

Minutes

HEALTH EVIDENCE REVIEW COMMISSION
Meridian Park Hospital
Community Health Education Center Room 117B&C
Tualatin, OR 97062
August 14, 2014

Members Present: Som Saha, MD, MPH, Chair; James Tyack, DMD; Beth Westbrook, PsyD; Wiley Chan, MD; Vern Saboe, DC; Irene Crosswell, RPh; Mark Gibson; Leda Garside, RN, MBA; Susan Williams, MD; Gerald Ahmann, MD, PhD.

Members Absent: None.

Staff Present: Darren Coffman; Ariel Smits, MD, MPH; Cat Livingston, MD, MPH; Wally Shaffer, MD; Jason Gingerich; Denise Taray, RN; Daphne Peck.

Also Attending:

Alison Little, MD, MPH, OHSU CeBP; Kevin Olson, MD, VbBS Chair; Kent Benner & Kaitlan Benner, The Oregon Clinic; Kerri Fowler, Umpqua Health Alliance; Christie & Eric Riehl; Adrienne Scavera, MHAO; Rebekah Brewis, PDX Trans* Pride; Jo Ann Sowers, Portland State University; Paul Neilson, Astra Zeneca (Medimmune); Ashlen Strong, Health Share of Oregon; Shannon Beatty, Medimmune; Seth Johnstone and Jenn Burleton, TransActive; Eric Larsson, Lovaas Institute; Laura Hill and Becky Reynolds, Abbvie; BJ Cavnor, One in Four Chronic Health; Seth Adams, WVP Health Authority; Cory Bradley, CareOregon; Tobi Rates, Autism Society; Dr. Maria Gilmour, Wynne Solutions; Alex Shebiel, Lindsay Hart; Camille Kerr and Deirdre Monroe, Allergan; Danielle Askini, Maura C. Roche, Alex Lausen, Peter Molof, Ryannah Quigley, Curtis Espinoza, & Amanda Spencer, Basic Rights Oregon; Ellen Miller, CFM/PHS; Lea Forsman, OHA/DMAP; Maria Wynne Gilmour, Wynne Solutions; Stacy Aria, Family Care; Amy Burn, All Care CCO; Jesse Little, OHA Actuarial Services Unit; Lorren Sandt, Caring Ambassadors.

Call to Order

Som Saha, Chair of the Health Evidence Review Commission (HERC), called the meeting to order. Role was called.

Approval of Minutes

MOTION: To approve the minutes of the June 12, 2014 meeting as presented.
CARRIES 10-0.

Director's Report

Darren Coffman confirmed there will be an interim modifications Prioritized List published October 1, 2014. The new biennial list will be published January 1, 2015. Going forward, we will produce lists each January and October 1st. The implementation of the next biennial list will be

on either October 1, 2015 or January 1, 2016, depending on CMS's final decision on the implementation of ICD-10.

Coffman reported that he and Saha held conversations with two potential osteopathic physician candidates for the DO HERC vacancy and there has been a strong candidate for the consumer representative who has indicated interest in that vacancy as well. The Governor's Office may hold off making appointments until October for a November Senate confirmation.

Value-based Benefits Subcommittee (VbBS) Report
[Meeting materials handout](#)

Treatments for Hepatitis C

Saha announced that the Commission is tabling the discussion of this topic after hearing the recommendation that came out of the VbBS's meeting that morning, along with input from CCOs and legislators and new reports/guidelines that will need to be reviewed.

Miscellaneous recommended changes to the Prioritized List

Ariel Smits, Cat Livingston and Kevin Olson, MD, VbBS Chair, each helped to summarize a number of topics discussed at recent meetings.

Smits reported the recommendations from the May 8, 2014 VbBS meeting not reported at the June HERC meeting:

May 8th recommendations for interim changes, effective 10/1/14 include:

- Add a surgical code to the colon cancer line
- Add a surgical code to the vascular insufficiency of intestines line
- Combine open and closed hip fracture diagnoses on the hip fracture line
- Add transurethral prostatic implants for treatment of benign prostatic hypertrophy
- Remove multiple surgical codes from the covered sleep apnea line
- Revise the rehabilitation guideline to reflect criteria for rehabilitation services rather than limits based on the number of visits
- Revise the sleep apnea guideline to further define daytime sleepiness and to specify that tonsillectomy/adenoidectomy surgical codes on that line are for treatment of children only
- Add a new diagnostic guideline specifying that computer-aided mammography for both screening and diagnostic purposes is not a covered service

August 14th recommendations for interim changes, effective 10/1/14 include:

- Remove certain nerve block procedure codes from the Prioritized List and advise DMAP to place these codes in the Ancillary File
- Add diagnosis codes for diabetic retinopathy to the diabetic retinopathy line
- Add ICD-10 diagnosis codes for certain types of diabetes to the appropriate diabetes lines
- Delete diagnosis codes for chiropractic and osteopathic manipulation from the migraine headache line
- Add a new coding specification to the tension headache line specifying that chiropractic and osteopathic manipulation are on this line only for pairing with cervicogenic headache.

