

Quality and Health Outcomes Committee

January 11, 2016

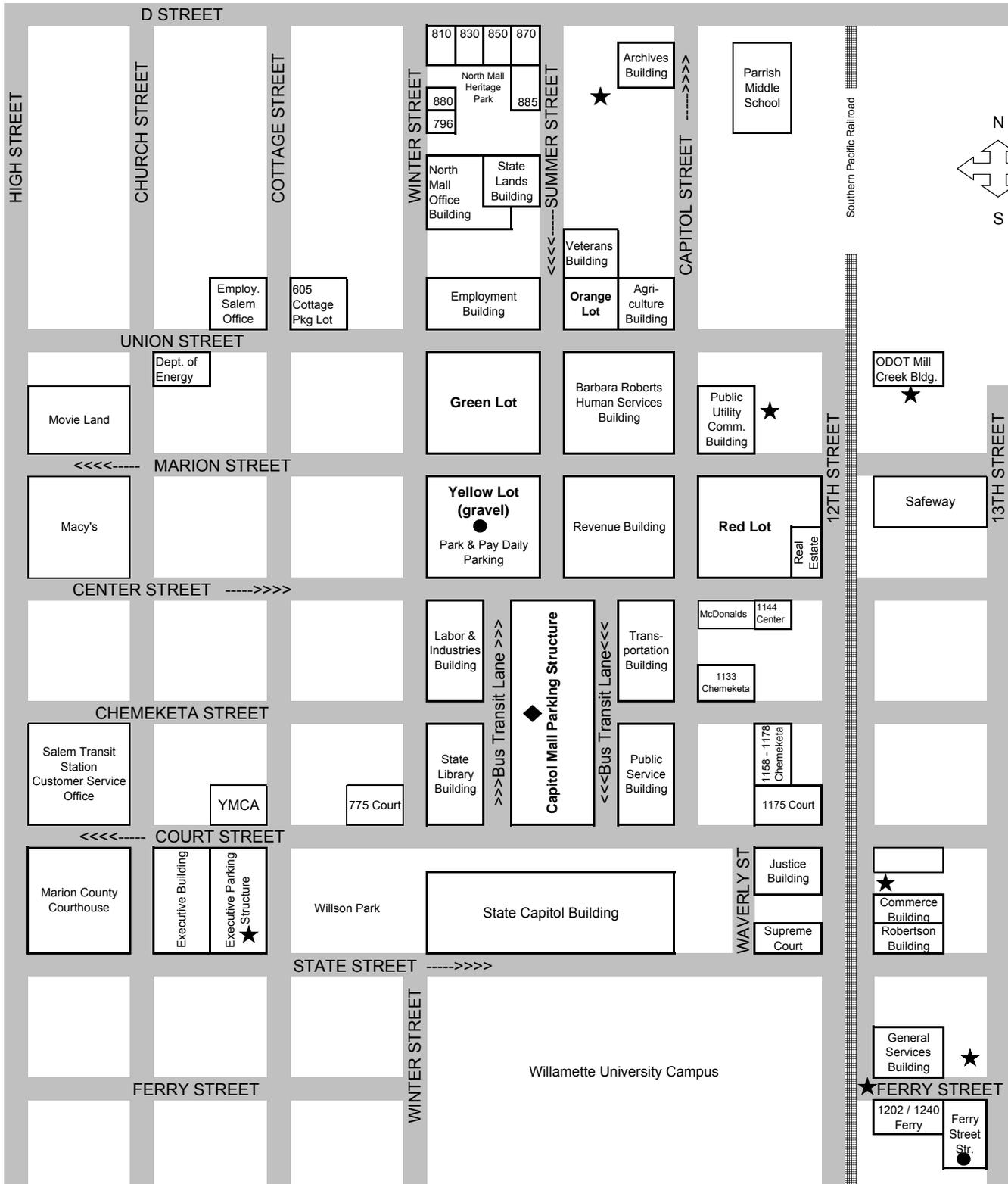
HSB Building Room 137A-D, Salem, OR

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Clinical Director Workgroup			
Time	Topic	Owner	Related Documents (page#)
9:00 – 9:10	Welcome / Introductions -Consent Agenda	Mark Bradshaw	-PH Update (2 – 3)
9:10 – 9:25	Older Adult BH Investment	Nirmala Dhar Diana White Kristen Swafford	
9:25 – 9:40	Hospital Performance Program	Sara Kleinschmit	
9:40 – 10:10	HERC Update	Cat Livingston	-Diagnostic Imaging for Back Pain Issue Summary (4 – 6) -Meeting minutes & Coverage Guidance (7 – 22) -Grade-Informed Framework (23 – 25) -Tobacco Cessation and Elective Procedures (26 – 28) -Value-based Benefits Subcommittee Recommendations & Meeting Minutes (29 – 74) -HERC Meeting Minutes (75 – 85)
10:10 – 10:40	Behavioral Health Home	Amy Harris	-Presentation slides (86 – 93)
10:40 – 10:50	Clinical Directors – Items from the floor	All	
10:50 – 11:00	BREAK		
Learning Collaborative Session			
11:00 – 12:30	Behavioral Health Integration	Panel	-Agenda (94 – 96) -Presentation slides (97 – 126)
12:30 – 1:00	LUNCH		
Quality and Performance Improvement Session (2 hrs)			
1:00 – 1:10	QPI Update/Introductions	Jennifer Johnstun	
1:10 – 1:25	Statewide PIP: Diabetes-SPMI -Final data report	Susan Arbor	-Statewide PIP (127 – 128)
1:25 – 1:55	Complaints/Grievances	Tressa Perlicheck	
1:55 – 2:10	Statewide PIP: Opioid -Next Steps: reporting fro 1/31	Acumentra	
2:10 – 2:45	QAPI -Discussion of elements	Lisa Bui	- National Disparities Report
2:45 – 3:00	Items from the Floor	All	

SALEM CAPITOL MALL AREA



- ★ State of Oregon Meters - OK to use Agency issued one-day permit
- ◆ Capitol Mall Structure Meters - OK to use Agency Issued one-day permit
- Yellow Lot & Ferry Structure Rooftop Visitor Spaces - OK to use Agency issued one-day permit

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Quality and Health Outcomes Committee Public Health Division updates – January 2016

Data and Reports

Oregon State Health Gaps Report: In November 2015, *County Health Rankings & Roadmaps* released the 2015 State Health Gaps Reports. These reports explore the significant differences in health outcomes across counties in each state. The information in these reports can be used to learn about the factors that influence health in different areas of the state and what state and local communities can do to address health gaps. The State Health Gaps Reports are available at: <http://www.countyhealthrankings.org/health-gaps>.

Resources and Updates

Birth Defects Prevention: January is National Birth Defects Prevention Month. The health care community can help all women (including teens) to lower their risk of having a baby with a birth defect and to avoid other complications of pregnancy. This year the Oregon Health Authority, Public Health Division is encouraging medical professionals to work with their patients to make a **PACT** for their own health, and if applicable, a healthy pregnancy. The National Birth Defects Prevention Network (NBDPN) has web resources to support these efforts to encourage patients to:

- Plan ahead
- Avoid harmful substances
- Choose a healthy lifestyle
- Talk with their doctor about their family and health history

For resources and more information, go to: <http://www.nbdpn.org/bdpm2016.php> or contact Lesa Dixon-Gray at Lesadixon-gray@state.or.us.

