

Value-based Benefits Subcommittee Recommendations Summary For Presentation to: Health Evidence Review Commission in March 2014

*For specific coding recommendations and guideline wording,
please see the text of the 3-13-14 VbBS minutes.*

CODE MOVEMENT

- The procedure code for repair of webbed finger was removed from 5 lines but remains on one covered line
- Screening for lung cancer among certain high risk persons was added to the covered prevention services line with a diagnostic guideline
- A dental risk assessment procedure code was added to the covered preventive services line with a new guideline
- The procedure code for chemodenervation for migraine was added to the covered migraine line with a future guideline planned to specify when this procedure is covered

BIENNIAL REVIEW

- A new line was created for fibromyalgia which will be located at approximately line 534, with a new guideline associated with the line regarding treatment.

GUIDELINE CHANGES

- The non-genetic testing guideline was modified to specify the training/experience requirements for clinicians who can provide genetic counseling.
- The prophylactic treatment for breast cancer among high risk women guideline was modified to refer to the non-genetic testing guideline specifications for the type of clinician who can provide genetic counseling.

ICD-10

- The final October 1, 2014 ICD-10 Prioritized List was approved

VALUE-BASED BENEFITS SUBCOMMITTEE
Meridian Park Health
Community Health Education Center, Room 117B&C
Tualatin, OR
March 13, 2014
8:30 AM – 1:00 PM

Members Present: Lisa Dodson, MD, Chair; Kevin Olson, MD, Vice-chair; James Tyack, DMD; David Pollack, MD; Mark Gibson; Laura Ocker, LAc.

Members Absent: Irene Crowell RPh; Susan Williams, MD

Staff Present: Darren Coffman; Ariel Smits, MD, MPH; Cat Livingston, MD, MPH; Jason Gingerich; Dorothy Allen; Denise Taray

Also Attending: Wally Shaffer, MD, DMAP; Jesse Little, OHA Actuarial Services Unit; Mike Willett CGC; Tami Stackelhouse, Jen Chambers, and Robert Staples, Fibromyalgia-Me/CFS; Melissa Gard, ORABA; Deirdre Monroe, Camille Kerr, and Jennifer Stoll, Allergan; Shannalisa Prusse, Zone Compounding; Kim Jones, PhD and Dr. Robert Bennett, OHSU; Tobi Rates, Autism Society; Matt Krebs, US Gov't Relation; Karen Kovak, OHA; Tom Culhane, Atrio; Jan Chambers, NFMCPA; Dianne Danowski Smith, Publix NW ; Jenn Burleton, TransActive Gender Center; Larry Burnett, DMD; David McElhattan, Peter Molof , Aubrey Harrison, and Maura Roche, Basic Rights Oregon; Deborah Weston, DMAP

Roll Call/Minutes Approval/Staff Report

The meeting was called to order at 8:30 AM and roll was called. Minutes from the January 9, 2104 VbBS meeting were reviewed and no corrections or changes were recommended.

MOTION: To approve the January 9, 2014 VbBS minutes as presented. CARRIES 6-0.

ACTION: HERC staff will post the approved minutes on the website as soon as possible.

Staff introduced Denise Taray, RN, who is the new coordinator of the Oregon Pain Management Commission and will be working with the HERC staff focusing on Prioritized List support.

➤ **Topic: Straightforward/Consent agenda**

Discussion: There was no discussion.

Actions:

- 1) Remove E&M codes from lines 654 and 655
- 2) Remove 26560-26562 from lines 290, 391, 430, 511, and 534
- 3) Rename line 122 NUTRITIONAL ~~ANEMIAS~~ DEFICIENCIES
- 4) Remove the following coding specification from line 364: "~~Chemodenervation with botulinum toxin injection (CPT 64612-64614) is included on this line only for treatment of blepharospasm (ICD-9 333.81), spasmodic torticollis (ICD-9 333.83), and other fragments of torsion dystonia (ICD-9 333.89).~~"

➤ **Topic: Biennial Review**

Discussion: Smits reviewed the progress to date on the 2014 Biennial Review. She informed the subcommittee that the suggested creation of a perinatal gastrointestinal condition line was not recommended by HERC staff after further review. The 6 ICD-10 codes proposed for placement on this line can be placed on other, existing lines with similar conditions and appropriate treatments. The subcommittee approved this change.