- Add codes for chemodenervation of the anal sphincter to the uncovered chronic anal fissure line
- Delete codes for chemodenervation of extraocular muscles from the covered amblyopia line; those codes will remain on two covered strabismus lines
- Modify the nerve block guideline to include the CPT codes for certain procedures and remake it into an ancillary guideline
- Add a new guideline which specifies that removal of tympanostomy tubes is a covered service
- Modify the spinal disorders guideline to require objective evidence of neurologic injury or radiculopathy
- Modify the rehabilitation guideline to limit the total number of therapy visits for all conditions to 30 per year, except for certain neurological conditions or when in an inpatient rehabilitation facility.
- Modify the lymphedema guideline to specify that compression dressings/garments are covered for treatment of lymphedema even in the absence of complications.
- Delete the Synagis guideline for RSV prophylaxis
- Add several new coding specifications regarding use of botulinum toxin; delete the guideline note regarding botulinum toxin use for bladder indications

| August 14th recommendations for interim changes, effective 10/1/14⁵ include:

- Add several surgical codes for sex reassignment surgery to the gender dysphoria line along with new guideline on when hormone therapy and surgical treatment is appropriate

| May 8th and August 14th recommendations for the 2016 biennial list include:

- Move the diagnostic code for unspecified myopathy from the covered dysfunction lines to the uncovered fibromyalgia line.
- Add the diagnostic code for chronic fatigue syndrome to the new fibromyalgia line and retitle it
- Remove the diagnosis codes for injuries to the major blood vessels of the neck from one covered line to a more appropriate covered line
- Create a new lymphedema line and prioritize it in the covered region of the Prioritized List
- Create a new line for miscellaneous conditions requiring no treatment and prioritize it to the last line on the Prioritized List
- Merge the somatization and factitious disorder lines; prioritize into the non-covered region of the Prioritized List
- Combine the two hyperbaric oxygen lines (merge line 373 into line 336)

Other recommendations were developed related to the prioritization of hyperbaric oxygen therapy, but those will be presented for discussion at the November meeting along with the coverage guidance that they were based on.

VbBS Chair Kevin Olson and staff then asked for clarification about incorporating coverage guidances into the List, specifically what to do with weak recommendations *for* and *against*. Saha clarified that VbBS has other considerations to weigh, including cost, public input, etc. They should use the entire document, including the GRADE-informed framework, to make an appropriate recommendation for placement on the Prioritized List of Health Services.

MOTION: To accept the VbBS recommendations on changes to upcoming Prioritized Lists as stated. See the VbBS minutes of 5/8/14, 8/8/14 and 8/14/14 for a full description. Carries: 10-0.

Applied Behavior Analysis (ABA) for Autism Spectrum Disorder (ASD)
[Meeting Materials page 143-264](#)

Dr. Cat Livingston reviewed the background on the Commission's evaluation of the evidence of ABA for ASD, which began in August of 2013.

Oregon Senate Bill 365 (2013) requirements.

- Requires state-regulated commercial health plans to approve and manage autism treatment, including ABA therapy and any other medical or mental health services identified in an individualized treatment plan.
 - Law applies to patients who seek care before age nine, minimum coverage of up to 25 hours of ABA per week, continuing as long as medically necessary.
 - Health plans that provide coverage to OEBS and PEBS must begin coverage in 2015
 - Other health plans are required to begin coverage in 2016.
- The bill required HERC to evaluate the evidence for ABA and make a coverage decision for OHP.

EbGS reviewed the evidence and adopted summary conclusions based on the modified GRADE methodology used in the coverage guidance development process. Expert input and public comment was solicited and reviewed. In addition to specific comments, a total of 336 unduplicated citations were provided by public commenters. Each citation was evaluated to determine study design or article type and population characteristics (number and ages of included individuals), the abstract was retrieved and a link to the article provided when available.

