

**Value-based Benefits Subcommittee Recommendations Summary
For Presentation to:
Health Evidence Review Commission on October 1, 2015 (Revised)**

For specific coding recommendations and guideline wording, please see the text of the 10-1-2015 VbBS minutes.

RECOMMENDED CODE MOVEMENT (effective 1/1/16)

- Remove the procedure codes for temporary prostatic stents from 2 covered lines and place on the Services Recommended for Non-Coverage Table as investigational
- Add the 2016 CDT codes to various dental lines as recommended by the Oral Health Advisory Panel
- Add the procedure code for silver diamine fluoride application to the covered dental caries line
- Delete the procedure code for vertebral fracture assessment using DXA from the Diagnostic File and add to the Services Recommended for Non-Coverage Table as investigational
- Add several ophthalmology visit and evaluation codes to the Diagnostic File to allow for the evaluation of urgent eye conditions
- Add procedure codes to a covered line to allow trochanteric bursitis to be treated with steroid injections
- Clarify placement of various procedures and diagnoses relating to nose deformities. The repair of the tip of the nose not involved with cleft palate was moved to the Services Recommended for Non-Coverage Table.
- Add procedure codes for stem cell transplant to the covered line containing neuroblastoma with a new guideline limiting use to high-risk neuroblastoma
- Move all child abuse and neglect diagnosis codes to a single covered line, which had all mental health service procedure codes also added to it
- Add diagnosis and procedure codes for repair of ear drum perforations to the two covered hearing loss lines with a guideline
- Add and delete codes related to various straightforward changes
- Add procedure codes for breast augmentation to the covered gender dysphoria line; remove procedure codes for penile implants from this line

ITEMS CONSIDERED BUT NO RECOMMENDATIONS FOR CHANGES MADE

- Optic neuritis did not have its prioritization changed from its current non-covered line

RECOMMENDED GUIDELINE CHANGES (effective 1/1/16)

- Add a new guideline governing the use of silver diamine fluoride for use only with dental caries up to twice a year
- Delete the existing guideline indicating lack of coverage for silver compounds for dental
- Add a new guideline outlining when ophthalmology codes are considered diagnostic

- Add a new guideline to clarify when trochanteric bursitis is included on a covered line (for steroid injections and physical therapy) and when it is included on a non-covered line (for surgical procedures)
- Modify the guideline for nose tip repair in cleft palate to clarify when this procedure is covered
- Delete the guideline regarding reconstruction of the nose
- Add new guidelines limiting the use of botulinum toxin injections for the treatment of migraines and bladder conditions.
- Modify the time period allowed for repair of peripheral nerve injuries from 8 weeks to 6 months in the nerve injury guideline
- Delete the statement of intent about behavioral and physical health integration
- Modify the ADHD guideline to clarify coverage
- Delete 3 mental health guidelines for children as no longer necessary
- Modify the gender dysphoria guideline to specify when breast augmentation is covered

MINUTES (REVISED)

VALUE-BASED BENEFITS SUBCOMMITTEE
Clackamas Community College
Wilsonville Training Center, Rooms 111-112
Wilsonville, Oregon
October 1, 2015
8:30 AM – 1:00 PM

Members Present: Kevin Olson, MD, Chair; David Pollack, MD; Susan Williams, MD; Mark Gibson; Irene Croswell, RPh; Holly Jo Hodges, MD; Laura Ocker, LAc.

Members Absent: none

Staff Present: Darren Coffman; Ariel Smits, MD, MPH; Cat Livingston, MD, MPH; Jason Gingerich; Denise Taray, RN; Daphne Peck (by phone).

Also Attending: Jesse Little, Kim Wentz, MD, MPH (by phone), Bruce Austin, DMD, and Brian Niebuurt (Oregon Health Authority); Megan Bird, MD (Legacy Health); Karen Campbell and Jane Stephen (Allergan); Katie Noah (Willamette Dental); Jeanne Stagner (Klamath's Women's Center); Amy Rainbow (Birth Network National); Courtney Johnson (COHO); Karen Nolon (ODS); Neola Young and Emily McCan (Basic Rights Oregon); Amy Penkin, LSCW and Erica Pettigrew, MD (OHSU); Carl Stevens (Care Oregon); Pau Nielsen (Allermes); Sharron Fuchs; Carole Levana; Duncan Nielsen, MD; Pam Keuncke (PHS); Silke Akerson (Oregon Midwifery Council).

➤ **Roll Call/Minutes Approval/Staff Report**

The meeting was called to order at 8:45 am and roll was called. Minutes from the August, 2015 VbBS meeting were reviewed and approved.

Staff reported that ICD-10-CM has been implemented as of today. All ICD-9 placement recommendations in the October VbBS packet are now informational only. HERC staff will keep ICD-9 codes available on an alternate version of the Prioritized List for the next few months for informational purposes as well. Staff are aware that there are likely errors in the ICD-10 codes on the Prioritized List and will be working diligently to correct these. Any errors found should be forwarded to staff.

The 2016 CPT codes are now available and being reviewed by staff. Hodges asked that the straightforward codes be sent to committee members for review and comment prior to the meeting in November. Smits replied that she will send out a spreadsheet with the 2016 CPT codes with suggested placement once she has been able to do an initial review. This list may include all codes or just straightforward codes, depending on the complexity of the review.

The Oral Health Advisory Panel (OHAP) and Behavioral Health Advisory Panel (BHAP) met and their recommendations are included in the VbBS meeting materials. The obesity taskforce is being constituted with a first meeting planned for the winter.

Gary Allen, DMD, has been senate approved for membership on the HERC. The HERC will be asked to appoint him to the VbBS at their meeting later today, to replace James Tyack, DMD, as the dental expert on the subcommittee.

The errata document was reviewed and there was no discussion.

➤ **Topic: Straightforward/Consent Agenda**

Discussion: There was no discussion about the consent agenda items.

Recommended Actions:

1. Add 43771 (Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only) to line 428 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
2. Add 93740 to the Services Recommended for Non-Coverage (SRNC) Table
3. Advise Health Services Division (HSD) to remove 93740 (Temperature gradient studies) from the Diagnostic Procedures File
4. Advise HSD to move 76831 (Saline infusion sonohysterography (SIS), including color flow Doppler, when performed) from the Ancillary File to the Diagnostic Workup File
5. Add 58321-58323 (Artificial insemination) to the SRNC
6. Advise HSD to remove 58321-58323 from the Ancillary File

MOTION: To approve the recommendations stated in the consent agenda. CARRIES 7-0.

