

MINUTES

Health Technology Assessment Subcommittee
Meridian Park Community Health Education Center
19300 SW 65th Avenue, Tualatin, OR
April 28, 2014
1:00-4:00pm

Members Present: James MacKay, MD, Vice-Chair; Gerald Ahmann, MD, PhD; George Waldmann, MD

Members Absent: Timothy Keenen, MD

Staff Present: Darren Coffman; Wally Shaffer, MD, MPH; Jason Gingerich, Rae Seltzer, (Preventive Medicine resident at OHSU)

Also Attending: Alison Little, MD (CEBP); Shannon Vandegriff (CEBP); Alejandro Perez, MD (Providence); Ann Demaree (Oregon Biotech); Enoch Huang, MD (Adventist Medical Center); Bridget Kiene (American Cancer Society); David Sibell (OHSU), MD; Noshad Rahimi (PSU); Liliya Hogaboam (PSU).

1. CALL TO ORDER

Jim MacKay, chair pro tem, called the meeting of the Health Technology Assessment Subcommittee (HTAS) to order at 1:00 pm.

2. MINUTES REVIEW/STAFF REPORT

No changes were made to the draft February, 2014 minutes.

Minutes approved 3-0.

Coffman announced that Dr. Muday has resigned from the subcommittee and the group discussed potential new members. Coffman said that the group does need new members, but that because of the process review currently underway at HERC, the subcommittee structure may be changing in the coming months, and this may impact selection of new members.

3. DRAFT COVERAGE GUIDANCES

A) Percutaneous interventions for cervical spine pain

Seltzer reviewed the coverage guidance and the additional sources reviewed at the subcommittee's request, along with the updated recommendations, which recommend coverage for interlaminar injections for some patients, but do not recommend transforaminal injections due to safety concerns. In addition she reviewed other payer policies from the Washington HTA project and Medicare, which specify indications and

limitations for coverage for neck injections and ablation and appear as appendices in the updated draft.

Seltzer reviewed the changes. The GRADE table has a new rationale column, and column header titles were changed to more accurately reflect the contents. The Epidural Steroids row and Radiofrequency Neurotomy rows were changed to weak recommendations for coverage with certain conditions. The recommendations are based on other policies, supplemental sources and expert input.

Waldmann asked whether (in the epidural steroid injection section) the pain should be consistent with the dermatomal distribution of the herniated disk (that is, the pain is in the part of the body associated with nerves which exit the spine near the affected disk). Sibell said that the guidance refers to neck pain, but should really be upper extremity pain. In addition he said that pain usually follows this distribution but sometimes people have two problems, such as shoulder injuries resulting in pain in additional areas. In addition some people have slightly different dermatomal distributions than the averages used in medical charts, or two nonconsecutive herniated discs resulting in pain in two locations. The group agreed to change the coverage guidance to reference chronic cervical pain with radiculopathy. The subcommittee agreed not to require objective findings but to require that the pain correspond to a dermatomal distribution, though plans such as the Oregon Health Plan may require neurologic deficit. Seltzer noted that neurologic deficit was among the exclusion criteria for one of the studies.

Sibell asked for one additional correction. He said that there are three types of radiofrequency denervation, standard, pulsed and cooled. Seltzer agreed to correct this. He also wanted to ensure that coverage for RF neurotomy would include the coverage of diagnostic medial branch blocks, since therapeutic medial branch blocks are not recommended for coverage. Shaffer suggested clarifying that only “therapeutic” medial branch blocks were not recommended for coverage. The group agreed that diagnostic medial branch blocks would need to be covered as a part of the workup prior to RF neurotomy.

Shaffer raised an additional suggestion, requiring two different local anesthetic agents be used for the two diagnostic medial branch block injections, as per the Institute for Clinical Systems Improvement guideline. Sibell agreed this would be the most evidence-based way to proceed. On Sibell’s advice, the group agreed to require that the agents used be commonly-used agents with different anticipated durations of action.

Waldmann asked Sibell about a patient with a herniated disc and documented neurologic deficit. A pain center might want to try an injection. He wonders if it would be better to send the patient straight to surgery. Sibell agreed in the case of a patient with documented weakness. Still, Sibell said he can’t predict whether surgeons want to operate. He said this is a judgement call. After discussion the group did not require certain patients to be referred directly to surgery.