Smits requested input on whether injury to blood vessels in the neck should be placed on a new line. Currently, these injuries are on Line 135 CRUSH INJURIES OTHER THAN DIGITS; COMPARTMENT SYNDROME. These diagnoses could be placed on their own, new line, or moved to either 82 INJURY TO MAJOR BLOOD VESSELS OF EXTREMITIES or 280 INJURY TO BLOOD VESSELS OF THE THORACIC CAVITY. Members felt that injuries to the major neck vessels would be similar in severity to injury of thoracic vessels. However, there was concern that these diagnoses should have a higher prioritization than the current line for repair of thoracic blood vessel injuries. This line was given lower priority than the repair of extremity blood vessels because of lower effectiveness of treatment. The decision was made to have staff bring a proposed new line for injuries to blood vessels of the neck to the next meeting with suggested scoring. If the scoring is determined to be close to a current line with similar conditions, then the neck blood vessel injury ICD-10 codes would move to that line. If not, then a new line would be created as part of the biennial review for the April 2016 Prioritized List.

Members approved the remaining topics on the list for the biennial review, to be discussed at the May meeting.

Actions:

- 1) HERC staff to create a proposal for a new line for injuries to the blood vessels of the neck
- 2) Other topics for the biennial review:
 - a. Restructuring of low back pain lines

- i. Create effective treatment line with high priority and non-effective treatment line with low priority
- ii. Replace current differentiation by neurological symptoms
- b. Creation of a miscellaneous line with no treatments necessary

➤ **Topic: Fibromyalgia**

Discussion: The summary document on fibromyalgia was reviewed. Testimony was heard from Kim Jones, PhD from OHSU, Dr. Robert Bennett from OHSU, and Jen Chambers from the National Fibromyalgia and Chronic Pain Association. This group testified that fibromyalgia has greater similarity to rheumatoid arthritis than to osteoarthritis in terms of suffering and life year scoring. Dr. Jones proposed that efficacy of treatment for fibromyalgia should be a 3, not a 1 as suggested by HERC staff. Dr. Bennett reviewed results of an unpublished survey of fibromyalgia patients. He also noted higher rates of suicidality among fibromyalgia in the literature. Ms. Chambers discussed her experience with fibromyalgia and noted that untreated fibromyalgia adversely affects the family and community.

Additional testimony was heard from Tammi Stackelhouse, from the Fibromyalgia Association. She showed results from a petition to have OHP cover fibromyalgia treatment. She argued that effective treatment helps patients become more functional and possibly return to work. Shannalisa Pruse from Zone Compounding testified that topical compounded medications are helpful in fibromyalgia. Robert Staples, whose wife has fibromyalgia, testified to the severity of her condition and to its effects on him as a caregiver.

The subcommittee discussed the scoring of the proposed new fibromyalgia line. Healthy years score was determined to be 4 given the disability some patients experience from this condition. Suffering was determined to be a 3 based on the severe effects on some patients and the lesser effects on other patients who do not seek specialty care. Effectiveness for treatment of pain from fibromyalgia in the medical literature was determined to be about 15%, or a score of 1. The members noted that future literature may show higher effectiveness, and the scoring could be revised in the future. Co-morbid conditions such as depression, migraine, etc. are in the covered area of the list and treatment would be covered. The group voted on the line scoring which gave a score of 112 with approximate line placement of 534.

The guideline for the new line which was discussed in January was again reviewed. There was discussion about what types of medications should be included in the first bullet point example. The decision was to simply specify that medications should not include opioids. There was some discussion about whether all patients need multi-modality care with two or more types of treatment, particularly those patients with mild disease. Multi-modal care is called out in

various evidence based guidelines, and the group decided it should continue to be in the new guideline.