National Prediabetes Awareness Campaign and March 2016 Lifestyle Coach Training:

A national campaign will be launched at the end of January to raise awareness of prediabetes among people at high risk for type 2 diabetes. As a result of this campaign, health care providers may experience an increased number of patients asking what they can do to prevent diabetes. The campaign will promote participation in CDC-recognized lifestyle change programs that operate under the National Diabetes Prevention Program (DPP). For

any organizations interested in offering a DPP for patients, employees or community members, a lifestyle coach training will be presented March 4-5 in Portland through Emory University's Diabetes Training and Technical Assistance Center. The cost for participation in this two-day training is \$750 per person. For more information, or to be notified when the training registration link is available, contact Don Kain at kaind@ohsu.edu. For more information about the Diabetes Prevention Program, go to www.healthoregon.org/takecontrol .

Diagnostic Imaging for Back Pain Issue Summary

Staff summary:

Epidural steroid injections do not appear to provide clinically significant pain relief or functional improvement in the short or long term, and are unlikely to reduce rates of surgery. From AHRQ: "The magnitude of effects on pain and function was small, did not meet predefined thresholds for minimum clinically important differences, and there were no differences on outcomes at longer-term followup."

Current coverage of ESI requires that MRIs be available for the evaluation of any type of low back pain with radiating pain. It is standard of care to obtain an MRI prior to ESI, and ESI is most commonly used for radiating pain without neurologic change. The liberalization of MRI criteria for low back pain will result in a vast increase in coverage and will have substantial cost impact.

Overall, when the additional cost of MRIs are factored in, ESI does not appear to be a cost-effective therapy. Removal of coverage for ESI would allow restoration of the previous guideline definition of radiculopathy.

HERC Staff Recommendations:

- 1) Remove coverage for epidural steroid injections
 - a. Remove CPT 64483 (Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level) and 64484 (each additional level) from line 407
 - b. Remove 64484 from line 159 HERPES ZOSTER; HERPES SIMPLEX AND WITH NEUROLOGICAL AND OPHTHALMOLOGICAL COMPLICATIONS
 - i. 64483 is not on that line and therefore additional levels cannot be injection
 - c. Place 64483 and 64484 on the Services Recommended for Non-Coverage table
 - d. Delete guideline note 105 EPIDURAL STEROID INJECTIONS FOR LOW BACK PAIN
- 2) Modify DIAGNOSTIC GUIDELINE D4, ADVANCED IMAGING FOR LOW BACK PAIN as shown below
 - a. Adds wording regarding when repeat MRI imaging is appropriate
 - b. Restores previous requirements for imaging for low back pain to patients with neurologic changes

Diagnostic Imaging for Back Pain Issue Summary

DIAGNOSTIC GUIDELINE D4, ADVANCED IMAGING FOR LOW BACK PAIN

In patients with non-specific low back pain and no “red flag” conditions [see Table D4], imaging is not a covered service; otherwise work up is covered as shown in the table. [Repeat imaging is only covered when there is a substantial clinical change \(e.g. progressive neurological deficit\) or new clinical indication for imaging \(i.e. development of a new red flag condition\). Repeat imaging for acute exacerbations of chronic radiculopathic pain is not covered.](#)

Electromyography (CPT 96002-4) is not covered for non-specific low back pain.

Table D4
Low Back Pain - Potentially Serious Conditions (“Red Flags”) and Recommendations for Initial Diagnostic Work-up

Possible cause	Key features on history or physical examination	Imaging ¹	Additional studies ¹
Cancer	<ul style="list-style-type: none"> History of cancer with new onset of LBP 	MRI	ESR
	<ul style="list-style-type: none"> Unexplained weight loss Failure to improve after 1 month Age >50 years Symptoms such as painless neurologic deficit, night pain or pain increased in supine position 	Lumbosacral plain radiography	
	<ul style="list-style-type: none"> Multiple risk factors for cancer present 	Plain radiography or MRI	
Spinal column infection	<ul style="list-style-type: none"> Fever Intravenous drug use Recent infection 	MRI	ESR and/or CRP
Cauda equina syndrome	<ul style="list-style-type: none"> Urinary retention Motor deficits at multiple levels Fecal incontinence Saddle anesthesia 	MRI	None
Vertebral compression fracture	<ul style="list-style-type: none"> History of osteoporosis Use of corticosteroids Older age 	Lumbosacral plain radiography	None
Ankylosing spondylitis	<ul style="list-style-type: none"> Morning stiffness Improvement with exercise Alternating buttock pain Awakening due to back pain during the second part of the night Younger age 	Anterior-posterior pelvis plain radiography	ESR and/or CRP, HLA-B27
Nerve compression/ disorders (e.g. herniated disc with radiculopathy)	<ul style="list-style-type: none"> Back pain with leg pain in an L4, L5, or S1 nerve root distribution present < 1 month Positive straight-leg-raise test or crossed straight-leg-raise test 	None	None
	<ul style="list-style-type: none"> Radiculopathic-signs² present >1 month Severe/progressive neurologic deficits (such as foot drop), progressive motor weakness 	MRI ³	Consider EMG/NCV
Spinal stenosis	<ul style="list-style-type: none"> Radiating leg pain Older age Pain usually relieved with sitting (Pseudoclaudication a weak predictor) 	None	None
	<ul style="list-style-type: none"> Spinal stenosis symptoms present >1 month 	MRI ³	Consider EMG/NCV

Diagnostic Imaging for Back Pain Issue Summary

- ¹ Level of evidence for diagnostic evaluation is variable
- ² Radiculopathic signs are defined for the purposes of this guideline as ~~pain, weakness, or sensory deficits, in a nerve root distribution~~ the presence of any of the following:
- A. Markedly abnormal reflexes
 - B. Segmental muscle weakness
 - C. Segmental sensory loss
 - D. EMG or NCV evidence of nerve root impingement
 - E. Cauda equina syndrome
 - F. Neurogenic bowel or bladder
 - G. Long tract abnormalities
- ³ Only if patient is a potential candidate for surgery ~~or, if indicated, lumbar epidural steroid injection (see guideline note 105)~~
- ~~⁴ Only if patient is a potential candidate for surgery~~

Red Flag: Red flags are findings from the history and physical examination that may be associated with a higher risk of serious disorders. CRP = C-reactive protein; EMG = electromyography; ESR = erythrocyte sedimentation rate; MRI = magnetic resonance imaging; NCV = nerve conduction velocity.

Extracted and modified from Chou R, Qaseem A, Snow V, et al: Diagnosis and Treatment of Low Back Pain: A Joint Clinical Practice Guideline from the American College of Physicians and the American Pain Society. Ann Intern Med. 2007; 147:478-491.

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

MINUTES

Evidence-based Guidelines Subcommittee

Clackamas Community College
Wilsonville Training Center, Rooms 111-112
29353 SW Town Center Loop E
Wilsonville, Oregon 97070
November 5, 2015
2:00-5:00pm

Members Present: Wiley Chan, MD, Chair; Eric Stecker, MD, MPH (arrived at 2:05), Vice-Chair; Vern Saboe, DC; Beth Westbrook, PsyD; George Waldmann, MD; Alison Little, MD, MPH.

Members Absent: Bob Joondeph, JD

Staff Present: Darren Coffman; Catherine Livingston, MD, MPH; Jason Gingerich.

Also Attending: Adam Obley, MD, Craig Mosbaek (Center for Evidence-Based Policy), CJ Dantine (OSIRIS), Dirk Sutherland (Alliqua Biomedical), Carol Howe and Lisa Chickadonz (American College of Nurse-Midwives), Jessie Little (OHA Actuarial Services), Erica Pettigrew (OHSU).

1. CALL TO ORDER

Wiley Chan called the meeting of the Evidence-based Guidelines Subcommittee (EbGS) to order at 2:00 pm.

2. MINUTES REVIEW

Chan asked that the September minutes be corrected to show approval of the scope document on Neuroimaging for Headache.

