

Minutes

HEALTH EVIDENCE REVIEW COMMISSION
Meridian Park Hospital
Community Health Education Center Room 117B&C
Tualatin, OR 97062
August 8, 2013

Members Present: Som Saha, MD, Chair; Alissa Craft, DO, MBA, Vice-Chair; Lisa Dodson, MD; James Tyack, DMD; Beth Westbrook, PsyD; Wiley Chan, MD; Vern Saboe, DC; Irene Croswell, RPh; Gerald Ahmann, MD; Mark Gibson (via teleconference); Susan Williams, MD.

Members Absent: Leda Garside, RN.

Staff Present: Darren Coffman; Ariel Smits, MD, MPH; Paige Hatcher, MD, MPH; Wally Shaffer, MD; Jason Gingerich; Dorothy Allen (via teleconference).

Also Attending: Alison Little, MD MPH, Shannon Vandegriff, and Stephanie Lyzell, OHSU CeBP; *Paul Terdal, Autism Speaks; *Jenny Fischer, ORABA; Shane Jackson, Lobbyist for ABA; Mary Kenny, Novartis; Austin Wilson and Joanne Rogovoy, March of Dimes; Laura Pech, GRS Oregon/Lilly; Venus Holder, Lilly; *Gayle Atteberry, Oregon Right to Life; *BJ Cavnor, NWPEN; Kristina Hemach, BMS; Jason Parks, ACS CAN; Duncan Neilson, MD, Legacy Health; *Jim Gardner, PhRMA.

**Offered testimony*

Call to Order

Som Saha, Chair of the Health Evidence Review Commission (HERC), called the meeting to order at 1:07 pm. Role was called.

Approval of Minutes

MOTION: To approve the minutes of the May 9, 2013 meeting as presented.
CARRIES 11-0.

Director's Report

Applied Behavioral Analysis

Director Coffman shared that [SB 365 \(2013\)](#) was passed this session and has mandates for commercial populations to cover applied behavior analysis (ABA) for treatment of autism spectrum disorder. Section 6 applies to HERC, requiring an evaluation of ABA for potential inclusion in the Oregon Health Plan:

SECTION 6. Not later than August 30, 2013, the Health Evidence Review Commission shall begin the process of evaluating applied behavior analysis, as defined in section 2 of this 2013 Act, as a

treatment for autism spectrum disorder, as defined in section 2 of this 2013 Act, for the purpose of updating the list of health services recommended under ORS 414.690.

Any adjustments to the list of health services that result from the evaluation process must be implemented not later than:

- (1) October 1, 2014, if the adjustments do not require the development of new medical coding; and
- (2) April 1, 2015, if the adjustments require the development or adoption of new medical coding.

Coffman noted it has been at least five years since the topic was studied in Oregon (by the now abolished Health Resources Commission (HRC)); it will be interesting to review any new evidence. He indicated the goal for this meeting is to decide what process should be employed for this evaluation and by which subcommittee. One challenge to overcome is the fact there are no billing codes specific to ABA treatment for potential placement on the Prioritized List.

Dr. Saha opined that the intent of our current evidence review process is to create coverage guidances that are aimed at guiding *coverage* decisions; because this guidance will *only* be OHP specific, VbBS may be the best subcommittee to complete this evidence review. We may view this process as an *exceptional product evidence review*; one that stops short of a coverage guidance. Since the legislation mandates the service be covered for commercial payer insurance, it may not make sense to write a full-blown coverage guidance that may end up being at odds with the legislated coverage mandate. He sees the goal as creating a guidance that just affects OHP.