MOTION: To approve the creation of a new line for fibromyalgia with coding as shown in the meeting materials, with scoring as shown below, and a new guideline for this line as revised. CARRIES 6-0.

Actions:

- 1) Create a new line for fibromyalgia effective January 1, 2016:

LINE XXX

Condition: Fibromyalgia

Treatment: Medical Therapy

ICD-10: M79.7

CPT: CBT (90785, 90832-90853), medical office visits (98966-99215, 99441-99449, 99487-99489), medical team conference (99366-99368), preventive medicine visit (99381-99429)

- 2) Adopted line scoring:

Category: 7

Healthy Life: 4

Pain & suffering: 3

Population effects: 0

Vulnerable population: 0

Tertiary prevention: 0

Effectiveness: 1

Need for service: 0.8

Net cost: 2

Score: 112

Approximate line placement: 534

- 3) Adopt a new guideline for this line as shown in Appendix A

➤ **Topic: Somatization/Factitious Disorder Line Merge**

Discussion: Tabled to the May, 2014 VBBS meeting

➤ **Topic: Lung Cancer Screening Guideline**

Discussion: The summary document was reviewed. There was discussion about requiring smoking cessation prior to screening, as this would be the most effective intervention to reduce lung cancer incidence. However, it was felt that in the high risk Medicaid population, and in the mental health population, this would be a large barrier. Olson stated that programs with a smoking cessation component have lower rates of screening. Stopping smoking did not affect outcomes in the trials of lung cancer screening. Coffman noted that the ACA

requires coverage of USPSTF level B recommendations, such as lung cancer screening. The group decided to place lung cancer screening on the higher preventive services line with a diagnostic guideline. A sentence was added to the proposed guideline stating that current smokers should be offered evidence-based smoking cessation interventions.

MOTION: To approve the addition of ICD-10 Z12.2 to line 3 and the new diagnostic guideline as amended. CARRIES 6-0

Actions:

- 1) Add ICD-10 Z12.2 to Line 3 PREVENTIVE SERVICES for the October 1, 2014 Prioritized List and advise DMAP to remove from the Excluded List
- 2) Add a new diagnostic guideline as shown in Appendix A

➤ **Topic: Genetic counseling in the non-prenatal genetic testing guideline**

Discussion: The summary document was reviewed. Karen Kovak testified about need to order appropriate testing and to know which patients should be tested. The group discussed when genetic counseling should be given by board-certified physicians without specialized board certification in genetics rather than specialized genetics professionals. It was determined that in a few time-sensitive cases, such as a woman with a breast tumor who needs a mastectomy and needs quick BRCA testing to determine best treatment, testing by a non-board certified physician would be acceptable as long as specialized genetic consultation was obtained as soon after testing as practical. The suggested wording for this portion of the guideline was changed to add in “time-sensitive cases” to stress that this exception should be very narrow.

MOTION: To approve the proposed changes to guideline note 3 and the amended changes to diagnostic guideline D1. CARRIES 6-0

Actions:

- 1) Modify diagnostic guideline D1 as shown in Appendix B
- 2) Modify guideline note 3 as shown in Appendix B

➤ **Topic: Guideline revision for treatment of sleep apnea**

Discussion: Tabled to the May, 2014 VBBS meeting

➤ **Topic: Fluoride varnish guideline revision**

Discussion: Tabled to the May, 2014 VBBS meeting

➤ **Topic: Rehabilitation guideline revision**

Discussion: The summary document was reviewed. There was discussion about whether a revised guideline should continue to include unlimited therapy visits for the first 3 months after an acute event. This coverage is not reflected in commercial plans, but allows intensive therapy after surgery or acute injury. The members expressed interest in input from the PT/OT community. Shaffer noted that increasing visit limits would have a budgetary impact. He also noted that the Medical Directors have requested a well-defined limit on therapy visits that is easy to implement.