➤ **Topic: 2016 CDT codes and OHAP report**

Discussion: Smits reviewed a spreadsheet with the OHAP recommendations for placement of the 2016 CDT codes, and a document reviewing placement recommendations for CDT codes appearing on both the Prioritized List and one of the HSD code files. There was no discussion about these documents.

Silver diamine fluoride (SDF) was discussed in detail. Bruce Austen, DMD, the dental director for OHA, testified that silver diamine fluoride does turn caries black, but arrests the decay process. Dentists can do a second step to clear out the decay and add a more cosmetically acceptable filling. However, the SDF allows the dentist to avoid anesthetics

and drilling in young children and in the elderly. This makes caries arrest more readily available and more acceptable to the patient and less traumatic. He is in favor of SDF coverage and feels that medicaments are a new paradigm in the treatment of decay.

Smits noted that the medicaments must currently be applied by dental trained personnel. It is very easy to apply and may be done by non-trained personnel in the future, for example in the school.

Gibson asked for relative cost information vs. standard restoration. Austen responded that SDF is very cost effective, with a 100 dose bottle costing about \$125. There is also no dental office time, anesthetic costs, etc.

Karen Nolan, who is an OHAP member, testified on behalf of her employer, ODS. ODS is not in favor of covering SDF. ODS dentists are concerned as it discolors teeth. Patients will need fillings eventually, so it will not save costs and will add cost for the exams and application twice a year on top of the usual filling costs. ODS feels that this treatment is experimental.

It was noted that Gary Allen, who is a member of OHAP and will be joining the HERC, has a conflict of interest regarding SDF as his company markets this product. Coffman noted that Dr. Allen had planned to recuse himself from any vote on this topic.

Recommended Actions:

1. Placement of 2016 CDT codes as shown in Appendix A
2. For CDT codes appearing on the Prioritized List and one of the HSD coding files, remove those codes from all other coding files and keep on their current line location on the Prioritized List
3. Add a new guideline for silver diamine fluoride as shown in Appendix B
4. Delete GN 91

MOTION: To recommend the code and guideline note changes as presented. CARRIES 7-0.

➤ **Topic: 2016 CPT codes**

Discussion: This section was informational only. HERC staff will bring back these codes for official approval with the other 2016 CPT codes at the November 2015 VbBS meeting.

The group discussed fetal MRI. There was discussion about the proposed guideline note. The group felt that there should be a requirement for two physicians, one a fetal or pediatric radiologist, to agree on the medical necessity of the MRI. Hodges requested that a clause be added requiring >17 weeks of estimated fetal age. There were

questions about any specific requirements for the MRI machine, the training of the MRI tech or the reading radiologist. HERC staff were directed to reach out to radiologist and maternal-fetal medicine specialists to determine the best guideline wording.

High dose radionucleotide skin surface brachytherapy was briefly discussed. The subcommittee agreed with the staff recommendation to place on the Services Recommended for Non-Coverage Table.

Intravascular non-coronary ultrasound was discussed. There was a question about whether a guideline should be developed to limit the vessels in which this could be used. The thought was that this would be difficult to determine and the code should be suggested for the Diagnostic Procedures File.

Reflectance confocal microscopy for skin lesions was briefly discussed. The subcommittee agreed that this procedure was experimental and should be placed on the Services Recommended for Non-Coverage Table.

Intrastromal corneal ring segments was reviewed without substantive discussion. The subcommittee agreed that this procedure should be added to the line containing keratoconus with the proposed guideline.

Recommended Actions:

HERC staff will further research the 2016 CPT codes and bring recommendations for the entire set to the next VBBS meeting.

➤ **Topic: Temporary prostatic stents**

Discussion: Smits reviewed the summary document. There was minimal discussion.

Recommended Action:

Delete temporary prostatic stents (CPT 53855) from lines 332 FUNCTIONAL AND MECHANICAL DISORDERS OF THE GENITOURINARY SYSTEM INCLUDING BLADDER OUTLET OBSTRUCTION and 334 CANCER OF PROSTATE GLAND and add to the Services Recommended for Non-Coverage Table as investigational.

MOTION: To recommend the code changes as presented. CARRIES 7-0.

➤ **Topic: Vertebral fracture assessment**

Discussion: Smits reviewed the summary document. There was minimal discussion.

Recommended Actions:

- a. Place CPT 77086 (Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA)) on the Services Recommended for Non-coverage Table as experimental
2. Advise HSD to remove CPT 77086 from the Diagnostic Procedures File

MOTION: To recommend the code changes as presented. CARRIES 7-0.

➤ **Topic: Optic neuritis**

Discussion: Smits reviewed the summary document. Pollack requested that the ophthalmology codes proposed for the Diagnostic Procedures File be reviewed in a year to see if they are being abused.

Recommended Actions:

1. Do not change the current prioritization of optic neuritis on line 654 INTRACRANIAL CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY
2. Advise HSD to add ophthalmology evaluation CPT codes to the Diagnostic Procedures File; also keep these codes on current lines on the Prioritized List as done with other evaluation and management codes
 - a. 92002, 92004, 92012, 92014 (Ophthalmological services: medical examination and evaluation, new and established patients)
 - b. 92081-92083 (Visual field examination)
 - c. 92100 (Serial tonometry for intraocular pressure measurement)
 - d. 92140 (Provocative tests for glaucoma)
 - e. 92133-92134 (Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve or retina)
3. Adopt a new diagnostic guideline for ophthalmology visits as shown in Appendix B

MOTION: To recommend the code and guideline note changes as presented. CARRIES 7-0.

➤ **Topic: Trochanteric bursitis**

Discussion: Smits reviewed the summary document. There was minimal discussion.

Recommended Actions:

1. Remove CPT 27062 (Excision; trochanteric bursa or calcification) from line 431 ACUTE PERIPHERAL MOTOR AND DIGITAL NERVE INJURY
2. Add CPT 20611 (Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance) to line 381

DISRUPTIONS OF THE LIGAMENTS AND TENDONS OF THE ARMS AND LEGS, EXCLUDING THE KNEE, RESULTING IN SIGNIFICANT INJURY/IMPAIRMENT

3. Add trochanteric bursitis (ICD-10 M70.6x, M70.7x) to line 508 PERIPHERAL ENTHESTOPATHIES Treatment: SURGICAL THERAPY
4. Adopt the new guideline regarding trochanteric bursitis as shown in Appendix B

MOTION: To recommend the code and guideline note changes as presented. CARRIES 7-0.