Dr. Dodson, Value-based Benefit Subcommittee (VbBS) chair, added her thought that legislation often changes; an evidence review resulting in a coverage guidance could indeed drive needed change. Dr. Chan, Evidence-based Guidelines Subcommittee (EbGS) chair, added a coverage guidance analysis using GRADE's net-balance of benefits/harms would help make an informed clinical recommendation. As EbGS includes a clinical psychologist and a disability rights advocate it may be a good choice for the study. Coffman added the coverage guidance process would allow for appointment of one or more ad hoc experts who could contribute to the evaluation of the evidence as well as a 30-day period for written public comment. Mr. Gibson felt we should consider reviewing this topic in the same fashion we review them all. He stated it would be interesting to report the findings back to the legislature. He proposed the topic be reviewed by EbGS. It was clarified that the coverage guidance development process would be used, but not result in a coverage guidance, but instead a recommendation to VbBS on coverage/non-coverage. VbBS would then determine what, if any changes, should be made to the Prioritized List to reflect this recommendation, taking into account any potential implementation issues.

MOTION: To assign EbGS the topic of applied behavior analysis for an evidence review. The commission will decide at a future date whether a full coverage guidance should be created. CARRIES 11-0.

Public testimony was heard from Paul Terdal, Autism Speaks, and Jen Fischer, Oregon Association for Behavioral Analysis (ORABA), both offering their assistance in the review process.

Mr. Terdal asserted his belief that ABA is the national standard of care for treatment of autism spectrum disorder. Further, he suggested that reference to a

source from the 2008 HRC report is flawed, concluding ABA treatment as having “limited evidence,” while his review of the original source stated there was “strong evidence.” He urged the Commission to readily make all sources, including full proprietary articles, available to the public so they may better participate in the review process.

Director Coffman clarified the HRC report issue may be due to the HRC’s directive to use only the highest quality or best evidence as compared to best available evidence.

Ms. Fischer offered assistance during the evaluation process and offered to discover how other state’s code ABA treatment.

Rescind the Guideline on Therapies with Minimal Benefit/High Cost

Coffman reminded the Commission that they had approved a guideline shell that was to make reference to the work of the Pharmacy & Therapeutics (P&T) committee on prescription drugs they found to have minimal benefit/high cost. The P&T committee determines prior authorization (PA) requirements for pharmaceuticals and it has been concluded by HERC and P&T Committee staff that existing PA process can be used to limit the use of these drugs and the Prioritized List does not need to be involved.

MOTION: To rescind the previously approved guideline framework. CARRIES: 11-0.

ICD-10 List Update

The draft Prioritized List for October 2014 may be found in the [meeting materials pages 31-236](#). Changes approved for implementation in October 2013 & April 2014 will be incorporated to produce the final October 2014 Prioritized List.

Subcommittee Reports

Value-based Benefits Subcommittee (VbBS) Report

[Meeting materials pages 261-341](#)

Drs. Ariel Smits, Paige Hatcher and Lisa Dodson reported the VbBS had met August 8, 2013 earlier in the day. Each helped to summarize a number of topics discussed.

Recommendations for the biennial list and interim changes, effective 10/1/13 include:

Code movement recommendations:

- Straightforward coding changes
- Add procedure codes for inserting ear tubes to the hearing loss line for young children
- Add diagnosis codes for certain conditions arising in the perinatal period to the line for birth of an infant and remove from the dysfunction lines
- Add fluoride varnish procedure codes to the preventive services lines
- Add several low back pain diagnosis codes to an uncovered line; add a guideline to define when those codes are included on the covered line

Guideline change recommendations:

- Add one diagnosis code to the guideline for use of IUDs for non-contraceptive indications
- Add the most current NCCN guidelines references to the diagnostic guideline for non-prenatal genetic testing guideline
- Amend the guideline note on chronic otitis media to allow more liberal treatment for high risk children.
- Modify the ADHD guideline to specify that parent training is first line therapy and medication is second line therapy for this condition.
- Edit the preventive dental care guideline to allow fluoride varnish to be applied at well-child visits with continued limits on total number of treatments allowed per year
- Add a new diagnostic guideline that disallows MRI for routine surveillance in multiple sclerosis
- Reinstate the diagnostic guideline for MRI use for cervical and thoracic spine imaging
- Amend the diagnostic guideline for advanced imaging in low back pain to give a definition for radiculopathy
- Delete the health behavior assessment/intervention guideline
- Edit the cystocele surgery guideline to include other types of pelvic surgery (other than hysterectomy) and to require a trial of alternative therapy prior to surgery
- Amend the smoking and cervical fusion guideline to remove specific requirements for confirming abstinence from smoking. The guideline will continue to restrict cervical surgeries to non-smokers.
- Modify the guideline defining neurological impairment to clarify its intended meaning

