustrations trying to obtain this procedure for his AVN. He argued that the procedure is effective, cost-effective, and should be covered for both early stage and late stage avascular necrosis of the hip.

Discussion started with the question about whether AVN progressed when not treated, or whether some patients treated with vascularized bone grafting may have not progressed in their disease due to the natural history of the disease. Livingston found a review in the Journal of Bone and Joint Surgery which found that the rate of progression is 59%.

Olson expressed that the presented literature constituted a low level of evidence. He explained how the Health Services Commission had added bone marrow transplant for the treatment of breast cancer based on similarly promising, but low level evidence. Once final data from randomized controlled studies was available it was shown that the treatment was of more harm than good and it was taken back off of the list. Olson stated that he would like an expert to come before the VBBS to give testimony and answer committee members' questions. He would like specific information on which patients could best benefit from this type of surgery, and what qualifications should the surgeon have who performs this surgery (extra training, etc.).

The group expressed interest in having more information on the outcomes of this surgery in various patient groups. The group felt that a guideline may be needed if coverage of this condition is added, which would specify which patients are candidates, and any restrictions on provider type.

**Actions:**

- 1) HERC staff will find an orthopedic expert in the treatment of avascular necrosis of the hip to provide testimony and answer subcommittee questions regarding vascularized bone grafting as a treatment option.
- 2) HERC staff will place this topic on a future VBBS agenda, the date to be determined by expert availability
- 3) Staff and subcommittee members will review additional literature provided by Mr. Adkins prior to this future meeting

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Topic: **Botox for blepharospasm and dystonia**

**Discussion:** Smits reviewed a summary document regarding the use of Botox for treatment of blepharospasm and dystonia. Submitted testimony from the manufacturer clarified which CPT codes are utilized for this treatment. Coffman pointed out that the proposed guideline should actually be a coding specification.

**Action:**

- 1) Add 64612-4 [Chemodenervation of muscle(s); extremity(s) and/or trunk muscle(s)] to line 388 DYSTONIA (UNCONTROLLABLE); LARYNGEAL SPASM AND STENOSIS
- 2) Add the following coding specification to line 388:
  - a. Chemodenervation with botulinum toxin injection (CPT 64612-64614) is included on this line only for treatment of blepharospasm (ICD-9 333.81), spasmodic torticollis (ICD-9 333.83), and other fragments of torsion dystonia (ICD-9 333.89).

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**Topic: Continuous glucose monitoring in diabetes**

**Discussion:** Smits introduced a summary document with suggested changes to the coverage of continuous glucose monitoring for patients with diabetes. Shaffer noted that DMAP currently has administrative rules that do not allow payment for the monitoring system. Therefore, despite having the procedure CPT code on the Prioritized List, there is currently no coverage for this type of monitoring through OHP.

There was discussion about which patients should be eligible for this type of therapy (type 2 diabetics who are insulin dependent or only type 1 diabetics), and what harms this therapy might have. Pollack raised a question about relative cost of standard monitoring vs continuous glucose monitoring. Staff indicated that standard monitoring costs \$4-\$10 a day based on usual cost for test strips, while continuous monitoring systems cost \$1000-\$1300 for the monitor and about \$35 for a probe that is replaced every 3 days.

Gibson raised concern about whether this technology should be covered for 3 days as a diagnostic strategy, or covered long term. Smits indicated that other major insurers typically cover for 3 days only. Gibson also raised concerns about the proposed guideline not containing enough specifics. The group felt that the guideline needed more information about the type of diabetic eligible, the length of therapy, what constituted hypoglycemia and whether the hypoglycemia needed therapy by a second person to qualify, and whether the patient should have previously been shown to be compliant with traditional glucose testing. Gibson pointed out that the MED project has recently reviewed this topic and that this review should be considered by the Subcommittee. Shaffer noted that the MED review conclusion was that there was insufficient evidence for use in type 1 diabetes. The group also felt that national guidelines such as CMS guidelines should be sought.

The group decided to have HERC staff find additional information about this topic and bring back to the March, 2012 VBBS meeting

**Action:**

- 1) HERC staff will obtain the MED review on this topic, CMS guidelines, and any other additional high quality information
- 2) This topic will be readdressed at the March, 2012 VBBS meeting.

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**Topic: Concussion NOS**

**Discussion:** Smits introduced a summary document with suggested changes to the placement of the ICD-9 code for concussion NOS. There was no discussion.

**Actions:**

- 1) Add 850.9 (Concussion, unspecified) to line 101 HEAD INJURY: HEMATOMA/EDEMA WITH PERSISTENT SYMPTOMS, COMPOUND/DEPRESSED FRACTURES OF SKULL
- 2) Keep 850.9 on line 641 HEAD INJURY: HEMATOMA/EDEMA WITH NO PERSISTENT SYMPTOMS

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**Topic: ICD-10 review--Cardiothoracic Surgery**

**Discussion:** Livingston introduced a summary document with suggested changes to the cardiothoracic surgery lines on the Prioritized List based on ICD-10 review. All recommendations were accepted except for a request to switch the Rheumatic Multiple Valvular Disease line with the Aortic Valvular Disease Line. There was a discussion about the process of ranking and that switching lines without adherence to the ranking methodology was not appropriate. A brief discussion occurred about combining separate valvular disease lines but the decision was made to keep them separate.

**Actions:**

- 1) DELETE Line 63 FLAIL CHEST. Codes go to open and closed rib fracture lines.
- 2) DELETE Line 309 PAPILLARY MUSCLE RUPTURE
- 3) Delete **GUIDELINE NOTE 13, MINIMALLY INVASIVE CORONARY ARTERY BYPASS SURGERY**
- 4) Modify **GUIDELINE NOTE 18, VENTRICULAR ASSIST DEVICES** as shown in Appendix A
- 5) Rename lines:
  - a. Line 109 CARDIOMYOPATHY, ~~HYPERTROPHIC MUSCLE~~
  - b. Line 153 PNEUMOTHORAX AND ~~HEMOTHORAX~~ PLEURAL EFFUSION TUBE THORACOSTOMY/THORACOTOMY Treatment: SURGICAL THERAPY, MEDICAL THERAPY
  - c. Line 192 RHEUMATIC MULTIPLE VALVULAR DISEASE
  - d. Line 237 Treatment: ~~AORTIC VALVE REPLACEMENT, VALVULOPLASTY, MEDICAL THERAPY~~ MEDICAL AND SURGICAL THERAPY
  - e. Line 307 Treatment: ~~SURGICAL TREATMENT~~ MEDICAL AND SURGICAL THERAPY
  - f. Line 385 ~~ANEURYSM DISEASES~~ OF PULMONARY ARTERY

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**Topic: ICD-10 review--Neonatology**

**Discussion:** Livingston introduced a summary document with suggested changes to the neonatology lines on the Prioritized List based on ICD-10 review. There was some discussion of ankyloglossia and the clarification that the diagnosis code for this condition is below the funded region, and so treatment of tongue tie would pair below the funded region. The comorbidity rule may be used if true feeding problems are present. All recommendations were accepted.

The new line: Feeding Problems in Newborn was ranked as follows:

Category: 6 (not intrinsic, diagnosis made after delivery)  
Impact on healthy life years: 10  
Impact on suffering: 5  
Population effects: 0  
Vulnerability of population affected: 2  
Tertiary prevention: 5  
Effectiveness: 5  
Cost: 2  
Score: 4400  
**Approximately Line: 21**

**Actions:**

- 1) New line for Feeding Problems in the Newborn was created and ranked at approximately line 21
- 2) Lines 28 and 29 were merged; the new line was titled INTRACRANIAL HEMORRHAGES; CEREBRAL CONVULSIONS, DEPRESSION, COMA, AND OTHER ABNORMAL CEREBRAL SIGNS OF THE NEWBORN
- 3) A coding specification was added to Line 112 – “E80.4 is included on this line for neonates only.”
- 4) Guideline Note 48 was modified as shown in Appendix A.
- 5) Line 14 was renamed OTHER-RESPIRATORY CONDITIONS OF FETUS AND NEWBORN
- 6) Line 674 was renamed EDEMA AND OTHER CONDITIONS INVOLVING THE ~~INTEGUMENTS~~SKIN OF THE FETUS AND NEWBORN

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**Topic: ICD-10 review--Pediatrics**

**Discussion:** Smits introduced a summary document with suggested changes to the pediatric lines on the Prioritized List based on ICD-10 review. The major proposal was to move all viral pneumonias currently on line 644 to line 330. The group debated whether RSV pneumonia should be distinguished from other viral pneumonias. There was some concern whether patients with mild viral pneumonia should receive care, as other viral illnesses are not covered. The group felt that a viral infection severe enough to cause pneumonia should at least have office visit coverage.

**Actions:**

- 1) Rename line 330 ~~PNEUMONIA DUE TO RESPIRATORY SYNCYTIAL VIRUS IN PERSONS UNDER AGE 3~~ VIRAL PNEUMONIA

- 2) Move all ICD-10 codes for viral pneumonias from line 664 to line 330
- 3) Rename line 644 **OTHER VIRAL INFECTIONS, EXCLUDING PNEUMONIA DUE TO RESPIRATORY SYNCYTIAL VIRUS IN PERSONS UNDER AGE 3**

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**Topic: ICD-10 review--Rheumatology**

**Discussion:** Livingston introduced a summary document with suggested changes to the rheumatology lines on the Prioritized List based on ICD-10 review. Recommendations made by the ICD 10 Rheumatology group were adopted with the additional following scoring decisions:

**CALCIUM PYROPHOSPHATE DEPOSITION DISEASE (CPPD) AND  
HYDROXYAPETITE DEPOSITION DISEASE**

Category: 7  
Impact on healthy life years: 3  
Pain and suffering: 2  
Population effects: 0  
Tertiary prevention: 0  
Vulnerable population: 0  
Effectiveness: 3  
Need for treatment: 50%  
Net cost: 3  
Score: 150  
**Approximate Line: 525**

**PANNICULITIS**

Category: 7  
Impact on healthy life years: 1  
Impact on pain and suffering: 2  
Population effects: 0  
Vulnerable population: 0  
Tertiary prevention – can cause ulceration, treatment may be able to prevent ulceration: 1  
Effectiveness of therapy - 25%: 2  
Net cost: 3  
Need for treatment: 75%  
Score: 120  
**Approximate Line: 545**

**SARCOIDOSIS**

Category: 6  
Impact on healthy life years: 3  
Impact on pain and suffering: 2  
Population effects: 0  
Vulnerable population: 1  
Tertiary prevention: 3  
Effectiveness of therapy: 4  
Net cost: unchanged  
Need for treatment: 50%  
Score: 720  
**Approximate Line: 380**

## RAYNAUDS

Category: 7  
Impact on healthy life years: 2  
Impact on pain and suffering: 2  
Population effects: 0  
Vulnerable population: 0  
Tertiary prevention: 1  
Effectiveness of therapy: 3  
Net cost: 4  
Need for treatment: 50%  
Score: 150  
**Approximate Line: 525**

### **Actions:**

- 1) A new line was created: "CALCIUM PYROPHOSPHATE DEPOSITION DISEASE (CPPD) AND HYDROXYAPETITE DEPOSITION DISEASE" and ranked at approximately line 525
- 2) A new line was created "PANNICULITIS" and ranked at apprximately line 545
- 3) Line 439 SICCA SYNDROME; POLYMYALGIA RHEUMATICA was deleted and all diagnoses moved to other lines
- 4) Line 357 was renamed SYSTEMIC SCLEROSIS; SJOGREN'S SYNDROME
- 5) Several lines were rescored as above
- 6) Line 447 SARCOIDISIS was rescored to about line 380
- 7) Line 560 RAYNAUD'S was rescored to about line 525
- 8) Line 140 was renamed WEGENER'S GRANULOMATOSIS GRANULOMATOSIS WITH POLYANGIITIS
- 9) Line 326 was renamed GOUT AND CRYSTAL ARTHROPATHIES
- 10) Line 117 was renamed GIANT CELL ARTERITIS, POLYMYALGIA RHEUMATICA, AND KAWASAKI DISEASE THROMBOANGITIS OBLITERANS

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### **Topic: ICD-10 Review—Family Medicine**

**Discussion:** Tabled to the March, 2012 VBBS subcommittee meeting.

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### **Topic: ICD-10 Review--Nephrology**

**Discussion:** Tabled to the March, 2012 VBBS subcommittee meeting.

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### **Topic: Straightforward Issues**

**Discussion:** Tabled to the March, 2012 VBBS subcommittee meeting.

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### **Topic: Larynoplasty**

**Discussion:** Tabled to the March, 2012 VBBS subcommittee meeting.

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**Public Comment**

Public testimony was heard from Kristine Andrews regarding coverage of home births. She provided verbal and written testimony about her family's experience with a birth center delivery that resulted in a poor outcome. She requested that the VBBS subcommittee consider limitations on home birth to low risk births as defined by the Dutch model, and to certain types of providers.

Written testimony was also received on the morning of the meeting from Dr. Stella Dantos. The subcommittee decided to hold off on hearing this testimony, and consider it in the context of a more indepth discussion of this topic.

The subcommittee decided to add this topic to a future agenda, to allow more time and consideration. HERC staff will research this topic, and place it on a future agenda.

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**Issues for next meeting:**

- 1) Vascular bone grafts for avascular necrosis of the hip
- 2) Continuous glucose monitoring in diabetes
- 3) Ranking of esophagitis line
- 4) Tympanostomy tubes for chronic otitis media and hearing loss guideline
- 5) Creation and ranking of new line for gender identity disorder
- 6) ICD-10 review for Family Medicine, Nephrology, Vascular Surgery, and other categories

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**Next meeting:**

March 8, 2012 at Meridian Park Hospital Rm 117B&C in Tualatin, OR

**Attachment A**  
**Guideline Changes as Part of the ICD-10 Review**  
**Note: these take effect October 1, 2013**

## **Guideline modifications**

### ***GUIDELINE NOTE 18, VENTRICULAR ASSIST DEVICES***

*Lines 108,279*

Ventricular assist devices are covered only in the following circumstances:

1. as a bridge to cardiac transplant;
2. as treatment for pulmonary hypertension when pulmonary hypertension is the only contraindication to cardiac transplant and the anticipated outcome is cardiac transplant; or,
3. as a bridge to recovery.

Ventricular assist devices are not covered for destination therapy.

Ventricular assist devices are covered for cardiomyopathy only when the intention is bridge to cardiac transplant.

Implantable VADs are covered for indications 1 and 2.

Temporary or short term VADs are covered for indications 1 and 3.

### ***GUIDELINE NOTE 48, FRENULECTOMY/FRENULOTOMY***

*Line 373*

Frenulectomy/frenulotomy (D7960) is included on this line for the following situations:

- ~~1. In the presence of ankyloglossia~~
- 2.1. When deemed to cause gingival recession
3. 2. When deemed to cause movement of the gingival margin when frenum is placed under tension.
- 4.3. Maxillary labial frenulectomy not covered until age 12 and above

## Value-based Benefits Subcommittee Recommendations Summary

For Presentation to:

Health Evidence Review Commission on April 12, 2012

For specific coding recommendations and guideline wording, please see the text of the 3/8/12 VbBS minutes.

### CODE MOVEMENT

- Coverage for continuous glucose monitoring for diabetes was removed from the Prioritized List
- Coverage was added for HPV vaccination for males. The age for coverage of HPV vaccination for males and females was changed to ages 9-26
- The diagnosis of lichen sclerosus on a covered line
- Tympanostomy tubes were removed from Line 383 Hearing loss, and the intent was clarified

### ITEMS CONSIDERED BUT NO CHANGES MADE

- Coverage of vascularized bone grafting as a treatment for avascular necrosis of the hip was not discussed. This topic will be addressed at the April meeting

### GUIDELINE CHANGES

- None

### CHANGES FOR THE OCTOBER 1, 2013 PRIORITIZED LIST AS PART OF THE ICD-10 CONVERSION PROCESS

- Specialty group recommendations review: Family Medicine, Nephrology, Vascular surgery, Gastroenterology, Urology, Allergy, Heart Transplant, Pediatric Surgery
- Multiple lines were renamed
- Multiple lines were deleted or merged
- New guidelines were created and two existing guidelines were modified as shown in Attachment A
- Line 570: SUBLINGUAL, SCROTAL, AND PELVIC VARICES was rescored to approximately line 550
- New line was created for FOREIGN BODY IN GASTROINTESTINAL TRACT and scored to the low 400s
- New line created for OTHER CONGENITAL ANOMALIES OF MUSCULOSKELETAL SYSTEM and scored to approximately line 40
- New line was created for ANGIOEDEMA and scored to approximately line 520
- New line was created for HEREDITARY ANGIOEDEMA and was scored to approximately line 166
- New line was created for ALLERGIC BRONCHOPULMONARY ASPERGILLOSIS and was scored to approximately line 390

### CHANGES FOR THE OCTOBER 1, 2013 PRIORITIZED LIST AS PART OF THE BIENNIAL REVIEW

- Line 513 GENDER IDENTIFICATION DISORDER, PARAPHILIAS AND OTHER PSYCHOSEXUAL DISORDERS was divided into two separate lines, Line XXX GENDER IDENTIFICATION DISORDER DYSPHORIA (scored to approximately line 430) and Line XXX PARAPHILIAS AND OTHER PSYCHOSEXUAL DISORDERS (scoring was not completed)

- Histrelin (Supprelin) insertion (GnRH analog used to suppress puberty) CPT (11981-11983) codes were added to new gender dysphoria line
- A new guideline was adopted for the new Gender Dysphoria line to specify included treatments
- The esophagitis line was reranked to approximately Line 540

DRAFT

## MEETING MINUTES

### VALUE-BASED BENEFITS SUBCOMMITTEE

#### Meridian Park Health Education Center

*March 8, 2012*

*9:00 AM – 1:00 PM*

**Members Present:** Lisa Dodson, MD, chair; Kevin Olson, MD, vice-chair; James Tyack, DMD; Chris Kirk, MD; Laura Ocker LAc.

**Members Absent:** Mark Gibson; Irene Crowell RPh.

**Staff Present:** Darren Coffman; Ariel Smits, MD, MPH; Cat Livingston, MD, MPH; Dave Lenar.

**Also Attending:** Isabel Bickle; and Denise Taray, DMAP; Jessie Little, ASU; Camille Kerr & Chris Doyle, Allergan; Heidi Allen, LCSW, Providence Health Systems; Jenn Burleton, Trans Active Education & Advocacy; Aubrey Harrison, Basic Rights Oregon.

The meeting was called to order at 9:05 AM. Roll call was done. Laura Ocker, LAc was introduced as a new member. Minutes from the February, 2012 VbBS meeting were reviewed and approved. ACTION: HERC staff will post the approved minutes on the website as soon as possible.

Smits gave the staff report. ICD-10 implementation has been delayed by the Centers for Medicare/Medicaid Services (CMS). The new implementation date has not yet been announced. HERC staff will move forward with the ICD-10 conversion process for the Prioritized List, as this process is about 80% completed. If ICD-10 is significantly delayed (2 or more years), then HERC staff will indentify important changes suggested to the List through this process and work to implement them in ICD-9 in a new version of the List.

*Note: All ICD-10 review changes take effect with the next Biennial Review Prioritized List (October 2013 or later)*

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#### Topic: **Straightforward Items**

**Discussion:** Smits reviewed the new process for approving the straightforward items. Committee members will review the items prior to the meeting and bring any concerns or desired changes to the meeting. The three items on the March agenda under straightforward had no concerns or desired changes and were approved as presented in the meeting packet.

**Actions:**

- 1) Add 33406 to line 237
- 2) Add 22305 and 22310 to line 507
- 3) Add 63045-63048 to line 271
- 4) Add 27075-27078 to line 208.
- 5) Add 11620-11626 to lines 275 and 311
- 6) Delete 38542 from Diagnostic Procedure File. Add 38542 to line 221
- 7) Add 66020 to line 413

- 8) Remove 403.91 from line 366. Add 403.91 to line 66. Keep 403.91 on 110
- 9) Add 382.9 to line 502
- 10) Add 27884 and 27886 to line 448
- 11) Add 27886 to line 308
- 12) Remove 17340 from lines 292, 524, 534, 618, 642, and 652
- 13) Remove 273.4 from line 479. Add 273.4 to lines 254 and 255
- 14) Add 77301 to line 197
- 15) Add 626.9 to line 446
- 16) Add 60521 and 60522 to lines 276 and 402
- 17) Delete 20605 from line 378
- 18) Add 29305 and 29325 to line 336
- 19) Add 31603 to line 14
- 20) Add 44125 to line 84
- 21) Add 43249 to lines 71 and 126
- 22) Add 50546 to line 54
- 23) Add 50650 to line 96
- 24) Add 29150 to line 250
- 25) Add 77301 and 77470 to line 275
- 26) Remove 44799 from line 111. Advise DMAP to add 44799 to Ancillary List
- 27) Add 37609 to line 117. Advise DMAP to remove 37609 from the Diagnostic Procedures List.
- 28) Add 33211-33212, 33214-33215, 33218-33219 to line 308
- 29) Add 31580 to line 14. Remove 31580 from line 214
- 30) Add 31582, 31587, and 31588 to line 49

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**Topic: ICD-10 Review Family Medicine**

**Discussion:** Smits introduced a summary document with suggested changes to the List from the Family Medicine review group. There were no significant suggestions and no discussion.

**Action:**

- 1) No significant changes recommended

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**Topic: ICD-10 Review Nephrology**

**Discussion:** Smits introduced a summary document with suggested changes to the nephrology lines base on the ICD-10 review. There was no discussion.

**Actions:**

- 1) Delete line 352 ACUTE GLOMERULONEPHRITIS AND OTHER ACUTE RENAL FAILURE, move all acute kidney injury codes to line 138 as renamed below and all chronic kidney disease codes to line 366 as renamed below. [Note: when lines 138 and 352 were proposed for merging, the new line scored out to place at 138]
- 2) Rename Line 138 ~~ACUTE GLOMERULONEPHRITIS: WITH LESION OF RAPIDLY PROGRESSIVE GLOMERULONEPHRITIS~~ ACUTE KIDNEY INJURY
- 3) Rename Line 366 ~~NEPHROTIC SYNDROME AND OTHER RENAL DISORDERS~~ CHRONIC KIDNEY DISEASE
- 4) Move all codes that do not specify end stage renal disease from line 66 to line 366 and renamed line 366 as above

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**Topic: ICD-10 review--Vascular Surgery**

**Discussion:** Smits introduced a summary document with suggested changes to the Vascular Surgery lines base on the ICD-10 review. There was no discussion.

**Actions:**

- 1) Delete line 350 ARTERIAL ANEURYSM OF NECK. All ICD-10 codes on line 350 also appear on line 349 NON-DISSECTING ANEURYSM WITHOUT RUPTURE and will remain there. Move all CPT codes from 350 to 349.
- 2) Rename 250 ~~PERIPHERAL VASCULAR DISEASE, LIMB THREATENING~~ LIMB THREATENING VASCULAR DISEASE, INFECTIONS, AND VASCULAR COMPLICATIONS
- 3) Rename 378 ~~ATHEROSCLEROSIS, PERIPHERAL~~ NON-LIMB THREATENING PERIPHERAL VASCULAR DISEASE
- 4) Place all peripheral vascular disease diagnoses with rest pain, ulcer, gangrene or other limb threatening conditions on upper vascular disease line (line 250)
  - a. Add to line 250: 34101-34203 (embolectomy), 35081 (repair of aneurysm), 35256 (repair of blood vessel with vein graft, lower extremity), 35450-35476 (balloon angioplasty), 35510-35671 (bypass graft), 35685, 35686, 35701-35761 (exploration of artery), 35879, 35881, 36002, 37184-37186 (thrombectomy), 37201-37209 (stenting), 37220-37235 (revascularization)
- 5) Place all non-limb threatening vascular disease diagnoses on lower vascular disease line (line 378)
  - a. Add to line 378: 24900-24931 (amputation, arm), 24935, 24940, 25900-25909 (amputation, forearm), 25915, 25920-25931 (hand amputation), 26910, 26951-2, 27025, 27290, 27295, 27590-27598 (amputation, thigh), 27880-27889 (amputation, leg), 28800-28825 (amputation, foot)
- 6) Remove all non-major blood vessels (vessels of the foot) from line 86 INJURY TO MAJOR BLOOD VESSELS OF EXTREMITIES as these vessels only require suture/ligation, not repair. Add these ICD-9 codes to line 216 DEEP OPEN WOUND, WITH OR WITHOUT TENDON OR NERVE INVOLVEMENT
  - a. S95.001A-S95.999A (laceration, specified or unspecified injury of the dorsal artery, plantar artery, dorsal vein, other specified artery of the ankle or foot, or unspecified artery of ankle or foot). Podiatry has reviewed this recommendation and concurs

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**Topic: ICD-10 review--Gastroenterology**

**Discussion:** Smits introduced a summary document with suggested changes to the gastroenterology lines base on the ICD-10 review. There was minimal discussion.

**Actions:**

- 1) Merge line 224 ESOPHAGEAL VARICES with line 62 ULCERS, GASTRITIS, DUODENITIS, AND GI HEMORRHAGE. Add all CPT codes on line 224 that do not appear on line 62 to line 62
- 2) Rename line 163, ACUTE VASCULAR INSUFFICIENCY OF INTESTINE
- 3) Move I84.6 (Gastric varices) from Excluded List to line 62 ULCERS, GASTRITIS, DUODENITIS, AND GI HEMORRHAGE
- 4) Move K57.11, K57.31, K57.51, K57.91 (Diverticulosis of small and/or large intestine with bleeding) to line 62 ULCERS, GASTRITIS, DUODENITIS, AND GI HEMORRHAGE from line 191 DIVERTICULITIS OF COLON
- 5) Move Z80.0 (Family history of malignant neoplasm of digestive organs) from the Excluded File to line 173 ANAL, RECTAL AND COLONIC POLYPS to allow for additional screening procedures, etc

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**Topic: ICD-10 review--Urology**

**Discussion:** Smits introduced a summary document with suggested changes to the urology lines on the Prioritized List based on ICD-10 review. There was some discussion about the creation of a new guideline allowing coverage of treatment of certain benign neoplasms of the urinary organs. Olson felt that the diagnosis codes for these benign tumors should be added to line 228, and kept on line 538, with the guideline referring to both lines to clarify in what cases these diagnoses are covered. Staff will work with experts to find the correct ICD-10 codes to move to line 228.

The recommendation to rescore line 538 Condition: BENIGN NEOPLASM OF KIDNEY AND OTHER URINARY ORGANS down to line 570 was rejected as it did not fulfill the intention of the expert reviewers.

The recommendation to swap line 570 SUBLINGUAL, SCROTAL, AND PELVIC VARICES with line 579 CHRONIC PROSTATITIS, OTHER DISORDERS OF PROSTATE was not accepted. Instead, the subcommittee rescored line 579, changing the effectiveness score from 1 to 2, which increased the line score to 120 and moving the line to approximately line 550. This should have the desired outcome of making prostatitis a higher priority condition than scrotal and pelvic varices.

**Actions:**

- 1) Delete line 294 RUPTURE OF BLADDER, NONTRAUMATIC and place only ICD-10 code (N32.89 Other specified disorders of bladder) on line 690 GENITOURINARY CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY. Move all CPT codes from line 294 to line 690
- 2) Delete line 353 VESICULAR FISTULA and move the 2 ICD-10 codes (N32.1 Vesicointestinal fistula and N32.2 Vesical fistula, not elsewhere classified) to line 245 URINARY FISTULA. Move all CPT codes from line 353 to line 245
- 3) Add a guideline to lines 228 and 538 as shown in Attachment A
- 4) Staff to work with experts to identify ICD-10 codes to add to line 228 to represent the diagnoses specified in this guideline note
- 5) Line 570: Condition: SUBLINGUAL, SCROTAL, AND PELVIC VARICES rescored to approximately line 550

- 6) A guideline was added to line 30 as shown in Attachment A
- 7) Change treatment description of line 30 to VESICoureTERAL REFLUX  
Treatment: MEDICAL THERAPY, ~~REIMPLANTATION SURGERY~~
- 8) Change name of Line 96 CONGENITAL ANOMALIES OF GENITOURINARY SYSTEM
- 9) Line 96 CONGENITAL ANOMALIES OF GENITOURINARY SYSTEM: many diagnoses moved to line 690 GENITOURINARY CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY, as there is no therapy available. These diagnoses include many congenital anomalies such as absence, aplasia, or hypoplasia of genitourinary organs
- 10) N43.3 (Hydrocele, unspecified) appears on line 567 HYDROCELE; should also appear on line 175 COMPLICATED HERNIAS (OTHER THAN DIAPHRAGMATIC HERNIA); UNCOMPLICATED INGUINAL HERNIA IN CHILDREN AGE 18 AND UNDER; PERSISTENT HYDROCELE for children only, with the current guideline applying

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**Topic: ICD-10 Review—Allergy**

**Discussion:** Livingston introduced a summary document outlining the changes suggested during the expert review of the allergy lines as part of the ICD-10 conversion process. The subcommittee accepted most of the suggested changes. The committee members decided **not** to accept the recommendation of moving L27.0 Generalized skin eruption due to drugs and medicaments taken internally to the complications line, because of the unintended consequences. It will remain the lower non-funded line (Line 594).

