

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

*For specific coding recommendations and guideline wording, please see the text of the 05/08/14 VbBS minutes.*

## **CODE MOVEMENT**

- A surgical code was added to the colon cancer line
- A surgical code was added to the vascular insufficiency of intestines line
- Open and closed hip fracture diagnoses were combined on the hip fracture line
- Transurethral prostatic implants were added for treatment of benign prostatic hypertrophy
- Multiple surgical codes were removed from the covered sleep apnea line

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

- The addition of cross-sex hormone therapy and sex reassignment surgery as treatments for gender dysphoria were discussed, but no decisions were made. This topic will be readdressed at the June 2014 meeting.
- The fluoride varnish guideline was reviewed but no changes made
- Electronic tumor treatment fields were not added for treatment of recurrent glioblastoma
- A new guideline regarding electroconvulsive therapy (ECT) was discussed, and will be further discussed at an upcoming meeting
- The structure of the low back pain lines was discussed, and will be readdressed at a future meeting
- Changes to the fluoride varnish guideline were discussed but no changes made

## **GUIDELINE CHANGES**

- The rehabilitation guideline was extensively revised to reflect criteria for rehabilitation services rather than limits on the number of visits.
- The sleep apnea guideline was revised to further define daytime sleepiness and to specify that tonsillectomy/adenoidectomy surgical codes on that line are for treatment of children only.
- A new diagnostic guideline was added specifying that computer aided mammography (screening and diagnostic) is not a covered service

## **BIENNIAL REVIEW**

- The diagnosis codes for injuries to the major blood vessels of the neck were moved from one covered line to a more appropriate covered line
- A new lymphedema line was created and prioritized into the covered region of the Prioritized List
- A new line for miscellaneous conditions requiring no treatment was created and prioritized to the last line on the Prioritized List
- The somatization and factitious disorder lines were merged and prioritized into the non-covered region of the Prioritized List

## MINUTES

### VALUE-BASED BENEFITS SUBCOMMITTEE

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

**May 8, 2014**

**Members Present:** Lisa Dodson, MD, Chair; Kevin Olson, MD, Vice-chair (left 1 PM); James Tyack, DMD; David Pollack, MD; Susan Williams, MD (arrived 8:50 AM); Mark Gibson (left 1:15 PM); Irene Crowell, RPh; Laura Ocker, LAc.

**Members Absent:** None

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

**Also Attending:** Jesse Little, OHA Actuarial Services Unit; Brian Nieubuurt, OHA; Danielle Askini, Peter Molof, Aubrey Harrison and Maura Roche, Basic Rights Oregon; Megan Bird, MD, Legacy Health Systems; Kathleen Klemann, FamilyCare; Bruce Boston, MD, OHSU; Shane Jackson, OR ABA; Brenna Legaard; Tobi Rates, Autism Society of Oregon; Susan Bamberger, Oregon Physical Therapy Association; Bridget Kiene, American Cancer Society; John Beckwith, PT, Sacred Heart Medical Center; Tim Baxter, Lane County Legal Aid.

### Roll Call/Minutes Approval/Staff Report

The meeting was called to order at 8:35 am and roll was called. Minutes from the March 2014 VbBS meeting were reviewed and approved without changes.

**MOTION: To approve the March 2014 VbBS minutes as presented. CARRIES 7-0 (Williams absent).**

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

Smits reported that ICD-10 implementation has been delayed until at least October 1, 2015 by CMS. The October 1, 2014 Prioritized List is in ICD-10 format. Staff has met with HERC leadership and decided to keep the previously adopted October 1, 2014 List and add the ICD-9 codes back to the lines, making the List “bilingual” with both ICD-9 and ICD-10 codes on each line. There was no objection or discussion about this plan.

Smits announced that Dr. Holly Jo Hodges from Trillium Healthcare will be joining the VbBS as the medical director/CCO representative beginning with the June, 2014 VbBS meeting. Dr. Lisa Dodson will be stepping down as Chair and resigning after the June,

2014 VbBS meeting due to a move to Wisconsin. Her service has been exemplary and her leadership will be sorely missed.

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Note: All line numbers in these minutes reflect the understanding at the time of this meeting that they would go into effect on October 1, 2014 with the implementation of the new biennial list. At the June 12, 2014 meeting the subcommittee will discuss implementing the biennial list on January 1, 2015 instead, as there is no longer an need to tie it to implementation of the ICD-10-CM codeset on that date and a January 1 effective date would correspond to the contracting period for the Coordinated Care Organizations, as has been done in previous years.