Recommended changes for the ICD-10 Prioritized List (Tentatively October 1, 2014) include:

- Add tongue-tie to the feeding disorders in newborns line with the tongue clipping procedure with a guideline to limit this code pairing to certain issues with breast feeding.

Guideline changes recommended by VbBS based on EbGS and HTAS Coverage Guidances:

- Recommendations may be found in the EbGS and HTAS sections of this document and will be presented later in the meeting for approval.

MOTION: To accept the VbBS recommendations as stated. [See the VbBS minutes of 8/8/13 for a full description. Carries: 11-0.](#)

Guideline for Treatment of Cancer near the End of Life

The Commission's goal is to ensure the most thoughtful and effective care for Oregon Health Plan (OHP) patients with very advanced cancers. Currently there is a guideline which helps doctors and health plans decide when to offer curative treatment. The Commission has heard concerns from cancer doctors, patients, and health plans suggesting the current guideline ("Guideline Note 12") restricts care too much and is difficult to implement.

The history of cancer care coverage by OHP was given:

- Early versions of the Prioritized List did not allow payment for *any* cancer treatment for patients who had less than a 5% 5 year expected survival due to their cancer.
- In 2009, the current Guideline Note 12 was adopted to allow payment for more treatment of more cancers for more patients. It outlines restrictions in care for those patients who have a life expectancy of 24 months or less.

The VbBS heard from a variety of doctors, patients and health plans that the current guideline was not working. Further, it was recognized that the existing language basing coverage on an individual's expected length of life appeared to be in conflict with statutory language in the Affordable Care Act (ACA) to go into effect January 1, 2014. VbBS convened a workgroup that held two public meetings. The workgroup was made up of oncologists, a nurse who works with cancer patients, a doctor who provides palliative care, an attorney who specialized in healthcare law and a health plan administrator. A patient member was not able to attend the meetings, but had the opportunity to participate in email discussions. The public meetings were very well attended, and testimony was heard from patient advocates, doctors, and others. Other stakeholders were able to provide input via discussions with HERC staff.

The new proposed guideline developed by this workgroup allows payment for curative treatment for nearly all cancer patients. Patients with metastatic cancer coupled with severe health issues (such as kidney failure or heart failure) for whom curative chemotherapy would prove too toxic should not be subjected to this time of inappropriate treatment. For patients treated with many types of current curative chemotherapy but continue to decline in health and have a very limited ability to care for themselves, should also not be subjected to more curative chemotherapy.

The new proposed guideline *requires* patients and doctors to have frank and open discussions about the patient's goals of care and what can really be expected from care options, including chemotherapy. This conversation must cover the harms and side effects of treatments, and allow the patient to make choices about what treatments he or she desires based on his or her values, in shared decision making with his or her doctor. This type of discussion has been shown in scientific studies to improve cancer patients' lives and allows these patients to spend more time with their families instead of in hospitals.

Cancer care is required to be provided following evidence-based pathways of care devised by leading national cancer expert groups. This ensures that Oregon cancer patients receive the type of care that has been shown to have the best results with the fewest side effects and other problems.

Smits added some of the public comment heard at the VbBS meeting earlier in the day included objections to functionality tests proposed in the guideline. It was also suggested during testimony that the proposed guideline is still in conflict with ACA statutes; however, VbBS was comfortable with the proposed language and felt that any remaining issues would have to be resolved at the federal level.

Chair Saha asked to hear additional public comment, beginning with those citizens not heard at that morning's VbBS meeting.