**Actions:**

1) Split Angioedema (Line 343) into 2 new lines, one is HEREDITARY ANGIOEDEMA and the other line is ANGIOEDEMA.

a. Ranking for HEREDITARY ANGIOEDEMA

Category 6

Impact on healthy life years 8

Vulnerable populations 0

Population effects 0

Impact on healthy life years 8

Impact on pain/suffering 3

Tertiary prevention – 0

Effectiveness of treatment – 4

Need for medical service 1

Net cost 1

**Score is 1760 which is Line 166**

b. Ranking for ANGIOEDEMA

Category 7

Impact on healthy life years 3

Vulnerable populations 0

Population effects 0

Impact on pain/suffering 1

Tertiary prevention 0

Effectiveness of treatment 4

Need for medical service 1

Net cost 4  
**Score 160, Line 520**

2) Split out allergic bronchopulmonary aspergillosis from Line 354 COCCIDIOIDOMYCOSIS, HISTOPLASMOSIS, BLASTOMYCOTIC INFECTION, OPPORTUNISTIC AND OTHER MYCOSES). This is an allergic issue, not an opportunistic infection issue. Can prevent bronchiectasis if treated, long term prednisone.

c. Rescoring recommendations for new line ALLERGIC BRONCHOPULMONARY ASPERGILLOSIS (ICD 10 code B44.81)

Category 7  
Impact on healthy life years 4  
Pain and suffering 2  
Vulnerable 0  
Contagion 0  
Tertiary prevention 2  
Effectiveness of treatment 4  
Need for service 1  
Net cost 3

**Score 640, Line 390**

3) Place Z01.82 Encounter for allergy testing (Currently located on the DMAP Ancillary File) on the Excluded List.

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### **Topic: ICD-10 Review—Heart and Lung Transplant**

**Discussion:** Livingston introduced a summary document outlining the changes suggested during the expert review of the heart and lung transplant lines as part of the ICD-10 conversion process. The recommendations were accepted to remove the penultimate diagnoses from the cardiac transplant lines, so only the final qualifying cardiac diagnoses remain on these lines (malignant arrhythmia, congestive heart failure, intractable angina, or myocarditis).

**Actions:**

- 1) Modify Guideline Note 70 re: heart-kidney transplants (Attachment A)
- 2) Rename Line 279 CONGESTIVE HEART FAILURE, CARDIOMYOPATHY, MALIGNANT ARRHYTHMIAS, AND COMPLEX CONGENITAL HEART DISEASE TRANSPOSITION OF GREAT VESSELS, HYPOPLASTIC LEFT HEART SYNDROME
- 3) Add malignant arrhythmia codes to Line 279 (I47.2 Ventricular tachycardia, I49.01 Ventricular fibrillation, I49.02 Ventricular flutter)
- 4) Add stage V and VI kidney disease to the heart-kidney transplant line 279.
- 5) Remove the following codes from 256, as these are penultimate diseases and not the terminal diagnosis leading to transplant.
  - Q20.0 Common arterial trunk 139,256
  - Q21.0 Ventricular septal defect 74,256
  - Q21.1 Atrial septal defect 129,256
  - Q25.0 Patent ductus arteriosus 85,256(D)
  - Q26.2 Total anomalous pulmonary venous connection 141,256(A)

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**Topic: ICD-10 Review—Pediatric Surgery**

**Discussion:** Smits introduced a summary document outlining the changes suggested during the expert review of the allergy lines as part of the ICD-10 conversion process. Two new lines were created and scored; the subcommittee agreed with these new lines and the scoring. However, Olson suggested that line 111 CONGENITAL ANOMALIES OF DIGESTIVE SYSTEM AND ABDOMINAL WALL EXCLUDING NECROSIS; CHRONIC INTESTINAL PSEUDO-OBSTRUCTION be rescored once the conditions in this line that were suggested for moving to the new line OTHER CONGENITAL ANOMALIES OF MUSCULOSKELETAL SYSTEM are moved. Staff will contact expert for advice on rescoreing. the Subcommittee only wants this topic brought back if the new line falls below the funding line.

Line XXX FOREIGN BODY IN GASTROINTESTINAL TRACT

Treatment: Medical therapy

ICD-10: T18.2xxA, T18.3xxA, T18.4xxA, T18.5xxA, T18.8xxA, T18.9xxA

CPT: 43247, 44363, 44383, 44390, 45307, 45332, 45378, 45379, 45915, 46608, 98966-98969, 99051, 99060, 99070, 99078, 99201-99217, 99241-99245, 99341-99366, 99441-99444

Ranking recommendations for Foreign Body in GI Tract

Category 7

Impact on healthy life years – 4

Vulnerable populations 0

Population effects 0

Impact on healthy life years 5

Impact on pain/suffering 1

Tertiary prevention – 0

Effectiveness of treatment – 5

Need for medical service 0.2

Net cost 3

**Score is 240 which is in the low 400s**

Line XXX

Condition: OTHER CONGENITAL ANOMALIES OF MUSCULOSKELETAL SYSTEM

Treatment: MEDICAL AND SURGICAL TREATMENT

ICD-10: Q79.0-Q79.59

CPT: 39503,39545,49600-49611,51500,98966-98969,99051,99060,99070,99078,99201-99360,99366,99374,99375,99379-99444,99468-99480,99605-99607

Ranking recommendations for OTHER CONGENITAL ANOMALIES OF MUSCULOSKELETAL SYSTEM

Category 6

Impact on healthy life years –10

Vulnerable populations 0

Population effects 0

Impact on healthy life years 5  
Impact on pain/suffering 5  
Tertiary prevention – 5  
Effectiveness of treatment – 4  
Need for medical service 1  
Net cost 0

**Scored around line 40.**

A new line was proposed to include non-congenital neonatal conditions. This line was approved in concept. HERC staff to contact neonatology experts to approve line and score it. The subcommittee would like this topic brought back if there are issues with line scoring or if the neonatal experts disagree with the line creation or major aspects of the new line.

Line XXX  
Condition: PERINATAL GASTROINTESTINAL CONDITIONS  
Treatment: Medical therapy  
ICD-10: P78.2, P78.3, P78.82, P78.83, P78.89, P78.9  
CPT: TBD  
Ranking: TBD

There was discussion about the proposal to combine three lines (204 CONGENITAL CYSTIC LUNG - MILD AND MODERATE, line 301 HYPOPLASIA AND DYSPLASIA OF LUNG, and line 677 CONGENITAL CYSTIC LUNG – SEVERE). Dodson wanted to know what the evidence was around the effectiveness of treatment of severe congenital cystic lung. Coffman noted that there was no distinction in the ICD-9 or ICD-10 codes for this condition (the only treatment distinction was noted in the line names). Nothing currently prevents treatment of severe cystic lung in the DMAP system. Dodson was then fine with the combining of these lines.

Line 204  
Condition: CONGENITAL LUNG ANOMALIES  
Treatment: MEDICAL AND SURGICAL TREATMENT  
ICD-10: J98.4, Q33.0, Q33.2, Q33.3, Q33.4, Q33.6  
CPT: 31601,31603,31820,31825,32140,32141,32480-32488,32500,32501,32662,32800,98966-98969,99051,99060,99070,99078,99201-99360,99366,99374,99375,99379-99444,99468-99480,99605-99607  
HCPCS: G0406-G0408,G0425-G0427,S0270-S0274

There was some discussion about the proposal to rescore line 40 SPINA BIFIDA. The group thought that perhaps the medical and surgical treatments for this condition should be separated. HERC staff was directed to discuss this with neurosurgical and possibly neonatal experts.

**Actions:**

- 1) New line created for FOREIGN BODY IN GASTROINTESTINAL TRACT and scored to a line in the low 400s
- 2) New line created for OTHER CONGENITAL ANOMALIES OF MUSCULOSKELETAL SYSTEM and scored to approximately line 40

- 3) HERC staff to work with gastroenterology experts to rescore line 111 once proposed diagnosis movement to new line has occurred
- 4) HERC staff to work with neonatal experts to create and score a new line concerning neonatal gastrointestinal conditions
- 5) Combine line 204 CONGENITAL CYSTIC LUNG - MILD AND MODERATE, line 301 HYPOPLASIA AND DYSPLASIA OF LUNG, and line 677 CONGENITAL CYSTIC LUNG - SEVERE. Rename "Congenital lung anomalies"
- 6) HERC staff to consult neurosurgery and possibly neonatology regarding scoring line 40 SPINA BIFIDA
- 7) Rename Line 444 INCONTINENCE OF FECES; FECAL IMPACTION
- 8) Move K56.41 (Fecal impaction) from line 48 INTUSSUSCEPTION, VOLVULUS, INTESTINAL OBSTRUCTION, AND FOREIGN BODY IN STOMACH, INTESTINES, COLON, AND RECTUM to line 444 and rename line 444 INCONTINENCE OF FECES; FECAL IMPACTION as noted above
- 9) Meconium diagnoses (P24) deleted from line 111 CONGENITAL ANOMALIES OF DIGESTIVE SYSTEM AND ABDOMINAL WALL EXCLUDING NECROSIS; CHRONIC INTESTINAL PSEUDO-OBSTRUCTION and left on other lines (not a congenital issue)

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**Topic: Vascular bone grafts for avascular necrosis of the hip**

**Discussion:** This topic was deferred to the April VbBS meeting due to lack of availability of experts to testify at the current meeting.

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**Topic: Continuous glucose monitoring**

**Discussion:** Smits introduced a summary document outlining proposed changes to the coverage for continuous glucose monitoring (CGM). New written testimony from the American Diabetes Association was distributed to the subcommittee members. Olson did not feel that the evidence supported the use of CGM. He wondered if in the few cases in which hypoglycemia is a recurrent problem that this device might be covered through the exceptions process. Kirk thought this would probably be the case. Dodson agreed that the science does not support the use of CGM, but that the group could review this topic again if new evidence is produced. Pollack agreed that CGM appeared to be a poor return on investment for OHP. The decision was to remove the procedure codes for CGM from the List.

**Actions:**

- 1) Remove continuous glucose monitoring (CPT 95250-1) from line 10 TYPE I DIABETES MELLITUS

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**Topic: Gender identity disorder**

**Discussion:** Smits introduced a summary document outlining proposed addition of coverage for gender identity disorder. Several experts from advocacy groups gave public testimony and answered the member's questions.

The group agreed with the proposal to split the current line Line 513 GENDER IDENTIFICATION DISORDER, PARAPHILIAS AND OTHER PSYCHOSEXUAL DISORDERS into two separate lines. The new Gender Dysphoria line was rescored as shown

below. The major discussion during the rescoring was about the level of vulnerability of this population. The major scoring weights were determined based on the evidence of improved outcomes for patients who had puberty suppression.

Reranking:  
Gender ID disorder  
Category: 7  
HLY: 3  
Suffering: 4  
Population effects: 0  
Vulnerability: 0  
Tertiary prevention: 3  
Effectiveness: 2  
Need for service: 1  
Net cost: 2  
Score: 400  
Rank: line 430 approximately

The line containing paraphilias was not rescored due to time constraints. The subcommittee directed HERC staff to work with Dr. Pollack (the mental health representative on the VbBS) to create a proposed ranking which will then be sent to members for approval. This topic will be brought back in April for final approval.

The new guideline restricting the types of treatments for gender dysphoria was discussed in detail. The experts testifying before the subcommittee recommended that puberty suppressing medications be limited to children who have attained at least Tanner stage 2 in sexual development, as children in Tanner stage 1 have not yet started puberty. The treatment should be allowed through Tanner stage 5 to allow for different stages of puberty.

Heidi Allen summarized the previously presented literature on the harms of not treating transgendered children during puberty. Tyack asked if there is evidence of the safety of these medications, to which the experts replied that there was. Pollack noted that the likelihood of misdiagnosis is very rare, and the use of puberty suppressing medication was not subject to abuse. Ocker asked the experts who provided care for these patients. The response was psychiatry, in conjunction with endocrinology and primary care. Kirk had concerns for access to appropriate care outside of Portland metro area. The experts indicated that resources are available throughout the state. Pollack reviewed DSM5 criteria for gender identity disorder, which has fairly restrictive diagnostic criteria. The group decided that there was evidence of effectiveness for treatment of adolescents with gender identity disorder and no evidence of harms. This treatment was specified as being included on this line with a guideline.

**Actions:**

- 1) Divide Line 513 GENDER IDENTIFICATION DISORDER, PARAPHILIAS AND OTHER PSYCHOSEXUAL DISORDERS into two separate lines
  - a. Line ~~XXX GENDER IDENTIFICATION DISORDER~~ DYSPHORIA was scored to approximately line 430

- b. Line XXX PARAPHILIAS AND OTHER PSYCHOSEXUAL DISORDERS scoring was not completed. HERC staff will work with Dr. Pollack to prepare a proposed line scoring, which will then be voted on by the group via email.
- 2) Add histrelin (Supprelin) insertion (GnRH analog used to suppress puberty) CPT (11981-11983) codes to new gender dysphoria line and alter existing guideline to include this line
- 3) Adopt the guideline as shown in Attachment B for the Gender Dysphoria line
- 4) The new guideline regarding implantable GNRH analog therapy was modified to include the new Gender Dysphoria line

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**Topic: HPV vaccination for males**

**Discussion:** Smits introduced a summary document outlining the proposed addition of coverage of HPV vaccination for males to the Prevention Tables. Olson noted that the Commission should follow ACIP recommendations, which are evidence based. He recommended increasing coverage for both males and females to age 26 (instead of the proposed 18) to be consistent with current ACIP guidelines. He felt that the vaccine should be covered for boys to both reduce the risk of head and neck cancer and to reduce the size of the viral pool for girls. Dodson agreed that the age for coverage should be increased to 26; she felt that the cut-off at age 18 was financially based, not evidence based. Bickle noted that DMAP recommends following ACIP. Current DMAP administrative rules requires following ACIP which conflicts with the current List coverage of HPV vaccine. Kirk noted that several medical directors are opposed to vaccinate over age 18, but he also agreed to increase coverage to age 26.

**Actions:**

- 1) Change the footnotes of the Prevention tables for Ages Birth to 10 and ages 11 to 24 -- Interventions for the General Population to read "HPV2 and HPV4 for ~~women~~ females aged 9 to ~~18~~ 26. ~~Discussion with provider regarding HPV4 for males aged 9 through 18~~ 26."

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**Topic: Lichen sclerosis**

**Discussion:** Smits introduced a summary document outlining the proposed addition of coverage for lichen sclerosis. Olson noted that the main intervention in the treatment of this condition was examinations, and there was a low potential for overuse of the medical system for treatment of this condition. Smits noted that possible treatments for this condition which would be covered if this condition was moved to a covered area of the List were topical medications, biopsies, and exams.

**Actions:**

- 1) Add 701.0 to line 460 DYSTROPHY OF VULVA; keep on line 534 CIRCUMSCRIBED SCLERODERMA
- 2) Add the following coding specification to line 460
  - a. "ICD-9 701.0 is included on this line only for the diagnosis of lichen sclerosis."

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**Topic: Re-ranking the esophagitis line**

**Discussion:** Livingston introduced a summary document outlining a proposed re-ranking of the esophagitis line. There was some discussion about the current ranking and the frequency of use of PPI medications. There was clarification that diagnostic endoscopy for those with worrisome dysphagia would be covered as usual in the diagnostic file. And a upcoming guideline on upper endoscopy is forthcoming.

**Actions:**

- 1) Change the following scores for Line 423 Esophagitis to Healthy Life Years to 3  
Effectiveness 3  
Need for Services 0.3  
Results in a score of 126  
Approximate New Line: 540

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**Topic: Tympanostomy tubes for chronic otitis media and hearing loss guideline**

**Discussion:** Livingston introduced a summary document outlining suggested changes to the coverage of tympanostomy tubes. Evidence was reviewed indicating that current ranking of 502 CHRONIC OTITIS MEDIA is still consistent with the evidence. There was a discussion of options of enabling certain cases of chronic otitis media to be covered in certain special cases; however, there is no evidence suggesting these subgroups benefit specifically, at at this time insufficient evidence supports making an exception for the List.

**Actions:**

- 1) Clarify intent (for Medical Directors and DMAP purposes) that until changes go into effect on October 1, 2012, the HERC intent is for Guideline Note 51, to provide parameters for tympanostomy tubes on Line 383 HEARING LOSS - AGE 5 OR UNDER
- 2) For the October 1, 2012 Prioritized List, the following change was made to Line 383
  - a. Remove CPT code 69436
  - b. Remove coding specification "CPT Code 69436 is included on this line only as treatment for conductive hearing loss (389.0,389.2)"

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**Public Comment**

No public testimony was received except as noted in topic sections above.

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**Issues for next meeting:**

- 1) Vascular bone grafts for avascular necrosis of the hip
- 2) Scoring of new paraphilias line
- 3) ICD-10 review for Podiatry, Dermatology, Infectious Disease, Sports Medicine, Oral Maxillofacial surgery, and Otolaryngology

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**Next meeting:** April 12, 2012 at Meridian Park Hospital in Tualatin, OR.

## Attachment A

### Guideline Changes as Part of the ICD-10 and/or Biennial Review

Note: these take effect with the next Biennial Review List (October 1, 2013 or later)

## New Guidelines

### **GUIDELINE NOTE XXX TREATMENT OF BENIGN NEOPLASM OF URINARY ORGANS**

*Line 228, 538*

Treatment of benign urinary system tumors is covered with evidence of bleeding or urinary obstruction. Treatment of 1) oncocytoma which is >5 cm in size or symptomatic and 2) angiomyolipoma (AML) which is >5cm in women of child bearing age or in symptomatic men or women is covered.

### **GUIDELINE NOTE XXX OBSTRUCTIVE AND REFLEX UROPATHY**

*Line 30*

ICD-10 N13.9 (Obstructive and reflux uropathy unspecified) appears on this line for pediatric populations only

### **GUIDELINE XXX GENDER DYSPHORIA**

*Line XXX*

Hormone treatment is included on this line only for use in delaying the onset of puberty and/or continued pubertal development for gender questioning children and adolescents (age 17 and younger) at Tanner stage 2 and above.

## MODIFIED GUIDELINES

### **GUIDELINE NOTE XXX IMPLANTABLE GNRH ANALOG THERAPY**

*Line 193,XXX*

Use of drug delivery implant therapy for GnRH analogue therapy (such as histrelin) (CPT 11981-11983) is covered only after injectable depot medications (such as Lupron) have been tried or are contraindicated.

### **GUIDELINE NOTE 70, HEART-KIDNEY TRANSPLANTS**

*Line 279*

Patients under consideration for heart/kidney transplant must qualify for each individual type of transplant under current DMAP administrative rules and transplant center criteria with the exception of any exclusions due to heart and/or kidney disease. Qualifying renal disease is limited to Stage V or VI.

# Overview of Recommendations for Converting Lines to ICD-10-CM Podiatry

*Specialty consultants: Dr. Andrew Schink; Dr. Clifford Mah; Dr. Chris Seufferling*

**CREATE NEW LINES:** none

**COMBINE MULTIPLE LINES:** none

**DELETE LINES:** none

**RESCORE LINES:** none

## **GUIDELINES/CODE PLACEMENT CHANGES**

- 1) Add coverage for high risk patients for certain currently uncovered diagnoses of foot conditions to a covered line, with a guideline.
  - a. Add M20.1x (Hallux valgus (acquired)—i.e.bunion), M20.3x (Hallux varus (acquired)), M20.4x (other hammer toes, acquired), M92.6x and M92.7x (juvenile osteochondrosis, ankle/foot), and L84 (corns and callosities) to line 172 PREVENTIVE FOOT CARE and keep on line 565 DEFORMITIES OF FOOT or 618 CORNS AND CALLUSES with a guideline as noted below
    - i. Add CPT codes 11055-11057 (paring or cutting of benign hyperkeratotic lesion) to line 172 to allow treatment of corns and calluses
    - ii. Add CPT codes 27612,27690-27692,28100-28011,28050-28054, 28070-28072,28086-28092,28110-28124,28126-28160,28200-28315, 28340-28341,28360,28705-28760,29750 to line 172 to allow treatment of hallus valgus and varus, and hammer toes. These are surgical repair codes.
    - iii. Add office visit CPT codes 98966-98969,99051,99060,99070,99078,99201-99360,99366,99374,99375,99379-99444,99468-99480,99605-99607 to line 172
    - iv. Note: line 172 currently has only a very limited set of CPT codes involving nail care
  - b. Create a new guideline allowing coverage of certain diagnoses for patients at high risk of developing foot ulcers

## **GUIDELINE XXX PODIATRIC PROCEDURES FOR PATIENTS AT HIGH RISK FOR DEVELOPING FOOT ULCERS**

*Lines: 172, 565, 618*

ICD-10 codes M20.1x [hallux valgus (acquired)], M20.3x [Hallux varus (acquired)], M20.4x (other hammer toes, acquired), M92.6x and M92.7x (juvenile osteochondrosis, ankle/foot), and L84 (corns and callosities) are included on line 172 PREVENTIVE FOOT CARE IN HIGH RISK PATIENTS only for patients at high risk of developing foot ulcers, defined as patients with 1) diabetes, 2) peripheral vascular disease, 3) peripheral neuropathy or 4) history of foot ulcer. For non-high risk patients, these diagnoses are located on lines 565 DEFORMITIES OF FOOT or 618 CORNS AND CALLUSES.

- 2) Allow coverage of certain bone fusion and osteotomies for tendon tears and ruptures. This would require code movement and the creation of a coding specification

# Overview of Recommendations for Converting Lines to ICD-10-CM

## Podiatry

- a. Add CPT codes 28705-28760, 29890-29907 to lines 406 DISRUPTIONS OF THE LIGAMENTS AND TENDONS OF THE ARMS AND LEGS, EXCLUDING THE KNEE, GRADE II AND III and 531 PERIPHERAL ENTHEOSOPATHIES
  - i. These CPT codes represent ankle arthrodesis and arthroscopy procedures
  - ii. The ICD-10 codes noted below are already on lines 406 or 531
- b. Add a coding specification to lines 406 and 531 as below
  - i. "CPT codes 28705-28760, 29890-29907 are included in this line only for the treatment of tibial and peroneal tendonitis, and tendon tears or ruptures of the ankle (ICD-10 codes M66.27x, M66.37x, M66.87x, M76.7x, M76.80, M76.86x, S86.01xx, S93.49xx, S96.01xx, S96.11xx, S96.21xx, S96.81xx, and S96.91xx)."
    1. Note: these ICD-10 codes represent anterior and posterior tibial tendonitis, spontaneous rupture of tendons of ankle, peroneal tendinitis, tendon sprains and strains at ankle level)

**RENAME LINES:** none

### OTHER CODE PLACEMENT

- 1) Move M20.2x (hallux rigidus) and M24.671-3 (Ankylosis, ankle) from line 565 DEFORMITIES OF FOOT to line 489 OSTEOARTHRITIS AND ALLIED DISORDERS, as these conditions are equivalent to arthritis
  - a. Add CPT codes 20920-20924,27612,27690-27692,28008,28010,28035,28050-28072,28086-28092,28110-28119,28126-28160,28220-28341,28360,28705-28760,29450,29750,29904-29907 to line 489 to allow treatment of hallux rigidus
- 2) Move M24.17x (Other articular cartilage disorders, ankle/foot) from line 565 DEFORMITIES OF FOOT to line 455 INTERNAL DERANGEMENT OF KNEE AND LIGAMENOUS DISRUPTIONS OF THE KNEE, GRADE II AND III as this condition is of equivalent severity
  - a. Add CPT codes 20920-20924,27612,27690-27692,28008,28010,28035,28050-28072,28086-28092,28110-28119,28126-28160,28220-28341,28360,28705-28760,29450,29750,29891-29907 to line 455 to allow treatment of other cartilage disorders
- 3) Move Q66.1 (Congenital talipes calcaneovarus), Q66.3 (Other congenital varus deformities of feet), and Q66.6 (Other congenital valgus deformities of feet) from line 565 DEFORMITIES OF FOOT to line 297 DEFORMITY/CLOSED DISLOCATION OF JOINT as these are equivalent to "club foot, congenital" which is contained on this line, and appropriate treatment CPT codes are present on this line.

# Overview of Recommendations for Converting Lines to ICD-10-CM Podiatry

## Appendix A: Podiatry changes for earlier implementation in ICD-9

### GUIDELINES/CODE PLACEMENT CHANGES

- 1) Add coverage for high risk patients for certain currently uncovered diagnoses of foot conditions to a covered line, with a guideline.
  - a. Add 727.1 (Hallux vulgaris (acquired)—i.e. bunion), 735.1 (Hallux varus (acquired)), 735.4 (other hammer toes, acquired), 732.4 and 732.5 (juvenile osteochondrosis, ankle/foot), and 700 (corns and callosities) to line 172 PREVENTIVE FOOT CARE and keep on line 565 DEFORMITIES OF FOOT or 618 CORNS AND CALLUSES with a guideline as noted below
    - i. Add CPT codes 11055-11057 (paring or cutting of benign hyperkeratotic lesion) to line 172 to allow treatment of corns and calluses
    - ii. Add CPT codes 27612,27690-27692,28100-28011,28050-28054, 28070-28072,28086-28092,28110-28124,28126-28160,28200-28315, 28340-28341,28360,28705-28760,29750 to line 172 to allow treatment of hallus vulgaris and varus, and hammer toes. These are surgical repair codes.
    - iii. Add office visit CPT codes 98966-98969, 99051,99060, 99070,99078, 99201-99360,99366,99374,99375,99379-99444,99468-99480,99605-99607 to line 172
    - iv. Note: line 172 currently has only a very limited set of CPT codes involving nail care
  - b. Create a new guideline allowing coverage of certain diagnoses for patients at high risk of developing foot ulcers

### GUIDELINE XXX PODIATRIC PROCEDURES FOR PATIENTS AT HIGH RISK FOR DEVELOPING FOOT ULCERS

*Lines: 172, 565, 618*

ICD-9/10 codes 727.1/M20.1x [hallux valgus (acquired)], 735.1/M20.3x [Hallux varus (acquired)], 735.4 /M20.4x (other hammer toes, acquired), 732.4 and 732.5/M92.6x and M92.7x (juvenile osteochondrosis, ankle/foot), and 700/L84 (corns and callosities) are included on line 172 PREVENTIVE FOOT CARE IN HIGH RISK PATIENTS only for patients at high risk of developing foot ulcers, defined as patients with 1) diabetes, 2) peripheral vascular disease, 3) peripheral neuropathy or 4) history of foot ulcer. For non-high risk patients, these diagnoses are located on lines 565 DEFORMITIES OF FOOT or 618 CORNS AND CALLUSES.

- 2) Allow coverage of certain bone fusion and osteotomies for tendon tears and ruptures. This would require code movement and the creation of a coding specification
  - a. Add CPT codes 28705-28760, 29890-29907 to lines 406 DISRUPTIONS OF THE LIGAMENTS AND TENDONS OF THE ARMS AND LEGS, EXCLUDING THE KNEE, GRADE II AND III and 531 PERIPHERAL ENTHEROPATHIES
    - i. These CPT codes represent ankle arthrodesis and arthroscopy procedures
    - ii. The ICD-9 codes noted below are currently on lines 406 or 531
  - b. Add a coding specification to lines 406 and 531 as below
    - i. "CPT codes 28705-28760, 29890-29907 are included in this line only for the treatment of tibial and peroneal tendonitis, and tendon tears or ruptures of the ankle (ICD-9 codes 726.72, 726.79, 727.68, 845.0)."
      1. Note: these ICD-10 codes represent anterior and posterior tibial tendonitis, spontaneous rupture of tendons of ankle, peroneal tendinitis, tendon sprains and strains at ankle level)

# Overview of Recommendations for Converting Lines to ICD-10-CM Podiatry

## OTHER CODE PLACEMENT

- 1) Move 735.2 (hallux rigidus) and 718.57 (Ankylosis, ankle) from line 565 DEFORMITIES OF FOOT to line 489 OSTEOARTHRITIS AND ALLIED DISORDERS, as these conditions are equivalent to arthritis
  - a. Add CPT codes 20920-20924,27612,27690-27692,28008,28010,28035,28050-28072,28086-28092,28110-28119,28126-28160,28220-28341,28360,28705-28760,29450,29750,29904-29907 to line 489 to allow treatment of hallux rigidus
- 2) Move 718.07 (Other articular cartilage disorders, ankle/foot) from line 565 DEFORMITIES OF FOOT to line 455 INTERNAL DERANGEMENT OF KNEE AND LIGAMENTOUS DISRUPTIONS OF THE KNEE, GRADE II AND III as this condition is of equivalent severity
  - a. Add CPT codes 20920-20924,27612,27690-27692,28008,28010,28035,28050-28072,28086-28092,28110-28119,28126-28160,28220-28341,28360,28705-28760,29450,29750,29891-29907 to line 455 to allow treatment of other cartilage disorders
- 3) Move 754.50 (Talipes varus), 754.59 (Congenital talipes calcaneovarus), 754.60 (talipes valgus), and 754.69 (Other congenital valgus deformities of feet) from line 565 DEFORMITIES OF FOOT to line 297 DEFORMITY/CLOSED DISLOCATION OF JOINT as these are equivalent to "club foot, congenital" which is contained on this line, and appropriate treatment CPT codes are present on this line.
  - a. Note: 754.51-3 (Talipes equinovarus, Metatarsus primus varus, Metatarsus varus) are currently on line 297 DEFORMITY/CLOSED DISLOCATION OF JOINT
  - b. Note: 754.61 (Congenital pes planus) is currently on line 550 DEFORMITIES OF UPPER BODY AND ALL LIMBS; 754.62 (Talipes calcaneovalgus) is currently on line 297 DEFORMITY/CLOSED DISLOCATION OF JOINT

# Dermatology Recommendations for ICD-10

Specialty consultants: Tavelli, Baker, and Simpson

## CREATE NEW LINES

### 1) MODERATE/SEVERE INFLAMMATORY SKIN DISEASE

Moderate to severe ~~psoriasis~~ [inflammatory skin disease](#) is defined as having functional impairment and one or more of the following:

1. At least 10% of body surface area involved; and/or,
2. Hand, foot or mucous membrane involvement.

First line agents include topical agents, oral retinoids, phototherapy and methotrexate. Use of other systemic agents should be limited to those who fail, have contraindications to, ~~or do not have access to~~ first line agents. [Biologics are only covered for moderate/severe psoriasis after documented failure of first line agents and second line agents.](#)

**Ranking recommendations:** (moderate severe psoriasis used to be 134 (was with pyoderma)

Category 7

Impact on Healthy Life Years 3 – QOL, these people suffer badly, affects what they do every day, disabling/disfiguring, if have psoriasis on palms/soles, can't work at all

Impact on pain and suffering 3

Population effects 0

Vulnerable populations 0

Tertiary prevention 0

Effectiveness 3

Need for treatment 0.9

Net cost 2

Score 324 which is Line 450

### 2) ACNE CONGLOBATA (SEVERE CYSTIC ACNE) (derived from line 545 Cystic Acne)

- a. Includes acne conglobata only, no other codes
- b. Adopt a guideline to define severe

Category 7.