➤ **Topic: Straightforward/Consent Agenda**

**Discussion:** There was no discussion.

**MOTION: To approve the consent agenda as presented. CARRIES 8-0.**

**Actions:**

- 1) Add 45397 (Laparoscopy, surgical; proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, J-pouch), with diverting enterostomy, when performed) to line 161 Cancer of colon, rectum, small intestine and anus
- 2) Add 44310 (Ileostomy or jejunostomy, non-tube) to line 158 Vascular Insufficiency of Intestine
- 3) Lymphedema, NOS (I89.0) was moved from line 579 LYMPHEDEMA to line 427 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
- 4) I89.1 (Lymphangitis) was moved from 579 LYMPHEDEMA to 209 SUPERFICIAL ABSCESSSES AND CELLULITIS

➤ **Topic: Quality of Evidence Document**

**Discussion:** Livingston reviewed the documents on quality of evidence and criteria for topic reviewed for VbBS. The subcommittee approved the criteria for topic selection document without changes. On the Quality of Evidence Document, the subcommittee made a few wording changes to the document, clarifying that consistency as well as strength of evidence is important. See Appendix C for the revised text, with meeting edits shown in red text.

**Actions:** Approved two documents on:

- 1) Criteria for Topic Review (approved as it appeared in the meeting materials.)

2) Quality of Evidence Statement for the Prioritized List of Health Services.  
(As shown in Appendix C)

➤ **Topic: Treatments for gender dysphoria**

**Discussion:** Smits reviewed the literature on the effectiveness and risks of cross-sex hormone therapy and sex reassignment surgery. Based on poor quality evidence, these treatments are effective at improving quality of life and reducing gender dysphoria symptoms. The high morbidity and mortality of gender dysphoria was reviewed, which includes increased deaths due to suicide, accidents, HIV infection, increase suicide attempts, and IV drug abuse.

Testimony was heard from Dr. Bruce Boston, pediatric endocrinologist at OHSU, from Dr. Megan Bird, OB/GYN at Legacy and Danielle Askini from Basic Rights Oregon. The high rate of suicide attempts (44%) among transgendered persons was noted. In a Belgian study, treatment of gender dysphoria with cross-sex hormones, surgery, or some combination, resulted in an 80% reduction in suicide attempts (from 30% to 5%). Transgender individuals also participate in other high risk activities, such as IV drug use, unprotected sex, etc. Hormone/surgical therapy have been found to reduce these risky behaviors as well. The experts testified that hormones and surgery are safe and effective treatments which are considered medically necessary by the American Congress of OB/GYNs, AAFP, APA, and AMA-. When questioned about whether hormone treatment alone without surgical options is effective at reducing suicide attempts and other risky behavior, the experts testified that that was not known. All studies have been done on patients who had access to surgical options as well as hormone therapy. In their expert opinion, offering only cross-sex hormone therapy without surgical options would not be very helpful. Boston noted that transgendered young adults who have received appropriate treatment have been found to be better adjusted than age-matched controls. The experts offered to provide citations to HERC staff for the above referenced studies. Dr. Bird will provide HERC staff with the WPATH guidelines, which are proprietary.

Pollack raised concerns about patients with personality disorders and other psychological/psychiatric problems. He states that if surgical treatment of gender dysphoria is added to the Prioritized List, it must be accompanied by a strict guideline about evaluation and treatment of psychiatric co-morbidities. The experts noted that the major guideline in this area, from WPATH, requires psychological evaluation by both an MD/PhD level clinician and from a master's level clinician.

The subcommittee directed staff to work with experts to look at the mortality reduction (from suicide and risky behaviors such as IV drug use) resulting from treatment of gender dysphoria.

The experts noted to staff that some patients cannot take hormones due to medical contraindications. Any guideline should allow for surgical options without hormonal options due to this fact.

There was discussion about the expected costs of covering cross-sex hormone therapy. It is not known how many transgendered persons are in the Oregon Medicaid program or what the cost of treatments might be. There are also possible cost savings from avoiding suicide attempts, etc. The experts noted that Washington, California, Vermont, and DC Medicaid all cover cross-sex hormone therapy and sex reassignment surgery. The California Department of Insurance has done a study on the costs of this treatment in California and found a minimal increase in the costs to the Medicaid program once these therapies were covered. There is also a study from UCLA and data from San Francisco on costs of coverage. The experts will help HERC staff find this data.

The subcommittee asked the experts if there was a black market in cross-sex hormone therapy and were told that there was a considerable market in the Portland area. Such therapy is not medically supervised, not at recommended dosages, etc. Allowing coverage of cross-sex hormones would reduce this black market.

Livingston expressed concern about the possible costs of fertility preservation. The experts testified that there was very little interest among these patients in fertility preservation.