Public Comment:

Gail Atteberry, Executive Director of Oregon Right to Life read a prepared statement that stated (in part) her opposition to sections of a previous version of the guideline, objecting to limiting coverage according to anticipated survival years.

Chair Saha clarified that the sections she objects to are not incorporated into the new, proposed guideline language.

Jason Parks, American Cancer Society, read a prepared statement, urging the Commission to reconsider the proposed guideline's reductions in cancer care resulting in

seemingly arbitrary denial of what is otherwise considered routinely accepted treatment and to enact a robust and transparent appeals process.

Director Coffman clarified the proposed guideline actually expands coverage to cancer patients.

BJ Cavnor, Executive Director of Northwest Patient Education Network, submitted a petition from Change.Org calling on the Commission to reject the proposed Guideline Note 12 language. In the interest of disclosing conflicts of interest, Mr. Cavnor stated his organization is scheduled to receive pharmaceutical funding in the near future.

Editorial note: The petition erroneously states there was only a week's notice of this meeting. While public meeting law only requires 48-hour notice, all HERC public meetings (and discussion topics) are announced at least 30-days prior to the meeting.

Jim Gardner, Pharmaceutical Research and Manufacturers of America (PhRMA), commended the Commission for recognizing conflict with Accountable Care Act (ACA) but believes rewrite is still in violation. He asserts the ACA prohibits using functional status as determination for access to medication.

Proposed New Guideline

GUIDELINE NOTE 12, TREATMENT OF CANCER WITH LITTLE OR NO BENEFIT PROVIDED NEAR THE END OF LIFE

Cancer is a complex group of diseases with treatments that vary depending on the specific subtype of cancer and the patient's unique medical and social situation. Goals of appropriate cancer therapy can vary from intent to cure, disease burden reduction, disease stabilization and control of symptoms. Cancer care must always take place in the context of the patient's support systems, overall health, and core values. Patients should have access to appropriate peer-reviewed clinical trials of cancer therapies. A comprehensive multidisciplinary approach to treatment should be offered including palliative care services (see Statement of Intent 1, Palliative Care).

Treatment with intent to prolong survival is not a covered service for patients who have progressive metastatic cancer with

- 1) severe co-morbidities unrelated to the cancer that result in significant impairment in two or more major organ systems which would affect efficacy and/or toxicity of therapy; OR
- 2) a continued decline in spite of best available therapy with a non reversible Karnofsky Performance Status or Palliative Performance score of <50% with ECOG performance status of 3 or higher which are not due to a pre-existing disability.

Treatment with intent to relieve symptoms or improve quality of life is a covered service as outlined in Statement of Intent 1, Palliative Care.

To qualify for treatment coverage, the cancer patient must have a documented discussion about treatment goals, treatment prognosis and the side effects, and knowledge of the realistic expectations of treatment efficacy. This discussion may take place with the patient's oncologist, primary care provider, or other health care provider, but preferably in a collaborative interdisciplinary care coordination discussion. Treatment must be provided via evidence-driven pathways (such as NCCN, ASCO, ASH, ASBMT, or NIH Guidelines) when available.

MOTION: To accept the VbBS recommendation to amend Guideline Note 12 as written. Carries: 11-0.

Coverage Guidances for HERC Review Discussed at May Meeting

[Meeting materials pages 342-364](#)

Treatment of Sleep Apnea

Dr. Wally Shaffer reported that, in May, HERC asked staff to review evidence on surgical interventions which they believe would result in a recommendation to not cover surgery. Further review yielded more issues around the apnea-hypopnea index (AHI) scoring. Mark Gibson asked if there was evidence for benefit of surgery outweighing harms. Shaffer shared this issue has not been reviewed. Saha commented there should be a process allowing further questions to be addressed and recommended re-vetting of the evidence. Shaffer concurred, noting a desire to use the GRADE methodology.

MOTION: To return the guidance for treatment of sleep apnea to HTAS to rework using the GRADE methodology. Carries: 11-0.