Impact on Healthy Life Years 2

Impact on Pain and Suffering 3

Population effects 0

Vulnerable populations 0

Tertiary prevention 2 (high likelihood of decrease permanent disfigurement/scarring; possible decrease in suicide risk)

Effectiveness 4

Need for treatment 1

Net cost 3

SCORE 560, PUTS ON LINE 410

## Dermatology Recommendations for ICD-10

### 3) HYDRADENITIS SUPPURATIVA; DISSECTING CELLULITIS OF THE SCALP

Both of these conditions are very resistant to treatment. The severity may be reduced with oral isotretinoin, antibiotics, dapsone, and injected or systemic steroids.

*Category 7.*

*Impact on Healthy Life Years 2*

*Impact on Pain and Suffering 3*

*Population effects 0*

*Vulnerable populations 0*

*Tertiary prevention 1 (decreases risk of scarring down axilla; abscesses; but surgery end stage decision, cure, but 50% graft entire axilla and get disease around graft)*

*Effectiveness 1*

*Need for treatment 1*

*Net cost 4*

*SCORE 120 , PUTS ON LINE 550*

### 4) HEMANGIOMAS, COMPLICATED

Hemangiomas are covered on this line when they are ulcerated, infected, recurrently hemorrhaging, or function-threatening (e.g. eyelid hemangioma).

TREATMENT: MEDICAL THERAPY

*Category 7*

*Impact on Healthy Life Years 5*

*Impact on Pain and Suffering 2*

*Population effects 0*

*Vulnerable populations 0*

*Tertiary prevention 5*

*Effectiveness 4*

*Need for treatment 1*

*Net cost 3*

*SCORE 960 , PUTS ON LINE 350*

### 5) ACTINIC KERATOSIS (was on 655 BENIGN NEOPLASMS OF SKIN AND OTHER SOFT TISSUES), only has L57.0 Actinic Keratosis. Should be its own line 5-8% become squamous cell carcinoma, not quite premalignant line.

*Category 7.*

*Impact on Healthy Life Years 1*

*Impact on Pain and Suffering 0*

*Population effects 0*

*Vulnerable populations 0*

*Tertiary prevention 2*

*Effectiveness 3*

*Need for treatment 0.6*

*Net cost 4*

*SCORE 108 , PUTS ON LINE 553*

# Dermatology Recommendations for ICD-10

## DELETE LINES

134 PYODERMA; MODERATE/SEVERE PSORIASIS MEDICAL THERAPY  
Pyoderma codes move to cellulitis line 214. Psoriasis divided into mild and moderate/severe disease

573 Xerosis, moving single code to 688

603 Erythema Multiforme Minor, codes moving 530 Erythematous Conditions line

## RESCORE LINES

- 1) 225 TOXIC EPIDERMAL NECROLYSIS AND STAPHYLOCOCCAL SCALDED SKIN SYNDROME; STEVENS-JOHNSON SYNDROME; ERYTHEMA MULTIFORME MAJOR; ECZEMA HERPETICUM needs to be ranked higher, life threatening  
*Category 6*  
*Impact on Healthy Life Years 9*  
*Impact on Pain and Suffering 5*  
*Population effects 0*  
*Vulnerable populations 0*  
*Tertiary prevention 2*  
*Effectiveness 3*  
*Need for treatment 1*  
*Net cost 1*  
*SCORE 1920, PUTS around LINE 160*

## GUIDELINES

Delete current moderate/severe psoriasis guideline to New moderate/severe inflammatory skin disease guideline as above.

## RENAME LINES

- 1) 530 TOXIC ERYTHEMA, ACNE ROSACEA, DISCOID LUPUS rename TO ERYTHEMATOUS CONDITIONS
- 2) 545 ~~CYSTIC ACNE~~ ACNE; ROSACEA
  - a. Moved rosacea codes from 530 to this line
  - b. Moved out hydradenitis suppurative to its own line
- 3) 566 FOREIGN BODY GRANULOMA OF MUSCLE, ~~GRANULOMA OF~~ SKIN, AND SUBCUTANEOUS TISSUE
- 4) 578 ~~KERATODERMA, ACANTHOSIS NIGRICANS, STRIAE ATROPHICAE~~, MILD ECZEMATOUS AND OTHER HYPERTROPHIC OR ATROPHIC CONDITIONS OF SKIN

## CODE MOVEMENT WORTH REVIEW

### Moved to Diagnostic files

Pruritis codes (L29.8 and L29.9)  
Hirsutism (L68.0)

## **Dermatology Recommendations for ICD-10**

Move Q82.8 Other specified congenital malformations of skin to both higher severe line and 688.

New coding specification

Q82.8 is only included [on the higher line] for the diagnosis of Keratosis follicularis that meets the severity guideline criteria. Other diseases included within Q82.8 are not covered on this line.

Note to actuaries section

- 1) Would start covering severe acne
- 2) Would start covering moderate/severe psoriasis
- 3) Would cover function-threatening hemangiomas

## Treatment Guidelines for Inflammatory Skin Disease

These guidelines were developed using some cost-effectiveness data, expert opinion, and physician preference data. A thorough systematic review of cost-effectiveness was not performed.

### Proposed Treatment Guideline for Moderate-to-Severe Psoriasis

#### First-line agents

Potent topical corticosteroids  
Narrowband UVB  
Methotrexate  
+/- cyclosporine

#### Second-line agents

Other systemic immunosuppressives: cyclosporine, mycophenolate mofetil  
Oral retinoids – acitretin or isotretinoin  
Biologics – infliximab, adalimumab, etanercept, ustekinumab, alefacept

Note: combinations of these medications are also used in certain clinical situations.

#### References

1. Hsu S, Papp KA, Lebwohl MG, Bagel J, Blauvelt A, Duffin KC, Crowley J, Eichenfield LF, Feldman SR, Fiorentino DF, Gelfand JM, Gottlieb AB, Jacobsen C, Kalb RE, Kavanaugh A, Korman NJ, Krueger GG, Michelin MA, Morison W, Ritchlin CT, Stein Gold L, Stone SP, Strober BE, Van Voorhees AS, Weiss SC, Wanat K, Bebo BF Jr; National Psoriasis Foundation Medical Board. Consensus guidelines for the management of plaque psoriasis. Arch Dermatol. 2012 Jan;148(1):95-102.

Note: Guidelines in this paper do not specify a first-line therapy.

2. Wan J, Abuabara K, Troxel AB, Shin DB, Van Voorhees AS, Bebo BF Jr, Krueger GG, Callis Duffin K, Gelfand JM. Dermatologist preferences for first-line therapy of moderate to severe psoriasis in healthy adult patients. J Am Acad Dermatol. 2012 Mar;66(3):376-86. Epub 2011 Aug 19.

### Proposed Treatment Guideline for Moderate-to-Severe Atopic Dermatitis

The prevalence of atopic dermatitis is approximately 10% in children and possibly 1% in adults. Up to 1/3 of children may have moderate-to-severe disease. The prevalence of moderate-to-severe disease in adults is unknown. The vast majority of moderate-severe disease may be adequately controlled with topical corticosteroids, especially in children.

#### First-line agents

Topical corticosteroids  
Narrowband UVB  
Cyclosporine (1 year limit)  
Methotrexate  
Azathioprine

#### Second-line agents

Topical pimecrolimus and topical tacrolimus  
Other systemic immunosuppressives: mycophenolate mofetil  
Biologics – interferon-gamma

## Treatment Guidelines for Inflammatory Skin Disease

### References

Schmitt J, Schäkel K, Schmitt N, Meurer M. Systemic treatment of severe atopic eczema: a systematic review. Acta Derm Venereol. 2007;87(2):100-11.

This paper concluded that cyclosporine should be first-line systemic therapy for severe atopic dermatitis

### **Proposed Treatment Guideline for Moderate-to-Severe Pityriasis Rubra Pilaris**

This is a very rare self-limited severe inflammatory skin disorder that last for several years. It may affect both adults and children. The incidence is unknown but may be 1 in 5000 new visits to a dermatologist. There are no randomized controlled studies available for this rare condition. Treatment guidelines based on expert opinion and case reports.

#### First-line agents

Topical corticosteroids

Acitretin

Methotrexate

Narrowband UVB

#### Second-line agents

Isotretinoin

Other systemic immunosuppressives: azathioprine, cyclosporine

Biologics – infliximab

### **Proposed Treatment Guideline for Moderate-to-Severe Discoid Lupus Erythematosus**

#### First-line agents

Topical corticosteroids

Intralesional corticosteroids

Hydroxychloroquine

#### Second-line agents

Topical tacrolimus or pimecrolimus

Chloroquine

Quinacrine

Acitretin and isotretinoin

Thalidomide

Dapsone

Azathioprine

### **Hemangiomas, ulcerated (usually lip or diaper area)**

#### First-line

Wound care with silvadene, zinc oxide

Antibiotics

#### Second line

Propranolol

## Treatment Guidelines for Inflammatory Skin Disease

Vascular laser therapy  
Becaplermin topical (Regranex)

### **Hemangiomas, function threatening such as eyesight, feeding**

#### First-line

Propranolol- emerging as new first-line over steroids  
Oral corticosteroids

# Overview of Recommendations for Converting Lines to ICD-10-CM Sports Medicine

*Specialty consultants:* Dr. Ryan Petering, Dr. Melissa Novak, Dr. Charles Webb

## CREATE NEW LINES

Create new line for Achilles tendonitis, lateral epicondylitis, and medial epicondylitis. These conditions are currently on lines 516 and 531. They have evidence for effectiveness of treatment. There is good evidence for cortisone injections allowing better compliance with physical therapy and other treatment modalities, earlier mobilization, and quicker return to function.

Line XXX ACHILLES TENDONITIS, LATERAL AND MEDIAL  
EPICONDYLITIS

Treatment: MEDICAL AND SURGICAL THERAPY

ICD-10: M76.60-M76.62, M77.01-M77.12

CPT: from 516 and 531

Scoring:

Category: 7

IHLY: 2

IPS: 2

Pop: 0

Vuln: 0

Tertiary: 0

Effect: 4

Cost: 4

Need for treatment: 0.9

Score: 288 Approx line: 475

## COMBINE MULTIPLE LINES

None

## DELETE LINES

None

## RESCORE LINES

None

## GUIDELINES

Add a guideline to line 443 DISORDERS OF SHOULDER,POTENTIALLY RESULTING IN SIGNIFICANT INJURY/IMPAIRMENT to apply to treatment of acromioclaviular joint sprains.

### GUIDELINE NOTE XXX MANAGEMENT OF ACROMIOCLAVICULAR JOINT SPRAIN

*Line 443, 638*

Sprain of acromioclavicular joint (ICD-10 S43.50-S43.52, and S43.60-S43.62) are only included on line 443 for Grade 4-6 sprains. Surgical management of these injuries is covered only after a trial of conservative therapy. Grade 1-3 acromioclavicular joint sprains are included only on line 638.

## Overview of Recommendations for Converting Lines to ICD-10-CM

### RENAME LINES

The current lines for joint injuries use Grade II and III to differentiate the upper line from the uncovered lower line for mild injuries. The Sports Medicine experts, as well as the Orthopedic experts, feel that these grading systems apply to only one type of injury on these lines (acromioclavicular joint sprain). They have recommended a name change for these lines to better represent the HERC intent to have more severe injuries only included on the upper, covered, lines.

Rename line 455 INTERNAL DERANGEMENT OF KNEE AND  
LIGAMENOUS DISRUPTIONS OF THE KNEE, ~~GRADE II AND III~~  
POTENTIALLY RESULTING IN SIGNIFICANT INJURY/IMPAIRMENT

Rename line 406: DISRUPTIONS OF THE LIGAMENTS AND TENDONS OF  
THE ARMS AND LEGS, EXCLUDING THE KNEE, ~~GRADE II AND III~~  
POTENTIALLY RESULTING IN SIGNIFICANT INJURY/IMPAIRMENT

### CODE PLACEMENT

No major issues

# Overview of Recommendations for Converting Lines to ICD-10-CM

## Appendix A: Recommended changes in ICD-9 format

### CREATE NEW LINES

Create new line for Achilles tendonitis, lateral epicondylitis, and medial epicondylitis. These conditions are currently on lines 516 and 531. They have evidence for effectiveness of treatment. There is good evidence for cortisone injections allowing better compliance with physical therapy and other treatment modalities, earlier mobilization, and quicker return to function.

Line XXX ACHILLES TENDONITIS, LATERAL AND MEDIAL EPICONDYLITIS

Treatment: MEDICAL AND SURGICAL THERAPY

ICD-10: 726.31, 726.32, 726.71

CPT: from 516 and 531

scoring:

Category: 7

IHLY: 2

IPS: 2

Pop: 0

Vuln: 0

Tertiary: 0

Effect: 4

Cost: 4

Need for treatment: 0.9

Score: 288 Approx line: 475

### GUIDELINES

Add a guideline to line 443 DISORDERS OF SHOULDER, POTENTIALLY RESULTING IN SIGNIFICANT INJURY/IMPAIRMENT to apply to treatment of acromioclavicular joint sprains.

#### GUIDELINE NOTE XXX MANAGEMENT OF ACROMIOCLAVICULAR JOINT SPRAIN

*Line 443, 638*

Sprain of acromioclavicular joint (ICD-10 840.0) is only included on line 443 for Grade 4-6 sprains. Surgical management of these injuries is covered only after a trial of conservative therapy. Grade 1-3 acromioclavicular joint sprains are included only on line 638.

# Overview of Recommendations for Converting Lines to ICD-10-CM Oral Maxillofacial Surgery

*Specialty consultants:* Dr. Leon Assael

## CREATE NEW LINES

None

## COMBINE MULTIPLE LINES

None

## DELETE LINES

None

## RESCORE LINES

None

## GUIDELINES

None

## RENAME LINES

Change name of line 627 ~~CYSTS OF ORAL SOFT TISSUES~~ INCONSEQUENTIAL CYSTS OF ORAL SOFT TISSUES to reflect benign nature of cysts on this line

## CODE PLACEMENT

- 1) K09.0 (Developmental odontogenic cysts) and K09.1 (Developmental (nonodontogenic) cysts of oral region) which are currently on line 549 BENIGN NEOPLASM BONE AND ARTICULAR CARTILAGE INCLUDING OSTEOID OSTEOMAS; BENIGN NEOPLASM OF CONNECTIVE AND OTHER SOFT TISSUE need be moved to covered line--move to line 486 BRANCHIAL CLEFT CYST; THYROGLOSSAL DUCT CYST; CYST OF PHARYNX OR NASOPHARYNX. These diagnoses are benign but can be highly locally aggressive and can become malignant.
- 2) K00.0 (Anodontia) moves from line 675 DENTAL CONDITIONS WHERE TREATMENT IS CHOSEN PRIMARILY FOR AESTHETIC CONSIDERATIONS to line 477 DENTAL CONDITIONS (EG. MISSING TEETH, PROSTHESIS FAILURE) Treatment: REMOVABLE PROSTHODONTICS (E.G. FULL AND PARTIAL DENTURES, RELINES) to allow coverage for dentures which has a very large impact on health and quality of life.

# Overview of Recommendations for Converting Lines to ICD-10-CM Oral Maxillofacial Surgery

## Appendix A: Recommended changes in ICD-9 format

### CODE PLACEMENT

- 1) 526.0 (Developmental odontogenic cysts) and 526.1 (Developmental (nonodontogenic) cysts of oral region) which are currently on line 549 BENIGN NEOPLASM BONE AND ARTICULAR CARTILAGE INCLUDING OSTEOID OSTEOMAS; BENIGN NEOPLASM OF CONNECTIVE AND OTHER SOFT TISSUE need be moved to covered line--move to line 486 BRANCHIAL CLEFT CYST; THYROGLOSSAL DUCT CYST; CYST OF PHARYNX OR NASOPHARYNX. These diagnoses are benign but can be highly locally aggressive and can become malignant.
- 2) 520.0 (Anodontia) moves from line 675 DENTAL CONDITIONS WHERE TREATMENT IS CHOSEN PRIMARILY FOR AESTHETIC CONSIDERATIONS to line 477 DENTAL CONDITIONS (EG. MISSING TEETH, PROSTHESIS FAILURE) Treatment: REMOVABLE PROSTHODONTICS (E.G. FULL AND PARTIAL DENTURES, RELINES) to allow coverage for dentures which has a very large impact on health and quality of life.

# Overview of Recommendations for Converting Lines to ICD-10-CM Burns

*Specialty consultants: Nathan Kemalyan, MD; Nick Eshraghi, MD*

## CREATE NEW LINES

None

## COMBINE MULTIPLE LINES

None

## DELETE LINES

None

## RESCORE LINES

None

## GUIDELINES

None

## RENAME LINES

80 BURN, PARTIAL THICKNESS GREATER THAN 30% OF BODY SURFACE OR WITH VITAL SITE; FULL THICKNESS WITH VITAL SITE, LESS THAN 10% OF BODY SURFACE

202 BURN, PARTIAL THICKNESS WITHOUT VITAL SITE **REQUIRING GRAFTING**, **UP TO** 40-30% OF BODY SURFACE

## CODE PLACEMENT

None

# Plastic Surgery ICD 10 Recommendations

Specialty consultants: Dr. Jennifer Murphy

## CREATE NEW LINES

### Line XXX

**Condition: ACUTE PERIPHERAL NERVE INJURY**

**Treatment: SURGICAL THERAPY**

ICD10: S74.00xA-S74.11x

CPT codes: CPT codes from line 531

Create a new line with diagnoses from lines 516 PERIPHERAL ENTHESOPATHIES  
Treatment: MEDICAL THERAPY and line 531 PERIPHERAL ENTHESOPATHIES  
Treatment: SURGICAL TREATMENT. The new line would be a surgical only line. The diagnoses on this line would stay on the current lines (516 and 531). Rationale: in the acute setting, urgent treatment can prevent lifelong complications and/or disability.

PLACED SENSORY NERVES ON LOWER LINES (535, 557) WITH THE EXCEPTION OF DIGITAL NERVES, WHICH REMAIN ON **ACUTE NERVE INJURY LINE**

S44.00xA-S44.42xA

S54.00xA-S54.22xA

S64.00xA-S64.498A

Codes S94.00xA-S94.22xA

The following guideline would apply to the new line

### **GUIDELINE NOTE XXX ACUTE PERIPHERAL NERVE INJURY**

*Line XXX*

Repair of acute peripheral nerve injuries are included on line XXX. Non-surgical medical care of these injuries are covered on line 535. Chronic nerve injuries are covered on line 557. **[Definition of acute vs chronic?]**

### Rescoring recommendations

Category 7

Impact on Healthy Life Years 4

Rationale: If you don't repair a nerve, you will have a residual defect. If upper extremity is desensate, will significantly impact functionality

Impact on Pain and Suffering 1

Population effects 0

Vulnerable 0

Tertiary Prevention 1

Effectiveness 3

Need for service 0.90

Net cost 2

Score 324

**Line 450**

**Divide Line 410 CHRONIC ULCER OF SKIN into 2 new lines**

1) **LINE XXX**

**CHRONIC OPEN WOUND, SUPERFICIAL; PRESSURE ULCER OF SKIN (STAGE 1 AND 2)**

**TREATMENT: MEDICAL THERAPY**

# Plastic Surgery ICD 10 Recommendations

ICD-10s: from line 410, with the exclusion of codes specified for stages 3 and 4  
CPT codes: 29580-29584 (wound wrapping); outpatient office visit codes

- i. Category 7
- ii. Impact on Healthy Life Years 1
- iii. Impact on Pain and Suffering 1
- iv. Population effects 0
- v. Vulnerable 1
- vi. Tertiary Prevention 2
- vii. Effectiveness 5
- viii. Need for service 1
  1. Frequent turning, nursing care, sometimes ointments and creams
- ix. Net cost 4
- x. Score 500
- xi. **Line 415**

## 2) LINE XXX

### **CHRONIC OPEN WOUND, DEEP; PRESSURE ULCER OF SKIN (STAGE 3 AND 4) TREATMENT: MEDICAL AND SURGICAL THERAPY**

ICD-10 codes: line 410, with the exclusion of codes specified for stages 1 and 2

CPT codes: from line 410

- i. Category 7
- ii. Impact on Healthy Life Years 4
- iii. Impact on Pain and Suffering 2
- iv. Population effects 0
- v. Vulnerable 4
- vi. Tertiary Prevention 3
- vii. Effectiveness 2
  1. Inadequate condition to enable surgical treatment to be effective.  
Poor wheelchair, inadequate supports.
- viii. Need for service
  1. Often require surgical intervention
- ix. Net cost 1
- x. Score 520
- xi. **Line 41**

## GUIDELINES

Hemangiomas are covered on this line (*new complicated hemangioma line*) when they are ulcerated, infected, [recurrently hemorrhaging](#) or function-threatening (e.g. eyelid hemangioma).

## RENAME LINES

315 ~~CRUSH~~ CLOSED INJURY OF DIGITS

## CODE PLACEMENT

The following codes mapped to the hyperbaric oxygen line, in ICD9 these specific codes are not mapped to hyperbaric oxygen. Both have some case reports but inconsistent results and very poor quality evidence. Plan to remove this mapping and leave only on Line 652.

L92.1 Necrobiosis lipoidica, not elsewhere classified 358,652

L94.2 Calcinosis cutis 358,652

# Neurology ICD 10 Recommendations

Specialty consultants: Ray Englander

## CREATE/MERGE/DELETE/RESCORE LINES

None

## GUIDELINES

### GUIDELINE NOTE XX

Line 268

Immune-modifying therapies for multiple sclerosis are only covered for:

- 1) Relapsing remitting multiple sclerosis

They are not covered for

- 1) Primary progressive multiple sclerosis
- 2) Secondary progressive multiple sclerosis

Rationale: Secondary progressive and primary progressive multiple sclerosis do not benefit from treatment. Lots of people are treated empirically and no one stops treating them because they are fearful that ceasing treatment may cause relapse, but there is no evidence either way. These medications are very expensive. There is clearly an indication for relapsing-remitting multiple sclerosis.

Suggestions for consideration of future evidence-based medicine guidelines or Coverage Guidances:

- 1) Management of migraine headaches
- 2) Carotid endarterectomies

## RENAME LINES

Line 441 PERIPHERAL NERVE ENTRAPMENT; [PALMAR FASCIAL FIBROMATOSIS](#)

Rationale: This line has M72.0 Palmar fascial fibromatosis [Dupuytren] is on this line which is not a peripheral nerve problem. Can interfere with hand function. The line title should include an appropriate description.

## CODE PLACEMENT

Line 268 MULTIPLE SCLEROSIS AND OTHER DEMYELINATING DISEASES OF CENTRAL NERVOUS SYSTEM – removed the ataxias (G11s), just placed these on dysfunction lines relating to posture and movement and activities of daily living (ADLs)

Code	Code Description	Other lines
G11.0	Congenital nonprogressive ataxia	78,268,318,375,407
G11.1	Early-onset cerebellar ataxia	78,268,318,375,407
G11.2	Late-onset cerebellar ataxia	78,268,318,375,407
G11.3	Cerebellar ataxia with defective DNA repair	78,268,318,375,407
G11.4	Hereditary spastic paraplegia	78,268,318,375,407
G11.8	Other hereditary ataxias	78,268,318,375,407
G11.9	Hereditary ataxia, unspecified	78,268,318,375,407

Rationale: there is no effective treatment, but may need supportive durable medical equipment.

# Otolaryngology ICD-10 Recommendations

Specialty consultants: Dr. Flint and Dr. Iuga

## CREATE NEW LINES

### 1) LARYNGEAL STENOSIS OR PARALYSIS WITH AIRWAY COMPLICATIONS

Guideline NOTE XX

Laryngeal paralysis is covered on this line if associated with recurrent aspiration pneumonia (unilateral or bilateral) or airway obstruction (bilateral). Hoarseness is on line 543. Laryngeal stenosis is covered on this line if it causes airway obstruction.

#### Rationale:

Most laryngeal paralysis is iatrogenic, prolonged intubation causes stenosis. Bilateral paralysis causes severe airway obstruction. Unilateral paralysis most associated with aspiration and can cause recurrent aspiration pneumonias. These are serious and need to be treated.

#### ICD 10 Codes to move on this line

J38.6 Stenosis of larynx (this line only)

J38.01 Paralysis of vocal cords and larynx, unilateral (both new line and 543)

J38.02 Paralysis of vocal cords and larynx, bilateral (both new line and 543)

**CPT codes** – based on line 543 and 31528, 31529 (laryngoscopy)

#### Scoring

Category 6

Impact on healthy life years (can be any age), 7

Impact on pain and suffering 4

Population 0

Impact on vulnerable populations (head injury patients, premature babies, those with long term intubation) – 2

Tertiary Prevention – 3, very effective at preventing aspiration pneumonia

Need for service – 2

Effectiveness – 4

Score 2560

#### **New Line 80**

Appropriate because airway obstruction in kids is line49. It is fixable and once fixed it is low cost.

## COMBINE MULTIPLE LINES

## DELETE LINES

## RESCORE LINES

### Line 217 CHOANAL ATRESIA

Treatment: REPAIR OF CHOANAL ATRESIA

## Otolaryngology ICD-10 Recommendations

Current ranking:

line	Score	Category	HL Y	Suffering	PopEffects	VulnerablePop	Tertiary Prev	Effectiveness	NeedForServices	NetCost	Text 65
217	1600	6	6	1	0	0	1	5	1	3	217

Should be higher than leukoplakia and carcinoma, because it can be life threatening. Kids are obligate nose breathers. Consider reranking this – serious issue

Impact on healthy life years, currently 6, should be changed to 8

Rationale: this occurs in newborns

Increase pain and suffering – 2 (or 3)

Rationale: they can't breathe, this is uncomfortable

Tertiary prevention 1 (or 2)

New score would be 2200, which would place it around Line 131

### Line 298 SENSORINEURAL HEARING LOSS - AGE 5 OR UNDER

Treatment: COCHLEAR IMPLANT

Current ranking:

txtDI line	txtScore	cmbCategory	HL Y	Suffering	PopEffects	VulnerablePop	Tertiary Prev	Effectiveness	NeedForServices	NetCost	Text 65
298	1200	7	6	2	2	0	5	4	1	2	298

Change healthy life years to 5, not fatal

Increase suffering to a 3

New score would be 1200, no change in Line number, but prioritization makes more sense

### Line 491 SENSORINEURAL HEARING LOSS - OVER AGE OF FIVE

Treatment: COCHLEAR IMPLANT

Should be ranked higher

Healthy Life Years is currently only a 3, they strongly think should be 4. Deafness in middle aged is a big problem

Suffering should be higher than a 1, should be a 2 (older than 5)

New score: 360; New Line placement: around 444

### Line 383 HEARING LOSS - AGE 5 OR UNDER

Treatment: MEDICAL THERAPY INCLUDING HEARING AIDS

Current ranking:

txtDI line	txtScore	cmbCategory	HL Y	Suffering	PopEffects	VulnerablePop	Tertiary Prev	Effectiveness	NeedForServices	NetCost	Text 65
383	720	7	5	2	0	0	5	3	1	3	383

# Otolaryngology ICD-10 Recommendations

Suffering should be a 3 (instead of 2)  
 Effectiveness should be increased from 3 to 4  
New score: 1040, New Line placement: around Line 338

## Line 498 CHRONIC SINUSITIS

txtD line	txtRankin gMethod	txtS core	cmbCat egory	H L Y	Suffe ring	PopEf fects	Vulnera blePop	Tertiar yPrev	Effectiv eness	NeedFor Services	Net Cos t	Tex t65
498	Auto Rank	200	7	3	2	0	0	0	2	1	2	502

It does have some fatality (same as acute), would change to **category 6**  
**Need to discuss impact on healthy life years – Darren to lead discussion**  
 New Score 600  
**Line 400**

*Dr. Flint to get complication rates for untreated chronic sinusitis*

## GUIDELINES

## RENAME LINES

## CODE PLACEMENT

A number of codes were moved below the funding region

- 1) Several unspecified codes were placed on low line 686
- 2) H61.92/3 Disorder of right and left external ear
- 3) Chronic myringitis, atrophic flaccid tympanic membrane, and tympanosclerosis H73.10-  
H84.09 moved to line 502 only. This will help with costs.
- 4) Polyps of middle ear H74.40-93 going to 502, unspecified disorders
- 5) Acquired stenosis of ear canals (H61) moved from 430 to 502
- 6) Eczematous otitis externa (H60.54s), acute contact otitis externa (H60.53) moved to  
contact dermatitis and eczema lines
- 7) H60.501 unspecified noninfective otitis externa, acute actinic otitis, acute chemical otitis,  
acute reactive, other noninfective all go below the line

## Pulmonary Valve Repair

Question: where on the Prioritized List should acquired pulmonary valve disease be located?

