

# **Value-based Benefits Subcommittee Recommendations Summary For Presentation to: Health Evidence Review Commission on 5/9/13**

*For specific coding recommendations and guideline wording, please see the text of the  
(3/14/2013) VbBS minutes.*

## **CODE MOVEMENT**

- Uterine artery embolization procedure was added to the uterine fibroid line
- The procedure code for therapeutic PT/OT activities was added to 2 covered lines
- Psychotherapy procedure codes were removed from the low back pain lines and replaced with the health and behavior assessment procedures codes
- Acupuncture procedure codes were added to the non-covered neck pain line
- Diagnostic codes for sleep apnea testing were recommended to DMAP to move from the Ancillary File to the Diagnostic File

## **ITEMS CONSIDERED BUT NO CHANGES MADE**

- No change was made to the prioritization of pseudobulbar affect
- No change was made to the current lack of coverage for CT angiogram or coronary artery calcium screening
- Acupuncture was not added for treatment of hip osteoarthritis or painful shoulder conditions
- No change was yet made to the chronic otitis media with effusion guideline, this will be reworded and brought back to the following meeting

## **NEW GUIDELINES**

- A new guideline on cervical cancer screening was adopted
- A new diagnostic guideline was adopted specifying that MRI is not covered for confirmation of a diagnosis of breast cancer
- A new guideline on continuous blood glucose monitoring was adopted
- A new guideline on diagnosis of obstructive sleep apnea was adopted
- A new guideline on vertebroplasty, kyphoplasty, and sacroplasty was adopted

## **GUIDELINE CHANGES**

- The fibroid guideline was modified to apply to all surgical treatments for fibroids and the definition of anemia was altered
- The dysfunctional uterine bleeding guideline had the definition of anemia altered
- The recurrent acute otitis media guideline was modified regarding the indications for tympanostomy tubes in higher risk populations
- The PT/OT guideline had a missing line number added
- The acupuncture guideline was changed to update line numbers, change coverage wording to prioritization wording, and to add limitations for treatment of neck pain
- The health and behavior assessment code guideline was modified to reflect an updated link to the CMS guideline and to update line numbers

**CHANGES FOR THE ICD-10 PRIORITIZED LIST (tentatively October 1, 2014)**

- The diagnosis codes for benign urinary lesions were added to a covered line and kept on an uncovered line with a guideline to clarify when they should be covered
- The CPT and ICD-10 codes for 2 new dermatologic lines were approved as a follow up to the dermatology line ICD-10 review

**VALUE-BASED BENEFITS SUBCOMMITTEE**  
**Meridian Park Health Education Center**  
**March 14, 2013**  
**8:30 AM – 2:00 PM**

**Members Present:** Lisa Dodson, MD, Chair; Kevin Olson, MD, Vice-Chair; James Tyack, DMD; David Pollack MD; Mark Gibson; Irene Croswell RPh (departed at 10:30 am); Laura Ocker, Lac; Susan Williams, MD (arrived at 9:00 am).

**Members Absent:** Chris Kirk, MD

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

**Also Attending:** Denise Taray, Wally Shaffer, MD, DMAP; Jessie Little, Actuarial Services Unit of DMAP; Mary Costantino, MD, Epic Imaging; Wayne Englander, MD (by phone); Annette Broddie, OT and Laurel Hughs (by phone); Ericka King, OHSU; Deborah Ackerman and Ben Marx, MAcOM, Lac, OCOM; Kathy Kirk, OPMC.

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

The meeting was called to order at 8:30 am and roll was called. Minutes from the January, 2013 VbBS meeting were reviewed and approved.

ACTION: HERC staff will post the approved January 2013 minutes on the website as soon as possible.

Smits reviewed an organizational chart of the various committees and commissions dealing with health issues at the state. She then reviewed several items that are “errata.” These items were informational; the commissioners did not have any concerns or corrections.

---

➤ **Topic: Pseudobulbar Affect**

**Discussion:** Smits introduced a summary document with additional information about pseudobulbar affect. Dr. Wayne Englander, a private practice Neurologist, provided testimony about the relative small value of treatment for this condition. The major discussion was around whether a moderately effective treatment for a condition whose treatment is not very beneficial should be covered. The group felt that it should not. There were concerns about the high cost of Nuedexta medication. The decision was to leave pseudobulbar affect on line 687.