Evidence-based Guidelines Subcommittee (EbGS) Report

Coverage guidances carried forward from the May 2013 meeting, [meeting materials pages 372-461](#).

Alison Little and Paige Hatcher presented all the proposed coverage guidances from EbGS.

Management of Recurrent Acute Otitis Media (AOM) in Children

Evidence summary presented:

- For recurrent AOM, prophylactic antibiotics modestly decrease the number of episodes of AOM, NNT=5
- Pressure equalization (tympanostomy) tubes may reduce the frequency of AOM in the short-term
- Adenoidectomy does not result in a clinically significant decrease in the frequency of AOM

For OHP implementation, VbBS recommended minor changes to Guideline Note 29 regarding children with specified high risk conditions which were not directly tied to coverage guidance and were already presented to HERC in May and approved at that time.:

MOTION: To approve the proposed coverage guidance for Management of Recurrent Acute Otitis Media in Children. Carries 11-0.

Approved Coverage Guidance:

HERC COVERAGE GUIDANCE

Prophylactic antibiotics should be covered for recurrent acute otitis media.*

Tympanostomy tubes may be covered for acute otitis media only for recurrent acute otitis media.

Adenoidectomy or adenotonsillectomy should not be covered for the treatment of recurrent acute otitis media.

**Recurrent acute otitis media is defined here as three or more episodes in six months or four or more episodes in one year.*

Note: Coverage guidance for chronic otitis media with effusion is addressed in a separate document.

Cervical Cancer Screening

Evidence summary presented:

- Cervical cancer screening initiation reasonable at age 21
- Cytology-based screening
 - Liquid-based cytology does not differ from conventional cytology in sensitivity, specificity, or relative CIN detection
- Women aged 21 to 65 years
 - Screening every 3 years with cytology – reasonable balance between benefits and harms
- Women aged 30 to 65 years
 - HPV testing combined with cytology (co-testing) every 5 years – comparable balance of benefits and harms
- Screening with cytology more often than every 3 years – little additional benefit, large increases in harms
- Women younger than 30 years
 - Screening with HPV testing (alone or in combination with cytology) – little to no benefit, moderate harms
- Treatment of lesions that would otherwise resolve on their own is harmful
 - Can lead to procedures with unwanted side effects
- Triage of women with atypical squamous cells of uncertain significance (ASCUS) cytology to colposcopy
 - Single HPV test has higher sensitivity, similar specificity compared to single repeat cytology
 - No additional benefits when HPV triage is combined with cytology
- HPV not useful for triage of women with low-grade squamous intraepithelial lesion (LSIL) cytology
- Discontinue routine cervical cancer screening:

- Women > 65 yrs who have had adequate screening with negative results and not otherwise at high risk for cervical cancer
- Undergone a hysterectomy with cervix removal, unless performed because of cervical cancer

For OHP implementation, a table outlining coverage by age group/history as proposed by the coverage guidance was developed for inclusion in a new guideline. This table was then incorporated into the coverage guidance itself.

MOTION: To approve the proposed coverage guidance for Cervical Cancer Screening and the addition of the associated guideline note to the Prioritized List. Carries 11-0.

Approved Coverage Guidance:

HERC COVERAGE GUIDANCE

Cervical cancer screening is recommended for coverage in women 21 to 29 years old with cytology alone, every 3 years

- HPV testing with or without cytology is not recommended for coverage

Cervical cancer screening is recommended for coverage in women 30 to 65 years old either with:

- Co-testing every 5 years
- Cytology alone every 3 years

Cervical cancer screening is not recommended for coverage for the following populations:

- Women less than age 21
- Women who have had a hysterectomy with removal of cervix for non-cervical cancer related reasons (i.e. other than high grade precancerous lesion, CIN 2 or 3, or cervical cancer)
- Women over age 65 who have had adequate prior screening and are not otherwise at high risk of cervical cancer