Question source: HERC staff, DMAP

Issue: DMAP requested a review for pairing of 424.3 (Pulmonary valve disorders) with 75561 (Cardiac MRI). On review of this question, HERC staff identified that there is currently no pulmonary valve surgical repair line on the List. The Cardiology ICD-10 review has identified acquired pulmonary valve disease (ICD-9 424.3, ICD-10 I37.0-9) as needing to move from its current line (line 363 DISEASES OF ENDOCARDIUM), which is a medical line, to a renamed line 274, DISEASES OF MITRAL, ~~AND~~ TRICUSPID, AND PULMONARY VALVES, which has surgical repair codes, MRI evaluation codes, etc. This change, however, will not take effect until October 1, 2013 at the earliest. It appears that this change is needed earlier to allow for surgical repair of non-congenital pulmonary valve issues. Note: congenital pulmonary valve disorders are located on lines 77 CONGENITAL PULMONARY VALVE STENOSIS and 95 CONGENITAL PULMONARY VALVE ATRESIA.

Line 363 contains the diagnoses of all non-congenital disorders of mitral, aortic, tricuspid, and pulmonary valves (424.0-.3) as well as endocarditis. It is a medical line except for 2 surgical codes (32660 and 33496). The surgical lines with these diagnoses are 237 and 274. The two surgical codes on this line need to be removed.

The CPT codes for pulmonary valve repair (33470-33478) appear only on lines 77 CONGENITAL PULMONARY VALVE STENOSIS, 95 CONGENITAL PULMONARY VALVE ATRESIA, 192 MULTIPLE VALVULAR DISEASE, and 308 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT. These codes need to be paired with 424.3 on the new surgical line.

### Recommendations:

- 1) Add 424.3 (pulmonary valve disorders) to line 274
  - a. Keep on line 363 for medical treatments
- 2) Rename line 274 DISEASES OF MITRAL, ~~AND~~ TRICUSPID, AND PULMONARY VALVES
- 3) Add pulmonary valve repair CPT codes to line 274
  - a. 33470 Valvotomy, pulmonary valve, closed heart; transventricular
  - b. 33471 Valvotomy, pulmonary valve, closed heart; via pulmonary artery
  - c. 33472 Valvotomy, pulmonary valve, open heart; with inflow occlusion
  - d. 33474 Valvotomy, pulmonary valve, open heart; with cardiopulmonary bypass
  - e. 33475 Replacement, pulmonary valve
  - f. 33476 Right ventricular resection for infundibular stenosis, with or without commissurotomy
  - g. 33478 Outflow tract augmentation (gusset), with or without commissurotomy or infundibular resection
- 4) Remove the two current surgical CPT codes from line 363 DISEASES OF ENDOCARDIUM
  - a. This line is a medical therapy line only
  - b. 32660—no longer a valid code
  - c. 33496 (Repair of non-structural prosthetic valve dysfunction with cardiopulmonary bypass)
    - i. On the current surgical lines (237 and 274)

## Pulmonary Valve Repair

**Line: 237**

Condition: DISEASES AND DISORDERS OF AORTIC VALVE (See Guideline Notes 1,6,64,65,76)

Treatment: AORTIC VALVE REPLACEMENT, VALVULOPLASTY, MEDICAL THERAPY

ICD-9: 395,424.1,V57.1-V57.3,V57.8,V58.61

CPT: 33400-33405,33410-33413,33496,33530,33620,33621,33973,33974,35452,75557-75565,75573,92960-92998,93797,93798,96150-96154,98966-98969,99051,99060,99070,99078,99201-99366,99374,99375,99379-99444,99468-99480,99605-99607

HCPCS: G0157-G0161,G0406-G0408,G0422,G0423,G0425-G0427,S0270-S0274

**Line: 274**

Condition: DISEASES OF MITRAL AND TRICUSPID VALVES (See Guideline Notes 1,6,64,65,76)

Treatment: VALVULOPLASTY, VALVE REPLACEMENT, MEDICAL THERAPY

ICD-9: 391.1,394,396,424.0,424.2,746.89,V57.1-V57.3,V57.8,V58.61

CPT: 33420-33465,33496,33530,33620,33621,33973,33974,75557-75565,75573,92960-92998,93797,93798,96150-96154,98966-98969,99051,99060,99070,99078,99201-99366,99374,99375,99379-99444,99468-99480,99605-99607

HCPCS: G0157-G0161,G0406-G0408,G0422,G0423,G0425-G0427,S0270-S0274

**Line: 363**

Condition: DISEASES OF ENDOCARDIUM (See Guideline Notes 6,64,65,76)

Treatment: MEDICAL THERAPY

ICD-9: 424,V57.1-V57.3,V57.8

CPT: 32660,33496,92960-92998,93797,93798,98966-98969,99051,99060,99070,99078,99201-99360,99366,99374,99375,99379-99444,99468-99480,99605-99607

HCPCS: G0157-G0161,G0406-G0408,G0422,G0423,G0425-G0427,S0270-S0274

## Nasal Endoscopy for Acute Sinusitis

Question: should nasal endoscopy be covered for treatment of acute sinusitis?

Question source: DMAP, HERC staff

Issue: DMAP has requested pairing of various nasal and sinus endoscopy procedures with acute sinusitis diagnoses. These procedures are currently covered on the chronic sinusitis line (line 498) and on the nasal polyps line (line 532). Currently, several nasal endoscopy codes are on the acute sinusitis line (line 391). Many other endoscopy codes are not included on this line. All diagnoses on the acute sinusitis line related to acute sinusitis (461.0-9).

According to Medscape, the indications for endoscopic sinus endoscopy are:

- Chronic sinusitis refractory to medical treatment
- Recurrent sinusitis
- Nasal polyposis
- Antrochoanal polyps
- Sinus mucoceles
- Excision of selected tumors
- Cerebrospinal fluid (CSF) leak closure
- Orbital decompression (eg, Graves ophthalmopathy)
- Optic nerve decompression
- Dacryocystorhinostomy (DCR)
- Choanal atresia repair
- Foreign body removal
- Epistaxis control

According to the **American Academy of Otolaryngology--Head and Neck Surgery (2007)** practice guideline:

“The clinician may obtain nasal endoscopy in diagnosing or evaluating a patient with chronic rhinosinusitis or recurrent acute rhinosinusitis. *Option based on expert opinion and a preponderance of benefit over harm.* Aggregate evidence quality: **Grade D**, expert opinion. Policy level: **option**”

Review of Medline found no current reviews examining whether nasal endoscopy should be completed for acute sinusitis. No guidance was found at NICE or SIGN.

Recommendations:

- 1) Changes shown in table on the following page
  - a. Codes to remove are shown in red with a crossed out X (X)
  - b. Do not cover nasal endoscopy for acute sinusitis
    - i. ENT experts consider this a “D” recommendation procedure
  - c. Other changes are “clean up” code clarifications

<b>CPT code</b>	<b>Code description</b>	<b>Diag</b>	<b>Line 262</b>	<b>Line 391</b>	<b>Line 498</b>	<b>Line 532</b>	<b>Line 548</b>	<b>Line 654</b>
31231	Nasal endoscopy, diagnostic, unilateral or bilateral	X						
31233	Nasal/sinus endoscopy, diagnostic with maxillary sinusoscopy	X						
31235	Nasal/sinus endoscopy, diagnostic with sphenoid sinusoscopy	X						
31237	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement	✗			X	X		
31238	Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage		X		X	X		✗
31239	Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy				X	X		X
31240	Nasal/sinus endoscopy, surgical; with concha bullosa resection				X	X		
31254	Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior)				X	X		
31255	Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior)				X	X		
31256	Nasal/sinus endoscopy, surgical, with maxillary antrostomy		✗		X	X		
31267	Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus				X	X		
31276	Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus	✗		✗	X	X	✗	
31287	Nasal/sinus endoscopy, surgical, with sphenoidotomy				X	X		
31288	Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus				X	X		
31295	Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa			✗	X	X		
31296	Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)			✗	X	X		
31297	Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (eg, balloon dilation)			✗	X	X		

**262** LIFE-THREATENING EPISTAXIS

**391** ACUTE SINUSITIS

**498** CHRONIC SINUSITIS

**532** NASAL POLYPS, OTHER DISORDERS OF NASAL CAVITY AND SINUSES

**548** BENIGN NEOPLASM OF NASAL CAVITIES, MIDDLE EAR AND ACCESSORY SINUSES

**654** STENOSIS OF NASOLACRIMAL DUCT (ACQUIRED)

## Avascular Necrosis Of The Hip And Vascular Bone Grafting

Question: Should avascular necrosis of the hip (AVN, ICD-9 733.42) pair with vascular bone grafting (CPT 27170, bone grafting, femoral head/neck)?

Question Source: OHP managed care patient

Issue: The VbBS discussed a patient request to pair coverage of vascular bone grafting with avascular necrosis of the hip (AVN) at their February, 2012 meeting. At that meeting, evidence regarding the effectiveness of this treatment for AVN was discussed (see February packet) and expert input from Dr. Huff in orthopedics was introduced. The subcommittee requested that HERC staff work to find additional evidence for review, and find an expert willing to attend a VbBS meeting to answer questions about this procedure.

HERC staff have worked to identify an expert who performs vascular bone grafting to speak with the Commission at an upcoming meeting. Staff have contacted numerous orthopedists in Oregon, as well as at the University of Washington in Seattle, and, despite numerous attempts, no provider has been found who currently performs this type of surgery in Oregon or nearby areas. HERC staff have also attempted to contact Dr. Urbaniak, a nationally recognized expert in this procedure, at Duke, but have been unsuccessful at reaching him either via phone or email. Dr. Mararchi from OHSU has performed this surgery in the past and is available to answer questions by phone at this meeting.

Evidence:

The Center for Evidence Based Policy has completed a new independent evidence review on this topic, which is attached. The summary of this report and other relevant excerpts are included below:

There is currently little consensus among hips surgeons about the optimal treatment of avascular necrosis of the femoral head (McGrory 2007).

McGrory et al (2007) surveyed all 753 members of the American Association of Hip and Knee Surgeons (AAHKS) who devoted greater than 50% of their time to hip and knee arthroplasty. Of the 403 (54%) respondents, total hip replacement was the most frequent intervention offered for post-collapse (Steinberg stage IIIB, IVB, V and VI) AVN. Core decompression was the most commonly offered surgery for patient scenarios with symptomatic pre-collapse AVN (Steinberg stage IB, IIB). Vascularized and non-vascularized bone-grafting was offered less frequently...with fewer than 15% of surgeons offering it.

We identified 13 poor quality studies that addressed the Key Questions in this report; thus the overall quality of evidence is poor, and the results summarized in this report should be viewed in this context (most studies were identified to have high risk of bias). The results of this review suggest:

Natural history: of 664 hips in 576 patients, 394 (59%) developed symptoms and/or collapse of the femoral head, which causes destruction of the hip joint, arthritis and pain, during an average follow-up period of 88 months (range, 2 to 240 months)...Size and location of the lesion was associated with progression to collapse: fewer than 10%

## **Avascular Necrosis Of The Hip And Vascular Bone Grafting**

of small (less than 25% of the femoral head) medially located lesions progressed to collapse, 25% of medium-sized (25% to 50%) progressed, and 84% of large (greater than 50%) lesions progressed.

Conversion to total hip replacement after vascularized bone grafting varies based on Stage of AVN (extent of necrosis) and patient age.

Based on the better quality cohort studies (Kawate 2007; Zhao 2010), conversion to total hip replacement ranges from 12% (88% survival) to 56% (44% survival). Patients' Harris Hip Score, a measure of pain and hip function, improves after vascularized bone grafting compared to prior to the surgery.

Three poor quality case series were found comparing vascularized bone grafting to core decompression. Survival of the hip was found to be better in the vascularized bone grafting groups in these studies, but there were significant differences in the groups (mean age of patients, etc.) in these studies, and no conclusions could be drawn.

No studies were found comparing vascularized bone grafting to total hip arthroplasty. Factors found to be associated with poorer outcomes and higher likelihood for conversion to total hip replacement were 1) patients with Stage III – V disease; 2) older patients (mean age for most study patients was mid-30s and older patients with mean ages in the 40s had higher conversion rates); and 3) patients' whose AVN was due to alcohol, steroids, and idiopathic causes.

Based on eight studies reporting adverse outcomes, the proportion of patients having adverse outcomes following vascularized bone grafting ranges from approximately 5% to 26%.

These results have lead Stulberg (2003) to conclude that vascularized fibular grafting may be falling from favor due to its limited indication (for patients with Steinberg stage IIA or less severe AVN) and greater morbidity. Others emphasize that patients need to be carefully selected for vascularized bone grafting (Aldridge 2007; Aldridge 2008). Aldridge and Urbaniak (2007) recommend that symptomatic patients older than 50 years and patients older than 40 years with Stage IV disease or 50% or more involvement of the femoral head and limited hip motion be offered total hip replacement.

### Expert Input

Expert input was received from Dr. Hertzberg, at OHSU Orthopedics. He felt that vascular bone grafting can be indicated in limited cases for young (<50) patients, with more than a 25-30 year life expectancy, who are otherwise healthy, active patients who do not have collapse of the femoral head but who also have a large area of involvement of the femoral head. Dr. Hertzberg recommended that two surgeons review the case and recommend this procedure prior to authorizing the procedure.

## Avascular Necrosis Of The Hip And Vascular Bone Grafting

### Current Prioritized List status

27170 Bone graft, femoral head, neck, intertrochanteric or subtrochanteric area (includes obtaining bone graft) appears on 3 lines on the current Prioritized List:

Code	Line	Condition	Treatment
27170	297	DEFORMITY/CLOSED DISLOCATION OF JOINT	SURGICAL TREATMENT
27170	467	MALUNION AND NONUNION OF FRACTURE	SURGICAL TREATMENT
27170	531	PERIPHERAL ENTHESOPATHIES	SURGICAL TREATMENT

Note: no other use for CPT 27170 other than vascularized bone grafting of the hip was identified on review.

The diagnosis of AVN (733.42) appears on line line, 384, paired with various treatments including joint replacement and hip core decompression (with a guideline limiting use).

Code	Code Description	Line title
733.42	Aseptic necrosis of head and neck of femur	384 RHEUMATOID ARTHRITIS, OSTEOARTHRITIS, OSTEOCHONDRITIS DISSECANS, AND ASEPTIC NECROSIS OF BONE

### **GUIDELINE NOTE 83, HIP CORE DECOMPRESSION**

#### *Line 384*

Hip Core Decompression (S2325) is covered only for early/pre-collapse (stage I or II; before X-ray changes are evident) avascular necrosis of the hip (femoral head and/or neck).

### HERC Staff Recommendations

1. Option 1 (HERC staff preferred):
  - a. Do not add coverage for vascular bone grafting for treatment of avascular necrosis of the hip to the Prioritized List
    - i. Poor evidence of effectiveness
    - ii. Consider review this issue again when a planned Cochrane systematic review on surgical treatment for advanced avascular necrosis is released
  - b. Remove coverage for vascular bone grafting for hip fractures and other indications as these have worse outcomes than for early stage avascular necrosis of the hip
    - i. Remove 27170 from lines 297, 467, and 531 and add to Excluded File
2. Option 2
  - a. If vascular bone grafting is added to line 384 for coverage for AVN, consider making the guideline change shown below:
    - i. Based on indications identified by experts and in the CEBP report
  - b. Remove 27170 from lines 297, 467, and 531
    - i. Later stage disease has worse outcomes and was identified as a relative contraindication to this procedure

## Avascular Necrosis Of The Hip And Vascular Bone Grafting

### **GUIDELINE NOTE 83, HIP CORE DECOMPRESSION AND VASCULAR BONE GRAFTING**

*Line 384*

Hip Core Decompression (HCPCS S2325) and vascular bone grafting (CPT 27170) are covered only for early/pre-collapse (stage I or II; before X-ray changes are evident) avascular necrosis of the hip (femoral head and/or neck). Vascular bone grafting is only covered for symptomatic patients who are younger than 50 years of age, otherwise healthy and active with a 25-30 year life expectancy, who have a large area of involvement (but less than 50% involvement) of the femoral head without collapse of the femoral head, who do not have limited hip motion, and whose avascular necrosis is not due to steroids or alcohol.

## Paraphilias

Question: Where should the new line for paraphilias be located on the Prioritized List?

Question Source: VbBS

Issue:

Line 513 GENDER IDENTIFICATION DISORDER, PARAPHILIAS AND OTHER PSYCHOSEXUAL DISORDERS was split at the March VbBS meeting into two new lines: “Gender Dysphoria” and “Paraphilias.” The paraphilias line was not scored at that meeting. HERC staff has worked with Dr. David Pollack, the mental health representative on the VbBS, to come up with a proposed line scoring for review.

As part of this review, two additional diagnoses (ego-dystonic sexual orientation and transsexualism) were found on the proposed Paraphilias line which were determined to be more appropriate for the Gender Dysphoria line. In DSM-5, these diagnoses are no longer distinguished from gender dysphoria.

The new line, as approved at the March meeting, appears below. The diagnoses on this line are summarized in the box following the line description.

Condition: PARAPHILIAS AND OTHER PSYCHOSEXUAL DISORDERS  
 Treatment: MEDICAL/PSYCHOTHERAPY  
 ICD-9: 302.0-302.5, 302.9  
 CPT: 90804-90815,90846-90857,90882,90887,96101,98966-98969,99051,99060,99201-99215,99241-99245,99366,99441-99444,99605-99607  
 HCPCS: G0176,G0177,G0425-G0427,H0004,H0023,H0032,H0034,H0035,H2010,H2011,H2014, H2027, H2032,H2033,S0270-S0274,S9484,T1016

ICD-9 codes currently proposed for the Paraphilias line

ICD-9 code	Code description
302.0	Ego-dystonic sexual orientation – proposed for Gender Dysphoria line
302.1	Zoophilia
302.2	Pedophilia
302.3	Transvestic fetishism
302.4	Exhibitionism
302.50	Trans-sexualism with unspecified sexual history – proposed for Gender Dysphoria line
302.9	Unspecified psychosexual disorder

*Current Ranking*

Line	Score	Category	HLY	Suffering	Pop Effects	Vulnerable Pop	Tertiary Prev	Effectiveness	Need For Services	Net Cost
513	160	7	2	4	1	0	1	1	1	2

## Paraphilias

### HSC Staff Recommendations

- 1) Move 302.0 (Ego-dystonic sexual orientation) and 302.50 (Trans-sexualism with unspecified sexual history) to the new Gender Dysphoria Line
- 2) Rank the new Paraphilias line as shown below.

### Paraphilias

Category 7

HLY 3

Suff 3

Pop effects 3

Vuln 0

Tertiary 2

Effect 1 (depending on which condition)

Need for service .7 (very difficult to estimate because of the mix of conditions, with pedophilia being very high and some of the other conditions being lower, even though treatment is generally not very effective for any of them)

Net cost 3

Line score 154

Approx line placement 530

## Neoplasm of Uncertain and Unspecified Behavior ICD 10 Fix

### Question:

How should the ICD 10 list be corrected to adapt to the new “uncertain” and “unspecified” neoplasm guidance by Medicare?

Question Source: HERC Staff

### Issue:

Medicare has changed their guidance for codes to describe the diagnostic workup of neoplasms. It used to be Neoplasm of “uncertain” behavior was used before diagnosis was made. However, this is changed, and now “Neoplasm of unspecified behavior” is the appropriate way to do a diagnostic workup, and if one still does not know after pathology results exactly what the neoplasm is (benign or malignant, then it would be of “uncertain behavior”.

Previously, the HSC moved to add “Neoplasms of unspecified behavior” from the Excluded to the Diagnostic List to allow for biopsies and other diagnostic work up. However, the “Neoplasms of uncertain nature” are still on the Diagnostic List. These codes are more appropriate for the organ-specific cancer lines. Some are inappropriately on two lines (e.g. parathyroid cancer mapping both to thyroid cancer line and non-thyroid cancer line) and recommendations were made to adjust this.

HERC Staff Recommendation

See Table on following page

## Cardiac MRI

Question: Should cardiac MRI be covered for evaluation of thoracic aneurysms?

Question source: HSC/HERC, DMAP

Issue: In January, 2011, the HOSC reviewed pairing of cardiac MRI (CPT 75561-5) with thoracic aneurysms. At that time, the discussion was whether an echocardiogram or CT angiogram might be a more cost-effective way to evaluate such an aneurysm. HSC staff was asked to research this further and bring back to a future meeting. This topic was never re-examined. DMAP has been receiving additional requests for coverage of cardiac MRI for thoracic aneurysms and has requested that this pairing be re-evaluated.

To date, cardiac MRI has been limited to evaluation of congenital heart disease and valvular heart disease.

### Expert input

Dr. Howard Song, OHSU Cardiology

TTE and TEE are not sufficient to evaluate any thoracic aneurysm in my practice. these studies are complimentary to cross sectional imaging in that they are excellent for evaluation of aortic valve function, which is frequently affected by large aortic root aneurysms. These studies do not however provide accurate measurements or image the entire extent of most thoracic aneurysms. In my practice, a complete evaluation of a thoracic aneurysm would include either a TTE or TEE AND cross sectional imaging--either a CT scan or MRI. MRIs are especially useful for patients with renal insufficiency or for patients who require serial exams and would have a substantial lifetime radiation exposure related to annual CT scans over time. I think HERC/HSC should cover MRIs for thoracic aneurysms, at least in instances where CT scanning is contraindicated due to contrast sensitivity, renal impairment, and radiation exposure.

Dr. Michael Shapiro, OHSU Cardiology

From my perspective, MRI is sometimes the preferred modality for many reasons:

- 1) If the aneurysm is not located at the aortic root, it will not be visualized by TTE
- 2) MRI is non-invasive and TEE is semi-invasive and requires sedation
- 3) There are sometimes other structural abnormalities associated with thoracic aneurysms that are well evaluated with MRI
- 4) MRI is the most accurate and reproducible technique for measurement of aneurysms

One reasonable way to guide resource allocation is to consider MRI for initial evaluation of the aneurysm. If the location is such that TTE can accurately assess the aneurysm and there are no other associated abnormalities that would require serial evaluation with MRI, then TTE could be used solely in follow-up

### Recommendation:

- 1) Add cardiac MRI (CPT 75561-5) to line 349 NON-DISSECTING ANEURYSM WITHOUT RUPTURE

## ICD-10 Guideline Changes/New Guidelines Suggested for Earlier Implementation

Question: should some of the new/modified guidelines which arose through the ICD-10 process be implemented earlier than October 1, 2013 (or later)?

Question source: HERC staff, DMAP

Issue: the ICD-10 review process has modified or created new guidelines, many of which are applicable to the ICD-9 list. DMAP and HERC staff feel that some guidelines could be useful for guiding coverage at the current time, rather than waiting two or more years for implementation with the new ICD-10 List. HERC staff has identified the following guidelines as being applicable in ICD-9.

Recommendation:

- 1) Apply the following new and modified guidelines to the October 1, 2012 Prioritized List
  - a. Note: there are two additional guidelines (urology guideline for coverage of benign neoplasms and cardiothoracic surgery changes to the VAD guideline) which are considered separately in the two attached documents

### **GUIDELINE NOTE 70, HEART-KIDNEY TRANSPLANTS**

Line 279

Patients under consideration for heart/kidney transplant must qualify for each individual type of transplant under current DMAP administrative rules and transplant center criteria with the exception of any exclusions due to heart and/or kidney disease. Qualifying renal disease is limited to Stage V or VI.

### **GUIDELINE NOTE 48, FRENULECTOMY/FRENULOTOMY**

Line 373

Frenulectomy/frenulotomy (D7960) is included on this line for the following situations:

1. ~~In the presence of ankyloglossia~~
- 2.1. When deemed to cause gingival recession
3. 2. When deemed to cause movement of the gingival margin when frenum is placed under tension.
- 4.3. Maxillary labial frenulectomy not covered until age 12 and above

### **GUIDELINE NOTE 8, BARIATRIC SURGERY**

Lines 33,607

Bariatric surgery for obesity is included on Line 33 TYPE II DIABETES MELLITUS, and Line 607 OBESITY under the following criteria:

- A) Age  $\geq$  18
- A) For inclusion on Line 33: BMI  $\geq$  35 with co-morbid type II diabetes. For inclusion on Line 607: BMI  $\geq$  35 with at least one significant co-morbidity other than type II diabetes (e.g., obstructive sleep apnea, hyperlipidemia, hypertension) or BMI  $\geq$  40 without a significant co-morbidity.
- B) No prior history of Roux-en-Y gastric bypass or laparoscopic adjustable gastric banding, unless they resulted in failure due to complications of the original surgery.
- C) Participate in the following four evaluations and meet criteria as described.
  - 1) Psychosocial evaluation: (Conducted by a licensed mental health professional)

## ICD-10 Guideline Changes/New Guidelines Suggested for Earlier Implementation

- a) Evaluation to assess potential compliance with post-operative requirements.
- b) Must remain free of abuse of or dependence on alcohol during the six-month period immediately preceding surgery. No current use of nicotine or illicit drugs and must remain abstinent from their use during the six-month observation period. Testing will, at a minimum, be conducted within one month of the surgery to confirm abstinence from nicotine and illicit drugs.
- c) No mental or behavioral disorder that may interfere with postoperative outcomes<sup>1</sup>.
- d) Patient with previous psychiatric illness must be stable for at least 6 months.
- 2) Medical evaluation: (Conducted by OHP primary care provider)
  - a) Pre-operative physical condition and mortality risk assessed with patient found to be an appropriate candidate.
  - b) Optimize medical control of diabetes, hypertension, or other co-morbid conditions.
  - c) Female patient not currently pregnant with no plans for pregnancy for at least 2 years post-surgery. Contraception methods reviewed with patient agreement to use effective contraception through 2nd year post-surgery.
- 3) Surgical evaluation: (Conducted by a licensed bariatric surgeon associated with program<sup>2</sup>)
  - a) Patient found to be an appropriate candidate for surgery at initial evaluation and throughout period leading to surgery while continuously enrolled on OHP.
  - b) Received counseling by a credentialed expert on the team regarding the risks and benefits of the procedure<sup>3</sup> and understands the many potential complications of the surgery (including death) and the realistic expectations of post-surgical outcomes.
- 4) Dietician evaluation: (Conducted by licensed dietician)
  - a) Evaluation of adequacy of prior dietary efforts to lose weight. If no or inadequate prior dietary effort to lose weight, must undergo six-month medically supervised weight reduction program.
  - b) Counseling in dietary lifestyle changes
- D) Participate in additional evaluations:
  - 1) Post-surgical attention to lifestyle, an exercise program and dietary changes and understands the need for post-surgical follow-up with all applicable professionals (e.g. nutritionist, psychologist/psychiatrist, exercise physiologist or physical therapist, support group participation, regularly scheduled physician follow-up visits).

<sup>1</sup> Many patients (>50%) have depression as a co-morbid diagnosis that, if treated, would not preclude their participation in the bariatric surgery program.

<sup>2</sup> All surgical services must be provided by a program with current certification by the American College of Surgeons (ACS) or the ~~Surgical Review Corporation (SCR)~~, American Society for Metabolic and Bariatric Surgery (ASMBS) or in active pursuit of such certification with all of the following: a dedicated, comprehensive, multidisciplinary, pathway-directed bariatric program in place; hospital to have performed bariatrics > 1 year and > 25 cases the previous 12 months; trained and credentialed bariatric surgeon performing at least 50 cases in past 24 months; qualified bariatric call coverage 24/7/365; appropriate bariatric-grade equipment in outpatient and inpatient facilities; appropriate medical specialty services to complement surgeons' care for patients; and quality improvement program with prospective documentation of

## ICD-10 Guideline Changes/New Guidelines Suggested for Earlier Implementation

surgical outcomes. If the program is still pursuing ACS or ~~SRG~~ ASMBS certification, it must also restrict care to lower-risk OHP patients including: age < 65 years; BMI < 70; no major elective revisional surgery; and, no extreme medical comorbidities (such as wheel-chair bound, severe cardiopulmonary compromise, or other excessive risk). All programs must agree to yearly submission of outcomes data to Division of Medicaid Assistance Programs (DMAP).

<sup>3</sup> Only Roux-en-Y gastric bypass, laparoscopic adjustable gastric banding and sleeve gastrectomy are approved for inclusion.