**Actions:**

- 1) Make no change to the current prioritization of pseudobulbar affect

➤ **Topic: Uterine Artery Embolization**

**Discussion:** Smits introduced a document summarizing the evidence for including uterine artery embolization (UAE) for treatment of fibroids. Dr. Mary Costatino provided oral testimony that, in her experience, the current rate of complications, rehospitalization, and repeat procedures is much lower than what is reported in the literature. There was minimal discussion.

**Actions:**

- 1) Add 37210 (Uterine fibroid embolization) to line 428 UTERINE LEIOMYOMA.
- 2) Change the treatment description of line 428 from TOTAL HYSTERECTOMY OR MYOMECTOMY to SURGICAL TREATMENT
- 3) Guideline Note 40 wording changed as shown in Appendix A
  - a. Note: additional changes made to this guideline based on discussion for menstrual bleeding disorders below

➤ **Topic: Therapeutic Activities**

**Discussion:** Smits reviewed various questions brought to the HERC by Annette Broddie, OT, and the staff recommendation for changes based on review of these suggestions. Ms. Broddie then provided testimony to the commissioners via phone. The subcommittee generally felt that there were significant issues with integration of mental and physical health, which should be considered by HERC staff and DMAP. Regarding Ms. Broddie's specific concerns, Taray indicated that she would contact her to discuss her coding questions and issues.

The group discussed the specific recommendations, and had questions about what 97530 actually represented. Taray indicated that it was a standard PT/OT billing code, and had approximately the same reimbursement as other PT/OT billing codes. The actual CPT code submitted depended on the type of therapy completed.

**Actions:**

- 1) Add 97530 to line 37 SEVERE BIRTH TRAUMA FOR BABY and to line 318 NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS
- 2) Add line 37 to the PT/OT guideline (Guideline Note 6)

➤ **Topic: Menstrual Bleeding Disorders**

**Discussion:** Smits reviewed suggested changes to the menstrual bleeding disorders guideline. Livingston shared that the OHP Medical Directors were very supportive of keeping a hemoglobin number cut off for this guideline, as it was a very useful tool for prior authorization. Smits noted that all other hysterectomy guidelines should be

modified to have the same definition of anemia. She will review the other guidelines and make this change and will bring back any guideline questions to the group at a later date. Note: later review found only the 2 guidelines below for which the definition of anemia change was applicable.

**Actions:**

- 1) Guideline Note 44 Menstrual Bleeding Disorders was modified as shown in appendix A.
- 2) Guideline Note 40 modified as shown in appendix A to reflect the same criteria to diagnose anemia.

➤ **Topic: ICD-10 Urology Guideline Follow Up**

**Discussion:** The diagnosis codes for benign urinary tract lesions for which a new urology guideline will apply need to be added to a covered line. There was minimal discussion. The group felt that the entire D30.0 series should be added to the covered line and kept on the uncovered line.

**Actions:**

- 1) D30.x (benign neoplasm of urinary organs) was added to line 228 and kept on line 538 for the 2014 ICD-10 Prioritized List

➤ **Topic: ICD-10 Dermatology Follow Up**

**Discussion:** Livingston reviewed a summary document with follow up issues from the ICD-10 Dermatology review. The commissioners requested that the new line name be “dermatological” hemangiomas rather than “superficial” as the term superficial seemed to indicate that these lesions are not serious. The proposed diagnosis and procedure codes for new lines 350 and 550 were accepted with minimal discussion.

**Actions:**

- 1) Rename proposed Line 350 HEMANGIOMAS, COMPLICATED to [DERMATOLOGIC](#) HEMANGIOMAS, COMPLICATED for the ICD-10 Prioritized List (tentatively October 1, 2014)
- 2) The CPT and ICD-10 codes for new lines 350 and 550 were accepted as presented in the meeting materials

➤ **Topic: Coverage guidance for chronic otitis media with effusion guideline**

**Discussion:** Livingston provided an update of the changes made to date in the chronic otitis media with effusion guideline. Dr. Ericka King, a pediatric otolaryngologist from OHSU testified that she supported the higher risk children having tubes but disagreed that coverage be limited to only these children. Dr.