**Actions:**

- 1) HERC staff will work with experts to find data on harm reduction and on costs for addition of cross-sex hormone therapy and sex reassignment surgery.
- 2) Staff will mock up a separate line for hormone and surgery as treatments for gender dysphoria and suggest prioritization scoring for it. If the scoring results in a line close to the existing line for gender dysphoria (413), then these services will be proposed for addition to the existing line. If not close, the proposal will be to create a separate line on the biennial list tentatively scheduled for April 1, 2017.

➤ **Topic: Applied behavioral analysis for autism spectrum disorder**

**Discussion:** Livingston reviewed the summary document on ABA therapy for autism spectrum disorder. She noted that staff recently participated in a conference call during which they became aware of potential issues with the current draft due to federal parity rules for mental health care, and asked the subcommittee to defer discussion of the hour and duration limits until the next meeting.

Dr. Larsson, who served as one of three appointed ad hoc experts during the EbGS evaluation of evidence, reviewed the new procedure codes created for ABA. These are temporary codes approved for use after July 1. He said he wasn't sure they added anything over codes currently being used by private payers. He also commented that the hour limits in the draft evaluation are not based on his understanding of the evidence but more on Senate Bill 365 and other factors, as many of the studies included in the source report used more than 25 hours per week of intensive therapy. He also discussed his alternate proposals which have more of a focus on progress evaluation for continued coverage than on limitations on intensity and duration of treatment. Dodson then invited public comment. Tobi Rates testified first, as the executive director of the Autism Society of Oregon and parent of two children with autism. She expressed appreciation for the recommendations for coverage but also expressed concern about the limits of eight hours per month. She said for her 9 year old, 8 hours per month isn't enough to make a difference in quality of life. She said that EbGS didn't adequately consider the impact on healthy life, and mentioned that Dr. Larsson and Dr. Zuckerman (also an appointed expert) disagreed with the hour limits in the draft evaluation of evidence, and expressed concern about compliance with mental health parity laws. She would prefer to have coverage begin as soon as possible, even if it is with pre-existing codes. Brenna Legaard also offered comment. She is the mother of a six year old with autism, and said she had to sue an insurance company in order to get coverage, and argued that waiting for the temporary codes to be approved might delay implementation. She said that parents of children with autism are limited in their ability to have jobs due to care demands, and expressed support for more intensive treatment than the current draft recommendations so as to maximize the chance for parents to return to the workforce and participation in the community.

Shane Jackson, a lobbyist from Oregon Association for Behavior Analysis and the Autism Society of Oregon also spoke, saying that the age and hour limits are inconsistent and will cause problems in the future due to some plans having such limits and others that will not due to federal standards. He also said that he didn't believe that the impact of autism on the society and family as well of the individuals.

Coffman addressed the comments about timing of implementation due to coding changes. The language in Senate Bill 365 was based on an expected ICD-10 implementation on October 1, 2014. ICD-10 has been delayed one year, and staff is still assessing the impact of this delay, along with the new temporary codes. The advocates proposed code H2010 as an appropriate code for ABA. Coffman pointed out that this code does not really relate to ABA services. He said the temporary codes more accurately reflect ABA services and would lead to more appropriate reimbursement.

Olson asked whether there are studies about the impact of autism on families. Legaard stated that the evidence evaluation was focused on efficacy of treatment, but that she believes there are studies on the larger impact. Livingston said that the subcommittee included a rating of “low variability” in the values and preferences column of the GRADE table in the evidence evaluation because it assumed that families would want the therapy and that improvements in these behaviors would be important for families. Legaard said that advocates began to doubt that they were being heard because of the limit of 8 hours per month for older children seems inadequate for children with severe behavioral issues, and the single subject research design literature shows effectiveness for these therapies for many children.

**Actions:**

- 1) Staff will bring back revised recommendations, including recommendations on self-injurious behavior for children with self injurious behavior.

➤ **Topic: Rehabilitation therapies guideline**

**Discussion:** Smits reviewed the proposed new rehabilitation therapies guideline. The discussion mainly centered on making the guideline as simple and straightforward as possible. The OHP plans are not finding a need to have specific limits on the number of visits. Taray noted that the wording regarding the need for services, the qualifications of provider, and the need for medical review are very helpful for DMAP and mirror current OHP rules. The subcommittee decided to not specify visit limits and left in wording only specifying medical necessity and review. The line specifying unlimited visits during hospitalization/rehabilitation facility stays was thought to be unnecessary and removed.

Pulmonary rehabilitation was noted to not be included in this guideline. Staff was directed to review whether a guideline should be included regarding pulmonary rehabilitation.