Cervical cancer screening is recommended for coverage in women over 65 years old

- Until adequate screening is achieved*
- Until 20 years after regression or appropriate management of a high-grade precancerous lesion

Specific testing considerations:

- Either liquid based cytology or conventional cytology are appropriate and are recommended for coverage.
- HPV testing is not recommended for coverage for further triaging when low-grade squamous intraepithelial lesions or higher are diagnosed
- Women who have previously had abnormal pap smears should undergo surveillance per ASCCP guideline. Once they have met criteria under that management guideline for returning to routine screening, then this guideline applies.**

** Adequate screening is defined as 3 consecutive negative cytology results or 2 consecutive negative HPV results within 10 years prior to the cessation of screening, with the most recent test occurring within 5 years.*

*** Management of abnormal cytology and HPV testing is not addressed in this coverage guidance. The United States Preventive Services Task Force refers to the American Cancer Society, American Society for Colposcopy and Cervical Pathology, and American Society for Clinical Pathology guideline (Saslow 2012) to address management of abnormal results.*

Note: This guidance does not apply to women who have received a diagnosis of a high-grade precancerous cervical lesion or cervical cancer, women with in utero exposure to diethylstilbestrol, or women who are immunocompromised (such as those who are HIV positive).

Coronary Artery Calcium Scoring (CACS)

Evidence summary presented:

- CACS for asymptomatic patients
 - No evidence that risk stratification reduces MI or CVD mortality compared with risk stratification and treatment using Framingham scoring alone
- CACS may have diagnostic role in “rule out” of obstructive CAD
 - ED patients with acute chest pain, normal ECGs, and initial cardiac enzymes
 - Outpatients with stable chest pain with low probability of obstructive CAD
- Little data available to support long-term outcomes using CACS
- CACS not a stand-alone test in clinical practice
- Potential impact of radiation exposure
 - Not adequately addressed in current studies

For OHP implementation, VbBS recommended no changes since this is currently an excluded service under the Oregon Health Plan.

MOTION: To approve the proposed coverage guidance for Coronary Artery Calcium Scoring. Carries 11-0.

Approved Coverage Guidance:

HERC COVERAGE GUIDANCE

Coronary artery calcium scoring (CACS) should not be covered.

Coronary Computed Tomography Angiography

Evidence summary presented:

- CCTA may have diagnostic role in “rule out” of obstructive CAD

- ED patients with acute chest pain, normal ECGs, and initial cardiac enzymes
- Outpatients with stable chest pain with low probability of obstructive CAD
- Cost-effectiveness analyses of CCTA
 - Comparable or less costly than other diagnostic strategies
 - Economic consequences of harms of radiation or further evaluation of incidental findings not considered
- CCTA use
 - Unclear understanding of use in clinical practice setting and applicability of cost-effectiveness assumptions to clinical practice
 - Not recommended in other patient populations due to unacceptable false positive or false negative results
 - Not evaluated in asymptomatic patients

For OHP implementation, VbBS recommended no changes since this is currently and excluded service under the Oregon Health Plan.

MOTION: To approve the proposed coverage guidance for CCTA. Carries 11-0.

Approved Coverage Guidance:

[HERC COVERAGE GUIDANCE](#)

Coronary Computed Tomography Angiography (CCTA) is not recommended for coverage.

New coverage guidances presentations as recommended by EbGS

Induction of Labor

Evidence summary presented:

- RCTs:
 - Elective induction of labor (EIOL) may decrease risk of Cesarean section (CS), but increase risk of operative delivery
- Observational evidence for EIOL:
 - May increase risk of CS in nulliparous women with unfavorable cervix, and possibly in multiparous women
 - May increase risk of operative delivery
 - EIOL at <39 weeks increases risk of NICU admission for infants
 - Associated with slightly higher birth weights and decreased risk of meconium stained amniotic fluid
 - Strong evidence of net benefit at > 41 weeks and prelabor rupture of membranes
- Indications for IOL:
 - Most indications for IOL have insufficient evidence of net benefit or harm
 - Only strong evidence of benefit for gestational age >41 weeks and PROM at term
 - Only evidence of net harm for macrosomia
- Recommendations from experts (ACOG, NICE) generally in agreement –Exceptions:
 - Severe intrauterine growth restriction
 - Maternal diabetes

- History of precipitous labor (likely reflects differences in the health care delivery system)

For OHP implementation, VbBS recommended revising Guideline Note 85 according to the coverage guidance language with no materials changes.