Given that the focus of most of the public comment pertained to requesting that ABA be recommended for coverage in individuals over age 12, a detailed review of citations was limited to those studies. A random sample of 10% of single-subject research design (SSRD) study types were reviewed in additional detail. In addition, all systematic reviews and meta-analyses of SSRDs were reviewed in more detail.

EbGS met April 24, 2014, having reviewed the evidence, public written comment, in-person public comment and expert input and approved a modified evaluation of the evidence to send to VbBS.

On further review of what is allowed under the Mental Health Parity and Addiction Equity Act, staff suggested and VbBS agreed to modify the language to be more descriptive of the studies and not include specific hour or duration limits of the treatment.

Proposed scoring would place treatment of autism at approximately line 199, up from the current prioritization of 313.

Coffman added that the implementation date, as determined by OHA leadership, will be January 1, 2015. This coincides with a new CCO contract/rate period and with the date when providers can be licensed/certified to provide this care.

In June 2014, VbBS approved a new guideline on treatment of autistic spectrum disorder with applied behavioral analysis. Many of the studies and discussion centered around self-injurious behavior. There was some concern expressed that the guideline being recommended only impacted patients diagnosed with autism and did not include treatment for non-autistic patients with self-injurious behaviors. This condition responds in the same way to ABA as does a person with an ASD diagnosis.

Public Comment

Christie & Eric Riehl, as a parents of a child with autism and self-injurious behavior, offered their perspective and advocated to allow coverage of ABA for patients outside of an ASD diagnosis. She urged the commission to include codes for inpatient treatment and to include other comorbid conditions.

Tobi Rates, Executive Director of the Autism Society of Oregon and parent of two children on the autism spectrum who receive OHP services, expressed her gratitude to the Commission for taking on this complex issue, for the recommendations presented today and announcing a clear implantation date. She expressed concern with conclusion that the evidence for ABA for children 13 years and older is inconclusive. She said her advocacy group would continue to examine this issue.

Maria Wynne Gilmour, Wynne Solution, an ABA provider and board certified behavior analyst of 15 years from Portland, added some statistics regarding self-injurious behavior. In the last 30 days, she has received 18 referrals for this condition of which 8 were children over 12 or adults.

Gibson asked if ABA for self-injurious behavior, in the absence of an ASD diagnosis, is effective. Saha stated that the subcommittee determined it is effective. Chan, the subcommittee chair, suggested the evidence summary be reframed for clarity. Saha agreed, the subcommittee may look at editing their work but that would not preclude a vote today.

Audience member Christie Riehl, asked additional implementation questions about coding problem behaviors vs. primary diagnosis, citing the guideline that is being replaced. Livingston assured all that ABA treatment will need prior authorization and will be considered by a medical reviewer.

MOTION: To accept the VbBS recommendations to add codes and a guideline to the Prioritized List based on the EbGS evidence evaluation on applied behavior analysis for autism spectrum disorder and approve the staff recommendation to add ABA to Line 442 of the 1/1/15 list including self-injurious behavior (see Attachment A).
CARRIES: 10-0.

Cross-Sex Hormone Therapy & Sex Reassignment Surgery for Gender Dysphoria
[Meeting Materials pages 265-269](#)

Dr. Ariel Smits explained, the January 1, 2015 Prioritized List includes gender dysphoria as a new, covered line (413).

- Currently, the only treatments approved for inclusion on that line are office visits, psychotherapy and puberty suppression medication for transgender and gender-questioning youth.
- Other treatments include cross-sex hormone therapy and sex reassignment (gender reassignment) surgery.
 - Additional evidence was reviewed about the efficacy of treatment, particularly in reducing suicide attempts, IV drug abuse, and other high-risk behavior.
 - Treatment significantly reduces depression and anxiety in patients.
 - The total cost to OHP of adding additional treatments is expected to be minimal.
 - Evidence supports adding cross-sex hormone therapy and sex reassignment surgery, excluding the more cosmetic-focused procedures (breast augmentation, facial bone reconstruction).
 - Proposed scoring would place treatment of autism at approximately line 312, up from the current prioritization of 413.

At the VbBS meeting earlier in the day, there was considerable discussion about the lack of an age restriction for surgical procedures. Smits confirmed that the Oregon age of consent for surgical procedures is age 15. Dr. Olson explained that these types of procedures should not be singled out for restriction until age 18 or even higher, as many other procedures which have life-long impact can be consented to at age 15.