Minutes approved as amended 5-0 (Absent: Stecker).

3. STAFF REPORT

Coffman welcomed Alison Little to the subcommittee, and announced that Vern Saboe will be rotating off of EbGS and onto VbBS when his HERC term ends at the end of the year. A new complimentary and alternative medicine representative is being sought for HERC, and when that person is appointed, they will join EbGS as well.

Coffman also suggested moving the November EbGS meeting to the first week of December in 2016. Waldmann said that date might be a problem for him. No decision was made.

Coffman also reported that HERC decided to open public meetings in listen-only mode. Members of the public will be allowed to call in, but only invited speakers will receive a code to allow them to be heard.

Livingston gave an update on the Coverage Guidance on Planned Out-of-Hospital Birth. It was discussed at the October VbBS and HERC meetings but discussion will be continued in November, when it will likely be approved. Livingston said some more minor changes were being suggested, including requiring documenting the absence of certain risk factors, which would end up meaning HIV, syphilis and hepatitis B would require screening in addition to other risk factors. There are many implementation considerations for this coverage guidance; she asked for feedback on how the subcommittee felt about the level of detail they got to in the coverage guidance.

Waldmann said that lack of malpractice insurance is one of the considerations for CCOs; for that reason he confirmed that coverage of the birth itself for providers lacking liability insurance would be provided by fee-for-service Medicaid and the mother and child would return to CCO coverage after the labor and delivery. He expressed concern that OHA fee-for-service staff might not do as much precertification work as the CCOs, but Livingston said there is a nurse responsible for reviewing these cases.

Westbrook responded to Livingston's question, saying that it was a detailed discussion for out-of-hospital birth, but she was willing to go into details if needed. Chan said that the Value-based Benefits Subcommittee is more accustomed to dealing with such implementation details, but the EbGS seems to be getting into that territory more and more. Westbrook said she is comfortable doing that to the extent that the group is reviewing the evidence rather than speculating. Livingston noted that the skin substitutes coverage guidance will get into some policy speculation issues.

4. Review of public comment— Nitrous Oxide Use for Labor Pain Management

Robyn Liu reviewed the single public comment, which focused on safety issues. The response is that the guidance assumes that the gas will be used by qualified personnel and used in a safe way. No changes were made to the draft coverage guidance.

Livingston reviewed some clarifying edits made by staff during the public comment period, shown in track changes in the meeting packet. There was no discussion of these edits.

Stecker asked about the billing codes. There is an anesthesia code for nitrous oxide but it can only be used by anesthesiologists and nurse anesthetists. In a hospital setting, nitrous oxide would be billed as part of a bundled payment. In the out-of-hospital settings, implementers will need to find a way to reimburse this service.

Livingston invited public comment. Carol House offered public comment. She recently retired as program director for the midwifery center at OHSU. She asked about the use of nitrous oxide during the delivery of the placenta. Liu clarified that the delivery of placenta is the third stage of labor, so would be included with the existing language.

Motion to approve the draft coverage guidance for review by VbBS and HERC was approved 6-0.

DRAFT COVERAGE GUIDANCE

Nitrous oxide for labor pain is recommended for coverage (weak recommendation).

5. Review need for updates on coverage guidances approved in 2013

For Induction of Labor, Liu reviewed the rescanning document. Livingston recommended not reviewing the topic as no change would be likely. After minimal discussion, the subcommittee voted 6-0 to defer consideration of a new coverage guidance for this topic until the next two-year review cycle.

For Recurrent Acute Otitis Media, Liu said this would likely be the most controversial. At the time that the coverage guidance was approved the American Academy of Pediatrics recommended use of prophylactic antibiotics. Liu said that there are new evidence reviews but they are poor quality and contradictory. The AAP no longer recommends use of prophylactic antibiotics, due in part to concerns about antibiotic resistance and limited benefit. Livingston said the staff recommendation is to review the topic again to address the AAP guideline as well as concerns about antibiotic resistance and adenoidectomies and tympanostomy tubes. After minimal discussion, the subcommittee voted 6-0 to recommend the development of a new coverage guidance on the topic.

For Neuroimaging for Headache, Livingston recommended not updating the coverage guidance until the next two-year cycle. After minimal discussion, the subcommittee voted 6-0 to defer consideration of a new coverage guidance for this topic until the next two-year review cycle.

6. Review draft coverage guidance—Skin substitutes for chronic skin ulcers

Coffman introduced Dr. Foy White-Chu, who will serve as clinical expert for this topic. Dr. White-Chu is Associate Geriatric Fellowship Director at the Portland VA Medical Center. She is certified as a Physician Specialist in Wound Care by the Council for Medicine Education and Testing, and a Diplomate of the American Board of Internal Medicine, with Geriatric Medicine Subspecialty. For conflicts of interest, in addition to her employment, she provides clinical medical education training on wound care at regional conferences several times each year.

Liu reviewed the draft coverage guidance. Subcommittee members asked several questions about the regulatory context. Some of these products are FDA-approved and as such have approved indications for use. Others are said to qualify as human tissue products, which do not require such approval and thus are regulated differently for safe handling rather than clinical effectiveness. There is litigation over which products fall into which category. Livingston said initially that staff wanted to separate products by tissue type but discovered that this doesn't provide a useful distinction as the effectiveness of each product needs to be considered individually to determine efficacy.

When Liu reviewed the parameters for the literature search, Livingston mentioned that the original scope included only comparison to usual care, but the search also returned some head-to-head comparisons of different products. Stecker noted that there are problematic issues combining

comparisons to usual care and comparisons of multiple products. Livingston agreed and said that the subcommittee will discuss these where appropriate.

Liu also discussed that some industry stakeholders submitted studies that weren't found in staff's literature search because the articles were very recent or hadn't been indexed by MedLine. According to the Coverage Guidance methodology, these studies were not considered in the initial draft coverage guidance, but will be included if submitted as a part of public comments and reviewed along with other public comments. Staff has already notified stakeholders that they will need to resubmit the studies during the formal comment period. The search strategy included only systematic reviews, evidence-based guidelines meta-analyses and randomized controlled trials indexed in MedLine.

Before Liu reviewed the evidence around the eight products for which staff found evidence, Livingston explained that the staff recommendations were based on a requirement for at least low quality evidence of benefit to justify a coverage recommendation. No evidence that met inclusion criteria was found for the treatment of pressure ulcers, and evidence for many of the products was rated as very low quality, so coverage was not recommended for these. Staff also clarified the difference between the level of certainty about the outcome from what the outcome is. In some cases we have low certainty of benefit. This means that the evidence is weak and indicates that the product doesn't have a benefit for the selected outcome.

Livingston reviewed the cost issues. Some products are applied only once; others are applied multiple times with different maximum amounts for different products. She explained how the cost varies by setting of care and billing methodology for Medicare. Many of the costs are similar, but there are some outliers. Stecker questioned the usefulness of this analysis because of the higher variability. An insurer could instead approve spending for a particular dollar amount over a time period. Chan said that another approach would be to determine whether the benefit is cost effective. You would only compare costs if you had evidence of benefit for two products with different costs in the same application.

After Livingston and Liu reviewed the cost information, Stecker questioned the use of this level of detailed cost information. White-Chu explained that Apligraf is a perishable product sold in large sizes. Frequently much of the product is wasted because the wound is small, and she has had cases where the product was wasted because of shipping delays due to storms in the Midwest. Other products such as Epifix are sold in smaller sizes and have a long shelf life. Pricing evolves rapidly and depends on facility negotiations. Stecker expressed concern about going into this level of detail. For instance, with ablation for atrial fibrillation, payers don't specify the kinds of catheters a surgeon uses or what kinds of anesthesia or imaging he uses; using cost data in this way would go beyond the HERC coverage guidance on that topic. Westbrook said it may be worth these amounts to prevent an amputation; there needs to be room for clinicians to make decisions, including cost effectiveness decisions, for their patients.