➤ **Topic: Nose repair**

Discussion: Smits reviewed the summary document. There was minimal discussion.

Recommended Actions:

1. Guideline note 80 was modified as shown in Appendix C
2. Guideline note 81 was deleted as shown in Appendix D
3. ICD-10 Q30.1 (Agenesis and underdevelopment of nose), Q30.2 (Fissured, notched and cleft nose), and Q30.8 (Other congenital malformations of nose) were deleted from line 261 DEFORMITIES OF HEAD
4. ICD-10 Q30.2 was added to line 305 CLEFT PALATE AND/OR CLEFT LIP
5. ICD-10 Q30.8 was added to lines 509 NASAL POLYPS, OTHER DISORDERS OF NASAL CAVITY AND SINUSES and 578 DEVIATED NASAL SEPTUM, ACQUIRED DEFORMITY OF NOSE, OTHER DISEASES OF UPPER RESPIRATORY TRACT
6. CPT 30430 (Rhinoplasty, secondary; minor revision (small amount of nasal tip work)) was removed from all lines and placed on the Services Recommended for Non-Coverage List
7. CPT 30460 (Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only) and 30462 (Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies) were removed from lines 469 CHRONIC SINUSITIS and 509 NASAL POLYPS, OTHER DISORDERS OF NASAL CAVITY AND SINUSES

MOTION: To recommend the code and guideline note changes as presented. CARRIES 7-0.

➤ **Topic: Stem cell transplant for neuroblastoma**

Discussion: Smits reviewed the summary document. There was minimal discussion.

Note: The new guideline was amended to add the ICD-10 code.

Recommended Actions:

1. Add stem cell transplantation (CPT 38204-38215, 38230-38241; HCPCS S2150) to line 264 CANCER OF ENDOCRINE SYSTEM, EXCLUDING THYROID; CARCINOID SYNDROME
2. Adopt a new guideline for line 264 as shown in Appendix B

MOTION: To recommend the code and guideline note changes as presented. CARRIES 7-0.

➤ **Topic: Integration of medical and mental health services for child abuse and neglect**

Discussion: Smits reviewed the summary document. There was minimal discussion.

Recommended Actions:

1. Delete diagnosis codes for child abuse and neglect from line 177 POSTTRAUMATIC STRESS DISORDER
 - a. ICD-10 T74 series, T76 series (child neglect, child abuse, child sexual abuse)
2. Add mental health CPT codes to line 125 ABUSE AND NEGLECT
 - a. CPT 90785 (interactive complexity)
 - b. 90832-90840, 90846-90853 (psychotherapy, including family and group)
 - c. 90882 (Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions)
 - d. 90887 (Interpretation or explanation of results of psychiatric, other medical examinations and procedures)
 - e. 96101 (psychological testing)
3. Delete GN25 as shown in Appendix D

MOTION: To recommend the code and guideline note changes as presented. CARRIES 7-0.

➤ **Topic: Acute substance intoxication and withdrawal**

Discussion: Smits reviewed the summary document. There was minimal discussion.

Recommended Action:

Rename line 69 SUBSTANCE-INDUCED DELIRIUM; [SUBSTANCE INTOXICATION AND WITHDRAWAL](#)

MOTION: To recommend the line title change as presented. CARRIES 7-0.

➤ **Topic: Botulinum toxin for migraines and bladder conditions**

Discussion: Smits reviewed the summary document. Gibson voiced concerns about the poor quality of the underlying studies cited in the botulinum toxin for migraine review. He was concerned about covering this treatment at all given its questionable efficacy. Williams agreed that there was little evidence to support the use of botulinum toxin for migraines. Gibson recommended increasing the proposed reduction in migraine frequency required for continued therapy from the proposed 6 to 8, to better reflect the study findings. Gibson also expressed concern about the use of urinary frequency reductions as a requirement for continuation for botulinum toxin for bladder indications as this symptom may just be a variant of normal. However, it was pointed out that earlier in the guideline, use is restricted to specific bladder indications and Gibson agreed that frequency reduction was acceptable as an outcome for those conditions.

Karen Campbell from Allergan testified that botulinum toxin for bladder indications is reserved for patients failing oral medications, and the only alternative to botulinum injections is nerve stimulation or bladder surgery. She noted that one injection may provide symptom relief for 6 months or longer.

Ms. Campbell further testified that migraine patients must also fail oral therapy prior to consideration for botulinum toxin. The other possible treatments for these patients include nerve block or neurostimulation, reflecting that few other options exist for this group of patients. She testified that many patients continue to improve the more injections they have. The treatment for migraines involve 31 injections during the session, and patients are only likely to endure this amount of injections if the treatment is actually helpful. She did not agree with requiring a reduction in headache days as a requirement for continuing therapy. She testified that patients improve in other ways, such as improvement in the level of pain on headache days or in quality of life measures. They may have shorter headaches, less intense headaches, have better response to their acute headache pain medications, less disability and improved ability to work. Chronic migraine patients have hypersensitivity to stimuli, and botulinum toxin injections can gradually help this. Clinical trials and practice show that botulinum toxin injection may require 2-3 injection cycles to improve hypersensitivity and headaches. She felt that the HERC should base coverage on symptomatic and functional improvement for these patients. She was concerned that the proposed guideline would mean that patients with reductions of 4 or 5 headache days would not qualify for further treatment and yet would have quality of life improvements. She suggested that the committee review utilization in Oregon to see if this treatment is overused or high.

Jane Stevens from Allergan testified that most private insurance plans require a reduction of 7 headache days per month or 100 headache hours per month for continued coverage of botulinum toxin injections for migraines.

The subcommittee debated whether to require a reduction of 6, 7 or 8 headache days per month for the migraine guideline. The reduction of 7 days was determined to be the best compromise.

The subcommittee debated about the number of incontinence incidents or episodes of urinary frequency required for the bladder conditions guideline. The group increased the reduction of frequency episodes to 8 and the incontinence episodes to 2 to better reflect the reductions seen with botulinum treatment in the clinical trials.

Recommended Actions:

1. Adopt a new guideline for line 414 as shown in Appendix B
2. Adopt a new guideline for line 331 as shown in Appendix B

MOTION: To recommend the guideline note changes as amended. CARRIES 7-0.

➤ **Topic: Coverage of perforations of the ear drum with hearing loss**

Discussion: Smits reviewed the summary document. There was minimal discussion.