Tyack explained his position by saying there are so many things a 15-year-old cannot do. They cannot drive, serve in the armed forces, vote, ingest alcohol, smoke, etc. In general, he supports the procedure and feels sympathy for people who need the surgery but cannot get passed the issue of age of medical consent. Ahmann added his agreement and concern.

Saha discussed whether anyone under the age of 18 should be able to consent to any surgery and stated that is a question for lawmakers in Oregon. He thought it would be a dangerous precedent to single out an exception for this one surgery.

Williams discussed her understanding is that surgery itself comes near end of a long treatment plan. No one rushes into this irreversible surgery lightly or without preparation. Smits added the evidence shows there is a very low rate of regret recorded. Saha believes the stipulations in the guideline preclude one making a rash decision.

Public Comment

Danielle Askini, policy director for Basic Rights Oregon, asserted that this invasive, life-altering treatment is only given as part of a lengthy continuum of care. Youth are required to have extensive evaluations by qualified mental health professionals and that the year of hormone therapy required in the guideline acts as another safeguard against rash decisions by youth.

Jenn Burleton, Executive Director of TransActive, agreed with Ms. Askini, adding details about the lengthy path to surgery: assessments, reassessment, evaluation, referral and many other steps throughout the growth cycle.

Saha asked if families often support youths with gender dysphoria. Burleton responded affirmatively. Moreover, those living outside the home have advocacy and support as well.

Ahmann wanted to know how many surgeries are completed per year in Oregon. Burleton and Askini stated there are two physicians in Oregon who perform gender-confirming surgeries and estimated a very small percentage would undergo genital reconstruction. Burleton added, with access to puberty suppressing drugs, many procedures will become unnecessary, as the undesired sex characteristics will never fully develop.

Smits added many individuals do well with certain medications and counseling and never pursue surgical interventions. She added, among California government employees, a study showed that 42 surgeries were performed over a 6.5-year period.

Gibson commented that while he shares the concerns about age, we cannot rewrite the state statute about age of medical consent though the HERC process.

MOTION: To approve the line rescoring, updated treatment description, and the addition of cross-sex hormone therapy and various surgical procedures to the gender dysphoria line, and the new guideline as recommended by VbBS (see Attachment B). CARRIES 8-2 (Opposed: Tyack, Abstained: Ahmann).

Retreat Planning

Coffman mentioned the HERC retreat is scheduled for October 30, 2014 at a location TBD.

Some commissioners expressed a wish to have the retreat be a closed meeting, feeling that would foster more open conversation. Coffman explained what constituted a public meeting; in part, a public body with quorum discussing or deliberating towards a decision. Saha advocated for a public meeting, commenting that a core HERC principle is *transparency*. Further, he argued, limiting the discussion to meet the restrictions of a closed meeting would effectively limit the Commission's ability for meaningful discussion, necessitating another public meeting to rehash topics to allow for public deliberations. All agreed using a facilitator with familiarity with the HERC process and products makes sense.

Staff suggested the possibility of a compromise, with half of the meeting closed, then opened as a public meeting to allow deliberation. Members would like participation in discussion limited to staff, commissioners, subcommittee members and advisory panel members. They clearly expressed their desire to hear *no* public comment that day. Staff will review public meeting laws to see what is possible.

Public Comment

There was no other public comment at this time.

Adjournment

Meeting was adjourned at 3:30 pm. Next scheduled regular meeting – November 13, 2014, Meridian Park Room 117 B&C.

ATTACHMENT A

Changes to Prioritized List Involving Applied Behavior Analysis

Add codes as follows to Line 313 and 442 of 1/1/15 Prioritized List:

Code	Description	Action
0359T	Behavior identification assessment	Add to 313 & 442
Follows 0359T 0360T 16-45 min 0361T each additional 30 min	Observational behavioral follow-up assessment	Add to 313 & 442
Follows 0359T 0362T 16-45 min 0363T each additional 30 min	Exposure behavioral follow-up assessment	Add to 313 & 442
0364T first 30 min 0365T each additional 30 min	Adaptive behavior treatment by protocol	Add to 313 & 442
0366T first 30 min 0367T each additional 30 min	Group adaptive behavior treatment by protocol	Add to 313 & 442
0368T first 30 min 0369T each additional 30 min	Adaptive behavior treatment with protocol modification	Add to 313 & 442
0370T	Family adaptive behavior treatment guidance	Add to 313 & 442
0373T first 60 minutes of technicians' time, 0374T each additional 30 minutes of technicians' time	Exposure adaptive behavior treatment with protocol modification	Add to 313 & 442