After discussion, the group determined that the guideline should be changed to allow 30 therapy visits a year, and to eliminate the unlimited 3 month coverage after an acute event. Consideration may be given for more visits in cases of rapid developmental changes, documented progress with continued need for services, and other special cases. Wording should be included in the revised guideline to require documented improvement to continue to receive services within the allowed initial 30 visits.

Actions:

- 1) HERC staff will draft wording for the rehabilitation guideline to reflect the above discussion and bring back to the May VBBS meeting

➤ **Topic: Transgender hormone therapy**

Discussion: The summary document was reviewed. Members noted that there is a low level of evidence supporting the use of cross-sex hormone therapy for gender dysphoria. There was concern that the level of evidence used to support coverage of treatments and conditions should be consistent across the Prioritized List. Staff noted that the Oregon Insurance Division has issued a bulletin requiring regulated health plans to require cross-sex hormone therapy when other types of hormone therapy are covered. This bulletin does not apply to the Medicaid program.

Testimony was heard from Jenn Burleton from TransActive and Aubrey Harrison from Basic Rights Oregon about the available evidence for cross-hormone therapy use and about the current legal landscape around treatment of transgendered persons. Ms. Burleton stressed that puberty suppression treatment, which is currently planned for coverage on the new gender dysphoria line, needs to transition to cross-sex hormone therapy after about 3-4 years. Both noted that it is difficult to study treatment of transgendered persons because of difficulty with identification of this population.

Actions:

- 1) HERC staff work with experts to obtain the current evidence of effectiveness for cross-sex hormone therapy and for sex reassignment surgery for gender dysphoria and bring back this evidence and recommendations for coverage to the May VBBS meeting

➤ **Topic: ABA intensity for treatment of autism spectrum disorder**

Discussion: Livingston reviewed the status of the draft evidence evaluation on applied behavior analysis (ABA) for autism spectrum disorder (ASD). The Evidence-based Guidelines Subcommittee (EbGS) is currently reviewing the topic and will complete its work at their April 24th meeting. She reviewed the current coverage for autism spectrum disorder, which includes up to 8 hours per month of behavioral treatment. The current draft being reviewed by EbGS (included in the meeting materials) recommends coverage of some types of ABA for children ages 2-12, but that subcommittee may not put forth recommendations on intensity and duration of treatment as the service is often highly individualized and the evidence doesn't suggest a specific minimum or maximum treatment. There are temporary new CPT codes that go into effect July 1st which may be used to specify ABA. Further discussion regarding treatment of autism will be held after the EbGS report is finalized, but as it will likely require extensive discussion, staff wanted to get initial input from VbBS to shape its recommendation.

Livingston reviewed the key evidence around coverage, including hours per week and duration of treatment, as well as parameters for evaluating treatment progress and the difference for comprehensive versus focused ABA. Eric Larsson, who serves as one of the HERC's three appointed ad hoc experts, testified and answered questions regarding this treatment. Larsson said focused treatment averages 18 months and intensive treatment averages about 3 years followed by 1 year of fadeout. However these are averages, not outside limits. About half of the children can expect to reach goal in that timeframe, but the others will require continued help, and 10 percent of these don't benefit from ABA at all and need a different approach. For the remaining 40 percent, the goal would be to titrate down the level hours over an extended period of time and have increasing care provided by parents and teachers. Livingston asked whether the outside duration would be 3 years. As for initiation of treatment, Larsson said if a child doesn't start intensive therapy by the age of nine, only one in 50 children would reach a point where they don't require special education. He then spoke on the need for individualized treatment rather than a hard cap on hours based on an average from studies and also the need for adequate supervision by adequately trained analysts. In addition, evidence supports both parent- and clinic-based interventions, but Larsson testified that some parents are unable to manage intensive treatment, as it is quite demanding on a family. The goal would be to transition a child from intensive clinic-based treatment to

treatment provided by the family, educational systems and other community supports.

The subcommittee then heard public testimony from Melissa Gard from the Oregon Association for Behavior Analysis and Tobi Rates from the Autism Society of Oregon. Gard briefly reviewed evidence and guidelines for this treatment and emphasized the need for individualized treatments. She emphasized the importance of intensity of treatment as well as the intensity of treatment supervision. She said there needs to be appropriate supervision for each case and said that more intensive supervision is associated with adaptive IQ gains and adaptive function.