MOTION: To approve the proposed coverage guidance for Induction of Labor and the associated changes to the Prioritized List guideline note. Carries 11-0.

Approved Coverage Guidance:

HERC COVERAGE GUIDANCE

Induction of labor is recommended for coverage for the following indications (*strong recommendation*):

- Gestational age beyond 41 weeks 0 days
- Prelabor rupture of membranes, term
- Fetal demise
- Preeclampsia, term (severe or mild)
- Eclampsia
- Chorioamnionitis

Induction of labor is recommended for coverage for the following indications (*weak recommendation*):

- Diabetes, pre-existing and gestational
- Placental abruption
- Preeclampsia, preterm (severe or mild)
- Severe preeclampsia, preterm
- Cholestasis of pregnancy
- Preterm, prelabor rupture of membranes;
- Gastroschisis
- Twin gestation
- Maternal medical conditions (e.g., renal disease, chronic pulmonary disease, chronic hypertension, cardiac disease, antiphospholipid syndrome)
- Gestational hypertension
- Fetal compromise (e.g. isoimmunization, oligohydramnios)
- Intrauterine growth restriction/Small for gestational age, term
- Elective purposes, >39 weeks 0 days to <41 weeks 0 days (without a medical or obstetrical indication) with a favorable cervix (for example, with a Bishop score ≥6)

Induction of labor is not recommended for coverage for the following indications (*weak recommendation*):

- Macrosomia (in the absence of maternal diabetes)
- Elective purposes, >39 weeks 0 days to <41 weeks 0 days (without a medical or obstetrical indication) with an unfavorable cervix (for example, a Bishop score <6)
- Intrauterine growth restriction/Small for gestational age, preterm (without other evidence of fetal compromise)

Induction of labor is not recommended for coverage for the following indications (*strong*

recommendation):

- Elective purposes <39 weeks (without a medical or obstetrical indication)

Neuroimaging in Heachache

Evidence summary presented:

- Prevalence of headache: high in adults, children & ER patients
- Prevalence of significant intracranial abnormalities in headache patients: low, occurring in 1-2% of children & adults
 - Exception: subarachnoid hemorrhage in patients presenting to the ER with sudden, severe (thunderclap) headache, prevalence between 3% & 25%
- Red flags with likelihood ratios sufficiently high to be helpful in predicting the presence of significant intracranial abnormalities:
 - Rapidly increasing headache frequency
 - Headache awakening from sleep
 - Headache with a history of dizziness
 - Lack of coordination
 - Numbness or tingling & an abnormal neurologic examination
- No individual red flags have likelihood ratios sufficiently low to be helpful in predicting the absence of significant intracranial abnormalities, although some clinical pathways may reach this goal
- No evidence suggests MRI or CT use results in altered management or improved outcomes for patients with headache & a normal neurologic exam

For OHP implementation, VbBS recommended adopting the coverage guidance language into Diagnostic Guideline Note D5 with minor changes to add examples of dizziness, lack of coordination, numbness and tingling to the appropriate lines and to make a grammatical change.

MOTION: To approve the proposed coverage guidance for Neuroimaging for Headache and the associated Prioritized List guideline note changes. Carries 11-0.

Approved Coverage Guidance:

HERC COVERAGE GUIDANCE

Neuroimaging is not recommended for coverage in patients with a defined tension or migraine type of headache, or a variation of their usual headache (e.g. more severe, longer in duration, or not responding to drugs).

Neuroimaging is recommended for coverage with headache when a red flag* is present.