Revise Guideline Note 75 as follows effective 1/1/15:

GUIDELINE NOTE 75, APPLIED BEHAVIOR ANALYSIS FOR AUTISM SPECTRUM DISORDER

Line 313

~~There is limited evidence of the effectiveness of treatment (e.g., Applied Behavioral Analysis) for Autism Spectrum Disorders (ASD). However, effective treatments may be available for co-morbid conditions such as mood disorders. When treating co-morbid conditions, that condition, not an ASD diagnosis, should be the primary diagnosis for billing purposes. The treatment of co-morbid mental health conditions should be consistent with the treatment methods, frequency, and duration normally applied to those diagnoses. Treatment of neurologic dysfunctions that may be seen in individuals with an ASD diagnosis are prioritized according to the four dysfunction lines found on the Prioritized List (Lines 78, 318, 375 and 407). Treatment for associated behaviors, such as agitation, that do not meet the criteria for co-morbid mental health diagnoses should be limited in frequency to a maximum of 8 hours of behavioral health service per month, subject to utilization management review by the mental health organization (MHO) or other relevant payer.~~

Applied behavior analysis (ABA), including early intensive behavioral intervention (EIBI), represented by CPT codes 0359T-0374T, is included on line 313 for the treatment of autism spectrum disorders.

ATTACHMENT A

Changes to Prioritized List Involving Applied Behavior Analysis

GUIDELINE NOTE 75, APPLIED BEHAVIOR ANALYSIS FOR AUTISM SPECTRUM DISORDER (Cont'd)

ABA services are provided in addition to any rehabilitative services (e.g. physical therapy, occupational therapy, speech therapy) included in guideline note 6, REHABILITATIVE THERAPIES that are indicated for other acute qualifying conditions.

Individuals ages 1-12

Specifically, EIBI (for example, UCLA/Lovaas or Early Start Denver Model), is included on this line.

For a child initiating EIBI therapy, EIBI is included for up to six months. Ongoing coverage is based on demonstrated progress towards meaningful predefined objectives (objectives should be achieved as a result of the EIBI, over and beyond gains that would be expected to arise from maturation alone) using a standardized, multimodal assessment, no more frequently than every six months. Examples of such assessments include Vineland, IQ tests (Mullen, WPPSI, WISC-R), language measures, behavior checklists (CBCL, ABC), and autistic symptoms measures (SRS).

The evidence does not lead to a direct determination of optimal intensity. Studies of EIBI ranged from 15-40 hours per week. Through Oregon's Senate Bill 365, other payers are mandated to cover a minimum of 25 hours per week of ABA. There is no evidence that increasing intensity of therapy yields improves outcomes. Studies for these interventions had a duration from less than one year up to 3 years.

If EIBI is not indicated, has been completed, or there is not sufficient progress toward multidimensional goals, then less intensive ABA-based interventions (such as parent training, play/interaction based interventions, and joint attention interventions) are included on this line to address core symptoms of autism and/or specific problem areas. Initial coverage is provided for six months. Ongoing coverage is based on demonstrated progress towards meaningful predefined objectives, with demonstration of medical appropriateness and/or emergence of new problem behaviors.

Effective interventions from the research literature had lower intensity than EIBI, usually a few hours per week to a maximum of 16 hours per week, divided into daily, twice-daily or weekly sessions, over a period of several months.

Parent/caregiver involvement and training is recommended as a component of treatment.

Individuals ages 13 and older

Intensive ABA is not included on this line.

Targeted ABA-based behavioral interventions to address problem behaviors, are included on this line. The quality of evidence is insufficient to support these

ATTACHMENT A

Changes to Prioritized List Involving Applied Behavior Analysis

GUIDELINE NOTE 75, APPLIED BEHAVIOR ANALYSIS FOR AUTISM SPECTRUM DISORDER (Cont'd)

interventions in this population. However, due to strong caregiver values and preferences and the potential for avoiding suffering and expense in dealing with unmanageable behaviors, targeted interventions may be reasonable. Behaviors eligible for coverage include those which place the member at risk for harm or create significant daily issues related to care, education, or other important functions. Ongoing coverage is based on demonstrated progress towards meaningful predefined objectives, with demonstration of medical appropriateness and/or emergence of new problem behaviors.

Very low quality evidence is available to illustrate needed intensity and duration of intervention. In the single-subject research design literature, frequency and duration of interventions were highly variable, with session duration ranging from 30 seconds to 3 hours, number of sessions ranging from a total of three to 8 times a day, and duration ranging from 1 to 20 weeks. These interventions were often conducted in inpatient or residential settings and studies often included patients with intellectual disabilities, some of which were not diagnosed with autism.