King reiterated the ENT concerns about the Cochrane review and the conclusions of the reviewers. There was a brief discussion about use of trusted sources and what would qualify for diverting from recommendations of trusted sources. Expert opinion was discussed as not a higher evidence level than systematic reviews, however, if the systematic review were outdated and newer evidence were available, a further search or consideration would need to occur.

There were a number of questions raised about the guideline, including clarification that the reason it would not be covered for a child without the specified high risk conditions (i.e. speech and language delay, craniofacial anomalies, Down Syndrome, cleft palate) is because of the current funding line on the list falling above line 502. The guideline note as written was felt to be misleading, and suggestions were made on wordsmithing it to clarify that even if all the conditions were met, children without those high risk conditions would not be able to have tympanostomy tubes covered (because of the funding line). It was clarified that those with anatomical difference were at higher clinical risk of non-resolution. Several suggestions were made. Staff to rework the language with the Chair and bring it back for review.

**Actions:**

- 1) Staff to work with Chair Dodson to reword the chronic otitis media guideline to enhance clarity.

➤ **Topic: Coverage guidance for management of recurrent acute otitis media in children**

**Discussion:** Livingston introduced the summary document and discussed the minor changes proposed regarding children with specified high risk conditions. Dr. Ericka King from OHSU testified. She did not have any concerns about the proposed wording. She provided some clinical background: 85-90% will have resolution of fluid after 3 months, but infections results in pain, time off from work/school, and possibility of severe (rare) acute complications or chronic complications. There was minimal discussion.

**Actions:**

- 1) Adopt the modified proposed guideline as shown in Appendix A

➤ **Topic: Coverage guidance for cervical cancer screening**

**Discussion:** Livingston presented the Coverage Guidance on routine cervical cancer screening. There were a number of clarification questions relating to the definition of “adequate screening.” There were questions asked about mandatory versus reflex HPV testing and it was clarified that the guideline does not affect reflex HPV testing except to not recommend it for LSIL or higher. It was

suggested to add a row to the table addressing the management of abnormal results and return to routine screening. Coffman brought up that the prevention tables will additionally need a reference to the new routine cervical cancer screening guideline. Members discussed that these recommendations were felt to be clarifying rather than substantive and also clarified that they would be brought to EbGS prior to HERC review.

**Actions:**

- 1) There were a series of clarifying recommendations made to the coverage guidance box: the two recommendations on women greater than 65 were switched, language was recommended to be added to clarify “cessation of screening”, language regarding those whom are to resume routine screening was modified.
- 2) Recommended adding table to the coverage guidance
- 3) For the Prioritized List guideline
  - a. A definition of co-testing was added
  - b. A table row was added addressing abnormal results
  - c. See Appendix B for the new guideline
- 4) In the Prevention Tables, add a reference to “See Guideline Note XXX for routine cervical cancer screening”

➤ **Topic: Coverage guidance for coronary artery calcium screening**

**Discussion:** There was minimal discussion.

**Actions:** No change in current lack of coverage.

**MOTION: To approve the coverage guidance for coronary artery calcium screening as presented. CARRIES 7-0.**

➤ **Topic: Coverage guidance for coronary computed tomography angiography**

**Discussion:** Livingston reviewed the summary document. There was minimal discussion.

**Actions:** No change in current lack of coverage.

**MOTION: To approve the coverage guidance for coronary computed tomography angiography as presented. CARRIES 7-0.**

➤ **Topic: Coverage guidance for continuous blood glucose monitoring in diabetes mellitus**

**Discussion:** Livingston presented a summary document. There were concerns raised about clinically insignificant changes in blood glucose levels. An ancillary guideline was discussed. The lack of data on retrospective monitors was mentioned and a discussion ensued about whether the retrospective monitors should be permitted for all type 1 diabetics with no limitations, or if the same limitations should apply as with real-time continuous blood glucose monitors. The decision was made to go with the more restrictive option, because it was more aligned with the evidence.

**MOTION: To approve a new guideline on continuous blood glucose monitoring with either: Option 1-No limitations for type 1 diabetics using retrospective monitors, or Option 2-Same limitations (>8.0% HbA1c) on use of both retrospective and real-time monitors by type 1 diabetics. The subcommittee voted, with five votes for option 2, one vote (Pollack) for option 1 and one abstention (Ocker). Option 2 CARRIES 5-1-1.**

A discussion ensued about what to do when subcommittees recommend different language. The GRADE process has modified decision making as well as the greater incorporation of experts. The VBBS decided to recommend a slightly different version, and this would be an example for HERC to give feedback to the subcommittees as to how GRADE analysis should be applied to the Prioritized List.