<sup>4</sup> The patient must meet criteria #1 , #2, and #3, and be referred by the OHP primary care provider as a medically appropriate candidate, to be approved for evaluation at a qualified bariatric surgery program.

## ICD-10 Urology Follow Up Issues

Question: How to best allow coverage of treatment for certain benign neoplasms of the urinary system which can have serious impact on health?

Question source: HERC staff

Issue: At the March, 2012 VBBS meeting, the recommendations from the Urology ICD-10 review group were reviewed. As part of that review, the urology experts had suggested adding a guideline to allow coverage for certain benign neoplasms of the urinary system which either because of bleeding, size, or other complication can have serious impact on health. The subcommittee was in favor of adding this guideline, but thought that 1) it should be implemented sooner than the ICD-10 Prioritized List, and 2) for ease of use, the ICD-9 codes for the benign neoplasm in question be added to the covered kidney cancer line with the guideline then acting to delineate when this diagnosis is covered (on the kidney cancer line) and when not covered (on the benign neoplasm line).

The ICD-9 codes in question were identified and vetted with the ICD-10 urology experts. Angiomyolipoma and concocytoma are coded under 223.0 (Benign neoplasm of kidney, except pelvis).

Recommendations:

- 1) Add 223.0 to line 228 effective October 1, 2012
  - a. Keep on line 538 BENIGN NEOPLASM OF KIDNEY AND OTHER URINARY ORGANS
- 2) Add D30.00-D30.02 to line 228 effective when ICD-10 List is implemented
  - a. Keep on line 538
- 3) Modify the following guideline which was approved to be added to lines 228 and 538 at the March 2012 meeting

### **GUIDELINE NOTE XXX TREATMENT OF BENIGN NEOPLASM OF URINARY ORGANS**

*Line 228, 538*

Treatment of benign urinary system tumors (ICD-9 223.0, ICD-10 D30.00-D30.02) is covered with evidence of bleeding or urinary obstruction. Treatment of 1) oncocytoma which is >5 cm in size or symptomatic and 2) angiomyolipoma (AML) which is >5cm in women of child bearing age or in symptomatic men or women is covered.

## Partial/Total Colectomy

Question: Where should partial colectomy codes appear on the Prioritized List?

Question source: DMAP, HERC staff

Issue: DMAP brought a pairing question to HERC staff, requesting pairing of 211.3 (Benign neoplasm of Colon) with laparoscopic partial colectomy (CPT 44204-8) as well as 44213 [Laparoscopic mobilization of splenic flexure performed in conjunction with partial colectomy (secondary code to 44204 family)]. On review of this question, HERC staff determined that the partial colectomy codes were on inconsistent lines.

211.3 is on line 173 ANAL, RECTAL AND COLONIC POLYPS, which does not contain any of the partial or total laparoscopic colectomy codes. All of the open partial and total colectomy codes (CPT 44140-44160) are on line 173. Occasionally, patients will have part or all of their colon removed for multiple polyps. Usual HSC/HERC policy is to add laparoscopic codes to any line with comparable open codes.

### Recommendations:

- 1) Changes as outlined in following table
  - a. Key: X presently on line, X add, ~~X~~ delete
  - b. Makes placement consistent
- 2) Add laparoscopic partial and complete colectomy CPT codes to line 173 ANAL, RECTAL AND COLONIC POLYPS
  - a. 44140-44160, 44204-44213

**Partial/Total Colectomy**

<b>CPT code</b>	<b>Code description</b>	<b>Line 35</b>	<b>Line 48</b>	<b>Line 78</b>	<b>Line 84</b>	<b>Line 111</b>	<b>Line 163</b>	<b>Line 165</b>	<b>Line 191</b>	<b>Line 339</b>	<b>Line 503</b>	<b>Line 593</b>	<b>Line 666</b>	<b>Line 667</b>
44204	Laparoscopy, surgical; colectomy, partial, with anastomosis	X	X	<del>X</del>	X	<del>X</del>	<del>X</del>	X	X	<del>X</del>	<del>X</del>			X
44205	with removal of terminal ileum with ileocolostomy	X	X	<del>X</del>	X	<del>X</del>	<del>X</del>	X	X	<del>X</del>	<del>X</del>		<del>X</del>	<del>X</del>
44206	with end colostomy and closure of distal segment (Hartmann type procedure)	X	X	X	X	X	X	X	X	X	X			X
44207	with anastomosis, with coloproctostomy (low pelvic anastomosis)	X	X	X	X	X	X	X	X	X	X			X
44208	with anastomosis, with coloproctostomy (low pelvic anastomosis) with colostomy	X	X	X	X	X	X	X	X	X	X			X
44213	Laparoscopy, surgical, mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure)	X	X	X	X	X	X	X	X	X	X	<del>X</del>		<del>X</del>

Line 35 REGIONAL ENTERITIS, IDIOPATHIC PROCTOCOLITIS, ULCERATION OF INTESTINE

Line 48 INTUSSUCEPTION, VOLVULUS, INTESTINAL OBSTRUCTION, AND FOREIGN BODY IN STOMACH, INTESTINES, COLON, AND RECTUM

Line 78 NEUROLOGICAL DYSFUNCTION IN BREATHING, EATING, SWALLOWING, BOWEL, OR BLADDER CONTROL CAUSED BY CHRONIC CONDITIONS

Line 84 DEEP ABSCESSSES, INCLUDING APPENDICITIS AND PERIORBITAL ABSCESS; INTESTINAL PERFORATION

Line 111 CONGENITAL ANOMALIES OF DIGESTIVE SYSTEM AND ABDOMINAL WALL EXCLUDING NECROSIS; CHRONIC INTESTINAL PSEUDO-OBSTRUCTION

Line 163 ACUTE VASCULAR INSUFFICIENCY OF INTESTINE

Line 165 CANCER OF COLON, RECTUM, SMALL INTESTINE AND ANUS

Line 191 DIVERTICULITIS OF COLON

Line 339 CANCER OF ESOPHAGUS

Line 503 RECTAL PROLAPSE

Line 666 BENIGN POLYPS OF VOCAL CORDS

Line 667 BENIGN NEOPLASMS OF DIGESTIVE SYSTEM

## MINUTES

Health Technology Assessment Subcommittee  
Portland State Office Building, Room 1B  
800 NE Oregon Street, Portland, OR  
March 22, 2012, 1:00-4:00pm

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**Members Present:** Alissa Craft, DO, MBA; James MacKay, MD; Gerald Ahmann, MD; George Waldmann, MD.

**Members Absent:** none

**Staff Present:** Darren Coffman; Cat Livingston, MD, MPH; Dave Lenar.

**Also Attending:** Alison Little, MD (CEBP); Val King, MD, MPH (CEBP); Shannon Vandergriff (CEBP); Anna Thompson (Medtronic); Dena Scarce (Medtronic); Anne Marie Licos (MedImmune); Ed Toggert (OHSU); Irene Crowell (HERC).

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### I. CALL TO ORDER AND INTRODUCTIONS

Dave Lenar called the first meeting of the Health Technology Assessment Subcommittee (HTAS) to order at 1:05 pm and the members and staff introduced themselves.

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### 2. ORIENTATION TO GOALS OF SUBCOMMITTEE

Darren Coffman explained the origin of the HTAS as one of three subcommittees created under the Health Evidence Review Commission (HERC). The HTAS will review and make recommendations on technology. He clarified the Value-based Benefits Subcommittee (VbBS) will examine issues related to the Prioritized List, the Evidence-based Guidelines Subcommittee (EbGS) will review practice guidelines, and drugs will be reviewed by the Pharmacy and Therapeutics Committee outside of the HERC.

The Health Technology Assessment Subcommittee (HTAS) will initially look at creating guidance documents along with the EbGS for several months. Following this period the HTAS will be reviewing technologies, continuing on with the work that the Health Resources Commission (HRC) was previously overseeing.

The goal for HTAS and EbGS is to have 20-30 guidelines or coverage guidances developed in the next 6 months. These coverage guidances will be evidence-based and looking at the most efficient ways to guide resources, control costs, and improve health care. These coverage guidances will be based on evidence reviews that have already been produced by trusted sources.

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### 3. ELECTION OF CHAIR AND VICE-CHAIR

Alissa Craft was nominated to be Chair and the motion was seconded. **Motion approved 4-0.** Jim MacKay was then nominated to be Vice-Chair and the motion was seconded. **Motion approved 4-0.**

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#### **4. REVIEW PROCESS OF DEVELOPMENT OF HEALTH TECHNOLOGY ASSESSMENTS AND COVERAGE GUIDANCE**

Dave Lenar reviewed the process documents for coverage guidance and technology assessments. Coverage guidance documents will take about three months to produce and technology assessments about 4-5 months. The EbGS will concurrently be developing coverage guidances as well.

The HERC has identified topics to be reviewed by the HTAS for coverage guidance development as will suggest topics for technology assessments in the future.

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#### **5. DISCUSSION OF THE PUBLIC INPUT PROCESS**

Darren Coffman discussed the process for public input for health technology assessments and presented a document outlining the proposed process. Under the proposed process, the HTAS would publically identify the selected topics for discussion at least 30 days prior to the scheduled meeting. Meeting materials would be posted 14 days prior to the HTAS meeting. Any reports generated by the HTAS should be posted 14 days prior to the HERC meeting at which it will be considered for approval.

There was discussion about making the 30 days public identification time flexible since there may be fewer than 30 days between meetings. Timelines may be somewhat different for the coverage guidance development process since these will each be based on a single existing evidence report instead of involving a more thorough investigation of all available evidence on a topic.

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#### **6. ORIENTATION TO THE USE OF EVIDENCE**

Martha Gerrity from the Center for Evidence-based Policy (CEbP) gave a presentation of the use of evidence in making health policy decisions. She described different methods of analyzing evidence to determine its quality, including systematic reviews, randomized control trials, and observational studies. She also discussed the key questions which should be asked when reviewing evidence. The subcommittee was presented with examples of health policy decisions which relied on poor evidence and resulted in poor outcomes for patients. Policies based on strong evidence are much less likely to cause harm.

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#### **7. REVIEW DRAFT COVERAGE GUIDANCE**

Dr. Cat Livingston reviewed the draft coverage guidance document on the use of MRI in breast cancer screening that was derived from the Washington HTA evidence review. There was a discussion about the lack of proven benefit on morbidity or mortality, as well as the concern about overdiagnosis leading to potential harms. An overall summary section was recommended to be included in the document, and information about the rationale for decision making was placed in the summary rather than the box including the coverage guidance.

It was clarified that this coverage guidance does not include diagnosis of breast cancer with I, which is felt to be an area of greater overuse without evidence of benefit. Dr. Ahmann explained that cancer is expected to be in neighboring breast tissue beyond that excised during a lumpectomy, and the purpose of post-lumpectomy radiation is to treat those other areas. It appears that MRI is often used right now in a diagnostic setting to identify those other affect

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areas of the breast; however, evidence does not show that further excision resulting from this additional imaging leads to improved outcomes beyond what is achieved through radiation. The members suggested this area be explored and considered by HERC as a separate coverage guidance topic.

Action item:

- 1) The recommended Screening Breast MRI Coverage Guidance be: Breast MRI should not be covered for screening for breast cancer.
- 2) Modify the coverage guidance document as discussed and post for public comment.
- 3) The Center will scope the topic of MRI In Diagnosis Of Breast Cancer and bring to HERC to see if it should be an additional coverage guidance topic.

**Motion to accept recommendations was approved 4-0.**

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## 10. PUBLIC COMMENT

There was no public comment.

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## 11. ADJOURNMENT

The meeting was adjourned at 3:55pm. The next meeting is scheduled for April 23, 2012 from 1:00-4:00 pm in Room 117B of the Meridian Park Hospital Community Health Education Center in Tualatin.

## MINUTES

Evidence-based Guidelines Subcommittee  
Clackamas Community College  
Wilsonville Training Center, Room 211  
29353 SW Town Center Loop E, Wilsonville, OR 97070  
March 1, 2012

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**Members Present:** Vern Saboe, DC; Som Saha, MD, MPH; Beth Westbrook, PsyD; Leda Garside, RN; Irene Crowell, PharmD; Wiley Chan, MD; Steve Marks, MD.

**Members Absent:** none

**Staff Present:** Darren Coffman; Ariel Smits, MD, MPH; Cat Livingston, MD, MPH; Dave Lenar; Margie Fernando.

**Also Attending:** Alison Little, MD (CEBP); Val King, MD, MPH (CEBP); Shannon Vandergriff (CEBP); Anna Thompson (Medtronic); Joanie Cosgrove (Medtronic); Jessie Little (ASU); Paul Nielsen (MedImmune); Eric Stecker (OHSU).

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### I. CALL TO ORDER AND INTRODUCTIONS

Cat Livingston called the first meeting of the Evidence-based Guideline Subcommittee (EbGS) to order at 2:05 pm and the members and staff introduced themselves.

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### 2. ORIENTATION TO GOALS OF SUBCOMMITTEE

Darren Coffman explained the origin of the EbGS as one of three subcommittees created under the Health Evidence Review Commission. He clarified the Value-based Benefits Subcommittee (VbBS) will examine issues related to the Prioritized List, the Health Technology Assessment Subcommittee (HTAS) will technologies, and drugs will be reviewed by the Pharmacy and Therapeutics Committee.

The Evidence-based Guidelines Subcommittee (EbGS) will look at evidence-based guidelines, continuing on with the work that the Health Services Commission (HSC) was overseeing last year which resulted in the guideline on the evaluation and management of low back pain. The Center for Evidence-based Policy (CEBP) was working with HSC staff, in collaboration with QCorp and Oregon Health Leadership Council, which are now represented on this subcommittee.

The goal is to have 20-30 guidelines or coverage guidances developed in the next 6 months. These coverage guidances will be evidence-based and looking at the most efficient ways to guide resources, control costs, and improve health care. These coverage guidances will be based on evidence reviews that are already out there. Simultaneously, EbGS will also be doing full evidence-based guidelines development, a longer process involving in-depth evidence searches by the Center for Evidence-based Policy from which shorter coverage guidance documents can also be developed.

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### 3. ELECTION OF CHAIR AND VICE-CHAIR

Wiley Chan was elected to be Chair. Som Saha was nominated to be Vice-Chair; however, due to his other roles with the HERC, felt that another nominee may be preferable. Steve Marks was then elected to be Vice-Chair.

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### 4. REVIEW PROCESS OF DEVELOPMENT OF GUIDELINES AND COVERAGE GUIDANCE

Dr. Livingston reviewed the process documents for coverage guidelines and EbGS guidelines. In addition to helping to guide and assess appropriate clinical care members suggested they could potentially be used as safe harbor for malpractice and for quality ratings of providers. Coverage guidance documents will take about three months to produce and full guidelines about 5-6 months. The HTAS will concurrently be developing coverage guidances as well.

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### 5. PRIORITIZATION OF TOPICS FOR COVERAGE GUIDANCE

Livingston introduced the document summarizing future topics. Some of these topics may be tabled or dismissed if they are found to be inappropriate for a guideline or if they are prioritized low. When a guideline has several different core areas of treatment, such as surgical intervention and non-surgical intervention, separate coverage guidances may be developed. Lack of evidence by itself would not be a reason to dismiss a topic if there are other compelling reasons to proceed, such as less expensive alternatives.

Dividing up topics to EbGS and HTAS for coverage guidance have occurred based on the elements of technology assessments and comparative effectiveness, which have gone to HTAS, and clinical practice which have gone to EbGS. If there is an imbalance of work in the future between the two subcommittees, topics may be rearranged as well.

#### Action Items:

In reviewing the draft prioritization of topics, several changes were made.

1. Ultrasound in low risk pregnancy is moved to high priority. Transvaginal and abdominal ultrasound (and both together) will need to be addressed in this guidance.
    - Rationale: if there are no compelling reasons to do a procedure, without evidence of benefit where there is evidence, this is a good topic for a guideline/guidance
  2. Chronic kidney disease was moved to low priority
    - Rationale: Sounds like a clinical practice guideline
  3. Change PET to medium priority
    - Rationale: because MED report not public and Washington HTA only addresses lymphoma
  4. Nonpharmacological treatment of depression is moved to high priority
    - Rationale: societal cost of refractory depression; although may need to be clinical practice guideline on refractory depression
- 

### 6. REVIEW DRAFT COVERAGE GUIDANCE

#### A. ELECTIVE INDUCTION OF LABOR

There was a concern about loopholes given the lack of clear guidance on appropriate medical and obstetric indications for induction. Induction of labor is both patient and provider driven.

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There is evidence that elective induction of labor is associated with higher rates of cesarean section, longer hospital stays, and increased NICU stays. Therefore, given there is evidence of harm, with benefit primarily being for convenience in those cases without medical/obstetric indication, members felt guidance indicated.

Some indications for medical and obstetric indications have strong evidence, but many areas of weak evidence. There were concerns about being overly restrictive by specifying which indications are appropriate when evidence is so weak.

The question was raised as to why we are not addressing up to 41 if the only indication is convenience. The evidence supports harms for less than 39 weeks, above 41-42 weeks there is evidence of benefit, and between 39 to 41 weeks, it depends.

The new guidance should reflect the following:

- 1) Elective induction of labor <39 weeks should not be a covered service
- 2) Which medical indications show evidence of benefit
- 3) Which medical indications show no evidence of benefit
  - a. Induction for macrosomia (in absence of diabetes) should not be a covered service
- 4) Which medical indications have insufficient evidence of benefit

**Action items:**

1. Staff and CEBP to see if they can:
  - a. Evaluate how evidence allows teasing out of harms <39 weeks and <41 weeks
  - b. Come back with more detail on specific obstetric and medical indications that would be helpful in defining elective

**B. CESAREAN SECTION ON MATERNAL REQUEST**

There were issues raised about the prevalence of this, which is estimated to be under 5% of cesareans. Vaginal births after cesarean would not be affected by this guideline as prior cesarean is considered a potential medical indication. It was also clarified that there is clear harm compared to vaginal delivery. Committee members felt there was more clarity on the meaning of elective by removing maternal request.

**Action:**

1. Change guidance to:  
Cesarean delivery ~~on maternal request~~ without medical or obstetrical indication should not be a covered service.

**C. EVALUATION AND MANAGEMENT OF LOW BACK PAIN**

Several options for guidance detail were reviewed. Members felt that it was appropriate to break up guidelines into several different guidance documents if there was clear distinctions (e.g. pharmacologic versus non-pharmacologic therapy). Staff clarified that there would be further discussion with the P&T committee to ensure appropriate coordination of pharmaceutical class guidance.

**Action Items**

1. Adopt succinct evidence summary (i.e. recommendations only in the LBP guidance) and place hyperlinks into the guideline
2. Ensure source guideline is located on HERC's server with appropriate permissions
3. Include cover page/disclaimer, but include explanation on purpose of the EbGS

4. Remove first paragraph referring to history and physician and neurologic exam.
    - Rationale: not as much a coverage guidance, as a guideline.
  5. Adopt non-pharmacological treatment coverage guidance with following changes:
    - a. Alphabetize treatments
    - b. Leave “may”, meaning that individual plans can choose which to cover. Insert asterisk indicating there is evidence these treatments work and individual insurance plans may choose to cover some or all of them
    - c. Un-italicize yoga and progressive relaxation treatments, as plans may choose to cover different things in the future.
    - d. Specify which type of yoga (viniyoga)
- 

## **7. REVIEW OF GUIDELINES CURRENTLY UNDERWAY**

### **A. ADVANCED IMAGING FOR LOW BACK PAIN**

Alison Little presented the guideline. It was clarified that each peer review comment was discussed and a disposition was made, which will be made available. There was a lengthy discussion about Table B, in that it was not seen as very instructive for clinicians, with the concern raised that many clinicians would not know what the L4 & L5 reflexes were and thus would not be able to effectively determine what the guideline recommended. In the context of overuse of MRI, this was felt to be important. Additionally, a concern was raised about the lack of clarity of emergence of imaging in cauda equina and other signs of cancer. However, there was then a discussion about the role of the EbGS in operationalizing the guidances with several members feeling that that was outside of the purview of the EbGS, with too much detail becoming more education than guidance.

#### **Action:**

1. Staff to work with Dr. Saboe to develop alternative option with further details to present back for discussion.

### **B. PERCUTANEOUS INTERVENTIONS FOR LOW BACK PAIN**

This discussion was tabled until the next meeting

### **C. SPINAL FUSION**

Given that the current guidelines available do not address the full scope pertaining to spinal fusion, and an AHRQ report is due in 12-18 months, this guideline is being tabled.

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## **9. PUBLIC COMMENT**

There was no public comment.

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## **10. ADJOURNMENT**

The meeting was adjourned at 5:02pm. The next meeting is scheduled for April 5, 2012.

## Advanced Imaging for Low Back Pain

State of Oregon Evidence-based  
Clinical Guidelines Project  
April 12, 2012



Center For Evidence-based Policy

## Background

- Direction to develop guidelines comes from “Oregon’s Action Plan for Health” released in December 2010
  - Eight foundational strategies
  - One strategy is to set standards for safe and effective care
    - “Identify and develop ten sets of Oregon-based best practice guidelines and standards”
- Work completed by Guideline Development Group (GDG), consisting of representatives of
  - Oregon Health Authority
  - Oregon Healthcare Leadership Council
  - Oregon Corporation for Healthcare Quality
  - Technical support from Center for Evidence-based Policy



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Center For Evidence-based Policy

## Background

- One of the first 10 Guidelines chosen to be developed
- Criteria for choosing topics:
  - Areas of high utilization
  - Areas of high cost
  - Areas with high variation
  - Good evidence available to support optimal practice
- Other related topics include:
  - Evaluation and Management of Low Back Pain
  - Advanced Imaging for Low Back Pain
  - Spinal Fusion (now on hold)



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Center For Evidence-based Policy



## Guideline Methods

- Methods: 17 databases searched for candidate guidelines with the following characteristics:
  - evidence-based, that is, guideline recommendations are based on systematic reviews of the literature,
  - address the use of percutaneous interventions in adults with chronic back pain,
  - published in English and,
  - freely available to the public.



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Center For Evidence-based Policy

## Guideline Methods

### Methods cont.

- 9 identified (3 rated poor from prior work, 1 not sufficiently comprehensive, remaining 5 assessed for methodological quality)
- The two good quality guidelines were examined further
- GDG chose ACP/APS guideline as base because it was most comprehensive
  - Chou, R., Qaseem, A., Snow, V., Cross, J.T. Jr., Shekele, P., Owens, D.K., Clinical Efficacy Assessment Subcommittee of the American College of Physicians, American College of Physicians, American Pain Society Low Back Pain Guidelines Panel (2007). Diagnosis and treatment of low back pain: An joint clinical practice guideline from the American College of Physicians and the American Pain Society. Ann Intern Med 147:7:478-91



5



## Guideline Recommendations

### Guideline includes three main recommendations:

1. Clinicians **should not** routinely obtain imaging in patients with nonspecific low back pain.
2. Clinicians should perform diagnostic imaging and testing for patients with low back pain when severe or pro-gressive neurologic deficits are present or when serious underlying conditions are suspected on the basis of history and physical examination.
3. Clinicians should evaluate patients with per-sistent low back pain and signs or symptoms of radiculopathy or spinal stenosis with magnetic resonance imaging (preferred) or computed tomography only if they are potential candidates for surgery or epidural steroid injection (for suspected radiculopathy).



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## Guideline Recommendations

- Addresses plain radiography, CT, MRI (not myelography)
- Includes strength of recommendation, quality of evidence grade
- Table B presents potentially serious conditions (“red flags”) and recommendations for initial diagnostic work up
  - Cancer
  - Spinal column infection
  - Cauda equina syndrome
  - Vertebral compression fracture
  - Ankylosing spondylitis
  - Nerve compression/disorders
  - Spinal stenosis



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## Peer Review

- Draft guideline peer-reviewed November 2011
- Solicited comments from 34 peer reviewers from the following specialties:
 

– Behavioral Health	– Pain Advocacy
– Complementary & Alternative Medicine (including Chiropractic)	– Pain Medicine
– Evidence-based Medicine	– Physical Therapy
– Family Medicine	– Physical Medicine & Rehabilitation
– Internal Medicine	– Radiology
– Occupational Medicine	– Sports Medicine
– Orthopedic Surgery	– Worker’s Compensation
– Neurosurgery	
- Responses received from 9
- Comments reviewed by GDG and incorporated as appropriate



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## Public Comment

- Draft guideline posted for public comment Feb 17-March 18
- No comments received
- Evidence-based Guideline Subcommittee reviewed first on March 1, changes made and revision approved April 5
- Now due for final adoption/approval by HERC

# State of Oregon Evidence-based Clinical Guidelines Project

## Advanced Imaging for Low Back Pain

A Clinical Practice Guideline Based on the Joint Practice Guideline of  
the American College of Physicians and the American Pain Society  
(Diagnosis and Treatment of Low Back Pain)

February 2012



## Guideline Development Group

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## Suggested Citation

Livingston, C., Little, A., King, V., Pettinari, C., Thielke, A., Vandegriff, S., & Gordon, C. (2012). *State of Oregon Evidence-based Clinical Guidelines Project. Advanced imaging for low back pain: A clinical practice guideline based on the joint practice guideline of the American College of Physicians and the American Pain Society (Diagnosis and treatment of low back pain)*. Salem: Office for Oregon Health Policy & Research. Available at: <http://www.oregon.gov/OHA/OHPR/HERC/Evidence-Based-Guidelines.shtml>

This document was prepared by the Center for Evidence-based Policy at Oregon Health & Science University (the Center) on behalf of the Guideline Development Group and the Office for Oregon Health Policy & Research. This document is intended to help providers, consumers and purchasers of health care in Oregon make informed decisions about health care services. The document is intended as a reference and is provided with the understanding that neither the Center nor the Guideline Development Group are engaged in rendering any clinical, legal, business or other professional advice.

These guidelines should not be construed as dictating an exclusive course of treatment or procedure. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the institution or type of practice.

The statements in this document do not represent official policy positions of the Center, the Guideline Development Group, or the Office for Oregon Health Policy and Research. Researchers and authors involved in preparing this document have no affiliations or financial involvement that conflict with material presented in this document.

**Objective:**

This guideline was developed by a collaborative group of public and private partners to provide up-to-date evidence-based guidance on the role of advanced imaging in low back pain. The guideline offers recommendations for the use of advanced imaging for evaluation of low back pain of any duration. The aim of the guideline is to identify evidence-based, appropriate indications for imaging of non-pregnant adults with low back pain. This guideline can then be used to create practice standards and coverage guidelines for use across public and private payers. Additional evidence concerning other elements of evaluation as well as recommendations for management of low back pain can be found in the State of Oregon Evidence-based Clinical Guidelines:

- Evaluation and Management of Low Back Pain<sup>1</sup> and
- Percutaneous Interventions for Low Back Pain<sup>2</sup>.

**Background to the Oregon Evidence-based Clinical Guidelines Project:**

In June 2009, the Oregon legislature passed health reform legislation, HB 2009, which created the Oregon Health Policy Board and charged it with creating a comprehensive health reform plan for our state. In December 2010, the Board released *Oregon's Action Plan for Health*, which lays out "strategies that reflect the urgency of the health care crisis and a timeline for actions that will lead Oregon to a more affordable, world-class health care system." They outlined eight foundational strategies, one of which is to "set standards for safe and effective care." To accomplish this, the plan directs the state to "Identify and develop 10 sets of Oregon-based best practice guidelines and standards that can be uniformly applied across public and private health care to drive down costs and reduce unnecessary care. This work will be conducted by the Health Services Commission and Health Resources Commission in close collaboration with providers, the Center for Evidence-Based Practice, and other key stakeholders."<sup>3</sup>

**Development of this guideline:**

This guideline was developed by a Guideline Development Group (GDG) consisting of representatives from the State's Health Authority with support from clinical evidence specialists from the Center for Evidence-based Policy. The Center provided expertise in the process of guideline development and undertook analysis and appraisal to support the development of this guideline.

**Methods:**

The GDG developed this guideline using the ADAPTÉ<sup>4</sup> framework which is a systematic approach to the endorsement or modification of guideline(s) produced in one cultural context or organizational setting for application in another context or setting. Guideline adaptation is used as an alternative to wholly

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<sup>1</sup> Livingston, C., King, V., Little, A., Pettinari, C., Thielke, A., & Gordon, C. (2012). *State of Oregon Evidence-based Clinical Guidelines Project. Evaluation and management of low back pain: A clinical practice guideline based on the joint practice guideline of the American College of Physicians and the American Pain Society (Diagnosis and treatment of low back pain)*. Salem: Office for Oregon Health Policy and Research.

<sup>2</sup> Livingston, C., Little, A., King, V., Pettinari, C., Thielke, A., Pensa, M., Vandegriff, S., & Gordon, C. (2012). *State of Oregon Evidence-based Clinical Guidelines Project. Percutaneous interventions for low back pain: A clinical practice guideline based on the 2009 American Pain Society Guideline (Interventional Therapies, Surgery, and Interdisciplinary Rehabilitation for Low Back Pain)*. Salem: Office for Oregon Health Policy and Research.

<sup>3</sup> Effective January 1, 2012, House Bill 2100 (2011) terminates the Health Services Commission and Health Resources Commission and transfers their duties related to evidence-based guideline development to a new Health Evidence Review Commission.