**MOTION: To approve the revised guideline as amended. CARRIES 8-0.**

**Actions:**

- 1) The rehabilitation guideline was modified as shown in Appendix A

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

**Discussion:** Livingston reviewed the summary of suggested changes for the treatment of sleep apnea line and guideline. The wording of “covered” was changed to “included on this line” in the guideline, and surgical codes which would be removed from the sleep apnea line to align with the guideline. After

brief discussion, the subcommittee approved the recommendation with slight wording changes to correctly indicate that surgery for sleep apnea is “not included on this line” rather than “not covered.”

**MOTION: To approve coding changes and the guideline as amended. CARRIES 8-0.**

**Actions:**

- 1) Remove from line 210 SLEEP APNEA AND NARCOLEPSY
  - a. 21193-21199, 21206-21215, 21230, 21235, 30117, 30140, 30520, 42140, 42145, 42160
- 2) Add to line 646
  - a. 21199
- 3) Advise DMAP to add to the Excluded List
  - a. 42140
- 4) Modify GN 27 as shown in Appendix A

➤ **Topic: Fluoride varnish guideline revision**

**Discussion:** Livingston introduced a summary document regarding suggested changes to the fluoride varnish guideline. The suggestion was to not allow primary care providers to apply fluoride varnish. Livingston reviewed the evidence that allowing PCPs to apply fluoride varnish reduces dental caries and increases referrals to dentists. Tyack said this is controversial among some dentists but agreed that fluoride varnish application in primary care homes should be covered.

**Actions:**

- 1) No changes made to the current guideline

➤ **Topic: Computer aided mammography**

**Discussion:** Livingston introduced the summary of evidence and recommendations for mammography with computer-aided detection (CAD). The subcommittee discussed adding 77051 (diagnostic mammography with CAD) to the Excluded List as well as 77052 (screening mammography with CAD) due to the lack of evidence of any benefit and the evidence of harm. The proposed diagnostic guideline note was changed to include both diagnostic and screening CAD mammograms and the wording “for breast cancer screening” was removed to reflect the VbBS desire to not cover CAD for any indication. There was some discussion about adding the CAD codes to the new section of the Prioritized List for items reviewed but not placed on the List; however, it was pointed out that the codes would be in the diagnostic guideline and therefore searchable and that the guidelines carried more weight than the new section due to their reference in statute.

**MOTION: To approve the coding changes and the amended diagnostic guideline.**  
**CARRIES 8-0.**

**Actions:**

- 1) Recommend to DMAP to remove 77051 and 77052 from the Diagnostic File and place in the Excluded File
- 2) A new diagnostic guideline was added as shown in Appendix B

➤ **Topic: Electronic tumor treatment fields**

**Discussion:** Smits reviewed the summary document. The subcommittee agreed with creation of a new section of the Prioritized List for items reviewed but not included. This section will include those technologies or treatments with CPT or HCPCS codes that could be placed on one or more lines on the List, but which the commission does not find evidence of effectiveness or finds to be a much more costly alternative. The subcommittee did not agree on the proposed title for this section and recommended staff work on a more streamlined name and bring back to the June meeting to discuss.

The subcommittee agreed that electronic tumor treatment fields (ETTF) should not be added to the Prioritized List, but rather added to this new section of reviewed but not included items. There was discussion about how the entry for ETTF should be written. The decision was made to not include wording about ETTF being second line therapy as the VBBS did not want it included at all. Wording about coverage was changed to inclusion. HERC staff was directed to work on the final wording for this topic and bring back to the June meeting.

**Actions:**

- 1) Staff will bring back revised wording of the title for the new reviewed but not included on the List section to the June meeting
- 2) Staff will bring back revised wording on the entry for ETTF to the June meeting

➤ **Topic: Electroconvulsive therapy (ECT)**

**Discussion:** Smits reviewed the staff evidence review and recommendations regarding ECT. Pollack noted that Dr. George Keepers, a psychiatrist at OHSU who specializes in ECT, objected to the draft guideline. He requested that Dr. Keepers be approached to give input. Pollack also recommended looking at the American Psychiatric Association guidelines for ECT.

**Actions:**

- 1) Staff will work with Drs. Pollack and Keepers to revised the proposed guideline and seek APA or other guidelines for additional input. This topic will be readdressed at the June meeting.