**Actions:**

- 1) No changes are made to the codes
- 2) Bring VBBS recommendations for the List compared to HTAS recommendations for the coverage guidance for discussion to HERC
- 3) Adopt proposed new guideline as shown in Appendix B

➤ **Topic: Coverage guidance for diagnosis of sleep apnea in adults**

**Discussion:** Livingston presented a summary document. Shaffer clarified that DMAP is not covering any home testing device, so the proposed coverage guidance would entail a significant shift in coverage. It was clarified that all types of monitors use the gold standard of AHI for diagnosis.

**Actions:**

- 1) A new diagnostic guideline was adopted as shown in Appendix B
- 2) Recommend to DMAP to move 95806-95811 and G0398 and G0400 from the Ancillary to the Diagnostic File.

➤ **Topic: Coverage guidance for treatment of sleep apnea in adults**

**Discussion:** Livingston presented a summary document. There was a discussion about the data on benefit of morbidity and at what AHI this benefit was seen. There was a discussion on the current coverage guidance language which would allow surgical coverage when any one of noninvasive or CPAP treatments had failed. Modified language was adopted specifying that both CPAP and an oral appliance would have to be failed prior to coverage of surgery. There was a suggestion to HTAS/HERC that the last paragraph of the coverage guidance be modified to mirror the VBBS adopted language.

**Actions:**

- 1) Modify Guideline Note 27 as shown in Appendix A
- 2) Let HTAS/HERC know about proposed modification to Coverage Guidance language on when surgery is covered

**MOTION: To approve the revisions to Guideline Note 27 on the treatment of sleep apnea in adults as presented. CARRIES 6-1.**

➤ **Topic: Coverage guidance for MRI for breast cancer diagnosis**

**Discussion:** Livingston presented a summary document. Olson summarized the lack of evidence for use of MRI for breast cancer diagnosis and clarified that this did not address MRI for screening for high risk women. There was minimal discussion.

**Actions:** A new diagnostic guideline was adopted as shown in appendix B

**MOTION: To approve the new diagnostic guideline on MRI For Breast Cancer Diagnosis as presented. CARRIES 7-0.**

➤ **Topic: Coverage guidance for vertebroplasty, kyphoplasty, and sacroplasty**

**Discussion:** Livingston presented a summary document. There was a discussion about conservative management.

**Actions:**

- 1) Remove S2360 and S2361(cervical vertebroplasty codes) from the List and recommend placement in the *DMAP Excluded File*
- 2) Add CPT codes 22520-22525 (thoracolumbar vertebroplasty codes) to line 507 CLOSED DISLOCATIONS/FRACTURES OF NON-CERVICAL VERTEBRAL COLUMN WITHOUT SPINAL CORD INJURY
- 3) Add a guideline as shown in Appendix B

➤ **Topic: Acupuncture for chronic pain conditions**

**Discussion:** Smits introduced a series of summary documents with recommendations for adding or not adding acupuncture for a variety of chronic pain conditions. Ben Marx from the College of Oriental Medicine gave verbal testimony.

There was considerable discussion about the strength of the data around acupuncture for knee osteoarthritis. The commissioners were concerned that there was not a significant clinical improvement with acupuncture vs sham acupuncture or PT, although there was a statistical difference. Livingston pointed out that there was a clinical difference in outcomes between the acupuncture group and the wait list group in one of more of the studies which is more of a “real life” outcome and that there is considerable debate about the appropriate placebo control given sometimes acupuncture is equivalent and other times superior to sham. Williams pointed out that there was not much difference in the clinical outcomes between viscosupplementation and acupuncture for this condition, and viscosupplementation had been not approved. Olson agreed that there seemed to be a somewhat lower evidence standard being considered. There was a suggestion that this could be related to the lower risk of harm than surgery, and the difficulty of having alternatives with harms (e.g. narcotics). There was considerable discussion about the Vickers study, and the group decided that they did not understand the magnitude of impact or the outcome measure value for this study. HERC staff was asked to further investigate the Vickers study, perhaps with statistical experts, and bring back a better understanding of this study to a future meeting.

The recommendations to not add acupuncture as a treatment for hip osteoarthritis or shoulder pain had little discussion and were accepted.