<sup>4</sup> <http://www.adapte.org/www/>

new guideline development, which can be time consuming, expensive and an inefficient use of resources, when existing quality guidelines are available.

The process for developing this guideline began by searching 17 different databases and other sources for guidelines related to Imaging for Low Back Pain (see appendix A). Candidate guidelines were required to satisfy the following requirements:

- To be evidence-based, that is, guideline recommendations are based on systematic reviews of the literature,
- to address the use of advanced imaging in adults with low back pain,
- to be published in English and,
- to be freely available to the public.

The GDG required that evidence-based recommendations be made on the basis of both the quality and strength of the underlying data from the guideline's systematic reviews.

The initial search identified nine guidelines which met the above stated criteria (Appendix B). Of the nine original candidate guidelines, three were rated as poor quality during the development of a previous State of Oregon guideline<sup>5</sup> and one was not sufficiently comprehensive (did not address the use of MRI or CT scanning) to warrant further assessment. The five remaining guidelines were then assessed for methodological quality using a modified AGREE II<sup>6</sup> (Appraisal of Guidelines Research and Evaluation) instrument (Appendix C). Assessments were conducted by two guideline quality assessors from the Center for Evidence-based Policy and discordant ratings were reconciled through further review and consensus. Two of the five guidelines were rated good quality, and the other three were rated fair quality. The two good quality guidelines were then examined further for scope and clarity of presentation.

After considering guideline scope and specific imaging modalities addressed, the GDG selected the American College of Physicians/ American Pain Society (ACP/APS) guideline as the base guideline, primarily because it had recommendations concerning the use of CT scanning, thermography and electrophysiology testing which were lacking in the National Institute for Clinical Excellence (NICE) guideline. Neither guideline addressed myelography. The ACP/APS guideline in its entirety can be found at the following link: <http://www.annals.org/content/147/7/478.long>. The ACP/APS guideline is accompanied by a full systematic review on imaging strategies for low back pain (<http://www.annals.org/content/147/7/492.full.pdf+html>).

The ACP/APS guideline used the ACP's guideline grading system that was adapted from the Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) working group<sup>7</sup>. Guideline recommendations were rated as either strong or weak. Strong recommendations were required to have clear evidence of benefit or harm. Weak recommendations were based on finely balanced benefits, risks and burdens. The overall strength of evidence for each intervention was rated based on factors such as the quality, quantity, consistency, generalizability and directness of the evidence. The ACP/APS guideline

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<sup>5</sup> Evaluation and Management of Low Back Pain: A Clinical Practice Guideline Based on the Joint Practice Guideline of the American College of Physicians and the American Pain Society (Diagnosis and Treatment of Low Back Pain) (2011).

<sup>6</sup> <http://www.agreecollaboration.org/>

<sup>7</sup> <http://www.gradeworkinggroup.org/>

panel considered interventions to have “proven” benefit if there was at least fair quality evidence of moderate or substantial benefit (or of small benefit with no significant harms, costs or burdens).

**Updating:**

The ACP/APS guideline was published in 2007. The authors of the guideline were contacted in March 2011 and stated that there had been no new published evidence which would change the recommendations of the guideline and that it was considered current. The GDG recommends that this guideline be reevaluated if the ACP/APS issues an updated guideline and at least every two years for currency if the original guideline is not updated.

**Recommendations**

Below are the recommendations of the ACP/APS clinical practice guideline, followed by discussion of each recommendation. These recommendations are further supported by a systematic review and meta-analysis of imaging strategies published in 2009<sup>8</sup>, as well as Best Practice Advice from the American College of Physicians published in 2011<sup>9</sup>.

**Table A: State of Oregon Evidence-based Clinical Guideline Recommendations for Advanced Imaging for Evaluation of Low Back Pain**

Recommendations		
Recommendation	Content	Strength of Recommendation & Evidence Grade
1. Routine Imaging for non-specific pain (X-ray, CT, MRI)	Clinicians <b>should not</b> routinely obtain imaging in patients with nonspecific low back pain.	Recommendation: Strong Grade: Moderate-quality evidence
2. Imaging for underlying conditions present or suspected (X-ray, CT, MRI)	Clinicians should perform diagnostic imaging and testing for patients with low back pain when severe or progressive neurologic deficits are present or when serious underlying conditions are suspected on the basis of history and physical examination. (See Table B for a list of potentially serious conditions)	Recommendation: Strong Grade: Moderate-quality evidence
3. Advanced Imaging* (CT, MRI)	Clinicians should evaluate patients with persistent low back pain and signs or symptoms of radiculopathy or spinal stenosis with magnetic resonance imaging (preferred) or computed tomography only if they are potential candidates for surgery or epidural steroid injection (for suspected radiculopathy).	Recommendation: Strong Grade: Moderate-quality evidence

\*This guideline does not address the appropriate use of myelography or other advanced imaging other than CT and MRI

<sup>8</sup> Chou, R, Fu, R, Carrino, J & Deyo, R. (2009). Imaging strategies for low-back pain: systematic review and meta-analysis. *The Lancet*, 373(9662): 463-72.

<sup>9</sup> Chou, R, Qaseem, A, Owens, D, Shekelle, P for the Clinical Guidelines Committee of the American College of Physicians. (2011). Diagnostic imaging for low back pain: Advice for high-value health care from the American College of Physicians. *Annals of Internal Medicine*, 154(3), 181-189.

### **Recommendation #1<sup>10</sup>:**

There is no evidence that routine plain radiography in patients with nonspecific low back pain is associated with a greater improvement in patient outcomes than selective imaging (Deyo 1987, Kendrick 2001, Kerry 2002). In addition, exposure to unnecessary ionizing radiation should be avoided. This issue is of particular concern in young women because the amount of gonadal radiation from obtaining a two view radiographic exam of the lumbar spine is equivalent to being exposed to a daily chest radiograph for more than one year (Jarvik 2003a). Routine advanced imaging (computed tomography [CT] or magnetic resonance imaging [MRI]) is also not associated with improved patient outcomes (Gilbert 2004) and identifies many radiographic abnormalities that are poorly correlated with symptoms (Jarvik 2002) but could lead to additional, possibly unnecessary interventions (Jarvik 2003b, Lurie 2003). Plain radiography is recommended for initial evaluation of possible vertebral compression fracture in selected higher-risk patients, such as those with a history of osteoporosis or steroid use (Jarvik 2002). Evidence to guide optimal imaging strategies is not available for low back pain that persists for more than one to two months despite standard therapies if there are no symptoms suggesting radiculopathy or spinal stenosis, although plain radiography may be a reasonable initial option. (See recommendation 2 for imaging recommendations in patients with symptoms suggesting radiculopathy or spinal stenosis.) Thermography and electrophysiologic testing are not recommended for evaluation of nonspecific low back pain.

### **Recommendation #2<sup>11</sup>:**

Prompt work-up with MRI or CT is recommended in patients who have severe or progressive neurologic deficits or are suspected of having a serious underlying condition (such as vertebral infection, the cauda equina syndrome, or cancer with impending spinal cord compression) because delayed diagnosis and treatment are associated with poorer outcomes (Loblaw 2005, Todd 2005, Tsiodras 2006). Magnetic resonance imaging is generally preferred over CT if available because it does not use ionizing radiation and provides better visualization of soft tissue, vertebral bone marrow, and the spinal canal (Jarvik 2002). There is insufficient evidence to guide precise recommendations on diagnostic strategies in patients who have risk factors for cancer but no signs of spinal cord compression. Several strategies have been proposed for such patients (Jarvik 2002, Joines 2001), but none have been prospectively evaluated. Proposed strategies generally recommend plain radiography or measurement of erythrocyte sedimentation rate (a rate of  $\geq 20$  mm/h is associated with 78% sensitivity and 67% specificity for cancer [van den Hoogen 1995]), with MRI reserved for patients with abnormalities on initial testing (Jarvik 2002, Joines 2001). An alternative strategy is to directly perform MRI in patients with a history of cancer, the strongest predictor of vertebral cancer (Joines 2001). While age over 50 years may be considered a red flag and justify more immediate imaging, delaying imaging while offering standard treatments and reevaluating within 1 month may also be a reasonable option for patients without other risk factors for cancer (Suarez-Almazor 1997).

### **Recommendation #3<sup>12</sup>:**

The natural history of lumbar disc herniation with radiculopathy in most patients is for improvement within the first four weeks with noninvasive management (Vroomen 2002, Weber 1983). There is no

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<sup>10</sup> Extracted verbatim from Chou, et al. (2007)

<sup>11</sup> Extracted verbatim from Chou, et al. (2007)

<sup>12</sup> Extracted verbatim from Chou, et al. (2007)

compelling evidence that routine imaging affects treatment decisions or improves outcomes (Modic 2005). For prolapsed lumbar disc with persistent radicular symptoms despite noninvasive therapy, discectomy or epidural steroids are potential treatment options (Gibson 2000, Gibson 2005, Nelemans 2001, Peul 2007, Weinstein, 2006). Surgery is also a treatment option for persistent symptoms associated with spinal stenosis (Amundsen 2000, Atlas 2005, Weinstein 2007, Malmivaara, 2007).

Magnetic resonance imaging (preferred if available) or CT is recommended for evaluating patients with persistent back and leg pain who are potential candidates for invasive interventions—plain radiography cannot demonstrate discs or accurately show the degree of spinal stenosis (Jarvik 2002). However, clinicians should be aware that findings on MRI or CT (such as bulging disc without nerve root impingement) are often nonspecific. Recommendations for specific invasive interventions, interpretation of radiographic findings, and additional work-up (such as electrophysiologic testing) are beyond the scope of this guideline, but decisions should be based on the clinical correlation between symptoms and radiographic findings, severity of symptoms, patient preferences, surgical risks (including the patient’s comorbid conditions), and costs and will generally require specialist input.

Additionally, the Best Practice Advice from the American College of Physicians published in 2011<sup>13</sup> provides the following advice:

“The ACP has found strong evidence that routine imaging for low back pain by using radiography or advanced imaging methods is not associated with a clinically meaningful effect on patient outcomes. Unnecessary imaging exposes patients to preventable harms, may lead to additional unnecessary interventions, and results in unnecessary costs. Diagnostic imaging studies should be performed only in selected, higher-risk patients who have severe or progressive neurologic deficits or are suspected of having a serious or specific underlying condition. Advanced imaging with MRI or CT should be reserved for patients with a suspected serious underlying condition or neurologic deficits, or who are candidates for invasive interventions. Decisions about repeated imaging should be based on development of new symptoms or changes in current symptoms. Patient education strategies should be used to inform patients about current and effective standards of care.”

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<sup>13</sup> Chou, R, Qaseem, A, Owens, D, Shekelle, P for the Clinical Guidelines Committee of the American College of Physicians. (2011). Diagnostic imaging for low back pain: Advice for high-value health care from the American College of Physicians. *Annals of Internal Medicine*, 154(3), 181-189.

**Table B: Potentially Serious Conditions (“Red Flags”) and Recommendations for Initial Diagnostic Work-up**

Possible cause	Key features on history or physical examination	Imaging*	Additional studies*
Cancer	<ul style="list-style-type: none"> <li>History of cancer with new onset of LBP</li> </ul>	MRI	ESR
	<ul style="list-style-type: none"> <li>Unexplained weight loss</li> <li>Failure to improve after 1 month</li> <li>Age &gt;50 years</li> <li>Symptoms such as painless neurologic deficit, night pain or pain increased in supine position</li> </ul>	Lumbosacral plain radiography	
	<ul style="list-style-type: none"> <li>Multiple risk factors for cancer present</li> </ul>	Plain radiography or MRI	
Spinal column infection	<ul style="list-style-type: none"> <li>Fever</li> <li>Intravenous drug use</li> <li>Recent infection</li> </ul>	MRI	ESR and/or CRP
Cauda equina syndrome	<ul style="list-style-type: none"> <li>Urinary retention</li> <li>Motor deficits at multiple levels</li> <li>Fecal incontinence</li> <li>Saddle anesthesia</li> </ul>	MRI	None
Vertebral compression fracture	<ul style="list-style-type: none"> <li>History of osteoporosis</li> <li>Use of corticosteroids</li> <li>Older age</li> </ul>	Lumbosacral plain radiography	None
Ankylosing spondylitis	<ul style="list-style-type: none"> <li>Morning stiffness</li> <li>Improvement with exercise</li> <li>Alternating buttock pain</li> <li>Awakening due to back pain during the second part of the night</li> <li>Younger age</li> </ul>	Anterior-posterior pelvis plain radiography	ESR and/or CRP, HLA-B27
Nerve compression/ disorders (e.g. herniated disc with radiculopathy)	<ul style="list-style-type: none"> <li>Back pain with leg pain in an L4, L5, or S1 nerve root distribution present &lt; 1 month</li> <li>Positive straight-leg-raise test or crossed straight-leg-raise test</li> </ul>	None	None
	<ul style="list-style-type: none"> <li>Radiculopathic symptoms present &gt;1 month</li> <li>Severe/progressive neurologic deficits, progressive motor weakness (such as foot drop)</li> </ul>	MRI**	Consider EMG/NCV
Spinal stenosis	<ul style="list-style-type: none"> <li>Radiating leg pain</li> <li>Older age</li> <li>Pain usually relieved with sitting</li> </ul> (Pseudoclaudication a weak predictor)	None	None
	<ul style="list-style-type: none"> <li>Spinal stenosis symptoms present &gt;1 month</li> </ul>	MRI**	Consider EMG/NCV

\* Level of evidence for diagnostic evaluation is variable

\*\* Only if patient is a potential candidate for surgery or epidural steroid injection

Red Flag: Red flags are findings from the history and physical examination that may be associated with a higher risk of serious disorders.

CRP = C-reactive protein; EMG = electromyography; ESR = erythrocyte sedimentation rate; MRI = magnetic resonance imaging; NCV = nerve conduction velocity.

Extracted and modified from Chou R, Qaseem A, Snow V, et al: *Diagnosis and Treatment of Low Back Pain: A Joint Clinical Practice Guideline from the American College of Physicians and the American Pain Society. Ann Intern Med. 2007; 147:478-491.*

## Appendix A. Sources Searched for Advanced Imaging for Low Chronic Back Pain Guidelines

1. British Medical Journal – Clinical Evidence
2. Cochrane Library
3. Agency for Healthcare Research and Quality
4. ECRI
5. Hayes, Inc
6. Veterans Administration – Technology Assessment Program (VA TAP)
7. Blue Cross Blue Shield HTA
8. Centers for Medicare and Medicaid
9. CADTH
10. Washington HTA Program
11. US Preventive Services Task Force
12. ICSI
13. Guidelines.gov
14. American College of Physicians AND American Pain Society
15. American Physical Therapy Association
16. PEDro.org.au (evidence-based physiotherapy database)
17. GIN Guidelines Database

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## Appendix B. Low Back Pain Guidelines Identified

### Methods Summary:

Initially, 17 databases and other sources for guidelines related to Advanced Imaging for Low Back Pain were searched. Candidate guidelines were required to:

- be evidence-based (recommendations based on a full systematic review)
- be comprehensive
- be published in English
- be freely available to the public

Nine pertinent guidelines were identified, of which five were sufficiently comprehensive and were assessed by two clinical epidemiologists for methodologic quality using a modified AGREE (Appraisal of Guidelines Research and Evaluation) II<sup>14</sup> instrument.

Candidate guidelines were then assessed considering:

- age
- source
- specific treatment elements addressed
- presentation

The GDG selected the two guidelines of highest quality that were most comprehensive. (See guideline text for comprehensive Methods discussion)

### Low Back Pain Guidelines Identified in Search – Selected for Quality Assessment

Brussieres, A.E., Taylor, J.A., & Peterson, C. (2008). Diagnostic imaging practice guidelines for musculoskeletal complaints in adults: An evidence-based approach-part 3: spinal disorders. *Journal of Manipulative and Physiological Therapeutics*, 31(1), 33-88.

**Overall guideline quality rating: Fair**

Chou, R., Qaseem, A., Snow, V., Casey, D., Cross, J.T. Jr., Shekelle, P., Owens, D.K., Clinical Efficacy Assessment Subcommittee of the American College of Physicians, American College of Physicians, American Pain Society Low Back Pain Guidelines Panel. (2007). Diagnosis and treatment of low back pain: A joint clinical practice guideline from the American College of Physicians and the American Pain Society. *Ann Intern Med*, 147(7), 478-91.

**Overall guideline quality rating: Good**

National Health and Medical Research Council. Australian Acute Musculoskeletal Pain Guidelines Group. (2003). Evidence-based management of acute musculoskeletal pain. (Website states that status is "current"). [Chapter 4 of document is on Acute Low Back Pain.]

<http://www.nhmrc.gov.au/files/nhmrc/file/publications/synopses/cp94.pdf>

**Overall guideline quality rating: Fair**

National Institute for Health and Clinical Excellence (NICE). (2009). Low back pain: Early management of persistent non-specific low back pain. London, UK: National Institute for Health and Clinical Excellence. Retrieved September 30, 2010, from <http://www.nice.org.uk/nicemedia/live/11887/44343/44343.pdf>

**Overall guideline quality rating: Good**

New Zealand Guidelines Group. (2004). New Zealand acute low back pain guide. Wellington, NZ: New Zealand Guidelines Group. Retrieved December 13, 2010, from

[http://www.nzgg.org.nz/guidelines/0072/acc1038\\_col.pdf](http://www.nzgg.org.nz/guidelines/0072/acc1038_col.pdf)

**Overall guideline quality rating: Fair**

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<sup>14</sup> <http://www.agreecollaboration.org/>

Low Back Pain Guidelines Identified in Search– Not Selected for Quality Assessment

Institute for Clinical Systems Improvement (ICSI). (2010). Adult low back pain. Fourteenth edition. Bloomington, MN: ICSI.

***Overall guideline quality rating: Poor***

Michigan Quality Improvement Consortium. (2008). Management of acute low back pain. Southfield, MI: Michigan Quality Improvement Consortium.

***Overall guideline quality rating: Poor***

Towards Optimized Practice. (2009). Management of low back pain. Edmonton, AB: Towards Optimized Practice Program.

***Overall guideline quality rating: Fair***

University of Michigan Health System. (2010). Acute low back pain. Ann Arbor, MI: University of Michigan Health System.

***Overall guideline quality rating: Poor***

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## Appendix C: Methodology Checklist Adapted from the AGREE II materials

Methodology Checklist: Guidelines		
Guideline citation <i>(Include name of organization, title, year of publication, journal title, pages)</i>		
Guideline Topic:		
Checklist completed by:		Date:
<b>SECTION 1: PRIMARY CRITERIA</b>		
<b>To what extent is there</b>		<b>Assessment/Comments:</b>
1.1	<b>RIGOR OF DEVELOPMENT: Evidence</b> <ul style="list-style-type: none"> <li>• Systematic literature search</li> <li>• Study selection criteria clearly described</li> <li>• Quality of individual studies and overall strength of the evidence assessed</li> <li>• Explicit link between evidence &amp; recommendations</li> </ul> <p><i>(If any of the above are missing, rate as poor)</i></p>	GOOD      FAIR      POOR
1.2	<b>RIGOR OF DEVELOPMENT: Recommendations</b> <ul style="list-style-type: none"> <li>• Methods for developing recommendations clearly described</li> <li>• Strengths and limitations of evidence clearly described</li> <li>• Benefits/side effects/risks considered</li> <li>• External review</li> </ul>	GOOD      FAIR      POOR
1.3	<b>EDITORIAL INDEPENDENCE<sup>15</sup></b> <ul style="list-style-type: none"> <li>• Views of funding body have not influenced the content of the guideline</li> <li>• Competing interests of members have been recorded and addressed</li> </ul>	GOOD      FAIR      POOR
<i>If any of three primary criteria are rated poor, the entire guideline should be rated poor.</i>		
<b>SECTION 2: SECONDARY CRITERIA</b>		
2.1	<b>SCOPE AND PURPOSE</b> <ul style="list-style-type: none"> <li>• Objectives described</li> <li>• Health question(s) specifically described</li> <li>• Population (patients, public, etc.) specified</li> </ul>	GOOD      FAIR      POOR

<sup>15</sup> Editorial Independence is a critical domain. However, it is often very poorly reported in guidelines. The assessor should not rate the domain, but write "unable to assess" in the comment section. If the editorial independence is rated as "poor", indicating a high likelihood of bias, the entire guideline should be assessed as poor.

**SECTION 2: SECONDARY CRITERIA, Cont.**

2.2	<p><b>STAKEHOLDER INVOLVEMENT</b></p> <ul style="list-style-type: none"> <li>• Relevant professional groups represented</li> <li>• Views and preferences of target population sought</li> <li>• Target users defined</li> </ul>	GOOD	FAIR	POOR
2.3	<p><b>CLARITY AND PRESENTATION</b></p> <ul style="list-style-type: none"> <li>• Recommendations specific, unambiguous</li> <li>• Management options clearly presented</li> <li>• Key recommendations identifiable</li> <li>• Application tools available</li> <li>• Updating procedure specified</li> </ul>	GOOD	FAIR	POOR
2.4	<p><b>APPLICABILITY</b></p> <ul style="list-style-type: none"> <li>• Provides advice and/or tools on how the recommendation(s) can be put into practice</li> <li>• Description of facilitators and barriers to its application</li> <li>• Potential resource implications considered</li> <li>• Monitoring/audit/review criteria presented</li> </ul>	GOOD	FAIR	POOR

**SECTION 3: OVERALL ASSESSMENT OF THE GUIDELINE**

3.1	How well done is this guideline?	GOOD	FAIR	POOR
3.2	Other reviewer comments:			

**Description of Ratings: Methodology Checklist for Guidelines**

The checklist for rating guidelines is organized to emphasize the use of evidence in developing guidelines and the philosophy that “evidence is global, guidelines are local.” This philosophy recognizes the unique situations (e.g., differences in resources, populations) that different organizations may face in developing guidelines for their constituents. The second area of emphasis is transparency. Guideline developers should be clear about how they arrived at a recommendation and to what extent there was potential for bias in their recommendations. For these reasons, rating descriptions are only provided for the primary criteria in section one. There may be variation in how individuals might apply the good, fair, and poor ratings in section two based on their needs, resources, organizations, etc.

**Section 1. Primary Criteria (rigor of development and editorial independence) ratings:**

- Good:** All items listed are present, well described, and well executed (e.g., key research references are included for each recommendation).
- Fair:** All items are present, but may not be well described or well executed.
- Poor:** One or more items are absent or are poorly conducted

## Appendix D. List of Peer Reviewers

### **Invited: Accepted & Reviewed**

**Susan Bamberger, PT, MPT, DIP MDT**

Past President

Oregon Physical Therapy Association

**Dianna Bardo, MD**

Associate Professor, Radiology

Oregon Health & Science University

**Roger Batchelor, DAOM, LAC**

Associate Professor

National College of Natural Medicine

**Roger Chou, MD**

Scientific Director, Oregon Evidence-based Practice Center

Associate Professor of Medicine, Division of General Internal Medicine and Geriatrics

Oregon Health & Science University

**Rahul N. Desai, MD**

Musculoskeletal/Interventional Pain Radiologist

EPIC Imaging

**Rick Deyo, MD, MPH**

Kaiser Permanente Professor of Evidence-Based Family Medicine

Director, KL2 Multidisciplinary Clinical Research Career Development Program

Director, OCTRI Community and Practice-based Research Program

Departments of Family Medicine and Internal Medicine

Oregon Health & Science University

**Dorothy Epstein, DPT, OCS**

Physical Therapist

Legacy Good Samaritan Pain Management Center

Legacy Good Samaritan Outpatient Rehabilitation

**Marc Gosselin, MD**

Associate Professor

Director, Thoracic Imaging

Department of Diagnostic Radiology

Oregon Health & Science University

**Mitch Haas, DC, MA**

Associate Vice President of Research

University of Western States

**LaVerne A. Saboe, Jr., DC, DACAN, FICC, DABFP, FACO**

Chiropractic Physician

Past president, Chiropractic Association of Oregon

**Invited: Declined/Did Not Respond/Did Not Review**

Nineteen additional reviewers were invited but either declined, did not respond, missed the deadline or did not return the review. Areas of professional expertise for invited reviewers included:

Anesthesiology  
Behavioral Health  
Complementary and Alternative Medicine  
Family Medicine  
Internal Medicine  
Occupational Medicine  
Orthopedic Surgery  
Neurosurgery  
Pain Advocacy  
Pain Medicine  
Physical Therapy  
Physical Medicine and Rehabilitation  
Radiology  
Sports Medicine  
Worker's Compensation

DRAFT

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## HERC Coverage Guidance Process

This process, and any revisions to it, will be made by the Health Evidence Review Commission, with recommendations and other input from its subcommittees encouraged. Separate HERC processes should be consulted for the development of evidence-based guidelines, health technology assessments and the review of topics involving the placement of services on the Prioritized List of Health Services.

### Overview

ORS 414.698 directs the HERC to conduct health technology assessments and develop evidence-based guidelines in an effort to use the best existing evidence to inform purchasing decisions by public programs in order to use its limited resources in the most effective manner. In a further effort to use existing evidence to the degree possible, the HERC is also developing coverage guidance using existing evidence reports from trusted sources such as the [MED Project](#)<sup>1</sup>, [Washington Health Technology Assessment Program](#), and [AHRQ](#)<sup>2</sup>. Such guidance will succinctly give direction on whether evidence indicates that certain health services should be covered as part of a standard benefit package, should be covered only under specific circumstances or with other limitations, or should not be covered.

### Topic Selection

Topics will be selected for potential coverage guidance development at a HERC meeting. Just because a topic is added to this list does not guarantee that a coverage guidance will be developed on that topic or that the topic will ever be reviewed. Topics will come from existing evidence reports from trusted sources and completed HERC evidence-based guidelines or health technology assessments. Topics with an existing report from a trusted source over three years old will not be added to the list for potential coverage guidance development. Prioritization of the topics may come from HERC or may be delegated to HERC staff or the EbGS or HTAS.

### Originating Body

Coverage guidance may be assigned to either the Evidence-based Guidelines Subcommittee (EbGS) or Health Technology Assessment Subcommittee (HTAS). In general, topics relating to technologies and devices will be assigned to the HTAS and other topics dealing with general medical & surgical or other health care services being reviewed by the EbGS. In some cases

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<sup>1</sup> The Medicaid Evidence-based Decisions (MED) Project is a self-governing collaboration of state Medicaid agencies (including 11 states as of April 2012) and their partners to provide policy-makers with the tools and resources they need to make evidence-based decisions.

<sup>2</sup> The US Department of Health & Human Services' Agency for Healthcare Research and Quality, which contracts with Evidence-based Practice Centers in the US and Canada (14 as of April 2012) to produce evidence reports and technology assessment for informing and developing coverage decisions.

topic assignments might deviate from this practice in order to centralize the discussion of related topics or to take advantage of the expertise of certain subcommittee members.

### Public Notice of Topic Review

At any point after a topic has been selected by the HERC for potential review, a public notice of at least 30 days may be given to indicate the initial discussion of that topic at an upcoming subcommittee meeting (EbGS or HTAS). Once discussions had begun at the subcommittee level on developing coverage guidance on a topic a full 30-day notice need not proceed continued discussion of that topic at subsequent meetings of that same subcommittee. Instead it should be assumed that discussion on that topic will continue at subsequent meetings of that subcommittee until either a final draft coverage guidance is complete for HERC consideration or a decision has been reached by the subcommittee to table further discussion of the topic or discontinue its review. While staff will make every effort to give as much advanced notice of the continued discussion of a topic at subsequent meetings, unforeseen events may dictate the elimination of substantive discussion of a topic at an upcoming meeting or the cancellation of a meeting in its entirety. Realize also that due to time constraints it is possible for a topic that was intended to be discussed at a meeting not have a discussion due to time constraints. Please consult the HERC's homepage at [www.oregon.gov/OHA/OHPR/HERC](http://www.oregon.gov/OHA/OHPR/HERC) prior to attending a meeting. Subscribing to the HERC's e-subscribe service will insure timely notice of all HERC activities. If two meetings of a subcommittee pass without a previously discussed topic appearing on the agenda, another 30-day public notice must precede a renewed discussion of the topic.

### Consideration of Initial Draft of Coverage Guidance

At the first meeting in which the subcommittee will discuss a topic, HERC staff will present a draft document which includes a draft version of the coverage guidance in a highlighted box, along with a summary of the evidence source that it was derived from, written by staff of the Center for Evidence-based Policy. In cases where the evidence source is not publicly available, this summary will be more comprehensive.

After discussion at one or more meetings, the subcommittee may accept the initial draft as presented or make modifications to it in creating a final draft. The subcommittee may also decide that it is not appropriate to develop a coverage guidance on a particular topic at that time and suggest to the HERC that the topic be tabled for future potential consideration. Written and verbal public testimony will be accepted, according to HERC policies and procedures, in conjunction with all subcommittee and commission meetings at which a topic is discussed.

### Public Comment on Final Draft of Coverage Guidance

If a final draft coverage guidance is approved by one of the subcommittees, it will be posted as soon as possible (usually within one week) to the HERC website at [www.oregon.gov/OHA/OHPR/HERC/Coverage-Guidance.shtml](http://www.oregon.gov/OHA/OHPR/HERC/Coverage-Guidance.shtml) for a 30-day public comment period. Comments should be limited to 500 words and be emailed to [HERC\\_info@state.or.us](mailto:HERC_info@state.or.us). Those providing comment should consult the Commission's *Guidelines for Submitting Materials*

at [www.oregon.gov/OHA/OHPR/HERC/docs/Submitted-Materials.pdf](http://www.oregon.gov/OHA/OHPR/HERC/docs/Submitted-Materials.pdf) if citing additional evidence sources.