Recommended Actions:

1. Add diagnosis codes for ear drum perforations/open wounds to lines 316 HEARING LOSS - AGE 5 OR UNDER and 450 HEARING LOSS - OVER AGE OF FIVE and keep on line 479 CHRONIC OTITIS MEDIA, OPEN WOUND OF EAR DRUM
 - a. ICD-10 H72.xx (perforation of tympanic membrane) and S09.2xx (Traumatic rupture of unspecified ear drum)
2. Add treatment CPT codes for perforations/open wounds to lines 316 and 450
 - a. 69610 (Tympanic membrane repair, with or without site preparation of perforation for closure, with or without patch)
 - b. 69620 (Myringoplasty)
 - c. 69631-69646 (Tymanoplasty with or without mastoidectomy)
3. Change the treatment description of lines 316 and 450 to MEDICAL THERAPY INCLUDING HEARING AIDS, [LIMITED SURGICAL THERAPY](#)
4. Adopt a new guideline note for lines 316, 450 and 479 as shown in Appendix B

MOTION: To recommend the code and guideline note changes as presented. CARRIES 7-0.

➤ **Topic: Acute peripheral nerve injury guideline**

Discussion: Smits reviewed the summary document. The subcommittee discussed the fact that the neurosurgeon who brought up the issue recommended extending the limit to 6 months and recommended that the guideline was modified only to extend the

surgical period to 6 months, rather than the proposed 1 year. The exceptions process could be used for patients who are between 6 months and 1 year from injury.

Recommended Actions:

1. Modify GN133 as shown in Appendix C

MOTION: To recommend the guideline note changes as amended. CARRIES 7-0.

➤ **Topic: Tobacco cessation coverage and prevention**

Discussion: This topic was tabled to the November, 2015 VBBS meeting

➤ **Topic: Tobacco use and elective surgery**

Discussion: This topic was tabled to the November, 2015 VBBS meeting

➤ **Topic: Acupuncture guideline referral requirement**

Discussion: Smits reviewed the summary document. There was discussion about whether acupuncturists can generate diagnosis codes, which are required to determine if a condition is covered by this guideline. If acupuncturists cannot make the diagnoses, then coverage of acupuncture must continue to be done by referral from a provider who can make diagnoses. Hodges argued that acupuncture should be covered like physical therapy; PT requires an ICD9/10 code from a provider and a referral/order. Ocker indicated that acupuncturists are capable of making certain diagnoses, but not complex diagnoses.

It was also noted that the staff proposed changed all acupuncture indications to have 12 covered acupuncture sessions. This is in conflict with the new back conditions guideline, which allows up to 30 visits. Staff was advised to rework this portion of the guideline.

Livingston recommended that retaining the referral requirement for pelvic pain during pregnancy was appropriate, as this symptom can be caused by many conditions, and should be evaluated by a maternity care provider first. Ocker raised no objections to this.

Staff was directed to work with the HSD clinical services unit to determine what acupuncturists can diagnosis and code and how referrals should work for acupuncture.

Recommended Actions:

HERC staff to research whether acupuncturists can make diagnoses and whether acupuncture services need a referral. This topic will be revisited at a future meeting.

➤ **Topic: Mental health guidelines for children**

Discussion: Smits briefly reviewed this topic which had been previously reviewed by BHAP. There was minimal discussion.

Recommended Actions:

- 1) Guideline note 20 ATTENTION DEFICIT/HYPERACTIVITY DISORDERS IN CHILDREN was amended as shown in appendix C
- 2) Guideline notes 28, 42 and 45 were deleted as shown in appendix D

➤ **Topic: Statement of Intent 3 - Behavioral Health Integration**

Discussion: Smits reviewed the summary document. There was minimal discussion.

Recommended Actions:

Delete SOI3 as shown in Appendix D

MOTION: To recommend the statement of intent be deleted as presented. CARRIES 7-0.

➤ **Topic: Breast augmentation and penile implant coverage for gender dysphoria**

Discussion: Smits reviewed the staff summary document. Gibson objected to adding coverage for breast augmentation, arguing that this service is not covered for other women with social functioning issues due to small breast size, and that this type of procedure is cosmetic. Hodges agreed that breast augmentation appears to be cosmetic and coverage for gender dysphoria is unfair to other women with breast size issues.

Dr. Megan Bird from Legacy testified that the goal of breast augmentation for patients with gender dysphoria is to reduce the dysphoria, suicide rates, and other negative outcomes. Breasts are an overwhelming cue for a person to be recognized by others as a woman. She argued that lack of coverage will increase the risk of violence and is therefore a safety issue.

Gibson raised concerns that the presence of breasts is a defining aspect of being a woman. Williams argued that the coverage for adolescents to receive early hormone treatment should lessen the need for breast reconstructions.

Bird responded that access to hormones, specifically estrogen for breast development, is limited for many patients due to medical or other issues.

Olson noted breast reconstruction is covered for patients with breast cancer, and he was wondering whether gender dysphoria should be considered a biologic condition on par with breast cancer. He also noted that patients with gender dysphoria as a group have terrible outcomes with no treatment, which is not the case for other women with simple cosmetic breast concerns.

Bird argued that the improvement in outcomes reviewed in the studies by HERC included breast augmentation as a possible therapy. The reduction in suicide rates and other negative outcomes were based on access to a package of therapy which included breast augmentation.

Amy Penkin, LCSW, from OHSU testified that breast surgery actually treats the dysphoria, rather than just being for social passing. She argued that linking it to gender dysphoria sets it apart from the cosmetic use.

Gibson asked when breasts could be considered large enough to be adequate to address gender dysphoria. Bird responded that there are guidelines based on Tanner developmental stages. Stage 5 on the Tanner scale corresponds to adult female breasts. This is a structural assessment, rather than based on size.

Neola Young, from Basic Rights Oregon, testified that breast surgery is more important to many transgender women than other types of gender dysphoria surgery. It is an important service to offer to reduce self harm in this population.

The discussion on penile implants was short. Bird testified that the only entity covering this is the city of San Francisco and they require 2 physicians to agree that the procedure is necessary, a surgeon's note that the phallus is appropriate for the prostheses, and evidence that the patient has used and failed external support devices.