Coverage of acupuncture for treatment of neck pain conditions was accepted with little discussion.

Several “housekeeping” changes to the acupuncture list were accepted without discussion.

**Actions:**

- 1) HERC staff to further research acupuncture for knee osteoarthritis and bring back to a future meeting
- 2) Acupuncture was not adopted for treatment of hip osteoarthritis or shoulder pain
- 3) Acupuncture (CPT 97810-4) was added to line 562 ACUTE AND CHRONIC DISORDERS OF SPINE WITHOUT NEUROLOGIC IMPAIRMENT
- 4) The acupuncture guideline was modified as shown in appendix A.

➤ **Topic: Mental health codes on back pain lines**

**Discussion:** Smits referred commissioners to the handout for the updated summary for this topic. There was minimal discussion.

**Actions:**

- 1) Remove psychotherapy CPT codes (CPT 90785, 90832-90838, and 90840) from line 400 DISORDERS OF SPINE WITH NEUROLOGIC IMPAIRMENT and 562 ACUTE AND CHRONIC DISORDERS OF SPINE WITHOUT NEUROLOGIC IMPAIRMENT
- 2) Keep the health and behavior assessment codes (CPT 96150-96154) on line 400
- 3) Add CPT 96150-96154 to line 562
- 4) Remove the coding specifications for line 400 and 562
- 5) Change Guideline Note 1 as shown in Appendix A

➤ **Topic: Lung volume reduction surgery guideline**

➤ **Topic: Bilateral cochlear implant guideline**

➤ **Topic: Cervicobrachial syndrome**

➤ **Topic: Chronic pelvic inflammatory conditions**

➤ **Topic: Straightforward table**

**Discussion:** These five items were tabled until the May 2013 VbBS meeting.

**Actions:** To be addressed at the May 2013 VbBS meeting

➤ **Public Comment:**

No additional public comment was received

➤ **Issues for next meeting:**

- Acupuncture for knee osteoarthritis
- Lung volume reduction surgery guideline
- Bilateral cochlear implant guideline
- Cervicobrachial syndrome
- Chronic pelvic inflammatory conditions
- March 2013 straightforward table
- ICD- 10 Dysfunction
- ICD –10 Orthopedics
- Sensory processing disorder
- Guideline changes required as part of the ICD-10 conversion process
- Concussion guideline
- Clarification for guideline note 28

- Straightforward issues for March and May, 2013
- Changes to the Prioritized List to bring into agreement with HERC coverage guidances for neuroimaging in headache, induction of labor, treatment of attention deficit hyperactivity disorder, and PET scan for breast cancer

➤ **Next meeting:**

- May 9, 2013 at the Clackamas Community College Wilsonville Training Center, Wilsonville, OR

## Appendix A

### Revised Guideline Notes

#### GUIDELINE NOTE 1, HEALTH AND BEHAVIOR ASSESSMENT/INTERVENTION

Lines 1,6,8,10-18,20-22,25,26,28,29,33-37,39-42,46,47,50,52,53,55,57,62,64,66,67,69,71,74, 76,79,80,82,84,85,87,92,94,96,98,100-103,105,108-111,113,115,119,122-124,128,134, 135,137,138,140,141,144,146,147,149-151,158,159,164-169,173,179,181-183,185,190,191,193,195-197,199,201,202,205,207-208,210,218,220,221,224,227-229,233,235-238,~~244,243~~-246,249,250,252-256,265-268,271-279,285,287,288,290,292,293,302,304,306,310-314,320,326,331,333,~~334~~,338-342,352,354,356,357,360,366,370,371,376,377,387,394,400,407,410,421-423,426,432,434, 435,439,442,444,446,447,459,~~462~~,466,470-472,478,489,491,506

Health and behavior assessment and interventions (CPT codes 96150-96154) are included on these lines when provided subject to the Centers for Medicare and Medicaid (CMS) guidelines dated 2/1/06 located at:

[http://www.cms.hhs.gov/med/viewlcd.asp?lcd\\_id=13492&lcd\\_version=48&basket=lcd%3A13492%3A48%3AHEALTH+AND+BEHAVIOR+ASSESSMENT%2FINTERVENTION%3ACarrier%3ANHIC%7C%7C+Corp%2E+%2831142%29%3A](http://www.cms.hhs.gov/med/viewlcd.asp?lcd_id=13492&lcd_version=48&basket=lcd%3A13492%3A48%3AHEALTH+AND+BEHAVIOR+ASSESSMENT%2FINTERVENTION%3ACarrier%3ANHIC%7C%7C+Corp%2E+%2831142%29%3A)