### Consideration of Public Comment

After the conclusion of the public comment period, the subcommittee will review the comments at its earliest opportunity. If no comments are received or the subcommittee deems that the comments received do not warrant changes to the final draft coverage guidance, the subcommittee may forward the document without change as their recommendation to the HERC. If changes are made as the result of public comment the subcommittee may, at their discretion, post the revised version for an additional comment period of no less than 21 days if they feel the changes are significant enough to warrant such an action, or they may immediately forward the revised coverage guidance on to the HERC. If changes are made to the final draft posted for public comment due to further consideration of the subcommittee and not due to public comments received, the revised coverage guidance must be posted for an additional public comment period of no less than 21 days. If the subcommittee finds that the public comments included credible evidence not previously considered and believes it may change their recommendation, they may direct the CEbP to conduct a comprehensive evidence search on the area(s) addressed by the new evidence, whereby the subcommittee would review all new related evidence at a subsequent meeting.

### HERC Consideration

Once the EbGS or HTAS has approved a coverage guidance for recommendation to the HERC, the coverage guidance will be posted on the HERC website at [www.oregon.gov/OHA/OHPR/HERC/Coverage-Guidance.shtml](http://www.oregon.gov/OHA/OHPR/HERC/Coverage-Guidance.shtml) at least 7 days prior to the HERC meeting at which it will be considered. Upon reviewing the recommended coverage guidance and hearing any additional public testimony on the topic, the HERC may:

- 1) Accept the coverage guidance as written.
- 2) Make edits to the coverage guidance and accept as modified.
- 3) Return the coverage guidance to the Subcommittee with recommendations for further work.

### Distribution for Incorporation into Benefit Packages

In addition to posting a HERC adopted coverage guidance to its website at [www.oregon.gov/OHA/OHPR/HERC/Coverage-Guidance.shtml](http://www.oregon.gov/OHA/OHPR/HERC/Coverage-Guidance.shtml) and sending a notice to its e-subscribers, the HERC will:

- 1) Forward the coverage guidance to its Value-based Benefits Subcommittee for incorporation into the Prioritized List of Health Services. If the HERC is to consider a recommended coverage guidance at its January or August meetings, the coverage guidance may be considered for incorporation into the Prioritized List by the VbBS during its meeting on the morning of the HERC meeting so that the coverage

guidance can be reflected in the April 1<sup>st</sup> or October 1<sup>st</sup> interim modifications to the List to be approved at the HERC meeting that afternoon. Should the HERC make any changes to the recommended coverage guidance, the HERC may make corresponding changes to Prioritized List and/or its guidelines to reflect those revisions.

- 2) Notify the following organizations of the coverage guidance for potential incorporation in their benefit plans/services provided:
  - a. Coordinated Care Organizations and managed care organizations providing services to Oregon Health Plan clients
  - b. the administrator of the Public Employees Benefit Board (PEBB) and Oregon Employers Benefit Board (OEBB)
  - c. the administrator of the Office of Private Health Partnerships
  - d. the administrator of the PERS Health Insurance Program
  - e. the Medical Director of the Oregon Department of Corrections
  - f. the Executive Director of the Association of Oregon Counties
  - g. the Executive Director of the League of Oregon Cities
  - h. the Executive Director of the Special Districts Association of Oregon
  - i. the President of Metro

#### Updating

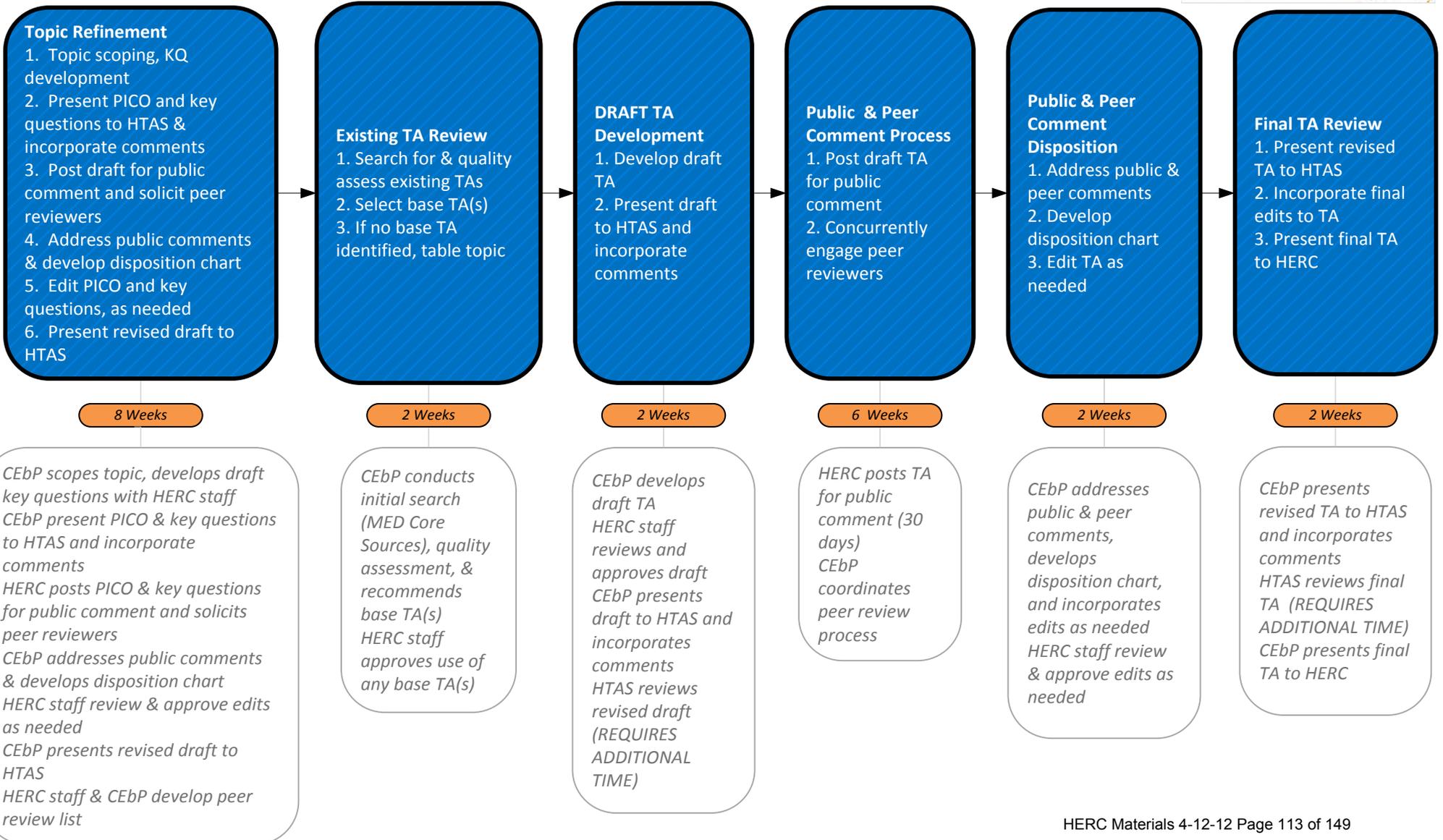
An existing coverage guidance must be reviewed by the HERC or one of its subcommittees at their earliest opportunity should the evidence report on which it was based be revised. Otherwise, the HERC or one of its subcommittees should review the need to update the coverage guidance within no later than every two years after its adoption.

The HERC developed and approved topic selection principles and established a preliminary topic list at the February 2012 meeting. The topic list will be revised periodically.

# HTAS Technology Assessment Development Process

**DRAFT 02/23/2012**  
**Timeline: 4-5 Months**

Center for Evidence-based Policy



## **Proposal for Public Input into Health Technology Assessment Process**

The Health Evidence Review Commission shall conduct comparative effectiveness research of health technologies by comprehensive review of the comparative effectiveness research undertaken by recognized state, national or international entities. The Commission shall identify approved sources of materials to serve as the basis for these reviews. The Commission may consider evidence relating to prescription drugs that is relevant to a health technology assessment but may not conduct a drug class evidence review or health technology assessment solely of a prescription drug.

### **Process Overview**

Health technology assessments shall be conducted by the Health Technology Assessment Subcommittee. Utilization of high quality sources of information assures uniformity and fairness in the evaluation process. The Subcommittee shall prepare a written report and conclusions at a public meeting with time allocated for public input. Depending on available evidence, the report may contain information regarding the science behind the assessed health technology, its appropriate indications for use, its benefits and risks and its clinical effectiveness relative to alternatives. The Subcommittee may also include other information it feels relevant that is found during its evaluation.

The Subcommittee shall present its report to the Commission at a public meeting with further opportunity for public comment.

After evaluating the report and public comments the Commission may take one of three actions:

- 1) Accept the report as written.
- 2) Make edits to the report and accept as modified.
- 3) Return the report to the Subcommittee with recommendations for further work.

Given the continuous evolution of medical technologies and how they are used, single-point-in-time assessments may need to be periodically reevaluated and updated. As significant new information and evidence regarding an assessed medical technology becomes available to the Commission, the Commission will evaluate the need for, and feasibility of, reassessing that technology.

## **Health Technology Assessment Subcommittee Process**

The selected topic shall be publically identified at least 30 days prior to the scheduled Subcommittee meeting, with meeting materials to be reviewed by the Subcommittee regarding health technology assessments posted at least 14 days prior to a meeting. The health technology assessment report generated during the Subcommittee meeting shall be posted at least 14 days prior to the full Commission meeting at which it will be considered. A majority of the members of the Subcommittee constitutes a quorum for the transaction of business.

Ad hoc experts may be used when expertise in the field of the review is desired as approved by the Commission and the Commission may delegate authority to the Subcommittee to appoint ex officio members for this purpose.

The Subcommittee shall formulate its report, conclusions and recommendations based on the information in materials incorporating the clinical context necessary for the information to be properly interpreted into useful information for policymakers.

Subcommittee meetings shall be public and conducted in a manner consistent with the Commission's policies and procedures, including those regarding written and verbal testimony.

After discussing the best evidence, the Subcommittee shall draw conclusions as to overall importance of beneficial effects, adverse effects, and compliance. If consensus is not possible, the decision shall be by majority vote.

Due to the nature of new technologies and the body of evidence related to them, reports shall contain an evaluation of the quality and sufficiency of available evidence for assessing the technical performance of the health technology, the strength of the recommendations and the confidence in the conclusions reflecting the power of the evidence.

## OREGON HERC CLINICAL EVIDENCE SOURCES

### Sources for Technology Assessments or Guidance

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Agency for Healthcare Research and Quality (AHRQ): Effective Healthcare Program

<http://effectivehealthcare.ahrq.gov/>

AHRQ Evidence Reviews

<http://www.ahrq.gov/clinic/epcix.htm>

AHRQ Health Technology Assessments

<http://www.ahrq.gov/clinic/techix.htm>

Blue Cross Blue Shield (BCBS)

<http://www.bcbs.com/blueresources/tec/tec-assessments.html>

British Medical Journal Clinical Evidence (*full text by subscription only*)

<http://clinicalevidence.bmj.com/ceweb/>

Canadian Agency for Drugs and Technologies in Health (CADTH)

<http://www.cadth.ca/index.php/en/hta/reports-publications/search>

Clinical Evidence (BMJ Publishing Group) (*full text by subscription only*)

<http://clinicalevidence.bmj.com>

Cochrane Library - (*full text by subscription only*) (limit to Database of Systematic Reviews, Database of Abstracts of Reviews of Effects (DARE), HTA Database and NHS Economic Evaluation Database)

<http://www.thecochranelibrary.com>

HAYES Inc. (*full text by subscription only, subscription provided by MED Project*)

<http://www.hayesinc.com/hayes> or [Log in to the MED Clearinghouse for access](#)

Medicaid Evidence-based Decisions (MED) Project (*proprietary reports available to MED members*)

<http://www.medclearinghouse.org>

National Institute for Health and Clinical Evidence (NICE) (England and Wales)

<http://www.nice.org.uk/>

Veterans Administration (VA)/Department of Defense (DoD) Technology Assessment Program

<http://www.va.gov/VATAP/Phase2pubspage.asp>

Washington Health Technology Assessment Program

<http://www.hta.hca.wa.gov/assessments.html>

## Sources for Guidelines or Guidance

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Australian Government National Health and Medical Research Council (NHMRC)  
<http://www.nhmrc.gov.au/publications/subjects/clinical.htm>

Center for Disease Control and Prevention's Advisory Committee on Immunization Practices  
<http://www.cdc.gov/vaccines/recs/acip/default.htm>

Center for Disease Control and Prevention's Community Preventive Services  
<http://www.thecommunityguide.org/index.html>

Evaluation of Genomic Applications in Practice and Prevention (EGAPP)  
<http://www.egappreviews.org/>

National Institute for Health and Clinical Evidence (NICE) (England and Wales)  
<http://www.nice.org.uk/>

New Zealand Guidelines Group  
[http://www.nzgg.org.nz/index.cfm?fuseaction=fuseaction\\_10](http://www.nzgg.org.nz/index.cfm?fuseaction=fuseaction_10)

Scottish Intercollegiate Guidelines Network (SIGN)  
<http://www.sign.ac.uk/guidelines/index.html>

US Preventive Services Task Force (USPSTF)  
<http://www.ahrq.gov/clinic/uspstfix.htm>

Veterans Administration (VA)/Department of Defense (DoD)  
<http://www.healthquality.va.gov/>

The sources listed below have variable methods, but are searched in the process of developing a new guideline. Not all guidelines found in these sources are guaranteed to use high quality methods, and some will not be appropriate for guidance development.

Institute for Clinical Systems Improvement (ICSI)  
[http://www.icsi.org/guidelines\\_and\\_more/](http://www.icsi.org/guidelines_and_more/)

National Guideline Clearinghouse  
<http://www.guidelines.gov/>

## Potential New Topics for HERC Consideration

### POTENTIAL GUIDELINE TOPICS

TOPIC	DATE ADDED	REPORTS AVAILABLE	REASON ADDED
Opiates for chronic pain	2/22/2012	Washington state, Multnomah county guidance	Major public health importance, Oregon has high rates of prescription opiate deaths. Community momentum
Medical management of migraine headaches	4/3/2012		At suggestion of ICD-10 neurology and internal medicine consultants

### POTENTIAL COVERAGE GUIDANCES TOPICS

TOPIC	DATE ADDED	REPORTS AVAILABLE	REASON ADDED
Diagnostic MRI for breast cancer	4/3/2012		At suggestion of HTAS

### POTENTIAL HEALTH TECHNOLOGY ASSESSMENT TOPICS

TOPIC	DATE ADDED	REPORTS AVAILABLE	REASON ADDED
Carotid endarterectomy versus medical management	4/3/2012		At suggestion of ICD-10 neurology consultant
Treatment of sleep apnea in children	2/22/2012		Added as coverage guidance topic by HERC but no evidence reports exist specifically for treatment of children

## Topics for Development by Evidence-based Guidelines Committee

### GUIDELINE TOPICS COMPLETED

TOPIC	STATUS	REPORTS AVAILABLE	HERC APPROVAL	PRIORITY
Evaluation and Management of Low Back Pain	Completed	HERC Guideline is online @ <a href="http://www.oregon.gov/OHA/OHPR/HERC/Evidence-Based-Guidelines.shtml">http://www.oregon.gov/OHA/OHPR/HERC/Evidence-Based-Guidelines.shtml</a>	Approved 1/12/12	

### COVERAGE GUIDANCES COMPLETED

TOPIC	STATUS	REPORTS AVAILABLE	HERC APPROVAL	PRIORITY

### GUIDELINE TOPICS CURRENTLY UNDER DEVELOPMENT

TOPIC	STATUS	REPORTS AVAILABLE	FOR HERC Review	PRIORITY
Advanced Imaging for Low Back Pain	30 day public comment period completed Mar 18, 2012	Draft report to EBGs Committee on Apr 5, 2012	For HERC Review on Apr 12, 2012	
Percutaneous Interventions for Low Back Pain	30 day public comment period completed Mar 18, 2012	Draft report to EBGs Committee on May 3, 2012	For HERC Review on Jun 14, 2012	

### COVERAGE GUIDANCES CURRENTLY UNDER DEVELOPMENT

TOPIC	STATUS	REPORTS AVAILABLE	For HERC Review	PRIORITY
Arthroscopic surgery of the knee for Osteoarthritis	Review at EbGS meeting on Apr 5, 12	Public MED, WA HTA	For HERC Review on Jun 14, 2012	<i>High</i>
Low Back Pain: Non-Pharmacologic/Non-Invasive Interventions	30 day public comment period completed Apr 4, 2012	HERC Guideline	For HERC Review on Jun 14, 2012	
Low Back Pain: Pharmacologic Interventions	30 day public comment period completed Apr 4, 2012; To P&T Committee for comment	HERC Guideline	For HERC Review on Jun 14, 2012	
Elective Delivery: Cesarean Section on maternal request	Initial 30 day public comment period completed Apr 4, 2012; To be reposted with revisions	Public MED, HSC guideline	For HERC Review on Jun 14, 2012	<i>High</i>
Elective Induction of Labor	Review at EbGS meeting on Apr 5, 12	Public MED, HSC guideline	For HERC Review on Jun 14, 2012	<i>High</i>
Femoracetabular impingement syndrome surgery	Review at EbGS meeting on Apr 5, 12	WA HTA	For HERC Review on Jun 14, 2012	<i>High</i>
Ultrasound in Low Risk Pregnancy	Review at EbGS meeting on Apr 5, 12	WA HTA	For HERC Review on Jun 14, 2012	<i>High</i>
PET Scan Guidelines for Cancer	Review at EbGS meeting on May 3, 12	MED report, WA HTA, HSC guideline	For HERC Review on Jun 14, 2012	<i>Medium</i>
Nonpharmacologic interventions for treatment resistant depression	Review at EbGS meeting on May 3, 12	AHRQ	For HERC Review on Jun 14, 2012	<i>High (CBT)</i>
Diagnosis and treatment of pediatric ADHD and bipolar	Review at EbGS meeting on May 3, 12	MED & AHRQ (addresses ADHD only)	For HERC Review on Jun 14, 2012	<i>Low</i>

Advanced imaging for Low Back Pain	Review at EbGS meeting on May 3, 12		For HERC Review on Jun 14, 2012	
Percutaneous interventions for low back pain	Review at EbGS meeting on May 3, 12		For HERC Review on Jun 14, 2012	

## FUTURE POTENTIAL TOPICS IDENTIFIED FOR EBGs

TOPIC	STATUS	REPORTS AVAILABLE	TOPIC APPROVED BY HERC	PRIORITY
<b>ENT</b>				
Bilateral cochlear implants in children		MED report	Added at Feb 9, 12 mtg	
Pressure equalization tubes in children		MED report	Added at Feb 9, 12 mtg	
Sinus surgery		HSC guideline	Added at Feb 9, 12 mtg	
Chronic otitis media with effusion		HSC guideline	Added at Feb 9, 12 mtg	
Tonsillectomy		HSC guideline	Added at Feb 9, 12 mtg	
<b>GYNAECOLOGY</b>				
Management of menstrual bleeding disorders		HSC guideline	Added at Feb 9, 12 mtg	
Urinary incontinence (female)		HSC guideline	Added at Feb 9, 12 mtg	
<b>IMAGING</b>				
Advanced imaging for cardiac disease				
Coronary computed tomographic angiography		MED report	Added at Feb 9, 12 mtg	
Imaging in dementia		MED report	Added at Feb 9, 12 mtg	
Red flags and imaging in headache		HSC guideline & MED Report	Added at Feb 9, 12 mtg	
<b>ONCOLOGY</b>				
Oncotype dx assay		MED report	Added at Feb 9, 12 mtg	
Prophylactic mastectomy		HSC guideline & MED Report	Added at Feb 9, 12 mtg	
<b>OPHTHALMOLOGY</b>				
Age-related macular degeneration		HSC guideline	Added at Feb 9, 12 mtg	
Cataract		HSC guideline	Added at Feb 9, 12 mtg	
<b>ORAL HEALTH</b>				
Carries Risk Assessment and Topical Fluoride Application in Primary Care Settings		MED report	Added at Feb 9, 12 mtg	
Dental Radiographs for diagnosing caries		MED report	Added at Feb 9, 12 mtg	
Early childhood caries Treatment: Stainless Steel Crowns vs Other		MED report	Added at Feb 9, 12 mtg	
Sedation vs Anaesthesia for Pediatric Dental Care		MED report	Added at Feb 9, 12 mtg	
Topical Fluoride for Prevention of Caries in Children and Adolescents		MED report	Added at Feb 9, 12 mtg	
<b>MISCELLANEOUS</b>				
Botulinum toxin type A for chronic migraine prophylaxis		MED report	Added at Feb 9, 12 mtg	
Diagnosis of sleep apnea in children		MED report	Added at Feb 9, 12 mtg	
Laser based treatment of venous disease		AHRQ draft report	Added at Feb 9, 12 mtg	Low

## Topics for Development by Health Technology Assessment Subcommittee

### COVERAGE GUIDANCES COMPLETED

TOPIC	STATUS	REPORTS AVAILABLE	HERC APPROVAL	PRIORITY

### COVERAGE GUIDANCES CURRENTLY UNDER DEVELOPMENT BY HTAS

TOPIC	STATUS	REPORTS AVAILABLE	For HERC Review	PRIORITY
<b>MRIs for Breast Cancer Screening</b>	30 Public Comment period ends May 2, 12	WA HTA	For HERC Approval on Jun 14, 2012	<i>High</i>
<b>Discography</b>	Review at HTAS Apr 23, 12 meeting	WA HTA	For HERC Approval on Aug 9, 2012	<i>High</i>
<b>Hip Resurfacing</b>	Review at HTAS Apr 23, 12 meeting	WA HTA & HSC guideline	For HERC Approval on Aug 9, 2012	<i>High</i>
<b>Vertebroplasty, Kyphoplasty and Sacroplasty</b>	Review at HTAS Apr 23, 12 meeting	WA HTA	For HERC Approval on Aug 9, 2012	<i>High</i>
<b>Artificial Disc Replacement</b>	Review at HTAS Apr 23, 12 meeting	WA HTA	For HERC Approval on Aug 9, 2012	<i>Medium</i>
<b>Self Monitoring of Blood Glucose</b>	Review at HTAS Apr 23, 12 meeting	MED Report & WA HTA	For HERC Approval on Aug 9, 2012	<i>High</i>
<b>Real Time Continuous Glucose Monitoring</b>	Review at HTAS Apr 23, 12 meeting	MED, WA HTA (children only) & HSC guideline	For HERC Approval on Aug 9, 2012	<i>Medium</i>

### FUTURE POTENTIAL TOPICS IDENTIFIED FOR HTAS

TOPIC	STATUS	REPORTS AVAILABLE	For HERC Review	PRIORITY
<b>Upper endoscopy (indications:GERD and Dyspepsia)</b>		AHRQ		<i>High (waiting for WA HTA report)</i>
<b>Functional electrical stimulators for spinal cord and head injury, CP and upper motor neuron diseases</b>		MED		
<b>Insulin pumps vs multiple daily injections for Type 1 and Type 2 diabetes</b>				
<b>Left ventricular assist devices (LVAD)</b>				
<b>New radiation therapies for non-intercranial malignancies</b>				
<b>Spinal cord stimulators for chronic pain</b>				
<b>Vacuum wound closure (negative pressure wound therapy)</b>				

# EbGS Future Potential Topics

# Providence - OEBB & PEBB

TOPIC	REPORTS AVAILABLE		Coverage (c=covered, e=excluded)	Utilization Management			
				PA or Practice Guidelines (Y/N)	Additional Cost Tier Procedure (Y/N)	Other Benefit Limit (Please Specify)	Medical Management or other Utilization Management (Please Specify)
<b>ENT</b>							
Bilateral cochlear implants in children	MED report	<b>OEBB</b>	C	Y	N		PA
		<b>PEBB</b>	C	Y	N		PA
Pressure equalization tubes in children	MED report	<b>OEBB</b>	C	N	N		
		<b>PEBB</b>	C	N	N		
Sinus surgery	HSC guideline	<b>OEBB</b>	C	N	N		
		<b>PEBB</b>	C	N	Y		
Chronic otitis media with effusion	HSC guideline	<b>OEBB</b>	c	N	n		
		<b>PEBB</b>	c	N	n		
Tonsillectomy	HSC guideline	<b>OEBB</b>	C	N	N		
		<b>PEBB</b>	C	N	N		
<b>Gynecology</b>							
Menstrual bleeding disorders	HSC guideline	<b>OEBB</b>	C	N	N		
		<b>PEBB</b>	C	N	N		
Urinary incontinence (female)	HSC guideline	<b>OEBB</b>	C	N	N		
		<b>PEBB</b>	C	N	N		
<b>Imaging</b>							
Advanced imaging for cardiac disease		<b>OEBB</b>	C	AIM	Y		AIM
		<b>PEBB</b>	C	AIM	Y		AIM

Coronary computed tomographic angiography	MED report	<b>OEBB</b>	C	AIM	Y		AIM
		<b>PEBB</b>	C	AIM	Y		AIM
Imaging in dementia	MED report	<b>OEBB</b>	C	AIM	Y-some		AIM
		<b>PEBB</b>	C	AIM	Y-some		AIM
Pet scan guidelines *	HSC guideline,WA HTA & MED Report	<b>OEBB</b>	C	Y	Y		PA
		<b>PEBB</b>	C	Y	Y		PA
Red flags and imaging in headache	HSC guidelines & MED Report	<b>OEBB</b>	C	AIM	Y-some		AIM
		<b>PEBB</b>	C	AIM	Y-some		AIM
<b>Mental Health</b>							
Diagnosis and Treatment of Pediatric ADHD and Bipolar Disease	AHRQ & MED reports	<b>OEBB</b>	C	PBH	N		PBH
		<b>PEBB</b>	C	PBH	N		PBH
Nonpharmacologic Interventions for Treatment Resistant Depression	AHRQ report	<b>OEBB</b>	need more info	PBH	N		PBH
		<b>PEBB</b>	need more info	PBH	N		PBH
<b>Musculoskeletal</b>							
Arthroscopic surgery of the knee for osteoarthritis *	MED report & Washington HTA	<b>OEBB</b>	C	Y	Y		PA
		<b>PEBB</b>	C	Y	Y		PA
Femoroacetabular impingement (FAI) syndrome	Washington HTA	<b>OEBB</b>	c	Y	n		PA
		<b>PEBB</b>	c	Y	n		PA
Hip resurfacing	HSC guideline and WA HTA	<b>OEBB</b>	C	Y	Y		PA
		<b>PEBB</b>	C	Y	Y		PA
Interventions for cervical spine pain		<b>OEBB</b>	C	Y - some	Y - some		PA
		<b>PEBB</b>	C	Y - some	Y - some		PA
<b>Obstetrics</b>							
Elective cesarean section *	MED report & HSC Guidelines	<b>OEBB</b>	c	N	n		
		<b>PEBB</b>	c	N	n		
Induction of labor *	MED report & HSC Guidelines	<b>OEBB</b>	C	N	N		
Medical and obstetric indications	No current report	<b>PEBB</b>	C	N	N		
<b>Oncology</b>							
Oncotype dx assay	MED report	<b>OEBB</b>	c	N	n		
		<b>PEBB</b>	c	N	n		

Prophylactic mastectomy	MED report & HSC guidelines	<b>OEBB</b>	<b>C</b>	N	n		
		<b>PEBB</b>	<b>C</b>	N	n		
<b>Ophthalmology</b>							
Age-related macular degeneration	HSC guideline	<b>OEBB</b>	<b>C</b>	N	N		
		<b>PEBB</b>	<b>C</b>	N	N		
Cataract	HSC guideline	<b>OEBB</b>	<b>C</b>	N	N		
		<b>PEBB</b>	<b>C</b>	N	N		
<b>Oral Health</b>							
Caries Risk Assessment and Topical Fluoride Application in Primary Care Settings	MED report	<b>OEBB</b>	dental**		n		
		<b>PEBB</b>	dental**		n		
Dental Radiographs for Diagnosing Caries	MED report	<b>OEBB</b>	dental**		n		
		<b>PEBB</b>	dental**		n		
Early Childhood Caries Treatment: Stainless Steel Crowns vs. Other	MED report	<b>OEBB</b>	dental**		n		
		<b>PEBB</b>	dental**		n		
Sedation vs. Anaesthesia for Pediatric Dental Care	MED report	<b>OEBB</b>	<b>C</b>	Y	N		PA
		<b>PEBB</b>	<b>C</b>	Y	N		PA
Topical Fluoride for Prevention of Caries in Children and Adolescents	MED report	<b>OEBB</b>	dental**		n		
		<b>PEBB</b>	dental**		n		
<b>Miscellaneous</b>							
Botulinum toxin type A for chronic migraine prophylaxis	MED report	<b>OEBB</b>	<b>C</b>	Y	N		PA
		<b>PEBB</b>	<b>C</b>	Y	N		PA
Chronic Kidney Disease Stages 1-3: Screening, Monitoring and Treatment	AHRQ report	<b>OEBB</b>	<b>C</b>	N	N		
		<b>PEBB</b>	<b>C</b>	N	N		
Diagnosis and treatment of sleep apnea							

In children	AHRQ & MED reports	<b>OEBB</b>	<b>C</b>	Y	N	y - testing	PA
		<b>PEBB</b>	<b>C</b>	Y	N	y - testing	PA
In adults	AHRQ & MED reports	<b>OEBB</b>	<b>C</b>	Y	N	y - testing	PA
		<b>PEBB</b>	<b>C</b>	Y	N	y - testing	PA
Laser based treatment of venous disease	AHRQ draft report	<b>OEBB</b>	<b>more info needed</b>	N			
		<b>PEBB</b>	<b>more info needed</b>	N			
Self-monitoring of blood glucose for type 1 and type 2 diabetes	MED report & Washington HTA	<b>OEBB</b>	<b>C</b>	N		PHE test strip	
		<b>PEBB</b>	<b>C</b>	N		PHE test strip	

\* Public MED reports available

\*\* DENTAL - would refer to dental carrier for management

AIM - American Imaging Management

PA - Prior authorization.