MacKay invited public comment but no one chose to testify.

A motion was made to approve the draft coverage guidance as modified and open it for public comment. **Motion approved 3-0.**

B) Topic: Indications for Hyperbaric Oxygen Therapy

Shaffer reviewed the changes to the draft coverage guidance made based on the additional resources provided by Dr. Huang.

For the indication of diabetic wound care, MacKay asked about adequate arterial blood supply. Shaffer said this is one of the criteria. Huang said there is a study which showed effectiveness in patients with vascular disease not amenable to surgery but they were able to document oxygenation using transcutaneous oximetry (using an electrode placed on the foot). Physicians can show response during hyperbaric treatment using oximetry before and during treatment, and at certain levels a response predicts that hyperbaric oxygen will benefit patients. After discussion the group decided to add language requiring arterial assessment before treatment. Huang advocated for immediate inpatient hyperbaric treatment after amputation but the subcommittee didn't add this language. Huang said there is only one study of this; most of the studies waited 30 days after amputation and did not show success. The group also discussed adding a requirement for glycemic control but on discussion did not add that, as waiting for glycemic control would delay urgently needed treatment.

For venous ulcers, surgical reconstruction without flaps and grafts, compromised flaps and grafts, and crush injuries there was no discussion. Shaffer noted that these decisions were consistent with Medicare and Washington HTA.

Huang acknowledged the low quality evidence for used in refractory osteomyelitis because of lack of randomized controlled trials, but said that it can be effective along with antibiotics and surgical therapy, according to the Undersea and Hyperbaric Medical Society (UHMS), and suggested that it might be covered when provided in conjunction with these other therapies. Seltzer asked about comparing surgical debridement and antibiotics with triple therapy. Huang and Perez mentioned studies showing arrest rates of 60 and 70 percent, which would imply that triple therapy has an advantage over surgery plus antibiotics. Subcommittee members requested that this information be provided during public comment period, if available, and left the recommendation unchanged.

The group next discussed carbon monoxide poisoning. Huang read from the transcript of the Washington HTA meeting where the topic was specifically chosen not to be reviewed. Shaffer reviewed the evidence from the coverage guidance. Huang explained the issues surrounding treatment and said that the Weaver study is higher quality than the others, which were underdosed, not controlled or had too long of a delay before treatment. He said the second and third treatments are for sequelae for carbon monoxide poisoning including mitochondrial poisoning. MacKay suggested simply ignoring the topic and not making a recommendation. After discussion, the group agreed to be silent on carbon monoxide poisoning in terms of the recommendation, but to leave the information in the report for others who may benefit from the summary. Coffman noted that hyperbaric oxygen is covered for carbon monoxide poisoning on the Oregon Health Plan.

For acute traumatic brain injury, Shaffer said there is moderate quality evidence but of uncertain clinical significance. Though the risk of death was lower, many of the patients still ended up severely limited in function. Huang said UHMS doesn't recommend this, as it may leave more patients in a vegetative state despite the reduced risk of death. After

discussion the group agreed to recommend against coverage for both acute traumatic brain injuries and brain injuries other than acute traumatic brain injuries and updated the coverage guidance development framework.

For sensorineural hearing loss, Shaffer reviewed the updated draft. Huang said there was a statistically significant improvement for patients with acute sensorineural hearing loss, but the Cochrane source reports questioned the clinical significance. However, the degree of improvement reported by Cochrane would make hearing aids unnecessary. Huang said this is a new recommendation from the UHMS and there is still some controversy in the field. After brief discussion, subcommittee members left the recommendation against coverage unchanged but asked Little to further investigate the issue of clinical significance during the public comment period.

MacKay offered an opportunity for public comment but no one wished to testify.

A motion was made to approve the draft coverage guidance as written and open it for public comment. **Motion approved 3-0.**

6. ADJOURNMENT

The meeting was adjourned at 4:00 pm. The next meeting is scheduled for July 28, 2014 from 1:00-4:00pm in Room 117B of the Meridian Park Hospital Community Health Education Center in Tualatin.