➤ **Topic: Hip fractures**

**Discussion:** There was minimal discussion.

**MOTION: To approve the changes to placement of hip fractures as presented.**  
**CARRIES 8-0.**

**Actions:**

- 1) Move open hip fracture ICD-9 and ICD-10 codes from line 136 to line 85
  - a. ICD-9 820.x (open fracture of neck of femur)
  - b. ICD-10 S72.0xxx (open fracture of head or neck of femur)
- 2) Remove hip fracture repair CPT codes from line 136
  - a. 27236 (Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement)
  - b. 27267 (Closed treatment of femoral fracture, proximal end, head; without manipulation)
  - c. 27268 (with manipulation)
- 3) Rename line 85 FRACTURE OF HIP, ~~CLOSED~~

➤ **Topic: Transurethral prostatic implants for benign prostatic hypertrophy**

**Discussion:** There was minimal discussion.

**MOTION: To approve the placement of the new HCPCS codes as presented.**  
**CARRIES 8-0.**

**Actions:**

- 1) Add HCPCS C9739 (Cystourethroscopy with transprostatic implant; 1 to 3 implants) and C9740 (4 or more implants) to line 331 FUNCTIONAL AND MECHANICAL DISORDERS OF THE GENITOURINARY SYSTEM INCLUDING BLADDER OUTLET OBSTRUCTION

➤ **Topic: Lymphedema**

**Discussion:** Smits introduced the summary of a suggested reorganization and rescoring of the lymphedema line. The subcommittee was in agreement that the lymphedema diagnoses be combined on a line with scoring that would place it in the funded region.

The HSC placed the post-mastectomy lymphedema and other lymphedema codes on a line for complications of a procedure. The intention was to cover the lymphedema that resulted as a complication of a surgery, radiation, etc. Taray informed the subcommittee that DMAP is currently interpreting the placement on the complications line as requiring the lymphedema itself to have a complication, such as ulceration, to allow treatment. This is not HSC/HERC intent. HERC desires lymphedema treatment as a preventive service to avoid such complications.

John Beckwith, PT, testified about his experiences working with patients with lymphedema. He noted that many lymphedema patients have lymphedema that does not arise as a complication from surgery, chemotherapy, etc. He also advocated for covering treatment of patients with severe venous insufficiency to prevent ulceration, etc. Venous insufficiency not related to lymphedema is not currently covered.

The subcommittee heard that DMAP determines coverage of DME, as there are decisions about vendor, type of product, etc. which is too much detail for HERC to determine. Pollack requested that this information be placed on the HERC organizational chart.

The subcommittee reiterated that the HERC intends that lymphedema treatment should be covered when the lymphedema has not resulted in any complications such as ulcerations. The HERC intends that appropriate DME be covered for treatment of lymphedema, such as compression sleeves.

**Actions:**

- 1) HERC staff to evaluate adding a sentence about DME to the current lymphedema guideline
- 2) HERC staff to review possible coverage of some types of preventive treatment for venous insufficiency
- 3) Move the following ICD-9 codes to the lymphedema line and remove from all other lines as part of the current biennial review
  - a. 457.0 Postmastectomy lymphedema syndrome
  - b. 457.1 Other lymphedema
- 4) Move the following ICD-10 codes to the lymphedema line and remove from all other lines as part of the current biennial review
  - a. Postmastectomy lymphedema (I97.2)
  - b. Lymphedema, NOS (I89.0)
- 5) Move 457.1/I89.1 (lymphangitis) to line 214/209 SUPERFICIAL ABSCESSSES AND CELLULITIS and remove from line 598/579 as part of the current biennial review
- 6) Reprioritize the lymphedema line as shown below as part of the current biennial review

Line XXX  
Condition: LYMPHEDEMA  
Treatment: MEDICAL THERAPY, OTHER OPERATION ON LYMPH  
CHANNEL  
ICD-9: 457.0-457.9, 757.0  
ICD-10: I89.0, I89.8, I89.9, Q82.0  
CPT codes: same as current lymphedema line

Scoring

Category : 7  
HL: 4  
Suffering: 1  
Population effects: 0  
Vulnerable population: 0  
Tertiary prevention: 2  
Effectiveness: 3  
Need for service: 0.8  
Net cost: 3  
Score: 288  
Approximate line placement: line 470

➤ **Topic: Somatization/factitious disorder line merge**

**Discussion:** Smits introduced a summary of the Behavioral Health Advisory Panel's (BHAP) recommendation to merge lines 462 FACTITIOUS DISORDERS and 497 SOMATIZATION DISORDER; SOMATOFORM PAIN DISORDER, CONVERSION DISORDER. BHAP had charged staff with devising proposed scoring for this new line. The subcommittee agreed with merging these lines, but had considerable debate on the scoring of this new line. It was noted that line 462 had been given a category score of "6" which includes fatal illnesses, which had resulted in its relatively high priority line placement. This condition is not fatal, and the appropriate category for the combined line is "7." Scores between 0.8 and 1.0 for "need for service" were proposed, with the final decision being 0.9. Net cost was given a 3, because correct treatment of these conditions involves only office visits and should have some cost savings due to reduced ER visits, testing, etc.