Recommended Actions:

1. Add coverage for breast augmentation for male to female patients
 - a. CPT codes to add to line 317 GENDER DYSPHORIA (Jan. 1, 2016)
 - i. 14000-14001 Adjacent tissue transfer or rearrangement, trunk
 - ii. 15200-15201 Full thickness graft, free, including direct closure of donor site, trunk
 - iii. 19316 Mastopexy
 - iv. 19324-19325 Mammoplasty, augmentation

- v. 19340 Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
 - vi. 19342 Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction
 - b. Modify GN127 as shown in Appendix C
2. Remove penile prostheses (CPT 54400, 54401, and 54405) from line 317

MOTION: To recommend the code and guideline note changes as presented (option B) for breast augmentation. CARRIES 4-3 (Opposed: Hodges, Williams, Gibson)

MOTION: To recommend the code changes as presented for penile prostheses. CARRIES 7-0.

➤ **Topic: Coverage Guidance—Planned Out-of-hospital births**

Discussion: Livingston presented the process overview, evidence summary and core issues addressed by public comment. Dr. Duncan Neilson was introduced as an appointed expert. He is the Clinical Vice President of surgical services of Legacy health system and an obstetrician/gynecologist. Dr. Neilson reviewed the history of this effort beginning with a legislative mandate that involved licensing direct entry midwives as of January 2015 and an Oregon Health Authority Licensed Direct Entry Midwifery Workgroup that recommended that HERC evaluate the evidence and update the appropriate risk criteria to try to ensure safe and effective planned out-of-hospital births.

The subcommittee discussed that these risk criteria are about coverage. A woman with risk criteria may choose to have a planned out-of-hospital birth, but this would not be covered by the Oregon Health Plan. There was an amendment made to the box language to clarify that the intent is about coverage.

Livingston proceeded to discuss the options, being explicit about which criteria needed to be ruled out and also allowing for ambiguity when certain criteria may remain unknown if there were not clinical suspicion that would indicate a workup was appropriate. The example of ultrasound was discussed and the subcommittee agreed that it would be necessary to rule out certain risk criteria. Livingston highlighted some of the risk criteria that had received more public comment as well as some suggestions for clarifying language.

There was a discussion as to whether lethal congenital anomalies with planned nonresuscitation would be appropriate for coverage in an out-of-hospital birth setting. Kim Wentz stated that there are times when the prenatal diagnosis is wrong or the parents change their mind when the baby is born. Neilson stated that there are some lethal congenital anomalies that are more black and white and others that are gray.

Also, in some cases it may be more explicit that nonresuscitation is clearly appropriate and changes in diagnosis or management plans are highly unlikely. There was a discussion about preserving the autonomy of the mother if the fetus doesn't require treatment. Anencephaly was given as an example. After discussion the subcommittee decided to move the revised language including "nonresuscitation planned" to be a criterion requiring consultation.

There was a discussion of a series of criteria that may not be known if there was no clinical suspicion, but also needing to define what those clinical factors may be. In a discussion about intrauterine growth reduction (IUGR), initially there was a proposal to define concerning clinical signs such as fundal height <3 cm from estimated gestational age over two measurements; however, Neilson suggested that other factors besides fundal height may be important and the estimation of fetal weight is multimodal. The language was changed to state that serial fundal measurements are required, but not to define what exactly suspicion for IUGR would entail. It was concluded that both serial blood pressure measurements and serial fundal heights would be required in order to verify the absence or presence of this high risk criteria.

There was a discussion of the unknown syphilis, HIV, or Hepatitis B status and a proposal to add "positive" status to the coverage exclusion criteria. Members discussed whether appropriate care could be given to a positive mother in a home setting and they decided that given the potential risk to the fetus/infant and the potential for intervention, that these would be risk criteria that would exclude a woman from coverage. Syphilis was added based on a staff recommendation as a result of recent public health data showing an increase in syphilis in Oregon.

Pollack commented and others agreed that readability of the box language would be improved with categorizing of the risk conditions.

Public comment:

Jeannie Stagner, CNM, of Klamath Falls. She stated she has been a midwife for 33 years, starting as direct entry midwife and later serving as a consultant to the Arizona State Department of Health Services. She stated she does not have hospital privileges and has a licensed birth center. She expressed concerns that inadequate stakeholder representation was involved in the process, and that guidelines are attempting to change midwifery statutes. She stated that 100% of her patients would have been found ineligible according to consultation guidelines, specifically raising concerns about VBAC and women receiving outpatient mental health care. She also raised concerns about the availability of consultants, especially in rural communities.

Neilson reviewed the history of this process starting with the legislation, the development of the licensed direct entry midwifery workgroup, including involvement

of stakeholders with midwifery representation, and how the HERC work results from those processes.

The subcommittee discussed revising the language around maternal mental illness. Pollack suggested requiring consultation in cases where there is suspicion for psychosis or self-harm. The subcommittee ran out of further discussion time.

There was a discussion about the word “compliance” and the feeling it invokes. It was clarified that this will serve as the basis for rules and compliance would be an appropriate choice of words.

Summary of changes agreed to prior to the end of the meeting:

- Clarify further that these high risk criteria relate to coverage
- Move life-threatening congenital anomalies (unless fatal anomalies with nonresuscitation planned) to consultation criteria
- Add that serial fundal height measurements and serial blood pressure measurements are required
- Add unknown, or positive, syphilis, HIV, or hepatitis B status to high risk coverage exclusion criteria
- Categorize risk conditions in box language to improve readability
- Discuss further modifying the language on maternal mental illness requiring outpatient psychiatric care

Discussion to continue at the November 12, 2015 VbBS/HERC meetings.

➤ **Topic: Coverage Guidance—Indications for proton beam therapy**

Discussion: This topic was tabled until the November 2015 VbBS meeting

➤ **Public Comment:**

No additional public comment was received.

➤ **Issues for next meeting:**

- 2016 CPT code placement
- Tobacco cessation for procedures guideline
- Tobacco cessation coverage and prevention guideline
- Acupuncture guideline
- Coverage guidances for proton beam therapy and planned out-of-hospital birth
- Posterior tibialis tendonopathy

- Adjustment disorder coding specification
- Feeding tube code placement review

➤ **Next meeting:**

November 12, 2015 at Clackamas Community College, Wilsonville Training Center, Rooms 111-112, Wilsonville, Oregon, Rooms.

➤ **Adjournment:**

The meeting adjourned at 1:15 PM.