Livingston then reviewed the Coverage Guidance box recommendation. Based on Liu's recommendation, Livingston endorsed changing the recommendation in the meeting materials for Oasis, changing it to a weak recommendation for coverage for diabetic foot ulcers based on the outcome of time to complete wound healing.

After discussion, the subcommittee decided to strike the paragraph on reference pricing and bundling, to leave such decisions to payers. In addition, the subcommittee revised the criteria for coverage of the products recommended for coverage. It moved requirements for offloading, multilayer compression dressings and tobacco cessation and made them part of the definition of prior appropriate wound care.

After discussion, the requirement for tobacco cessation was also changed to a requirement for participation in smoking cessation counseling. (The subcommittee didn't find sufficient evidence in this review to require smoking cessation, but did retain the requirement for provision of smoking cessation counseling.)

The subcommittee also added a requirement for an ABI (Ankle-Brachial Index) of 0.7 as evidence of adequate arterial blood flow.

The subcommittee added a definition of failure of conservative wound care as failing to achieve a 50 percent reduction in ulcer surface area. In place of the limit on additional use of products which had failed previously, the subcommittee added a clause requiring continued significant improvement at six week intervals for continued coverage. After extensive discussion, the subcommittee specifically decided not to add a maximum total duration for therapy or maximum number of applications for a particular product because of lack of evidence to support such a restriction. Coffman said that VbBS may consider putting an upper limit based on limited resources.

Livingston invited public comment.

CJ Dantine testified representing Osiris, manufacturer of Grafix. He addressed the exclusion criteria for the Lavery study discussed earlier, which was HbA1c >12, or ABI >1.3 or <0.7. He said Noridian recently changed its criteria from requiring smoking cessation to requiring patients to be advised to stop smoking. He described the Grafix products, and cited the NICE guidance which finds benefits from Grafix based on a randomized trial which was stopped early for overwhelming efficacy. He said 34 million Medicaid lives have access to Grafix right now. In addition Noridian recently removed Grafix from the noncovered list.

Livingston said that staff would review the recommendation on Grafix based on this study during the public comment period. Liu said that this study had been included but the quality had been downgraded to very low based on lack of description of randomization and concealment as well as potential funder bias. No changes were made to the coverage guidance based on this testimony.

The subcommittee also discussed the strength of recommendation for Apligraf. After discussion the subcommittee decided to leave the recommendation as weak.

Motion to post the draft coverage guidance for public comment as amended was approved 6-0.

Staff note: After the meeting it was discovered that this part of Liu's presentation contained an error with respect to the OASIS Wound Matrix, so this change was removed from the version posted for comment. EbGS will discuss this matter along with the public comments.

DRAFT HERC Coverage Guidance

Skin substitutes for chronic venous leg ulcers and chronic diabetic foot ulcers are recommended for coverage (*weak recommendation*) when all of the following criteria are met:

1. Product is recommended for the type of ulcer being treated (see table below)
2. FDA indications and contraindications are followed, if applicable

3. Wound has adequate arterial flow (ABI > 0.7), no ongoing infection and a moist wound healing environment
4. For patients with diabetes, Hba1c level is < 12.
5. Prior appropriate wound care therapy (including but not limited to appropriate offloading, multilayer compression dressings and smoking cessation counseling) has failed to result in significant improvement (defined as at least a 50 percent reduction in ulcer surface area) of the wound over at least 30 days
6. Ulcer improves significantly over 6 weeks of treatment with skin substitutes, , with continued significant improvement every 6 weeks required for coverage of ongoing applications
7. Patients is able to adhere to the treatment plan

The following products are recommended/not recommended for coverage as shown below. All recommendations are weak recommendations except as specified.

Product	Diabetic foot ulcers	Venous leg ulcers
Dermagraft	Recommended	Not recommended
Apligraf	Recommended	Recommended
OASIS Wound Matrix	Not Recommended	Recommended
Epifix	Not recommended	Not recommended
Grafix	Not recommended	Not recommended
Graftjacket	Not recommended	Not recommended
Talymed	Not recommended	Not recommended
Theraskin	Not recommended	Not recommended
Other skin substitutes	Not recommended	Not recommended

The use of skin substitutes is not recommended for coverage of chronic skin ulcers other than venous leg ulcers and diabetic foot ulcers (e.g. pressure ulcers) (*weak recommendation*).

7. ADJOURNMENT

The meeting was adjourned at 4:32 pm. The next meeting is scheduled for February 4, 2016 from 2:00-5:00pm in Room 111-112 of the Wilsonville Training Center.

HEALTH EVIDENCE REVIEW COMMISSION (HERC)

COVERAGE GUIDANCE: SKIN SUBSTITUTES FOR CHRONIC SKIN ULCERS

DRAFT as posted for public comment 11/13/2015 to 8 a.m. 12/16/2015

†Note: the recommendation for OASIS Wound Matrix has been changed for the purposes of this draft to “Not recommended for coverage” after approval by the subcommittee due to an error in the presentation. The subcommittee will discuss this change along with any public comments received.

HERC Coverage Guidance

Skin substitutes for chronic venous leg ulcers and chronic diabetic foot ulcers are recommended for coverage (*weak recommendation*) when all of the following criteria are met:

1. Product is recommended for the type of ulcer being treated (see table below)
2. FDA indications and contraindications are followed, if applicable
3. Wound has adequate arterial flow (ABI > 0.7), no ongoing infection and a moist wound healing environment
4. For patients with diabetes, Hba1c level is < 12.
5. Prior appropriate wound care therapy (including but not limited to appropriate offloading, multilayer compression dressings and smoking cessation counseling) has failed to result in significant improvement (defined as at least a 50 percent reduction in ulcer surface area) of the wound over at least 30 days
6. Ulcer improves significantly over 6 weeks of treatment with skin substitutes, , with continued significant improvement every 6 weeks required for coverage of ongoing applications
7. Patients is able to adhere to the treatment plan

The following products are recommended/not recommended for coverage as shown below. All recommendations are weak recommendations except as specified.

Product	Diabetic foot ulcers	Venous leg ulcers
Dermagraft	Recommended	Not recommended
Apligraf	Recommended	Recommended
OASIS Wound Matrix	<u>Not</u> Recommended†	Recommended
Epifix	Not recommended	Not recommended
Grafix	Not recommended	Not recommended
Graftjacket	Not recommended	Not recommended
Talymed	Not recommended	Not recommended

Theraskin	Not recommended	Not recommended
Other skin substitutes	Not recommended	Not recommended

The use of skin substitutes is not recommended for coverage of chronic skin ulcers other than venous leg ulcers and diabetic foot ulcers (e.g. pressure ulcers) (*weak recommendation*).

Note: Definitions for strength of recommendation are provided in Appendix A *GRADE Informed Framework Element Description*.

PLAIN LANGUAGE SUMMARY

[Staff will insert lay language summary once the coverage guidance has been reviewed by subcommittee]

RATIONALE FOR GUIDANCE DEVELOPMENT

The HERC selects topics for guideline development or technology assessment based on the following principles:

- Represents a significant burden of disease
- Represents important uncertainty with regard to efficacy or harms
- Represents important variation or controversy in clinical care
- Represents high costs, significant economic impact
- Topic is of high public interest

Coverage guidance development follows standard methodology to translate evidence reviews into a policy decision. Coverage guidances are based on a thorough review of the evidence by the Evidence-based Guideline Subcommittee or the Health Technology Assessment Subcommittee. The evidence review used in the coverage guidance development process may use existing systematic reviews of the evidence on a given topic and incorporate additional individual studies published more recently than the included systematic reviews. Included evidence sources are generally published within the last three to five years. A full description of the evidence review methodology is included in each coverage guidance as an appendix. The translation of the evidence review to a policy decision is based on a GRADE-informed framework, as described below.