Parent/caregiver involvement and training is encouraged.

Add the following guideline note to the 1/1/15 Prioritized List:

GUIDELINE NOTE 126, APPLIED BEHAVIOR ANALYSIS (ABA) INTERVENTIONS FOR SELF-INJURIOUS BEHAVIOR

Line 442

Targeted ABA-based interventions towards self-injurious problem behaviors are included on this line when meeting criteria as defined in guideline note 75 APPLIED BEHAVIOR ANALYSIS FOR AUTISM SPECTRUM DISORDER.

Rescore the autism spectrum disorder line as shown below for the 1/1/2016 Prioritized List:

- Category: 3
- HL: 5
- Suffering: 4
- Population effects: 2
- Vulnerable population: 0
- Tertiary prevention: N/A
- Effectiveness: 3
- Need for service: 0.7
- Net cost: 1
- Approximate new line placement: 199

ATTACHMENT B

Changes to Prioritized List Involving Treatments for Gender Dysphoria

Make the following changes to the Prioritized List effective 1-1-2015:

- 1) Change the treatment description of Line 413 GENDER DYSPHORIA to ~~MEDICAL/PSYCHOTHERAPY~~ MEDICAL AND SURGICAL TREATMENT: PSYCHOTHERAPY
- 2) Add cross-sex hormone therapy to Line 413
- 3) Add CPT 19301-19304, 53430, 54125, 54400-54417, 54520, 54660, 54690, 55175-55180, 55970, 55980, 56625, 56800, 56805, 56810, 57106-57107, 57110-57111, 57291-57292, 57335, 58150, 58180, 58260-58262, 58275-58291, 58541-58544, 58550-58554, 58570-58573, 58661, 58720 to Line 413
 - a. Advise DMAP to remove CPT 55970 and 55980 from the Excluded List
- 4) Add the following guideline:

GUIDELINE NOTE 127, GENDER DYSPHORIA

Line 413

Hormone treatment is included on this line for use in delaying the onset of puberty and/or continued pubertal development with GnRH analogues for gender questioning children and adolescents. This therapy should be initiated at the first physical changes of puberty, confirmed by pubertal levels of estradiol or testosterone, but no earlier than Tanner stages 2-3. Prior to initiation of puberty suppression therapy, adolescents must fulfill eligibility and readiness criteria, and must have a comprehensive mental health evaluation. Ongoing psychological care is strongly encouraged for continued puberty suppression therapy.

Cross-sex hormone therapy is included on this line for treatment of adolescents and adults with gender dysphoria who meet appropriate eligibility and readiness criteria. To qualify for cross-sex hormone therapy, the patient must:

- 1) have persistent, well-documented gender dysphoria
- 2) have the capacity to make a fully informed decision and to give consent for treatment
- 3) have any significant medical or mental health concerns reasonably well controlled
- 4) have a thorough psychosocial assessment by a qualified mental health professional with experience in working with patients with gender dysphoria

Sex reassignment surgery is included for patients who are sufficiently physically fit and meet eligibility criteria. To qualify for surgery, the patient must:

- 1) have persistent, well documented gender dysphoria
- 2) have completed twelve months of continuous hormone therapy as appropriate to the member's gender goals unless hormones are not clinically indicated for the individual
- 3) have completed twelve months of living in a gender role that is congruent with their gender identity unless a medical and a mental health professional both determine that this requirement is not safe for the patient
- 4) have the capacity to make a fully informed decision and to give consent for treatment
- 5) have any significant medical or mental health concerns reasonably well controlled

ATTACHMENT B

Changes to Prioritized List Involving Treatments for Gender Dysphoria

GUIDELINE 127, GENDER DYSPHORIA (Cont'd)

- 6) have two referrals from qualified mental health professionals with experience in working with patients with gender dysphoria who have independently assessed the patient. Such an assessment should include the clinical rationale supporting the patient's request for surgery, as well as the rationale for the procedure(s)

Rescore the gender dysphoria line as shown below for the 1/1/2016 Prioritized List:

- Category: 6
- HL: 6
- Suffering: 4
- Population effects: 0
- Vulnerable population: 0
- Tertiary prevention: 3
- Effectiveness: 2
- Need for service: 1
- Net cost: 2
- Score: 1040
- Approximate new line placement: 312