[http://downloads.cms.gov/medicare-coverage-database/lcd\\_attachments/30514\\_1/L30514\\_031610\\_cbg.pdf](http://downloads.cms.gov/medicare-coverage-database/lcd_attachments/30514_1/L30514_031610_cbg.pdf)

In addition, Managed Care Organizations may authorize employees of organizations holding certificates or letters of approval from DHS and a Medicaid vendor number to deliver these services (i.e., not delivering services as an independent practitioner).

#### GUIDELINE NOTE 27, TREATMENT OF SLEEP APNEA

Line 210

Continuous Positive Airway Pressure devices (CPAP) should be covered initially when all of the following conditions are met:

- 12 week 'trial' period to determine benefit. This period is covered if apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) is greater than or equal to 15 events per hour, or if between 5 and 14 events with additional symptoms including excessive daytime sleepiness (Epworth Sleepiness Scale score > 10), or documented hypertension, ischemic heart disease, or history of stroke;
- Providers must provide education to patients and caregivers prior to use of CPAP machine to ensure proper use; and
- Positive diagnosis through polysomnogram or Home Sleep Test

CPAP coverage subsequent to the initial 12 weeks should be based on documented patient tolerance, compliance, and clinical benefit. Compliance (adherence to therapy) is defined as use of CPAP for at least four hours per night on 70% of the nights during a consecutive 30 day period.

Surgery for sleep apnea for adults is only covered after a diagnosis of sleep apnea has been made, and there is documented failure or intolerance of both CPAP and an oral appliance, and patients have been informed of the benefits and risks of surgery.

## Appendix A

### GUIDELINE NOTE 29, TYMPANOSTOMY TUBES IN ACUTE OTITIS MEDIA

Line 418

Tympanostomy tubes (69436) are only included on this line as treatment for 1) recurrent acute otitis media (three or more episodes in six months or four or more episodes in one year) that fail appropriate medical management, 2) for patients who fail medical treatment secondary to multiple drug allergies or who fail two or more consecutive courses of antibiotics, or 3) complicating conditions (immunocompromised host, meningitis by lumbar puncture, acute mastoiditis, sigmoid sinus/jugular vein thrombosis by CT/MRI/MRA, cranial nerve paralysis, sudden onset dizziness/vertigo, need for middle ear culture, labyrinthitis, or brain abscess). Patients with craniofacial anomalies, Down's syndrome, cleft palate, and patients with speech and language delay may be considered for tympanostomy [if unresponsive to appropriate medical treatment or having recurring infections \(without needing to meet the strict "recurrent" definition above\)](#). ~~with their first episode of acute otitis media.~~

### GUIDELINE NOTE 40, UTERINE LEIOMYOMA

Line 428

Hysterectomy, [myomectomy, or uterine artery embolization](#) for leiomyomata may be indicated when all of the following are documented (A-D):

A) One of the following (1 or 2):

1) Patient history of 2 out of 3 of the following (a, b and c):

a. Leiomyomata enlarging the uterus to a size of 12 weeks or greater gestation

b. Pelvic discomfort cause by myomata (i or ii or iii):

i) Chronic lower abdominal, pelvic or low backpressure

ii) Bladder dysfunction not due to urinary tract disorder or disease

iii) Rectal pressure and bowel dysfunction not related to bowel disorder or disease

c. Rapid enlargement causing concern for sarcomatous changes of malignancy

2) Leiomyomata as probable cause of excessive uterine bleeding evidenced by

(a, b, ~~and~~ c, [and d](#)):

a. Profuse bleeding lasting more than 7 days or repetitive periods at less than 21-day intervals

b. Anemia due to acute or chronic blood loss (hemoglobin less than 10 or hemoglobin less than 11 g/dL if use of iron is documented)

c. Documentation of mass by sonography

[d. Bleeding causes major impairment or interferes with quality of life](#)

B) Nonmalignant cervical cytology, if cervix is present

C) Assessment for absence of endometrial malignancy in the presence of abnormal bleeding