Appendix A
Recommended Placement of 2016 CDT Codes

CDT Code	Code Description	Suggested Placement
D0251	extra-oral posterior dental radiographic image	Diagnostic List
D0422	collection and preparation of genetic sample material for laboratory analysis and report	Services Recommended for Non-Coverage Table
D0423	genetic test for susceptibility to diseases – specimen analysis	Services Recommended for Non-Coverage Table
D1354	interim caries arresting medicament application	348 DENTAL CONDITIONS (EG. CARIES, FRACTURED TOOTH) <i>Note: With guideline limiting to silver diamine fluoride only, used up to twice per year</i>
D4283	autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	496 DENTAL CONDITIONS (EG. PERIODONTAL DISEASE)
D4285	non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	496 DENTAL CONDITIONS (EG. PERIODONTAL DISEASE)
D5221	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	594 DENTAL CONDITIONS (EG. CARIES, FRACTURED TOOTH)
D5222	immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	594 DENTAL CONDITIONS (EG. CARIES, FRACTURED TOOTH)
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	594 DENTAL CONDITIONS (EG. CARIES, FRACTURED TOOTH)
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	594 DENTAL CONDITIONS (EG. CARIES, FRACTURED TOOTH)
D7881	occlusal orthotic device adjustment	552 TMJ DISORDER
D8681	removable orthodontic retainer adjustment	47 CLEFT PALATE WITH AIRWAY OBSTRUCTION 305 CLEFT PALATE AND/OR CLEFT LIP 621 DENTAL CONDITIONS (EG. MALOCCLUSION)
D9223	deep sedation/general anesthesia – each 15 minute increment	Exempt List
D9243	intravenous moderate (conscious) sedation/analgesia – each 15 minute increment	Exempt List
D9932	cleaning and inspection of removable complete denture, maxillary	Services Recommended for Non-Coverage Table
D9933	cleaning and inspection of removable complete denture, mandibular	Services Recommended for Non-Coverage Table

Appendix A
Recommended Placement of 2016 CDT Codes

CDT Code	Code Description	Suggested Placement
D9934	cleaning and inspection of removable partial denture, maxillary	Services Recommended for Non-Coverage Table
D9935	cleaning and inspection of removable partial denture, mandibular	Services Recommended for Non-Coverage Table
D9943	occlusal guard adjustment	650 DENTAL CONDITIONS WHERE TREATMENT RESULTS IN MARGINAL IMPROVEMENT

Appendix B

New Guideline Notes

DIAGNOSTIC GUIDELINE DXX, OPHTHALMOLOGY DIAGNOSTIC VISITS

Ophthalmology diagnostic visits (CPT 92002, 92004, 92012, 92014, 92081-92083, 92100, 92140, 92133, 92134) are covered for the evaluation of serious eye symptoms such as sudden vision loss or eye pain.

GUIDELINE XXX, CRIES ARRESTING MEDICAMENT APPLICATION

Line 348

D1354 is limited to silver diamine fluoride applications, with a maximum of two applications per year.

GUIDELINE NOTE XXX, TROCHANTERIC BURSITIS

Lines 381, 508

Trochanteric bursitis (enthesopathy of the hip, ICD-9 726.5/ ICD-10 M70.6x, M70.7x) is included on line 381 for pairing with physical therapy and steroid joint injections. Trochanteric bursitis is included on line 508 for pairing with surgical interventions (i.e. CPT 27062).

GUIDELINE NOTE XXX, STEM CELL TRANSPLANTATION FOR NEUROBLASTOMA

Line 264

Stem cell transplantation (CPT 38204-38215, 38230-38241) is only included on this line for treatment of high risk neuroblastoma (ICD-9 194.0/ICD-10 C74.xx).

GUIDELINE NOTE XXX, CHEMODENERVATION FOR CHRONIC MIGRAINE

Line 414

Chemodeneration for treatment of chronic migraine (CPT 64615) is included on this line for prophylactic treatment of adults who meet all of the following criteria:

- 1) have chronic migraine defined as headaches on at least 15 days per month of which at least 8 days are with migraine
- 2) has not responded to or have contraindications to at least three prior pharmacological prophylaxis therapies (beta-blocker, calcium channel blocker, anticonvulsant or tricyclic antidepressant)
- 3) treatment is administered in consultation with a neurologist or headache specialist.

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Treatment is limited to two treatments given 3 months apart. Additional treatment requires documented positive response to therapy. Positive response to therapy is defined as a reduction of at least 7 headache days per month compared to baseline headache frequency.

GUIDELINE NOTE XXX, CHEMODENERVATION OF THE BLADDER

Line 331

Chemodenervation of the bladder (CPT 52287) is included on this line only for treatment of idiopathic detrusor over-activity or neurogenic detrusor over-activity (ICD-9 596.5x/ICD-10-CM N32.81) in patients who have not responded to or been unable to tolerate at least two urinary incontinence antimuscarinic therapies (e.g. fesoterodine, oxybutynin, solifenacin, darifenacin, tolterodine, trospium). Treatment is limited to 90 days, with additional treatment only if the patient shows documented positive response. Positive response to therapy is defined as a reduction of urinary frequency of 8 episodes per day or urinary incontinence of 2 episodes per day compared to baseline frequency.

GUIDELINE NOTE XXX, EAR DRUM REPAIR

Lines 316,450,479

Repair of open wounds or perforations of the ear drum (ICD-9 384.2x, 389.02, 872.61, 872.71/ICD-10 H72.xx, S09.2xx) are only included on lines 316 and 450 when there is documented conductive hearing loss greater than or equal to 25dB persistent for more than three months. Otherwise, such repairs are included on line 479.

Appendix C

Modified Guidelines

GUIDELINE NOTE 20, ATTENTION DEFICIT/HYPERACTIVITY DISORDERS IN CHILDREN ~~AGE FIVE AND UNDER~~

Line 126

~~When using Use of ICD-9-CM 314.9/ICD-10-CM F90.9, Attention deficit/hyperactivity disorder, unspecified type, in children age 5 and under, it is appropriate only when the following apply:~~

- Child does not meet the full criteria for the full diagnosis because of their age.
- For children age 3 and under, when the child exhibits functional impairment due to hyperactivity that is clearly in excess of the normal activity range for age (confirmed by the evaluating clinician’s observation, not only the parent/caregiver report), and when the child is very limited in his/her ability to have the sustained periods of calm, focused activity which would be expected for the child’s age.

For children age 5 and under diagnosed with disruptive behavior disorders, including those at risk for ADHD, first line therapy is evidence-based, structured “parent-behavior training.” (i.e. Triple P (Positive Parenting of Preschoolers) Program, Incredible Years Parenting Program, Parent-Child Interaction Therapy and New Forest Parenting Program). The term “parent” refers to the child’s primary care givers, regardless of biologic or adoptive relationship. ~~Second line therapy is pharmacotherapy.~~

For children age 6 and over who are diagnosed with ADHD, pharmacotherapy alone or pharmacotherapy with psychosocial/behavioral treatment are included on this line for first line therapy.