A member asked whether that contradicted the evidence in the evaluation which didn't associate treatment intensity with improved outcomes. Livingston said the core source reports do not show a direct relationship between intensity and these outcomes. Livingston asked Gard about a separate study showing an association between intensity and outcomes. That study compared 3 to 8 hours of supervision. Gard clarified that the 3-8 hours of supervision was the behavior analyst's supervision and treatment planning and that additional hours of comprehensive treatment were provided by less skilled staff totaling about 30 hours per week for each child. Livingston asked how important it is to specify the different levels of care—whether the VbBS should recommend a global number of hours or require a certain level of supervision. Gard replied that it would be important to specify the level of supervision, but said as long as the bill is in place it might be redundant to have VbBS add additional requirements.

The subcommittee discussed the requirements of Senate Bill 365, which requires state-regulated health plans cover 25 hours per week of medically necessary ABA therapy for children who initiate therapy by the age of 9. However Gard said that children who require additional therapy can rely on mental health parity and other laws to get additional hours of treatment. She said that advocates wanted Senate Bill 365 because families previously sometimes needed to go through appeals and to court in order to get coverage. She advocates coverage based on the child's individual progress rather than maximum limits on duration and intensity. The subcommittee discussed how families might be unlikely to bring their children in for treatment if it is not working, so that might limit overuse. Olson suggested that hard limits on intensity and duration might be impractical and not add value, especially due to low reimbursement rates under OHP. Pollack suggested that plans might want to have each health plan have an ASD expert to manage cases.

Dodson asked about whether this is a health service or educational service. Gard said that this intervention can be done in school, but questioned whether that is the appropriate place, especially for very young children. In an educational setting, the treatment goals are limited to accessing education rather than the child's overall needs. Dodson asked how medical treatment should interact with

educational care. Gard said that consultation between mental health providers and educators are important. The goal would be to move towards less mental health care and more educational services.

Livingston asked the subcommittee if there are specific areas the subcommittee would like to have proposed language about. Pollack asked for draft language from the experts, especially regarding duration and intensity.

➤ **Topic: Oral health risk assessment codes**



Discussion: The summary document was reviewed. Testimony was heard by Larry Burnett, DMD regarding the need for early screening and intervention. Livingston stated that the dental screening code proposed for addition to the prevention line would allow this screening. The members requested that the word “undergone” be changed to “successfully completed” in the proposed guideline.

MOTION: To approve the suggested changes for D0145, D0601-D0603, and D0191. Approve the guideline note as amended. CARRIES 6-0.

Actions:

- 1) Remove D0145 from Line 3. Keep only on Line 58
- 2) Do not add D0601-D0603 to Lines 1 and 3
- 3) Keep D0191 on Line 3
- 4) Revise Guideline Note 122 Oral Health Risk Assessment as shown in Appendix B

➤ **Topic: Botulinum toxin for chronic migraine**

Discussion: The summary document was reviewed. Medicaid law regarding need to provide a “pathway to coverage” for medications was reviewed.

MOTION: To approve the addition of CPT 64615 to line 414. CARRIES 5-0 (Pollack abstained).

Actions:

- 1) Add CPT 64615 (Chemodenervation for migraine) to line 414 MIGRAINE HEADACHES
- 2) HERC staff to bring a guideline to the June or August VBBS with specific limitations for this procedure based on the coverage criteria determined at the May P&T Committee meeting.

➤ **Topic: Final approval of October 1, 2014 ICD-10 Prioritized List**

Discussion: Staff summarized the staff work to date to correct errors and otherwise finalize the October 1, 2014 ICD-10 Prioritized List.

MOTION: To approve the October 1, 2014 ICD-10 Prioritized List. CARRIES 6-0.

Actions:

- 1) The October 1, 2014 Prioritized List will be published on the website soon after the April 1, 2014 Prioritized List goes into effect.