D) Negative preoperative pregnancy test result unless patient is postmenopausal or has been previously sterilized

### GUIDELINE NOTE 44, MENSTRUAL BLEEDING DISORDERS

Line 446

Endometrial ablation or hysterectomy for abnormal uterine bleeding in premenopausal women may be indicated when all of the following are documented (A-C):

A) Patient history of (1, 2, 3, 4, and 5):

## Appendix A

- 1) Excessive uterine bleeding evidence by (a, ~~and~~ b, ~~and~~ c):
    - a) Profuse bleeding lasting more than 7 days ~~and~~ or repetitive periods at less than 21-day intervals
    - b) Anemia due to acute or chronic blood loss (hemoglobin less than 10 g/dL or hemoglobin less than 11 g/dL if use of iron is documented) ~~prior to iron therapy~~
    - c). Bleeding causes major impairment or interferes with quality of life
  - 2) Failure of hormonal treatment for a six-month trial period or contraindication to hormone use (oral contraceptive pills or patches, progesterone-containing IUDs, injectable hormone therapy, or similar)
  - 3) No current medication use that may cause bleeding, or contraindication to stopping those medications
  - 4) Endometrial sampling performed
  - 5) No evidence of treatable intrauterine conditions or lesions by (a, b or c):
    - a) Sonohysterography
    - b) Hysteroscopy
    - c) Hysterosalpingography
- B) Negative preoperative pregnancy test result unless patient has been previously sterilized  
C) Nonmalignant cervical cytology, if cervix is present

### GUIDELINE NOTE 92, ACUPUNCTURE

Lines 1,212,435,~~489,562,563~~

Inclusion of acupuncture (CPT 97810-97814) on the Prioritized List has the following limitations:

#### Line 1 PREGNANCY

Acupuncture (~~97810-97814~~) pairs on Line 1 for the following conditions and codes.

##### *Hyperemesis gravidarum*

ICD-9 codes: 643.00, 643.03, 643.10, 643.11, 643.13

Acupuncture is paired with ~~for~~ hyperemesis gravidarum ~~is covered~~ when a diagnosis is made by the maternity care provider and referred for acupuncture treatment for uUp to 2 sessions of acupressure/acupuncture ~~are covered~~.

##### *Breech presentation*

ICD-9 codes: 652.20, 652.23

Acupuncture (and moxibustion) is paired with ~~for~~ breech presentation ~~is covered~~ when a referral with a diagnosis of breech presentation is made by the maternity care provider, the patient is between 33 and 38 weeks gestation, for up to 2 visits.

##### *Back and pelvic pain of pregnancy*

ICD-9 codes: 648.70, 648.73

Acupuncture is ~~covered~~ paired with ~~for~~ back and pelvic pain of pregnancy when referred by maternity care provider/primary care provider for up to 12 sessions.

#### Line 212 DEPRESSION AND OTHER MOOD DISORDERS, MILD OR MODERATE

Acupuncture is paired with ~~covered on this line for~~ the treatment of post-stroke depression only. Treatments may be billed to a maximum of 30 minutes face-to-face time and limited to 15 total sessions, with documentation of meaningful improvement.

#### Line 400 DISORDERS OF SPINE WITH NEUROLOGIC IMPAIRMENT

Acupuncture (~~97810-97814~~) is included on Line 400 only for pairing with disorders of the spine with myelopathy and/or radiculopathy represented by the diagnosis codes M47.26, M47.27, M51.06, M51.07, M51.16, M51.17, M51.26, M51.27, M54.16, M54.17 with

## Appendix A

referral ~~—Acupuncture for the treatment of these conditions is only covered, when referred,~~ for up to 12 sessions.

### Line 435 MIGRAINE HEADACHES

Acupuncture pairs on Line 435 for ICD-9 346, when referred, for up to 12 sessions.

### Line 562 ACUTE AND CHRONIC DISORDERS OF SPINE WITHOUT NEUROLOGIC IMPAIRMENT

Acupuncture pairs on Line 562 ~~only~~ with the low back diagnoses (M47.816, M47.817, M47.896, M47.897, M48.36, M48.37, M51.26, M51.27, M51.36, M51.37, M51.86, M51.87, M54.5, M62.830, S33.5xxA, S33.9xxA, S39.092A, S39.82xA, S39.93xA), when referred, for up to 12 sessions. Acupuncture pairs with chronic (>90 days) neck pain diagnoses (723.1, 723.8, 723.9, 847.0), when referred, for up to 12 sessions.