~~Use of ICD-9-CM 314.9/ICD-10-CM F90.9 for children age five and younger is limited to pairings with the following procedure codes:~~

- ~~Assessment and Screening: 90791, 90792, H0002, H0031, H0032, T1023~~
- ~~Family interventions and supports: 90832-90838, 90846, 90847, 90849, 90887, H0038, H0045, H2021, H2022, H2027, S5151, S9125, T1005~~
- ~~Group therapy: 90785, 90832-90838, 90853, 99201-99215, H2032~~
- ~~Medication management: 90832-90838, 99201-99215~~
- ~~Case Management: 90882, T1016~~
- ~~Provider/teacher care coordination: 99366, 99367, 99368~~
- ~~Interpreter Service: T1013~~

The development of this guideline note was informed by a HERC coverage guidance. See <http://www.oregon.gov/oha/herc/Pages/blog-treatment-adhd.aspx>

Appendix C

GUIDELINE NOTE 80, REPAIR OF NOSE TIP

Line 305

Nose tip repair ([CPT 30460](#)) is included on this line only to be used in conjunction with codes 40700, 40701, 40702, or 40720~~or~~ . If not done in the context of a larger cleft palate/lip surgery, then nose tip repair is only included on this line if required for subsequent correction of physical functioning.

GUIDELINE NOTE 127, GENDER DYSPHORIA

Line 413

Hormone treatment with GnRH analogues for delaying the onset of puberty and/or continued pubertal development is included on this line 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 comprehensive mental health evaluation provided in accordance with Version 7 of the World Professional Association for Transgender Health (WPATH) Standards of Care (www.wpath.org).

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
6. for breast/chest surgeries, have one referral from a mental health professional provided in accordance with version 7 of the WPATH Standards of Care.

Appendix C

7. for genital surgeries, have two referrals from mental health professionals provided in accordance with the version 7 WPATH Standards of Care.

Electrolysis (CPT 17380) is only included on this line for surgical site electrolysis as part of pre-surgical preparation for chest or genital surgical procedures also included on this line. It is not included on this line for facial or other cosmetic procedures or as pre-surgical preparation for a procedure not included on this line.

Mammoplasty (CPT 19316, 19324-19325, 19340, 19342, 19350, 19357-19380) is only included on this line when 12 continuous months of hormonal (estrogen) therapy has failed to result in breast tissue growth of Tanner Stage 5 on the puberty scale OR there is a medical contraindication to hormonal therapy.

GUIDELINE NOTE 133, ACUTE PERIPHERAL MOTOR AND DIGITAL NERVE INJURY

Lines 430,491,515,522,541

Repair of acute (<~~8 weeks~~ 6 months) peripheral nerve injuries are included on Line 430. Non-surgical medical care of these injuries are included on Line 491. Chronic nerve injuries are included on Lines 515, 522 and 541.

Appendix D

Deleted Guidelines

~~STATEMENT OF INTENT 3: INTEGRATED CARE~~

~~Recognizing that many individuals with mental health disorders receive care predominantly from mental health care providers, and recognizing that integrating mental and physical health services for such individuals promotes patient-centered care, the Health Evidence Review Commission endorses the incorporation of chronic disease health management support within mental health service systems. Although such supports are not part of the mental health benefit package, mental health organizations (MHOs) that elect to provide these services may report them using psychiatric rehabilitation codes which pair with mental health diagnoses. If MHOs choose to provide tobacco cessation supports, they should report these services using 99407 for individual counseling and S9453 for classes.~~

~~GUIDELINE NOTE 25, MENTAL HEALTH PROBLEMS IN CHILDREN AGE FIVE AND UNDER RELATED TO NEGLECT OR ABUSE~~

Line 177

~~ICD-10-CM T76.02xA and T76.02xD (Child neglect or abandonment, suspected), (ICD-10-CM T74.02xA and T74.02xD (Child neglect or abandonment, confirmed), T74.22xA and T74.22xD (Child sexual abuse, confirmed), T76.22xA and T76.22xD (Child sexual abuse, suspected), T76.12xD (Child physical abuse, suspected, subsequent encounter) or T74.12xA and T74.12xD (Child physical abuse, confirmed) and corresponding ICD-9-CM codes 995.52, 995.53, 995.54 and 995.59, may be used in any children when there is evidence or suspicion of abuse or neglect. These codes are to be used when the focus of treatment is on the alleged child victim. This can include findings by child welfare of abuse or neglect; or statements of abuse or neglect by the child, the perpetrator, or a caregiver or collateral report. Although these diagnoses can be used preventively, i.e. for children who are not yet showing symptoms, presence of symptoms should be demonstrated for interventions beyond evaluation or a short-term child or family intervention.~~

~~The codes T74.02xA, T74.02xD, T74.02XA, T74.02XD, T74.22xA, T74.22xD, T76.22xA, T76.22xD, T76.12xA, T76.12xD, 74.12xA or T74.12xD and corresponding ICD-9-CM codes 995.52, 995.53, 995.54 and 995.59 may be used in children age five and younger and, in these instances only, is limited to pairings with the following procedure codes:~~

- ~~• Assessment and Screening: 90791, 90792, H0002, H0031, H0032, T1023~~
- ~~• Family interventions and supports: 90832-90838, 90846, 90847, 90849, 90887, H0038, H0045, H2021, H2022, H2027, S5151, S9125, T1005~~
- ~~• Individual counseling and therapy: 90785, 90832-90838, 99201-99215~~
- ~~• Group therapy: 90832-90838, 90853, 90857, H2032~~
- ~~• Case Management: 90882, T1016~~
- ~~• Interpreter Service: T1013~~
- ~~• Medication management is not indicated for these conditions in children age 5 and under.~~

Appendix D

~~GUIDELINE NOTE 28, MOOD DISORDERS IN CHILDREN AGE EIGHTEEN AND UNDER~~

Line 207

~~The use of ICD-10-CM code F39 Unspecified Mood [Affective] Disorder/ICD-9-CM code 296.90, Unspecified Episodic Mood Disorder, is appropriate only for children 18 years old and under, who have functional impairment caused by significant difficulty with emotional regulation.~~

~~Use of ICD-10-CM F39/ICD-9-CM 296.90 is limited to pairings with the following procedure codes:~~