MINUTES

Health Technology Assessment Subcommittee

Clackamas Community College
Wilsonville Training Center, Room 210
29353 SW Town Center Loop E
Wilsonville, Oregon 97070
December 10, 2015
1:00-4:00pm

Members Present: Som Saha, MD, MPH (Chair Pro Tempore); Chris Labhart; Gerald Ahmann, MD; Leda Garside, RN, MBA; Mark Bradshaw, MD; Jim MacKay, MD (left at 3:40). Derrick Sorweide, DO (arrived 2:05)

Members Absent: Tim Keenen, MD

Staff Present: Darren Coffman; Cat Livingston, MD, MPH; Jason Gingerich.

Also Attending: Adam Obley, MD, Val King MD, MPH & Craig Mosbaek (OHSU Center for Evidence-based Policy), Amber Stifter (Medtronic), Joe Badolato, DO (FamilyCare), Valerie Halpin, MD (Legacy), Bruce Wolfe, MD (OHSU), Rene Taylor (DexCom).

1. CALL TO ORDER

Saha called the meeting to order at 1 p.m.

2. MINUTES REVIEW

Minutes from the September, 2015 meeting were reviewed and approved 6-0.

3. STAFF REPORT

Coffman noted that the topic of Vertebroplasty, Sacroplasty and Kyphoplasty was inadvertently omitted from the public notice for this meeting. The rescan of this topic will come to a future meeting.

4. REVIEW NEED FOR UPDATES ON COVERAGE GUIDANCES APPROVED IN 2013

Obley reviewed the results of the rescan for Continuous Glucose Monitoring provided in the meeting packet. Livingston said she recommends an update as there are randomized trials with mixed evidence. There are also implementation concerns about the duration and indications for these devices. Som said in a rescan, we'd only want to take up a topic if the evidence is likely to change the recommendation. Obley said there are two reasons to consider an update. First, the new randomized trial is the largest

and best-conducted to date. In addition, these devices are now being paired with insulin pumps, which is a novel use of the device.

Saha invited public comment.

Joe Badolato from FamilyCare testified that the evidence is mixed for this very expensive device. It is difficult to know when to start, when to stop use and for how long to continue use. He gave the example of a newly-diagnosed 8-year-old Type 1 diabetes patient who would qualify under the HERC guideline, but her HbA1c was barely over the limit after a short course of management without the device. Families are demanding the device and hoping for better control, but the evidence of significant benefit is lacking. In addition, the requirement for considering insulin pump therapy causes difficulty as the continuous monitors are usually prescribed before therapy. He said that these devices are being pushed by Byram and Medtronic representatives. He expressed surprise that HERC approved the current guideline based on limited evidence. In addition he said that determining compliance with previous treatment is difficult, as compliance isn't defined. He requested additional clarity from the next review.

Rene Taylor, a diabetes educator with DexCom, a manufacturer, also testified, requesting additional clarity around the requirement related to insulin pumps being considered or utilized. Consideration is not often documented in progress notes, and this is limiting access. There are devices approved for children as young as two years old, which are shown to reduce hypoglycemia in this vulnerable population. In addition, the evidence shows equivalence for the device with insulin injections or an insulin pump so the requirement for an insulin pump is not consistent with the evidence.

Staff noted an edit to the previously approved scope statement, adding mention that diabetes-related hospitalizations and emergency department visits were excluded as outcomes.

After brief additional discussion, the subcommittee voted 6-0 (Sorweide absent) to recommend the development of a new coverage guidance on the topic.

For Self Monitoring of Blood Glucose, Obley reviewed the rescanning summary. The reviews all suggested small improvements in HbA1c, but evidence is lacking on direct outcomes. Livingston said she doesn't believe this evidence has the potential to change the existing coverage guidance. The subcommittee voted 6-0 (Sorweide absent) to defer consideration of a new coverage guidance for this topic until the next two-year review cycle.

Obley reviewed the rescan for MRI for Breast Cancer. Livingston recommended not updating the current coverage guidance. The subcommittee voted 6-0 (Sorweide absent) to defer consideration of a new coverage guidance for this topic until the next two-year review cycle.

Obley reviewed the rescan for PET for Breast Cancer after initial diagnosis. Livingston recommended not updating the current coverage guidance. The subcommittee voted 6-0 (Sorweide absent) to defer consideration of a new coverage guidance for this topic until the next two-year review cycle.

Obley reviewed the rescan for Diagnosis of Obstructive Sleep Apnea. Livingston recommended the subcommittee consider updating the current coverage guidance in light of new evidence for home testing devices. The HERC may wish to address clinical pathways to reduce costs for diagnosis for sleep apnea. Livingston said that the recommendation wouldn't be likely to change but there could be recommendations to optimize efficient utilization of these tests. OHP medical directors have requested

review. After brief additional discussion, the subcommittee voted 6-0 (Sorweide absent) to recommend the development of a new coverage guidance on the topic.

5. SCOPE DEFINITION: Hypofractionated Whole Breast Irradiation for Breast Cancer

Obley reviewed the scope statement, which was created with input from Samuel Wang, a radiation oncologist from OHSU and after public comment. He also reviewed the changes in response to public comments. Based on staff recommendation, the subcommittee members added gender in addition to age to Key Question 2, then approved the revised scope statement by a vote of 6-0.

6. METABOLIC AND BARIATRIC SURGERY

Coffman introduced Bruce Wolfe, the appointed expert for this topic. He is a retired bariatric surgeon, and also an investigator for research on a nerve stimulation device for treatment of obesity.

Obley reviewed the limitations on the evidence base as reviewed in the previous meeting as well as the newly-added evidence on reoperations. Livingston reviewed the GRADE-informed table and the box recommendations.

Saha noted that in this case values and preferences won't guide whether the procedures are conducted. Instead, society's values and preferences will guide the coverage decision; the variability in patient preferences can be decided by the patient. But society has values around diabetes prevention, the costs and risks of surgery. Ahmann suggested the language on page 30 of the coverage guidance expresses the issues very well. The subcommittee instructed Livingston to edit the values and preferences statements to reflect this before the guidance is posted for comment.

Discussion turned to the coverage recommendations themselves.

Under the first bullet for adult obese patients, the subcommittee removed the words "and <40" to avoid the perception that surgery would not be covered for adults with BMI of 40 or higher."

In addition, the subcommittee discussed the comorbidities other than diabetes which would qualify someone with a BMI of 35-40 for surgery. These are not strictly evidence-based though other payers cover the surgery for patients with varying numbers and types of comorbidities. Those listed in the meeting materials reflected many of the more common ones. Saha noted that we have evidence about hypertension, even though that's not as significant since hypertension has other treatment. Gingerich reviewed some grammatical differences between the last row of the GRADE table and the box and asked permission to align them for clarity. The subcommittee agreed to allow this and also decided to remove dyslipidemia from the list of comorbidities that would allow a person with BMI between 35 and 40 to have surgery, even though some other payers allow surgery for this comorbidity.

Wolfe argued for not specifying specific comorbidities, pointing out that psychosocial reasons have been considered indications. The subcommittee elected to retain its list of comorbidities as edited.