➤ **Public Comment:**

No additional public comment was received.

➤ **Issues for next meeting:**

- Biennial review
 - Injury to major blood vessels in the neck
 - Somatization/factitious disorder line merge
 - Restructuring of low back pain lines
 - Creation of a miscellaneous line with no treatments necessary
- Cross sex hormone therapy and gender reassignment surgery for gender dysphoria
- Guideline revision for treatment of sleep apnea
- Fluoride varnish guideline revision
- Rehabilitation guideline revisions
- Electronic tumor field treatment
- Electroconvulsive therapy
- Bone anchored hearing aids

➤ **Next meeting:**

May 8, 2014 at:

Clackamas Community College, Room 111-112
Wilsonville Training Center
29353 SW Town Center Loop E
Wilsonville, Oregon 97070

➤ **Adjournment:**

The meeting was adjourned at 1:35 PM.

Appendix A

New Guidelines

DIAGNOSTIC GUIDELINE DXX LUNG CANCER SCREENING

Low dose computed tomography is included for annual screening for lung cancer in persons aged 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery. Current smokers should be offered evidence based smoking cessation interventions.

GUIDELINE XXX, FIBROMYALGIA

Line AAA

Fibromyalgia (ICD-9 729.1/ICD-10 M79.7) treatment should consist of a multi-modal approach, which should include two of more of the following:

- 1) medications other than opioids
- 2) exercise advice/programs
- 3) cognitive behavioral therapy.

Care should be provided in the primary care setting. Referrals to specialists are generally not required. Use of opioids should be avoided due to evidence of harm in this condition.

Appendix B

Revised Guidelines

DIAGNOSTIC GUIDELINE D1, NON-PRENATAL GENETIC TESTING GUIDELINE

Coverage of genetic testing in a non-prenatal setting shall be determined [by](#) the algorithm shown in Figure D1 unless otherwise specified below.

- A) Related to genetic testing for patients with breast/ovarian and colon/endometrial cancer [or other related cancers](#) suspected to be hereditary, or patients at increased risk to due to family history.
 - 1) Services are provided according to the Comprehensive Cancer Network Guidelines.
 - a) Lynch syndrome (hereditary colorectal and endometrial cancer, [and other cancers associated with Lynch syndrome](#)) services (CPT 81292-81300, 81317-81319) and familial adenomatous polyposis (FAP) services (CPT 81201-81203) should be provided as defined by the NCCN Clinical Practice Guidelines in Oncology. Colorectal Cancer Screening. V.1.2013 (5/13/13). www.nccn.org
 - b) BRCA1/BRCA2 testing services (CPT 81211-81217) for women without a personal history of breast, ~~and/or~~ ovarian, [and other associated cancers](#) should be provided to high risk women as defined in Guideline Note 3 or as otherwise defined by the US Preventive Services Task Force.
 - c) BRCA1/BRCA2 testing services (CPT 81211-81217) for women with a personal history of breast, ~~and/or~~ ovarian, [and other associated cancers](#) and for men with breast cancer should be provided according to the NCCN Clinical Practice Guidelines in Oncology. Genetic/Familial High-Risk Assessment: Breast and Ovarian. V.1.2011 (4/7/11). www.nccn.org
 - d) PTEN (Cowden syndrome) services (CPT 81321-81323) should be provided as defined by the NCCN Clinical Practice Guidelines in Oncology. Colorectal Screening. V.1.2013 (5/13/13). www.nccn.org.
 - 2) Genetic counseling should precede genetic testing for hereditary cancer [whenever possible](#). ~~Very rarely, it may be appropriate for a genetic test to be performed prior to genetic counseling for a patient with cancer. If this is done, genetic counseling should be provided as soon as practical.~~
 - a) Pre and post-test genetic counseling ~~by the following providers~~ should be covered when provided by [a suitably trained health professional with expertise and experience in cancer genetics](#)
 - i) [“Suitably trained” is defined as board certified or active candidate status from the American Board of Medical Genetics, American Board of Genetic Counseling, or Genetic Nursing Credentialing Commission.](#)
 - ~~ii) Medical Geneticist (M.D.) – Board Certified or Active Candidate Status from the American Board of Medical Genetics~~
 - ~~iii) Clinical Geneticist (Ph.D.) – Board Certified or Active Candidate Status from the American Board of Medical Genetics.~~
 - ~~iv) Genetic Counselor – Board Certified or Active Candidate Status from the American Board of Genetic Counseling, or Board Certified by the American Board of Medical Genetics.~~