### Line 563 TENSION HEADACHES

Acupuncture is included on Line 563 for treatment of tension headaches, when referred, for up to 12 sessions.

## Appendix B

### New Guidelines

#### **GUIDELINE NOTE XXX ROUTINE CERVICAL CANCER SCREENING**

*Line 4*

Cervical cancer screening is covered on Line 4 for women:

<b>Age group in years</b>	<b>Type of screening covered</b>	<b>Frequency</b>
<21	None	Never
21-29	Cytology alone Mandatory HPV testing (87620-87621) is not covered for women age 21-29	Every 3 years
30-65	Co-testing* or cytology alone	Co-testing every 5 years Cytology alone every 3 years
>65	None Unless adequate screening** has not been achieved, or it is <20 years after regression or appropriate management of a high-grade precancerous lesion	Never
Women who have had a hysterectomy with removal of cervix for non-cervical cancer related reasons (i.e. other than high grade precancerous lesion, CIN 2 or 3, or cervical cancer)	None	Never
Women who have abnormal testing	Per ASCCP*** Guideline, until indicated to resume routine screening	Per ASCCP Guideline, until indicated to resume routine screening

\*Co-testing is defined as simultaneous cytology and mandatory HPV testing.

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

\*\*\* American Cancer Society, American Society for Colposcopy and Cervical Pathology, and American Society for Clinical Pathology guideline (Saslow 2012)

Women who have received a diagnosis of a high-grade precancerous cervical lesion or cervical cancer, women with in utero exposure to diethylstilbestrol, or women who are immunocompromised (such as those who are HIV positive) are intended to have screening more frequently than delineated in this guideline.

## Appendix B

### **GUIDELINE NOTE XXX CONTINUOUS BLOOD GLUCOSE MONITORING**

*Line 10*

Continuous blood glucose monitoring (*CPT codes 95250-95251, HCPCS codes S1030-S1031*) [with real-time or retrospective continuous glucose monitoring systems](#) are only included on Line 10 for Type 1 diabetics with HbA1c levels greater than 8.0% OR a history of recurrent hypoglycemia, AND for whom insulin pump management is being considered, initiated, or utilized.

### **GUIDELINE NOTE XXX VERTEBROPLASTY, KYPHOPLASTY, AND SACROPLASTY**

*LINE 507*

Vertebroplasty and kyphoplasty are not included on this line (or any other line) for the treatment of routine osteoporotic compression fractures.

Vertebroplasty and kyphoplasty are only included on this line for the treatment of vertebral osteoporotic compression fractures when they are considered non-routine and meet all of the following conditions:

1. The patient is hospitalized under inpatient status due to pain that is primarily related to a well-documented acute fracture, and
2. The severity of the pain prevents unassisted ambulation, and
3. The pain is not adequately controlled with oral or transcutaneous medication, and
4. The patient must have failed an appropriate trial of conservative management.

Sacroplasty is not included on these or any lines of the Prioritized List for coverage consideration.

### **DIAGNOSTIC GUIDELINE XX DIAGNOSTIC TESTING FOR OBSTRUCTIVE SLEEP APNEA (OSA)**

The following diagnostic tests for OSA are covered for adults:

1. Type I PSG is covered when used to aid the diagnosis of OSA in patients who have clinical signs and symptoms indicative of OSA if performed attended in a sleep lab facility.
2. Type II or Type III sleep testing devices are covered when used to aid the diagnosis of OSA in patients who have clinical signs and symptoms indicative of OSA if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility.
3. Type IV sleep testing devices measuring three or more channels, one of which is airflow, are covered when used to aid the diagnosis of OSA in patients who have signs and symptoms indicative of OSA if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility.
4. Sleep testing devices measuring three or more channels that include actigraphy, oximetry, and peripheral arterial tone, are covered when used to aid the diagnosis of OSA in patients who have signs and symptoms indicative of OSA if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility.

## **Appendix B**

### **DIAGNOSTIC GUIDELINE XX MRI FOR BREAST CANCER DIAGNOSIS**

In women with recently diagnosed breast cancer, preoperative or contralateral MRI of the breast is not a covered service.