The subcommittee discussed requirements for support groups, surgeon volume and acceptable complication rate. Wolfe recommended that the subcommittee not create requirements based on the limited evidence but instead require the surgery be provided in a facility accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program. It requires outcomes reporting, postoperative support groups and requires adequate surgeon and hospital volume. He said Medicare used to require this but no longer does, and that some private payers are beginning to adopt it. After discussion of the difficulty in evaluating some of the listed criteria, the subcommittee accepted Wolfe's recommendation. Accredited bariatric surgery programs are available in various regions of the state, mitigating the impact of the requirement on patients in many more rural areas, though Labhart expressed concern that Bend is the only program east of the Cascade Mountains. Saha said he doesn't believe anyone is trying to do bariatric surgeries in other parts of Eastern Oregon, but even if there were, the benefit of having surgery available locally would need to be balanced with the risks associated with a lower-volume center. Garside expressed concern that the subcommittee should evaluate the evidence with regard to these factors rather than limiting access based on an external entity, but others doubted that the HERC could monitor these factors as well as a dedicated group. Gingerich asked whether the accreditation includes outpatient surgery centers. Wolfe said there is a separate program for these facilities.

After discussion, the subcommittee removed the requirements that the surgery be performed by an experienced surgeon as well as the requirements for hospital surgical volume and specific postoperative groups and outcomes. These were replaced with a requirement (a weak recommendation) that the surgeries be performed in an accredited facility. Wolfe said that this accreditation would capture the intent of the subcommittee, but without the subcommittee having to stay up-to-date on the intricacies of the evolving evidence base on such requirements.

Livingston reviewed the GRADE table on surgery for children. Saha expressed doubt that waiting until age 18 would create irreversible harm. Wolfe said he didn't object to the summary statement, but referred to a recent study and suggested the subcommittee revisit this topic as well as surgery for BMI under 35 as new evidence becomes available. After discussion the subcommittee agreed not to recommend coverage of this surgery for children.

The subcommittee discussed the recommendation against coverage for complications. Wolfe said this would be problematic for patients with gastric bands which have a high failure rate and risk of severe complications. He noted that other payers separate band removal from other reoperations. Saha questioned whether band removal would be considered bariatric surgery. Wolfe said in some cases it would. Halpin said that other payers do get confused about this. Livingston asked what the indications for removal of a band are. Wolfe said that he will remove them if the patient wants them removed. You don't always know if they plan another surgery at that point. Halpin said there are also complications from bands and associated erosion and scar tissue. There is a risk of irreversible harm from leaving a band in. Wolfe said most payers cover the conversion of a band to a more complicated procedure (e.g. from lap band to sleeve gastrectomy or gastric bypass).

The subcommittee also discussed the issues around patients who convert to another bariatric surgery. Obley said there is low-certainty evidence that patients lose additional weight with these conversion surgeries, and also a higher complication rate. Obley said we don't have direct evidence about whether the benefits of conversion outweigh the harms from the higher complication rate. No data on the numbers of patients with bands are available for Oregon, but Wolfe said the number is much lower than it was a few years ago. Livingston said that access to bariatric surgery is limited as many providers only

take on a limited number of Medicaid patients, and questioned whether patients undergoing an initial surgery should be given priority due to proven benefit. Garside noted we need to take into account the costs of the complications of not having surgery. King suggested allowing accredited centers to make decisions for individual patients about reoperations.

Saha said there are different kinds of conversions—from band to sleeve gastrectomy or from sleeve gastrectomy to bypass or biliopancreatic diversion for example. Obley said there is evidence on these, but there is not much on conversion of gastric bypass to biliopancreatic diversion. He reviewed the weight loss for various conversion surgeries.

Garside asked about recommending against coverage for banding based on the failure rate. The group discussed this but didn't decide to make a change. Wolfe and Halpin said that bands aren't used much anymore because of the complications.

After further discussion, the subcommittee removed the clause recommending against coverage for reoperations based on evidence of additional weight loss, but left the GRADE table row on reoperations and additional evidence as a part of the coverage guidance. The GRADE table will contain a statement that the subcommittee makes no recommendation that coverage criteria for re-operations should be different from primary surgery. The rationale will be based on very low quality evidence that conversion surgeries are associated with increased complications as well as additional weight loss.

The subcommittee addressed recommending coverage for BMI of 30 to 35. There was no discussion and coverage was not recommended for this population.

The subcommittee voted 6-0 (MacKay absent) to post the draft coverage guidance for public comment, with the revisions made during the meeting as well as the additional edits made by staff at the subcommittee's request.

DRAFT HERC Coverage Guidance

Coverage of metabolic and bariatric surgery (including Roux-en-Y gastric bypass, gastric banding, and sleeve gastrectomy) is recommended for:

- Adult obese patients (BMI \geq 35) with
 - Type 2 diabetes (*strong recommendation*) OR
 - at least two of the following other serious obesity-related comorbidities: hypertension, coronary heart disease, mechanical arthropathy in major weight bearing joint, sleep apnea (*weak recommendation*)
- Adult obese patients (BMI \geq 40) (*strong recommendation*)

Metabolic and bariatric surgery is recommended for coverage in these populations only when provided in a facility accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (*weak recommendation*).

Metabolic and bariatric surgery is not recommended for coverage in:

- Patients with BMI $<$ 35, or 35-40 without the defined comorbid conditions above (*weak recommendation*)
- Children and adolescents (*weak recommendation*)

5. ADJOURNMENT

The meeting was adjourned at 3:45 pm. The next meeting is scheduled for February 18, 2016 from 1:00-4:00pm in Room 111-112 of the Wilsonville Training Center of Clackamas Community College.

HEALTH EVIDENCE REVIEW COMMISSION (HERC)

COVERAGE GUIDANCE: METABOLIC AND BARIATRIC SURGERY

DRAFT as posted for public comment 12/15/2015 to 8 a.m. 1/18/2016

HERC Coverage Guidance

Coverage of metabolic and bariatric surgery (including Roux-en-Y gastric bypass, gastric banding, and sleeve gastrectomy) is recommended for:

- Adult obese patients (BMI \geq 35) with
 - Type 2 diabetes (*strong recommendation*) OR
 - at least two of the following other serious obesity-related comorbidities: hypertension, coronary heart disease, mechanical arthropathy in major weight bearing joint, sleep apnea (*weak recommendation*)
- Adult obese patients (BMI \geq 40) (*strong recommendation*)

Metabolic and bariatric surgery is recommended for coverage in these populations only when provided in a facility accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (*weak recommendation*).

Metabolic and bariatric surgery is not recommended for coverage in:

- Patients with BMI $<$ 35, or 35-40 without the defined comorbid conditions above (*weak recommendation*)
- Children and adolescents (*weak recommendation*)

Note: Definitions for strength of recommendation are provided in Appendix B: GRADE Informed Framework – Element Descriptions.

PLAIN LANGUAGE SUMMARY

[Staff will insert lay language summary once the coverage guidance has been reviewed by subcommittee]

RATIONALE FOR GUIDANCE DEVELOPMENT

The HERC selects topics for guideline development or technology assessment based on the following principles:

- Represents a significant burden of disease
- Represents important uncertainty with regard to efficacy or harms
- Represents important variation or controversy in clinical care
- Represents high costs, significant economic impact
- Topic is of high public interest

COVERAGE GUIDANCE: ADVANCED IMAGING FOR STAGING OF PROSTATE CANCER

CLINICIAN SUMMARY:

Prostate cancer is the most common cancer in men and is usually diagnosed after a blood test in primary care has shown elevated prostate-specific antigen (PSA) levels. A number of treatments are available for localized disease, including: active surveillance, radical prostatectomy, external beam radiotherapy and brachytherapy. Hormone therapy (androgen deprivation or anti-androgens) is the usual primary treatment for metastatic prostate cancer.