**MOTION: To approve the new combined line as presented with amended scoring. CARRIES 8-0.**

**Actions:**

- 1) Merge lines 462 FACTITIOUS DISORDERS and 497 SOMATIZATION DISORDER; SOMATOFORM PAIN DISORDER, CONVERSION DISORDER with line details and scoring as shown below

**Line XXX**

Condition: SOMATIC SYMPTOMS AND RELATED DISORDERS

Treatment: CONSULTATION

ICD-9: 300.16, 300.19, 300.7-300.9, 301.51, 306.x, 307.8x

ICD-10: F68.1x, F44.x, F45x, F52.5

CPT: from line 462 + 96150-96154

HCPCS: from line 497

Scoring

Category: 7

HL: 2

Suffering: 2

Population effects: 0

Vulnerable population: 0

Tertiary prevention: 0

Effectiveness: 1

Need for service: 0.9

Net cost: 3

Score: 72

Approximate line placement: 556

➤ **Topic: Restructuring of low back pain lines**

**Discussion:** Smits introduced a summary document outlining a proposed change of the low back pain lines from distinguishing the two lines based on radiculopathy/neurologic symptoms to distinguishing them based on effective vs ineffective treatments. In general, the subcommittee liked the general idea of change to effective/ineffective treatments. However, there was discussion that effective treatments are a “moving target” and therefore would require a large amount of continuous review. There was also concern that some therapies may not be effective for a large population, but might be very effective for an individual.

Susan Bamburger, PT, past president of the OR PT association, gave testimony. She testified that most patients with radicular pain started with non-radicular pain, which was not adequately managed and therefore progressed to radicular pain. Treating the patient earlier in the course of the disease, before radicular symptoms or other complications develop, is more effective. She urged treatments to be chosen that are right for the individual patient rather than best in an RCT. She thought the lines should be distinguished based on signs and symptoms rather than cause of the pain.

Further discussion in the subcommittee included a discussion that surgical care is very much determined by neurological symptoms. Any change in how the List

is structured would have a significant financial impact based on changing surgical indications. Williams requested that the two spinal deformity lines be included in a review of the low back pain lines. Taray suggested also including the dysfunction lines in this review.

There was a sense that a larger review of the back pain lines should be done, and that such a review would take time. It is unlikely to be completed by August to be a part of the current biennial review. However, the new lines could be modifications of the existing lines and therefore be a non-biennial review change.

The subcommittee requested that staff create a task force to review the low back pain lines as well as the spinal deformity lines and come up with a proposal restructuring these lines. The dysfunction lines should be reviewed and some diagnoses and treatments moved to the back pain lines as well. This task force would be charged with determining how to determine when a diagnosis or treatment would be on the covered line. Task force membership should include a physical therapist, an acupuncturist or other alternative medicine practitioner, a spinal surgeon, a primary care provider, a member of the Oregon Pain Management Commission, physical medicine and rehabilitation, and other members as staffs sees fit.

**Actions:**

- 1) HERC staff will convene a taskforce on low back pain as outlined above

➤ **Topic: Miscellaneous Conditions with No or Minimally Effective Treatments or No Treatment Necessary**

**Discussion:** There was minimal discussion.

**MOTION: To approve the new line as presented. CARRIES 8-0.**

**Actions:**

- 1) Rename line 669 GASTROINTESTINAL CONDITIONS ~~AND OTHER MISCELLANEOUS CONDITIONS~~ WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY
- 2) Create a new line for miscellaneous conditions with no treatment necessary or no effective treatment with scoring as shown below
  - a. Remove all included ICD-9 and ICD-10 diagnoses from their current lines
- 3) Move the following ICD-9 diagnoses from current lines to line 684 ENDOCRINE AND METABOLIC CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY
  - a. 256.0 (Hyperestrogenism), 272.6 (Lipodystrophy), 272.8 (Other disorders of lipid metabolism)

**Line XXX**

Condition: MISCELLANEOUS CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY

Treatment: EVALUATION

ICD-9: 744.5, 744.8x and 744.9, 748.1, 754.0, 994.5

ICD10: E66.3, E67.2, E67.8, Q18.3, Q18.4, Q18.5, Q18.6, Q18.7, Q18.8, Q18.9, Q30.x, Q67.x, T73.3

CPT: 98966-98969,99051,99060,99070,99078,99201-99215,99281-99285, 99341-99355,99358-99378,99381-99404,99408-99412,99429-99449, 99487-99496,99605-99607

HCPCS: G0396,G0397,G0463

Scoring

Category: 9

HL: 0

Suffering: 0

Population effects: 0

Vulnerable population: 0

Tertiary prevention: 0

Effectiveness: 0

Need for service: 0

Net cost: 0

Score: 0

Line placement: 670 (last line of the list)

➤ **Topic: Injuries to blood vessels of the neck**

**Discussion:** There was discussion about whether a new line was needed for injuries to blood vessels of the neck. The subcommittee decided to add these diagnoses to the existing injury to major blood vessels of the extremities line and change the line title to include the neck. This was thought to be a simpler solution and the line priority appropriate for the seriousness of these injuries.