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- ~~v) Advance Practice Nurse in Genetics—Credential from the Genetic Nursing Credentialing Commission.~~
- b) If timely pre-test genetic counseling is not possible for time-sensitive cases, appropriate genetic testing accompanied by pre- and post- test informed consent and post-test disclosure performed by a board-certified physician with experience in cancer genetics should be covered.
 - i) i) Post-test genetic counseling should be performed as soon as is practical.

GUIDELINE NOTE 3, PROPHYLACTIC TREATMENT FOR PREVENTION OF BREAST CANCER IN HIGH RISK WOMEN

Line 195

Bilateral prophylactic breast removal is included on Line 195 for women without a personal history of invasive breast cancer who are at high risk for breast cancer. Prior to surgery, women without a personal history of breast cancer must have a genetics consultation as defined in section A2 of the DIAGNOSTIC GUIDELINE D1, NON-PRENATAL GENETIC TESTING GUIDELINE. High risk is defined as:

- A) Having a BRCA1/BRCA2 mutation;
- B) Having a strong family history of breast cancer, defined as one of the following:
 - 1) 2 first-degree or second degree relatives diagnosed with breast cancer at younger than an average age of 50 years (at least one must be a first-degree relative);
 - 2) 3 first-degree or second-degree relatives diagnosed with breast cancer at younger than an average age of 60 years (at least one must be a first-degree relative);
 - 3) 4 relatives diagnosed with breast cancer at any age (at least one must be a first-degree relative);
 - 4) 1 relative with ovarian cancer at any age and, on the same side of the family, either 1 first-degree relative (including the relative with ovarian cancer) or second-degree relative diagnosed with breast cancer at younger than age 50 years, or 2 first-degree or second-degree relatives diagnosed with breast cancer at younger than an average age of 60 years, or another ovarian cancer at any age;
 - 5) 1 first-degree relative with cancer diagnosed in both breasts at younger than an average age of 50 years;
 - 6) 1 first-degree or second-degree relative diagnosed with bilateral breast cancer and one first-degree or second-degree relative diagnosed with breast cancer at younger than an average age of 60 years; or,
 - 7) a male relative with breast cancer at any age and on the same side of the family at least 1 first-degree or second-degree relative diagnosed with breast cancer at younger than age 50 years, or 2 first-degree or second-degree

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- relatives diagnosed with breast cancer at younger than an average age of 60 years.
- c) A history of LCIS with a family history of breast cancer; or,

 - d) A history of treatment with thoracic radiation between ages 10 and 30.

Contralateral prophylactic mastectomy is included on Line 195 for women with a personal history of breast cancer and any of the high risk categories listed above. In addition, contralateral prophylactic mastectomy of the unaffected breast is indicated for women with invasive lobular carcinoma.

Prophylactic oophorectomy is included on Line 195 for women who have the BRCA1/BRCA2 mutation

GUIDELINE NOTE 122, ORAL HEALTH RISK ASSESSMENT IN MEDICAL SETTINGS

Lines 1,~~3,58~~

~~CDT codes D0601-D0603 and D0191 coverage is restricted on these lines as follows:~~

~~Line 1: pregnant women only~~

~~Line 3: children under the age of 6 only~~

~~Line 56: children under the age of 21 only~~

~~These services are included when performed using approved tools and when D0191 is limited to children under age 6 and requires an additional specific oral health risk assessment using a standardized tool, such as AAP Bright Futures, and should be performed by a provider who has successfully completed an approved training program (such as First Tooth or Smiles for Life).~~