- ~~● Assessment and Screening: 90791, 90792, H0002, H0031, H0032, T1023~~
- ~~● Family interventions and supports: 90832-90838, 90846, 90847, 90849, 90887, H0038, H0045, H2021, H2022, H2027, S5151, S9125, T1005~~
- ~~● Individual Counseling and Therapy: 90785, 90832-90838, 99201-99215, H0004~~
- ~~● Group therapy: 90785, 90832-90838, 90853, 99201-99215, H2032~~
- ~~● Medication management: 99201-99215~~
- ~~● Case Management: 90882, T1016~~
- ~~● Interpreter Service: T1013~~

~~GUIDELINE NOTE 42, DISRUPTIVE BEHAVIOR DISORDERS IN CHILDREN AGE FIVE AND UNDER~~

Line 425

~~The use of ICD-10-CM code F91.9 Conduct disorder, unspecified/ICD-9-CM 312.9, Unspecified Disturbance of Conduct), is appropriate only for children five years old and under, who display sustained patterns of disruptive behavior beyond what is developmentally appropriate. Interventions should prioritize parent skills training in effective behavior management strategies or focus on other relational issues.~~

~~Use of F91.9/312.9 is limited to pairings with the following procedure codes:~~

- ~~● Assessment and Screening: 90791, 90792, H0002, H0031, H0032, T1023~~
- ~~● Family interventions and supports: 90832-90838, 90846, 90847, 90849, 90887, H0038, H0045, H2021, H2022, H2027, S5151, S9125, T1005~~
- ~~● Individual Counseling and Therapy: 90785, 90832-90838, 99201-99215, H0004~~
- ~~● Group therapy: 90785, 90832-90838, 90853, 99201-99215, H2032~~
- ~~● Case Management: 90882, T1016~~
- ~~● Interpreter Service: T1013~~
- ~~● Medication management is not indicated for these conditions in children age 5 and under.~~

~~GUIDELINE NOTE 45, ADJUSTMENT REACTIONS IN CHILDREN AGE FIVE AND UNDER~~

Line 449

~~ICD-10-CM code F43.2x/ICD-9-CM 309.89 can be used for individuals of any age. However, when using it for children five years of age or younger, who have experienced abuse or neglect, the following must apply:~~

~~The child must demonstrate some symptoms of PTSD (such as disruption of his or her usual sleeping or eating patterns, or more increased irritability/lower frustration tolerance) but does not meet the full criteria for PTSD or any other disorder.~~

~~A) F43.2x/309.89 is limited to pairings with the following procedure codes:~~

- ~~● Assessment and Screening: 90791, 90792, H0002, H0031, H0032, T1023~~
- ~~● Group Therapy: 90785, 90832-90838, 90853, 99201-99215, H2032~~

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- ~~Family Interventions and Supports: 90832-90838, 90846, 90847, 90849, 90887, H0038, H0045, H2021, H2022, H2027, S5151, S9125, T1005~~
- ~~Case Management: 90882, T1016~~
- ~~Interpreter Service: T1013~~
- ~~Individual Counseling and Therapy: 90785, 90832-90838, 99201-99215~~
- ~~Medication Management is not indicated for this condition in children five years of age or younger.~~

~~Note: Cessation of the traumatic exposure must be the first priority. Infants and toddlers may benefit from parental guidance regarding management of the child's symptoms, parental guidance around enhancing safety and stability in the child's environment, and therapeutic support for the parents.~~

~~ICD-10-CM codes Z62.82x (Parent-child conflict) and Z63.4 (Disappearance and death of family member), may only be used as secondary diagnoses to the primary diagnosis of F43.2x, and only for children five years of age or younger. Two ICD-9-CM codes, V61.20 (Counseling for Parent-Child Problem, Unspecified) and V62.82 (Bereavement, Uncomplicated), may only be used as secondary diagnoses to the primary diagnosis of 309.89 (Other specified adjustment reactions), and only for children five years of age or younger.~~

~~A) When using codes Z62.82x/V61.20, the following must apply:~~

- ~~1) Service provision will have a clinically significant impact on the child.~~
- ~~2) A rating of 40 or lower has been assessed on the PIR-GAS (Parent-Infant Relationship Global Assessment Scale).~~
- ~~3) The same limitations in pairings to CPT and HCPCS codes as given for ICD-10-CM code F43.2x apply, with the only exception being that 90785 cannot be used.~~

~~B) When using ICD-10-CM Z63.4 (Disappearance and death of family member)/ICD-9-CM V62.82, the following must apply:~~

- ~~1) The child exhibits a change in functioning subsequent to the loss of a primary caregiver;~~
- ~~2) The child exhibits at least three of the following eight symptoms:
 - ~~a) Crying, calling and/or searching for the absent primary caregiver;~~
 - ~~b) Refusing attempts of others to provide comfort;~~
 - ~~c) Emotional withdrawal manifesting in lethargy, sad facial expression, and lack of interest in age-appropriate activities that do not meet mood disorder criteria;~~
 - ~~d) Disruptions in eating and sleeping that do not meet criteria for feeding and eating disorders of infancy or early childhood;~~
 - ~~e) Regression in or loss of previously achieved developmental milestones not attributable to other health or mental health conditions;~~
 - ~~f) Constricted range of affect not attributable to a mood disorder or PTSD;~~
 - ~~g) Detachment, seeming indifference toward, or selective "forgetting" of the lost caregiver and/or of reminders of the lost caregiver;~~
 - ~~h) Acute distress or extreme sensitivity in response to any reminder of the caregiver or to any change in a possession, activity, or place related to the lost caregiver;~~~~
- ~~3) The symptoms in B(2) above are exhibited for most of the day and for more days than not, for at least 2 weeks.~~
- ~~4) The same limitations in pairings to CPT and HCPCS codes as given for ICD-10-CM code F43.2x/ICD-9-CM code 309.89 apply.~~

~~Note: Intervention should include persons significantly involved in the child's care and include psychoeducation and developmentally specific guidance.~~

Appendix D

~~GUIDELINE NOTE 81, RECONSTRUCTION OF THE NOSE~~

~~Lines 261,648~~

~~ICD-10-CM codes Q30.1, Q30.2 and Q30.8/ICD-9-CM code 748.1 are on this line only for reconstruction of absence of the nose and other severe nasal anomalies which significantly impair physical functioning.~~

~~GUIDELINE NOTE 91, SILVER COMPOUNDS FOR DENTAL CARIES~~

~~Lines 57,347,348,473,599~~

~~Silver compounds for dental caries prevention and treatment are not included on these or any lines on the Prioritized List for coverage consideration~~