The TNM classification is used to stage prostate cancer, and management depends on the TNM stage of the disease as well as both biochemical information (e.g. PSA) and pathological information (e.g. Gleason score). The decision about treatment intent will be based on the man's life expectancy, his values, and the anticipated clinical course of the prostate cancer. Both the clinical presentation and the treatment intent influence the decision about when and how to image the individual. Imaging may inform the choice between different radical treatments, or assist in the identification of metastatic disease thereby leading to more appropriate treatment options.

Magnetic resonance imaging is sufficiently sensitive and specific for determining the T or N stage of the disease, and has been shown to both up-stage or down-stage a significant percentage of patients. It has also been found to influence the choice of radiotherapy strategy or surgical procedure.

Isotope bone scans can be used to look for bone metastases at the time of presentation, or at the time of biochemical relapse. The positivity rate for bone scans increases with PSA or Gleason score, and men with PSA less than 10 ng/ml are unlikely to have a positive bone scan.

Positron-emission tomography (PET) imaging using the radiopharmaceutical agent 18-FDG does not reliably show primary prostate cancer.

CLINICAL BOTTOM LINE:

Men with a recent diagnosis of prostate cancer should undergo clinical staging that includes PSA level and prostate biopsy with Gleason score. If knowledge of the T or N stage could affect management, a MRI is appropriate. Radionuclide bone scanning is not needed if the cancer is low risk and localized. PET imaging is not indicated.

GRADE-INFORMED FRAMEWORK

The HERC develops recommendations by using the concepts of the Grading of Recommendations Assessment, Development and Evaluation (GRADE) system. GRADE is a transparent and structured process for developing and presenting evidence and for carrying out the steps involved in developing recommendations. There are several elements that determine the strength of a recommendation, as listed in the table below. The HERC reviews the evidence and makes an assessment of each element, which in turn is used to develop the recommendations presented in the coverage guidance box. Estimates of effect are derived from the evidence presented in this document. The level of confidence in the estimate is determined by the Commission based on assessment of two independent reviewers from the Center for Evidence-based Policy. Unless otherwise noted, estimated resource allocation, values and preferences, and other considerations are assessments of the Commission.

Coverage question: Should nitrous oxide (50% N2O) be recommended for coverage for labor pain management?				
Outcomes	Estimate of Effect for Outcome/ Confidence in Estimate	Resource allocation	Values and Preferences	Other considerations
Fetal/neonatal adverse effects <i>(Critical outcome)</i>	No significant differences in Apgar scores at 1 and 5 minutes, or umbilical cord gasses after birth when maternal N2O is compared to epidural anesthesia use. ●●●○ <i>(Moderate certainty, based on multiple RCTs and other studies with consistent findings)</i>	Use of N2O is likely to be cost-saving compared to epidural anesthesia. The cost of N2O is low. Use of N2O is associated with lower rates of assisted vaginal birth and cesarean delivery, and shorter length of stay on labor and delivery units.	High variability: Some women would want this additional option because of the reduced risk of caesarean section or assisted delivery. Concerns about harms would be mitigated because they could easily discontinue it and consider an epidural if adverse events occur or if analgesia is insufficient. Other	There is no specific CPT code for this service, other than an anesthesia code, so reimbursement to providers may require use of a non-specific code that may require manual review.
Mode of birth <i>(Critical outcome)</i>	Compared to women using epidural anesthesia, for those using N2O: 15 to 34 more women per 100 are likely to have an unassisted vaginal birth; 9 to 27 fewer women per 100 would experience assisted vaginal (forceps/vacuum) birth; and there would be about 6 fewer Cesarean births per 100 compared to those using epidural anesthesia for labor pain. ●●○○ <i>(Low certainty based on prospective cohort and cross sectional studies with consistent findings)</i>			

Coverage question: Should nitrous oxide (50% N2O) be recommended for coverage for labor pain management?				
Outcomes	Estimate of Effect for Outcome/ Confidence in Estimate	Resource allocation	Values and Preferences	Other considerations
Maternal adverse effects <i>(Important outcome)</i>	<p>Women may experience unpleasant side effects when using N2O. (These data come from studies of women using N2O as the sole form of labor analgesia and are not compared to any other methods.) Nausea (0-28%), vomiting (0-14%), dizziness/lightheadedness (3-23%), and drowsiness/sleepiness (0-67%) were commonly reported side effects. Effects dissipated quickly when N2O use is stopped.</p> <p>●●●○ <i>(Moderate certainty based on multiple RCTs and other studies with consistent findings)</i></p>		women may prefer epidural anesthesia because of its greater effect in reducing labor pain.	
Maternal satisfaction <i>(Important outcome)</i>	<p>70 to 80% of women who used N2O said they would want to use it in a subsequent pregnancy compared to 45 to 88% of women who would request an epidural again. (These data come from studies where multiple labor pain management modalities are readily available and women using N2O or epidural were asked if they would want to use that method for a future birth.)</p> <p>●●○○ <i>(Low certainty based on prospective cohort and cross-sectional studies with consistent findings)</i></p>			
Use of neuraxial (e.g., epidural) anesthesia <i>(Important outcome)</i>	<p>When multiple pain management methods are available for women 13% to 79% will use N2O, compared to 34 to 42% who will select epidural anesthesia. There is no direct evidence on whether</p>			

Coverage question: Should nitrous oxide (50% N2O) be recommended for coverage for labor pain management?				
Outcomes	Estimate of Effect for Outcome/ Confidence in Estimate	Resource allocation	Values and Preferences	Other considerations
	availability or use of N2O changes the use of neuraxial anesthesia. ●○○○ (Very low certainty based on cross-sectional studies with consistent findings)			
Rationale: On balance, there are potential benefits to the use of N2O and no serious harms to its use. Costs are low and variable maternal preferences argue for increased availability of N2O for management of labor pain. Coverage is recommended because of the potential benefits of fewer cesarean and assisted deliveries, the lack of significant harms, maternal preferences, and low costs. The recommendation is a weak recommendation because there are few studies available for benefit outcomes, and the external validity of the data and its applicability in U.S. settings is limited. The confidence in the quality of evidence for most outcomes is low to moderate certainty.				
Recommendation: Nitrous oxide for labor pain is recommended for coverage (<i>weak recommendation</i>).				

Note: GRADE-informed framework elements are described in Appendix A. Appendix B provides a GRADE Evidence Profile.

Tobacco cessation and elective procedures - excerpt

HERC Staff Assessment

There is a strong association with smoking and increased morbidity with surgical procedures. The Prioritized List currently has restrictions on surgery requiring smoking cessation for at least 6 months for lung volume reduction surgery, bariatric surgery, and for spinal fusion. Other elective surgeries may result in improved post-surgical outcomes with similar smoking cessation requirements based on limited evidence. NICE specifically recommends not having smoking status being a barrier to joint replacement referral. There are effective interventions to improve cessation rates that are covered for OHP.

QHOC medical directors have requested greater clarity about defining the frequency of cotinine testing.

HERC Staff Recommendations:

- 1) Continue requiring smoking cessation 6 months prior to lung volume reduction surgery, bariatric surgery, and spinal fusion.

- 2) Discuss adding a Guideline Note:

CHOICE 1

ANCILLARY GUIDELINE NOTE XXX, SMOKING CESSATION AND ELECTIVE SURGICAL PROCEDURES

Participation in intensive smoking cessation interventions (multiple sessions of behavioral counseling +/- nicotine replacement) in active tobacco users are required at least 4-8 weeks prior to elective surgical procedures.