PBH - Providence Behavioral Health. A capitated behavioral health management program.

**HTAS Potential Future Topics**

**Providence - OEBB & PEBB**

TOPIC	REPORTS AVAILABLE		Coverage (c=covered, e=excluded)	Utilization Management			
				PA or Practice Guidelines (Y/N)	Additional Cost Tier Procedure (Y/N)	Other Benefit Limit (Please Specify)	Medical Management or other Utilization Management (Please Specify)
Artificial discs	Washington HTA	<b>OEBB</b>	C	Y	Y		PA
		<b>PEBB</b>	C	Y	Y		PA
Bone growth stimulators	MED & Washington HTA	<b>OEBB</b>	C	Y	N		PA
		<b>PEBB</b>	C	Y	N		PA
Discography	Washington HTA	<b>OEBB</b>	C	Y	N		PA
		<b>PEBB</b>	C	Y	N		PA
Functional electrical stimulators for spinal cord and head injury, CP and upper motor neuron diseases	MED report	<b>OEBB</b>	C	Y- spinal	N		PA
		<b>PEBB</b>	C	Y- spinal	N		PA
Implantable infusion pumps	Washington HTA	<b>OEBB</b>	need more info				
		<b>PEBB</b>	need more info				
Insulin pumps vs multiple daily injections for type 1 and 2 diabetes	MED report	<b>OEBB</b>	C	Y-external	N		PA
		<b>PEBB</b>	C	Y-external	N		PA
Left ventricular assist devices (LVAD)	MED report & HSC Guidelines	<b>OEBB</b>	C	Y	N		PA
		<b>PEBB</b>	C	Y	N		PA
New radiation therapies for non-intercranial malignancies	MED report	<b>OEBB</b>	need more info				
		<b>PEBB</b>	need more info				
Real time continuous glucose monitoring	MED & Washington HTA & HSC guidelines	<b>OEBB</b>	C	Y- long term	N		PA

HTAS Potential Future Topics, Providence - OEBB PEBB

		<b>PEBB</b>	C	Y- long term	N		PA
Spinal cord stimulators for chronic pain	MED report	<b>OEBB</b>	C	y	N		PA
		<b>PEBB</b>	C	Y	N		PA
Vacuum wound closure (negative pressure wound therapy)	MED report	<b>OEBB</b>	C	y	N		PA
		<b>PEBB</b>	C	y	N		PA
Vagus nerve stimulators for depression *	MED report	<b>OEBB</b>	need more info	n			
		<b>PEBB</b>	need more info	n			
Vagus nerve stimulators for epilepsy *	MED report	<b>OEBB</b>	need more info	n			
		<b>PEBB</b>	need more info	n			
Vertebroplasty, kyphoplasty and sacroplasty	Washington HTA	<b>OEBB</b>	C	y	Y		PA for vertebroplasty, kyphoplasty only
		<b>PEBB</b>	C	y	Y		PA for vertebroplasty, kyphoplasty only
Viscosupplementation for osteoarthritis of the knee *	MED report	<b>OEBB</b>	c	n			In process of developing medical policy
		<b>PEBB</b>	c	n			In process of developing medical policy

\* Public MED Reports Available

AIM - American Imaging Management

PA - Prior authorization.

PBH - Providence Behavioral Health. A capitated behavioral health management program.

TOPIC	REPORTS AVAILABLE		Coverage (c=covered, e=excluded)	Utilization Management			
				PA or Practice Guidelines (Y/N)	Additional Cost Tier Procedure (Y/N)	Other Benefit Limit (Please Specify)	Medical Management or other Utilization Management (Please Specify)
<b>ENT</b>							
Bilateral cochlear implants in children	MED report	<b>OEBB</b>	<b>C</b>	Y	N	N/A	None
		<b>PEBB</b>					
Pressure equalization tubes in children	MED report	<b>OEBB</b>	<b>C</b>	N	N	N/A	None
		<b>PEBB</b>					
Sinus surgery	HSC guideline	<b>OEBB</b>	<b>C</b>	Y	N	N/A	IP LOS/LOC
		<b>PEBB</b>					
Chronic otitis media with effusion	HSC guideline	<b>OEBB</b>	<b>C?</b>		N	N/A	None
		<b>PEBB</b>					
Tonsillectomy	HSC guideline	<b>OEBB</b>	<b>C</b>	Y	N	N/A	IP LOS/LOC
		<b>PEBB</b>					
<b>Gynecology</b>							
Menstrual bleeding disorders	HSC guideline	<b>OEBB</b>	<b>C</b>	Y	N	N/A	If surgical tx - IP LOS/LOC
		<b>PEBB</b>					
Urinary incontinence (female)	HSC guideline	<b>OEBB</b>	<b>C</b>	Y	N	N/A	If surgical tx - IP LOS/LOC
		<b>PEBB</b>					
<b>Imaging</b>							
Advanced imaging for cardiac disease							
Coronary computed tomographic angiography	MED report	<b>OEBB</b>	<b>C</b>	Y	Y	N/A	HC for HD
		<b>PEBB</b>					
Imaging in dementia	MED report	<b>OEBB</b>	<b>C</b>	Y	Y	N/A	None

		<b>PEBB</b>					
Pet scan guidelines *	HSC guideline,WA HTA & MED Report	<b>OEBB</b>	C	Y	Y	N/A	If for cancer or other chronic illness CM
		<b>PEBB</b>					
Red flags and imaging in headache	HSC guidelines & MED Report	<b>OEBB</b>	Too broad. Need clarification on procedure type.			N/A	None
		<b>PEBB</b>					
<b>Mental Health</b>							
Diagnosis and Treatment of Pediatric ADHD and Bipolar Disease	AHRQ & MED reports	<b>OEBB</b>	Too broad. Need clarification on procedure type.		N	N/A	BH
		<b>PEBB</b>					
Nonpharmacologic Interventions for Treatment Resistant Depression	AHRQ report	<b>OEBB</b>	C	N	N	N/A	BH, HC for DC
		<b>PEBB</b>					
<b>Musculoskeletal</b>							
Arthroscopic surgery of the knee for osteoarthritis *	MED report & Washington HTA	<b>OEBB</b>	C	Y	Y	N/A	OP PT, possibly IP LOS/LOC if complex
		<b>PEBB</b>					
Femoroacetabular impingement (FAI) syndrome	Washington HTA	<b>OEBB</b>	Too broad. Need clarification on procedure type.	Y	N	N/A	IP, LOS/LOC, OP PT/OT, DP, SNF, DME, HC for SJ
		<b>PEBB</b>					
Hip resurfacing	HSC guideline and WA HTA	<b>OEBB</b>	C	Y	Y	N/A	IP, LOS/LOC, OP PT/OT, DP, SNF, DME, HC for SJ

		<b>PEBB</b>					
Interventions for cervical spine pain		<b>OEBB</b>	Too broad. Need clarification on procedure type.		Y-some	N/A	IP, LOS/LOC, OP PT/OT, HC for SJ
		<b>PEBB</b>					
<b>Obstetrics</b>							
Elective cesarean section *	MED report & HSC Guidelines	<b>OEBB</b>	<b>C</b>	N	N	N/A	IP, LOS/LOC, HC for MC
		<b>PEBB</b>					
Induction of labor *	MED report & HSC Guidelines	<b>OEBB</b>	<b>C</b>	N	N	N/A	IP, LOS/LOC, HC for MC
Medical and obstretic indications	No current report	<b>PEBB</b>					
<b>Oncology</b>							
Oncotype dx assay	MED report	<b>OEBB</b>	<b>C</b>	Y	N	N/A	May require CM for cancer
		<b>PEBB</b>					
Prophylactic mastectomy	MED report & HSC guidelines	<b>OEBB</b>	<b>C</b>	Y	N	N/A	IP, LOS/LOC, DP
		<b>PEBB</b>					
<b>Ophthalmology</b>							
Age-related macular degeneration	HSC guideline	<b>OEBB</b>	<b>C</b>	N	N	N/A	None
		<b>PEBB</b>					
Cataract	HSC guideline	<b>OEBB</b>	<b>C</b>	N	N	N/A	None
		<b>PEBB</b>					
<b>Oral Health</b>							
Caries Risk Assessment and Topical Flouride Application in Primary Care Settings	MED report	<b>OEBB</b>	<b>C</b>	N	N	Covered. Topical application of fluoride is covered once in any 6- month period for members age 18 and under. For members age 19 and over, topical application of fluoride is covered once in any 6-month period* if there is a history of periodontal disease or high risk of decay due to medical disease or chemotherapy or similar type of treatment (poor diet or oral hygiene does not constitute a medical disease).	

		<b>PEBB</b>	<b>C</b>	N	N	Covered. Topical application of fluoride is covered twice per calendar year for members age 18 and under. For members age 19 and over, topical application of fluoride is covered twice per calendar year if there is recent history of periodontal surgery or high risk of decay due to medical disease or chemotherapy or similar type of treatment (poor diet or oral hygiene does not constitute a medical disease).	
Dental Radiographs for Diagnosing Caries	MED report	<b>OEBB</b>	<b>C</b>	N	N	Covered. Complete series x-rays or a panoramic film is covered once in any 3-year period*.  Supplementary bitewing x-rays are covered once in any 6-month period*.	
		<b>PEBB</b>	<b>C</b>	N	N	Covered. Complete series x-rays or a panoramic film is covered once in any 5-year period. This time period is calculated from the previous date of service. iii. Supplementary bitewing x-rays are covered once in a calendar year for children under 15 years of age and once in a two calendar year period for persons age 15 years of age and older. A member may qualify for a higher x-ray frequency based on the dentist's assessment of the individual's oral health and risk factors. (The maximum frequency, available only by dentist assessment, is bitewings twice in a calendar year; complete series or panoramic once in a 3-year period.  Only the following x-rays are covered by the Plan: complete series or panoramic, periapical, occlusal, and bitewing.	
Early Childhood Caries Treatment: Stainless Steel Crowns vs. Other	MED report	<b>OEBB</b>	<b>C</b>	N	N	Covered. Replacements are not covered if performed by the dentist who did the initial stainless steel crown within 24 months. The fee for the replacement is included in the initial placement	
		<b>PEBB</b>	<b>C</b>	N	N	Covered. Replacements are not covered if performed by the dentist who did the initial stainless steel crown within 24 months. The fee for the replacement is included in the initial placement	
Sedation vs. Anaesthesia for Pediatric Dental Care	MED report	<b>OEBB</b>	<b>C</b>	N	N	The Plan does not cover general anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in his or her office or in conjunction with covered services when necessary due to concurrent medical conditions	May coordinate care if medically necessary and included benefit
		<b>PEBB</b>	<b>C</b>	N	N	General anesthesia and/or IV sedation is only a benefit when administered by a dentist in conjunction with covered surgery.	
Topical Fluoride for Prevention of Caries in Children and Adolescents	MED report	<b>OEBB</b>	<b>C</b>	N	N	Covered - same coverage as in Primary Care settings	
		<b>PEBB</b>	<b>C</b>	N	N	Covered - same coverage as in Primary Care settings	
<b>Miscellaneous</b>							
Botulinum toxin type A for chronic migraine prophylaxis	MED report	<b>OEBB</b>	<b>C</b>	Y	N	N/A	None
		<b>PEBB</b>					

Chronic Kidney Disease Stages 1-3: Screening, Monitoring and Treatment	AHRQ report	<b>OEBB</b>	Too broad. Need clarification on procedure type.		N	N/A	If CKD from DM - HC for DM
		<b>PEBB</b>					
Diagnosis and treatment of sleep apnea							
In children	AHRQ & MED reports	<b>OEBB</b>	C	Y	Y-sleep studies	N/A	May have CM for other co-morbid disease i.e DM or Obesity
		<b>PEBB</b>					
In adults	AHRQ & MED reports	<b>OEBB</b>	C	Y	Y-sleep studies	N/A	May have CM for other co-morbid disease i.e. DM or HD
		<b>PEBB</b>					
Laser based treatment of venous disease	AHRQ draft report	<b>OEBB</b>	C	Y	N	N/A	None
		<b>PEBB</b>					
Self-monitoring of blood glucose for type 1 and type 2 diabetes	MED report & Washington HTA	<b>OEBB</b>	Too broad. Need clarification on procedure type.		N	N/A	HC for DM
		<b>PEBB</b>					

\* Public MED reports available

- IP Inpatient admission
- LOS/LOC Length of stay/level of care
- OP PT/OT Outpatient physical therapy/occupational therapy
- HH Home Health referral
- HC Health Coaching referral
- BH Behavioral Health Referral
- DME Durable Medical Equipment coordination
- DP Discharge Plan
- CM Case Management referral
- SNF Skilled Nursing Facility referral

LTAC	Long term acute care referral
AR	Acute Rehabilitation facility referral
DM	Diabetes Mellitus-Health coaching or case management
HD	Heart Disease-Health coaching or case management
SJ	Spine and Joint Readmission prevention
MC	Maternity Care
DC	Depression Care

## EbGS Future Potential Topics

## ODS-OEBB & PEBB (Dental)

TOPIC	REPORTS AVAILABLE		Coverage (c=covered, e=excluded)	Utilization Management			
				PA or Practice Guidilens (Y/N)	Additional Cost Tier Procedure (Y/N)	Other Benefit Limit (Please Specify)	Medical Management or other Utilization Management (Please Specify)
Artificial discs	Washington HTA	<b>OEBB</b>	C	Y	Y	N/A	IP, LOS/LOC, OP PT/OT
		<b>PEBB</b>					
Bone growth stimulators	MED & Washington HTA	<b>OEBB</b>	C	Y	N	N/A	If related to surgery and depending on the complexity of the surgery, IP, LOS/LOC, DP, OP PT/OT, AR, SNF, HC for SJ
		<b>PEBB</b>					
Discography	Washington HTA	<b>OEBB</b>	C	Y	N	N/A	N/A
		<b>PEBB</b>					
Functional electrical stimulators for spinal cord and head injury, CP and upper motor neuron diseases	MED report	<b>OEBB</b>	Too broad. Need clarification on procedure type.		N	N/A	If related to surgery and depending on the complexity of the surgery, IP, LOS/LOC, DP, OP PT/OT, AR, SNF, HH, DME, HC for SJ
		<b>PEBB</b>					
Implantable infusion pumps	Washington HTA	<b>OEBB</b>	C	Y	N	N/A	If related to surgery and depending on the complexity of the surgery, IP, LOS/LOC, DP, OP PT/OT, AR, SNF, HC for SJ
		<b>PEBB</b>					
Insulin pumps vs multiple daily injections for type 1 and 2 diabetes	MED report	<b>OEBB</b>	C	Y	N	N/A	HC for DM
		<b>PEBB</b>					

Left ventricular assist devices (LVAD)	MED report & HSC Guidelines	<b>OEBB</b>	C	Y	N	N/A	IP, LOS/LOS, DP, SNF, OP for Cardiac rehab if level of function allows, CM for HD
		<b>PEBB</b>					
New radiation therapies for non-intercranial malignancies	MED report	<b>OEBB</b>	Too broad. Need clarification on procedure type.			N/A	If for cancer - CM
		<b>PEBB</b>					
Real time continuous glucose monitoring	MED & Washington HTA & HSC guidelines	<b>OEBB</b>	C	Y	N	N/A	HC for DM
		<b>PEBB</b>					
Spinal cord stimulators for chronic pain	MED report	<b>OEBB</b>	C	Y	N	N/A	HC for SJ
		<b>PEBB</b>					
Vacuum wound closure (negative pressure wound therapy)	MED report	<b>OEBB</b>	C	Y	N	N/A	Depending on the underlying disease - IP, LOS/LOC, OP PT/OT, LTAC, SNF, DME, HC for DM/HD
		<b>PEBB</b>					
Vagus nerve stimulators for depression *	MED report	<b>OEBB</b>	E				N/A
		<b>PEBB</b>					
Vagus nerve stimulators for epilepsy *	MED report	<b>OEBB</b>	C	Y	N	N/A	Depending underlying co-morbidity - IP, LOS/LOC, CM, HH, DME, SNF, OP PT/OT
		<b>PEBB</b>					
Vertebroplasty, kyphoplasty and sacroplasty	Washington HTA	<b>OEBB</b>	C	Y	Y	N/A	IP, LOS/LOS, OP PT/OT
		<b>PEBB</b>					
Viscosupplementation for osteoarthritis of the knee *	MED report	<b>OEBB</b>	C	Y	N	N/A	OP PT/OT
		<b>PEBB</b>					

IP Inpatient admission  
LOS/LOC Length of stay/level of care

OP PT/OT	Outpatient physical therapy/occupational therapy
HH	Home Health referral
HC	Health Coaching referral
BH	Behavioral Health Referral
DME	Durable Medical Equipment coordination
DP	Discharge Plan
CM	Case Management referral
SNF	Skilled Nursing Facility referral
LTAC	Long term acute care referral
AR	Acute Rehabilitation facility referral
DM	Diabetes Mellitus-Health coaching or case management
HD	Heart Disease-Health coaching or case management
SJ	Spine and Joint Readmission prevention
MC	Maternity Care
DC	Depression Care

# EbGS Future Potential Topics

# Kaiser - OEBB & PEBB

TOPIC	REPORTS AVAILABLE		Coverage (c=covered, e=excluded)	Utilization Management			
				PA or Practice Guidelines (Y/N)	Additional Cost Tier Procedure (Y/N)	Other Benefit Limit (Please Specify)	Medical Management or other Utilization Management (Please Specify)
ENT							
Bilateral cochlear implants in children	MED report	<b>OEBB</b>	C		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	C		N/A		Utilization/medical management built into delivery system.
Pressure equalization tubes in children	MED report	<b>OEBB</b>	C		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	C		N/A		Utilization/medical management built into delivery system.
Sinus surgery	HSC guideline	<b>OEBB</b>	C		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	C		N/A		Utilization/medical management built into delivery system.
Chronic otitis media with effusion	HSC guideline	<b>OEBB</b>	C		N/A		Utilization/medical management built into delivery system.

		<b>PEBB</b>	C		N/A		Utilization/medical management built into delivery system.
Tonsillectomy	HSC guideline	<b>OEBB</b>	C		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	C		N/A		Utilization/medical management built into delivery system.
<b>Gynecology</b>							
Menstrual bleeding disorders	HSC guideline	<b>OEBB</b>	C		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	C		N/A		Utilization/medical management built into delivery system.
Urinary incontinence (female)	HSC guideline	<b>OEBB</b>	C		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	C		N/A		Utilization/medical management built into delivery system.
<b>Imaging</b>							
Advanced imaging for cardiac disease							
Coronary computed tomographic angiography	MED report	<b>OEBB</b>	C		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	C		N/A		Utilization/medical management built into delivery system.

Imaging in dementia	MED report	<b>OEBB</b>	yes, and covered where medically indicated		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	yes, and covered where medically indicated		N/A		Utilization/medical management built into delivery system.
Pet scan guidelines *	HSC guideline,WA HTA & MED Report	<b>OEBB</b>	C		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	C		N/A		Utilization/medical management built into delivery system.
Red flags and imaging in headache	HSC guidelines & MED Report	<b>OEBB</b>	C		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	C		N/A		Utilization/medical management built into delivery system.
<b>Mental Health</b>							
Diagnosis and Treatment of Pediatric ADHD and Bipolar Disease	AHRQ & MED reports	<b>OEBB</b>	C		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	C		N/A		Utilization/medical management built into delivery system.
Nonpharmacologic Interventions for Treatment Resistant Depression	AHRQ report	<b>OEBB</b>	C		N/A		Utilization/medical management built into delivery system.

		<b>PEBB</b>	C		N/A		Utilization/medical management built into delivery system.
<b>Musculoskeletal</b>							
Arthroscopic surgery of the knee for osteoarthritis *	MED report & Washington HTA	<b>OEBB</b>	Not done		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	Not done		N/A		Utilization/medical management built into delivery system.
Femoroacetabular impingement (FAI) syndrome	Washington HTA	<b>OEBB</b>	C		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	C		N/A		Utilization/medical management built into delivery system.
Hip resurfacing	HSC guideline and WA HTA	<b>OEBB</b>			N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>			N/A		Utilization/medical management built into delivery system.
Interventions for cervical spine pain		<b>OEBB</b>	C		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	C		N/A		Utilization/medical management built into delivery system.
<b>Obstetrics</b>							

Elective cesarean section *	MED report & HSC Guidelines	<b>OEBB</b>	C		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	C		N/A		Utilization/medical management built into delivery system.
Induction of labor *	MED report & HSC Guidelines	<b>OEBB</b>	C		N/A		Utilization/medical management built into delivery system.
Medical and obstretic indications	No current report	<b>PEBB</b>	C		N/A		Utilization/medical management built into delivery system.
<b>Oncology</b>							
Oncotype dx assay	MED report	<b>OEBB</b>	C		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	C		N/A		Utilization/medical management built into delivery system.
Prophylactic mastectomy	MED report & HSC guidelines	<b>OEBB</b>	C		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	C		N/A		Utilization/medical management built into delivery system.
<b>Ophthalmology</b>							
Age-related macular degeneration	HSC guideline	<b>OEBB</b>	C		N/A		Utilization/medical management built into delivery system.

		<b>PEBB</b>	C		N/A		Utilization/medical management built into delivery system.
Cataract	HSC guideline	<b>OEBB</b>	C		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	C		N/A		Utilization/medical management built into delivery system.
<b>Oral Health</b>							
Caries Risk Assessment and Topical Flouride Application in Primary Care Settings	MED report	<b>OEBB</b>	C		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	C		N/A		Utilization/medical management built into delivery system.
Dental Radiographs for Diagnosing Caries	MED report	<b>OEBB</b>	C		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	C		N/A		Utilization/medical management built into delivery system.
Early Childhood Caries Treatment: Stainless Steel Crowns vs. Other	MED report	<b>OEBB</b>	C		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	C		N/A		Utilization/medical management built into delivery system.

Sedation vs. Anaesthesia for Pediatric Dental Care	MED report	<b>OEBB</b>	C (anaesthesia-dental, sedation-medical)		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	C (anaesthesia-dental, sedation-medical)		N/A		Utilization/medical management built into delivery system.
Topical Flouride for Prevention of Caries in Children and Adolescents	MED report	<b>OEBB</b>	C		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	C		N/A		Utilization/medical management built into delivery system.
<b>Miscellaneous</b>							
Botulinum toxin type A for chronic migraine prophylaxis	MED report	<b>OEBB</b>	C		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	C		N/A		Utilization/medical management built into delivery system.
Chronic Kidney Disease Stages 1-3: Screening, Monitoring and Treatment	AHRQ report	<b>OEBB</b>	C		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	C		N/A		Utilization/medical management built into delivery system.
Diagnosis and treatment of sleep apnea							
In children	AHRQ & MED reports	<b>OEBB</b>	C		N/A		Utilization/medical management built into delivery system.

		<b>PEBB</b>	C		N/A		Utilization/medical management built into delivery system.
In adults	AHRQ & MED reports	<b>OEBB</b>	C		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	C		N/A		Utilization/medical management built into delivery system.
Laser based treatment of venous disease	AHRQ draft report	<b>OEBB</b>					
		<b>PEBB</b>					
Self-monitoring of blood glucose for type 1 and type 2 diabetes	MED report & Washington HTA	<b>OEBB</b>	C		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	C		N/A		Utilization/medical management built into delivery system.

\* Public MED reports available

## HTAS Potential Future Topics

## Kaiser - OEBB & PEBB

TOPIC	REPORTS AVAILABLE		Coverage (c=covered, e=excluded)	Utilization Management			
				PA or Practice Guidilens (Y/N)	Additional Cost Tier Procedure (Y/N)	Other Benefit Limit (Please Specify)	Medical Management or other Utilization Management (Please Specify)
Artificial discs	Washington HTA	<b>OEBB</b>	<b>c</b>		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	<b>c</b>		N/A		Utilization/medical management built into delivery system.
Bone growth stimulators	MED & Washington HTA	<b>OEBB</b>	<b>c</b>		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	<b>c</b>		N/A		Utilization/medical management built into delivery system.
Discography	Washington HTA	<b>OEBB</b>	<b>c</b>		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	<b>c</b>		N/A		Utilization/medical management built into delivery system.
Functional electrical stimulators for spinal cord and head injury, CP and upper motor neuron diseases	MED report	<b>OEBB</b>					

		<b>PEBB</b>					
Implantable infusion pumps	Washington HTA	<b>OEBB</b>					
		<b>PEBB</b>					
Insulin pumps vs multiple daily injections for type 1 and 2 diabetes	MED report	<b>OEBB</b>	<b>c</b>		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	<b>c</b>		N/A		Utilization/medical management built into delivery system.
Left ventricular assist devices (LVAD)	MED report & HSC Guidelines	<b>OEBB</b>	<b>c</b>		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	<b>c</b>		N/A		Utilization/medical management built into delivery system.
New radiation therapies for non-intercranial malignancies	MED report	<b>OEBB</b>					
		<b>PEBB</b>					
Real time continuous glucose monitoring	MED & Washington HTA & HSC guidelines	<b>OEBB</b>	<b>e</b>				
		<b>PEBB</b>	<b>e</b>				
Spinal cord stimulators for chronic pain	MED report	<b>OEBB</b>	<b>c</b>		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	<b>c</b>		N/A		Utilization/medical management built into delivery system.

Vacuum wound closure (negative pressure wound therapy)	MED report	<b>OEBB</b>	<b>c</b>		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	<b>c</b>		N/A		Utilization/medical management built into delivery system.
Vagus nerve stimulators for depression *	MED report	<b>OEBB</b>	<b>c</b>		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	<b>c</b>		N/A		Utilization/medical management built into delivery system.
Vagus nerve stimulators for epilepsy *	MED report	<b>OEBB</b>	<b>c</b>		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	<b>c</b>		N/A		Utilization/medical management built into delivery system.
Vertebroplasty, kyphoplasty and sacroplasty	Washington HTA	<b>OEBB</b>	<b>c</b>		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	<b>c</b>		N/A		Utilization/medical management built into delivery system.

Viscosupplementation for osteoarthritis of the knee *	MED report	<b>OEBB</b>	<b>c</b>		N/A		Utilization/medical management built into delivery system.
		<b>PEBB</b>	<b>c</b>		N/A		Utilization/medical management built into delivery system.

\* Public MED Reports Available

Evidence Based Guidelines - Future Potential Topics Willamette Dental - OEGB & PEBB

TOPIC	REPORTS AVAILABLE		Coverage (c=covered, e=excluded)	Utilization Management				
				PA or Practice Guidilens (Y/N)	Additional Cost Tier Procedure (Y/N)	Other Benefit Limit (Please Specify)	Medical Management or other Utilization Management (Please Specify)	Other Efforts or Initiatives (i.e. facility protocols, contracting, etc.)
Oral Health								
Caries Risk Assessment and Topical Flouride Application in Primary Care Settings	MED report	OEGB	C - if done by primary care dentist E- if done by a medical provider	N	N	N/A	N/A	N/A
		PEBB	C - if done by primary care dentist E- if done by a medical provider	N	N	N/A	N/A	N/A
Dental Radiographs for Diagnosing Caries	MED report	OEGB	C	Y - ADA recommended frequency for radiographs	N	N/A	N/A	N/A
		PEBB	C	Y - ADA recommended frequency for radiographs	N	N/A	N/A	N/A
Early Childhood Caries Treatment: Stainless Steel Crowns vs. Other	MED report	OEGB	C - stainless steel & porcelain metal crowns	N	N	N/A	N/A	N/A
		PEBB	C - stainless steel & porcelain metal crowns	N	N	N/A	N/A	N/A
Sedation vs. Anaesthesia for Pediatric Dental Care	MED report	OEGB	C - conscious sedation including local anesthesia & nitrous oxide E - general anesthesia	Y - medical history reviewed to determine most appropriate sedation method	N	N/A	N/A	N/A
		PEBB	C - conscious sedation including local anesthesia & nitrous oxide E - general anesthesia	Y - medical history reviewed to determine most appropriate sedation method	N	N/A	N/A	N/A
Topical Flouride for Prevention of Caries in Children and Adolescents	MED report	OEGB	C	N	N	N/A	N/A	N/A
		PEBB	C	N	N	N/A	N/A	N/A

\* Public MED reports available