**MOTION: To approve the movement of the injury to blood vessel in the neck codes to line 82. CARRIES 8-0.**

**Actions:**

- 1) Move ICD-9 (900.xx) and ICD-10 (S15.xxx) codes for injuries to the blood vessels of the neck from Line 135 CRUSH INJURIES OTHER THAN DIGITS; COMPARTMENT SYNDROME to line 82 INJURY TO MAJOR BLOOD VESSELS OF EXTREMITIES
- 2) Move the CPT codes for repair of neck vessels from line 135 to line 82
  - a. 35201 Repair blood vessel, direct; neck
  - b. 35231 Repair blood vessel with vein graft; neck

- c. 37615 Ligation, major artery (eg, post-traumatic, rupture); neck
  - d. 37565 Ligation, internal jugular vein
- 3) Rename line 82 INJURY TO MAJOR BLOOD VESSELS OF EXTREMITIES  
[AND NECK](#)

➤ **Public Comment:**

No additional public comment was received.

➤ **Next Steps**

Issues for next meeting:

- Continued discussion of treatments for gender dysphoria:
  - Cross-sex hormone therapy
  - Sex reassignment surgery
- Continued discussion of ABA therapy for autism spectrum disorders
- Hearing loss issues
  - Biennial review deletion of audiant bone conductor for conductive hearing loss line
  - Unilateral hearing loss
  - Bone anchored hearing aids
- Physical therapy for urinary incontinence
- Electronic tumor treatment fields
- Electroconvulsive therapy (ECT) guideline
- Potential new guidelines on:
  - Treatment of hepatitis C
- Potential revisions to existing guidelines on:
  - Bariatric surgery (clarification)
  - Lymphedema
- Treatments for venous insufficiency
- Microwave thermoplasty for benign prostatic hypertrophy
- Physical therapy for urinary incontinence
- Pairing of diagnoses with osteopathic manipulation

➤ **Next meeting:**

June 12, 2014 at Meridian Park Hospital Health Education Center, Conference Room 117B&C in Tualatin, OR

➤ **Adjournment**

The meeting was adjourned at 1:40 pm.

# Appendix A

## Revised Guidelines

### GUIDELINE NOTE 6, REHABILITATIVE THERAPIES

*Lines 37,50-52,64,74-76,78,80,85,89,90,94,95,98-101,108,109,115,116,122,129,139,141-143,145,146,158,161,167,179,184,185,189,190,192,194,195,201,202,208,209,216,226,237,239,270,271,273,274,279,288,289,293,297,302,304,307-309,318,336,342,349,350,363,367,369,375,376,378,382,384,385,387,400,406,407,434,441,443,448,455,467,478,489,493,507,516,535,549,562,580,597,619,638*

Physical, occupational and speech therapy, and cardiac and vascular rehabilitation are only included on these lines when the following criteria are met:

- 1) therapy is provided by a licensed physical therapist, occupational therapist, speech language pathologist, physician, or other practitioner licensed to provide physical, occupational, or speech therapy.
- 2) there is objective, measurable documentation of progress toward the therapy plan of care goals and objectives.
- 3) the therapy plan of care requires the skills of a therapist, and
- 4) the client and/or caregiver cannot be taught to carry out the therapy regimen independently.

~~Physical, occupational and speech therapy, and cardiac and vascular rehabilitation, are covered for diagnoses paired with the respective CPT codes, depending on medical appropriateness, for up to 3 months immediately following stabilization from an acute event.~~

~~Following the 3 month stabilization after an acute event, or, in the absence of an acute event, the following number of combined physical and occupational therapy visits are allowed per year, depending on medical appropriateness:~~

- ~~• Age < 8: 24~~
- ~~• Age 8-12: 12~~
- ~~• Age > 12: 2~~

~~And the following number of speech therapy visits are allowed per year, depending on medical appropriateness (with the exception of swallowing disorders, for which limits do not apply):~~

- ~~• Age < 8: 24~~
- ~~• Age 8-12: 12~~
- ~~• Age > 12: 2~~

~~Whenever there is a change in status, regardless of age, such as surgery, botox injection, rapid growth, an acute exacerbation or for evaluation/training for an assistive communication device, the following additional visits are allowed:~~