*The following represent red flag conditions for underlying abnormality with headache:

- new onset or change in headache in patients who are aged over 50
- thunderclap headache: rapid time to peak headache intensity (seconds to 5 min)
- focal neurologic symptoms (e.g. limb weakness, lack of coordination, numbness or

tingling)

- non-focal neurological symptoms (e.g. altered mental status, dizziness)
- abnormal neurological examination
- headache that changes with posture
- headache wakening the patient up (nota bene migraine is the most frequent cause of morning headache)
- headache precipitated by physical exertion or Valsalva maneuver (e.g. coughing, laughing, straining)
- patients with risk factors for cerebral venous sinus thrombosis
- jaw claudication
- nuchal rigidity
- new onset headache in a patient with a history of human immunodeficiency virus (HIV) infection
- new onset headache in a patient with a history of cancer
- cluster headache, paroxysmal hemicrania, short-lasting unilateral neuralgiform headache attacks with conjunctival injection and tearing (SUNCT), or short-lasting unilateral neuralgiform headache attacks with cranial autonomic features (SUNA)

Health Technology Assessment Subcommittee (HTAS) Report
[Meeting materials, pages 470-487](#)

Alison Little and Wally Shaffer presented the proposed coverage guidances from HTAS.

PET Scan for Breast Cancer

Evidence summary presented:

- Choosing Wisely® campaign recommends:
 - NOT performing PET scanning in early stage breast cancer (DCIS, stage I, IIa, IIb)
 - No evidence demonstrating clinical benefit
 - Unnecessary imaging can lead to harm
 - NOT performing PET scanning for surveillance of asymptomatic patients who have been treated for breast cancer with curative intent
- Initial staging
 - Detecting axillary lymph node metastasis: PET vs. axillary lymph node dissection alone or in combination with sentinel lymph node biopsy
 - PET: sensitivity (27-94%); specificity (67-100%)
 - PET/CT: sensitivity (48-80%); specificity (84-100%)
- Detecting distant metastases: PET vs. conventional imaging or biopsy
 - PET: sensitivity (80-100%); specificity (83-96.7%)
- Detection of recurrence
 - PET: significantly higher sensitivity and specificity vs. conventional imaging tests
 - PET/CT: higher sensitivity than CT, no significant difference in specificity
 - MRI and PET: similar accuracy, equal to or better than scintigraphy in visualizing bone metastases (other than osteoblastic lesions)
- Monitoring response to treatment
 - Evidence is insufficient

For OHP implementation, VbBS concluded there is insufficient evidence to support inclusion of PET scans for breast cancer and no changes were recommended to the Prioritized List.

MOTION: To approve the proposed coverage guidance for PET Scanning for Breast Cancer. Carries 11-0.

Approved Coverage Guidance:

HERC COVERAGE GUIDANCE

PET scanning is not recommended for coverage in initial staging of breast cancer at low risk for metastasis (asymptomatic individuals with newly identified ductal carcinoma in situ, or clinical stage I or II disease).

PET scanning is not recommended for coverage as a modality to monitor response to treatment of breast cancer.

PET scanning is not recommended for coverage for surveillance testing for asymptomatic individuals who have been treated for breast cancer with curative intent.

Next Steps

Coffman noted the next biennial review, which allows for changes to the Prioritized List that may include moving, splitting and combining lines, in addition to moving lines that may have a fiscal impact to the State, must be completed by June of 2014; the resulting List would go into effect January 2016. This timing of this review is troublesome as there won't be an opportunity to focus on issues resulting from the ICD-10-CM conversion, since that list doesn't go into effect until October 1, 2014. Members are urged to share their ideas of potential topics with staff.

Public Comment on Topics not listed on agenda

There was no additional public comment at this time.

Adjournment

Meeting was adjourned at 3:51 pm. Next meeting will be from 1:30-4:30 pm on Thursday, October 10, 2013 at the Meridian Park Hospital Health Education Center in Conf. Room 117 B&C.