- ~~• 6 visits of speech therapy and/or~~
- ~~• 6 visits of physical or occupational therapy~~

## Appendix A

~~No limits apply while in a skilled nursing facility for the primary purpose of rehabilitation, an inpatient hospital or an inpatient rehabilitation unit.~~

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

*Line 210*

CPAP is 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 one or more of the following:
  - excessive daytime sleepiness [defined as either an Epworth Sleepiness Scale score >10 or daytime sleepiness interfering with ADLs that is not attributable to another modifiable sedating condition \(e.g. narcotic dependence\), or](#)
  - documented hypertension, or
  - 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 (PSG) or Home Sleep Test (HST).

CPAP coverage subsequent to the initial 12 weeks is 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.

Mandibular advancement devices (oral appliances) are covered for those for whom CPAP fails or is contraindicated.

Surgery for sleep apnea in adults is not included [on this line \(due to lack of evidence of efficacy\)](#). [Tonsillectomy and adenoidectomy codes are included on this line only for children who meet criteria according to Guideline Note 118 OBSTRUCTIVE SLEEP APNEA DIAGNOSIS AND TREATMENT IN CHILDREN.](#)

## **Appendix B**

### **New Guidelines**

#### **DIAGNOSTIC GUIDELINE DXX COMPUTER-AIDED MAMMOGRAPHY**

Computer-aided mammography (CPT code 77051 and 77052) is not a covered service.

# Appendix C

## Health Evidence Review Commission

### Quality of Evidence Statement

HERC relies heavily on high quality evidence and evidence-based guidelines in making prioritization decisions.

The following source list illustrates how HERC and the Value-based Benefits Subcommittee (VbBS) view various types of evidence for prioritization decisions. The existence of evidence in the form of a high-quality study design does not necessarily mean that the overall evidence on that topic will be considered high quality. For instance, a high quality systematic review might find that the available studies have significant potential for bias and may conclude there is a low strength of evidence or insufficient evidence to support an intervention.

Lower quality evidence may sometimes be considered in situations where higher quality evidence is difficult to obtain (for example, in rare clinical conditions).

The commission **also** includes other factors into its decision making process, such as harms, treatment alternatives, health equity and the needs of specific subgroups when relevant data exists.

HERC may consider various factors in evaluating a particular study, including:

- Potential for bias
- Clinical significance of outcomes studied
- Strength **and consistency** of evidence, not just **study** quality
- Study relevance based on population and health system characteristics
- Conflicts of interests of the authors

**The following sources generally produce high quality evidence and are preferred by HERC:**

- Agency for Healthcare Research and Quality (AHRQ) <http://www.ahrq.gov/clinic/>
- Blue Cross Blue Shield Technology Evaluation Center (TEC) <http://www.bcbs.com/blueresources/tec/>
- British Medical Journal (BMJ) Clinical Evidence <http://www.clinicalevidence.com>
- Canadian Coordinating Office for Health Technology Assessment (CCOHTA) <http://www.cadth.ca/index.php/en/hta>
- Cochrane Database of Systematic Reviews <http://www2.cochrane.org/reviews/>
- Evidence-Based Practice Centers (EPC) [www.ahrq.gov/clinic/epc](http://www.ahrq.gov/clinic/epc)
- Health Technology Assessment Programme - United Kingdom <http://www.hta.nhsweb.nhs.uk/ProjectData>
- National Institute for Clinical Excellence (NICE) - United Kingdom <http://guidance.nice.org.uk/>
- Scottish Intercollegiate Guidelines Network (SIGN) <http://www.sign.ac.uk/guidelines/index.html>
- University of York <http://www.york.ac.uk/inst/crd/>

**The following types of study designs can be considered high quality and are preferred by HERC:**

- Systematic reviews of randomized controlled trials

## Appendix C

- Systematic reviews of prospective cohort studies
- Evidence-based guidelines from trusted sources

**The following types of study designs/documents can be considered lower quality and are often reviewed by HERC:**

- Guidelines issued by professional societies and advocacy organizations (e.g. American Heart Association)
- Coverage decisions by private health plans (e.g. Aetna)
- Well-conducted, peer-reviewed individual studies (experimental or observational)

**The following types of evidence can be considered very low quality and are seldom reviewed by HERC:**

- Case reports, case series
- Unpublished studies (posters, abstracts, presentations, non-peer reviewed articles)
- Individual studies that are poorly conducted, do not appear in peer-reviewed journals, are inferior in design or quality to other relevant literature, or duplicate information in other materials under review by the Commission