Certain procedures, such as lung volume reduction surgery, bariatric surgery, [erectile dysfunction surgery](#), and spinal fusion have 6 month tobacco abstinence requirements.

CHOICE 2

ANCILLARY GUIDELINE NOTE XXX, SMOKING CESSATION AND ELECTIVE SURGICAL PROCEDURES

Smoking cessation is required prior to elective surgical procedures for active tobacco users. Cessation is required at least 4 weeks prior to the procedure, as shown by a cotinine level.

Certain procedures, such as lung volume reduction surgery, bariatric surgery, [erectile dysfunction surgery](#), and spinal fusion have 6 month tobacco abstinence requirements.

CHOICE 3 – Do not add a guideline on smoking cessation and elective surgical procedures

- 3) Modify guideline notes 8, 100, and 112

Tobacco cessation and elective procedures - excerpt

- A) to be consistent in requiring cotinine level testing, and
- B) consider adding language about the frequency of testing.

GUIDELINE NOTE 100, SMOKING AND SPINAL FUSION

Lines 51,154,204,258,374,412,484,533,588

Non-emergent spinal arthrodesis (CPT 22532-22634) is limited to patients who are non-smoking for 6 months prior to the planned procedure, [as shown by negative cotinine levels \(at least one level within one month of the quit date and one level within one month of surgery\)](#). Patients should be given access to appropriate smoking cessation therapy.

GUIDELINE NOTE 8, BARIATRIC SURGERY

Lines 30,594

...Excerpt

Must remain free of abuse of or dependence on alcohol during the six-month period immediately preceding surgery. No current use of nicotine or illicit drugs and must remain abstinent from their use during the six-month observation period. Testing will, at a minimum, be conducted within one month of the surgery to confirm abstinence from ~~nicotine and~~ illicit drugs. [Tobacco abstinence to be confirmed in active smokers by negative cotinine levels \(at least one level within one month of the quit date and one level within one month of surgery\)](#).

GUIDELINE NOTE 112, LUNG VOLUME REDUCTION SURGERY

Line 288

Lung volume reduction surgery (LVRS, CPT 32491, 32672) is included on Line 288 only for treatment of patients with radiological evidence of severe bilateral upper lobe predominant emphysema (diagnosis code ICD-10-CM J43.9/ICD-9-CM 492.0, 492.8) and all of the following:

1. BMI ≤ 31.1 kg/m² (men) or ≤ 32.3 kg/m² (women)
2. Stable with ≤ 20 mg prednisone (or equivalent) dose a day
3. Pulmonary function testing showing
 - a. Forced expiratory volume in one second (FEV₁) $\leq 45\%$ predicted and, if age 70 or older, FEV₁ $\geq 15\%$ predicted value
 - b. Total lung capacity (TLC) $\geq 100\%$ predicted post-bronchodilator
 - c. Residual volume (RV) $\geq 150\%$ predicted post-bronchodilator
4. PCO₂ ≤ 60 mm Hg (PCO₂ ≤ 55 mm Hg if 1-mile above sea level)
5. PO₂ ≥ 45 mm Hg on room air (PO₂ ≥ 30 mm Hg if 1-mile above sea level)
6. Post-rehabilitation 6-min walk of ≥ 140 m
7. Non-smoking for 6 months prior to surgery, as shown by [negative cotinine levels \(at least one level within one month of the quit date and one level within one month of surgery\)](#).

The procedure must be performed at an approved facility (1) certified by the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) under

Tobacco cessation and elective procedures - excerpt

the LVRS Disease Specific Care Certification Program or (2) approved as Medicare lung or heart-lung transplantation hospitals. The patient must have approval for surgery by pulmonary physician, thoracic surgeon, and anesthesiologist post-rehabilitation. The patient must have approval for surgery by cardiologist if any of the following are present: unstable angina; left-ventricular ejection fraction (LVEF) cannot be estimated from the echocardiogram; LVEF <45%; dobutamine radionuclide cardiac scan indicates coronary artery disease or ventricular dysfunction; arrhythmia (>5 premature ventricular contractions per minute; cardiac rhythm other than sinus; premature ventricular contractions on EKG at rest).

- 4) Add a new guideline about surgical treatment of erectile dysfunction based on the November VbBS discussion.

GUIDELINE NOTE XXX SMOKING AND SURGICAL TREATMENT OF ERECTILE DYSFUNCTION

Line 526

Surgical treatment of erectile dysfunction is only included on this line when patients are non-smoking for 6 months prior to surgery, as shown by [negative cotinine levels \(at least one level within one month of the quit date and one level within one month of surgery\)](#).

- 5) Do not add a requirement for transplantation. While there is certainly evidence of poorer outcomes associated with smoking and transplant, these criteria are managed by the transplant centers and through OARs; a guideline note may be redundant and/or unnecessary.

**Value-based Benefits Subcommittee Recommendations Summary
For Presentation to:
Health Evidence Review Commission on November 12, 2015**

For specific coding recommendations and guideline wording, please see the text of the 11-12-2015 VbBS minutes.

RECOMMENDED CODE MOVEMENT (effective 1/1/16)

- Add or delete various codes related to straightforward coding changes
- Add the 2016 CPT and HCPCS codes to various lines/Health Systems Division files
- Add various diagnosis codes to a covered line for conditions which might affect young children placed on foster care or who have otherwise had early childhood trauma
- Add the diagnosis code for Buerger's disease to a covered line and remain on an uncovered line with a new guideline specifying that it is only on the covered line for treatment of ulcers and/or gangrene and does not pair with revascularization procedures.

RECOMMENDED GUIDELINE CHANGES (effective 1/1/16)

- Modify the nerve block ancillary guideline to add new 2016 nerve block CPT codes
- Modify the non-prenatal genetic testing guideline to incorporate the current figure D1 (which will be removed), to update NCCN references, to add new BRCA testing CPT codes, to add a section recommending genetic counseling and indicated testing of cancer survivors, to add back a deleted section regarding a cystic fibrosis (CF) testing code, to limit CF testing to once per lifetime, and to move a requirement for the least costly/broadest testing which would give the required information.
- Modify the prenatal genetic testing guideline to allow panel testing for Ashkenazi Jewish patients, to limit CF testing to the 2 CPT codes most commonly used for this, and to add CPT codes to the chorionic villus sampling (CVS)/amniocentesis entry to better capture the range of codes intended for coverage.
- Modify the hyperbaric oxygen guideline to include all the appropriate ICD-10 codes for diabetic ulcers and gangrene.
- Add new guidelines to limit use of 2016 CPT codes, including sclerotherapy, fetal MRI, and genetic testing for cardiac transplant rejection.
- Add a new guideline to limit the use of a non-specific conduct disorder diagnosis to children 5 and younger.
- Modify the acupuncture guideline to remove the requirement for referrals for non-pregnancy related indications, standardize the number of visits for various conditions to 12 (6 for breach fetal presentation), and correct ICD-10 codes for various conditions.
- Modify the tobacco cessation guideline to align the recommended services for coverage with ACA requirements
- Add a new guideline for planned out-of-hospital birth based on a new coverage guidance
- Add a new multisector intervention statement regarding tobacco prevention and cessation practices

VALUE-BASED BENEFITS SUBCOMMITTEE
Clackamas Community College
Wilsonville Training Center, Rooms 111-112
Wilsonville, Oregon
November 12, 2015
8:30 AM – 1:00 PM

Members Present: Kevin Olson, MD, Chair; Susan Williams, MD (via phone until 10:30, then in person); Holly Jo Hodges, MD; Laura Ocker, Lac; Gary Allen, DMD; Mark Gibson (via phone 8:10-10:40, 12:10-end of meeting).

Members Absent: David Pollack, MD; Irene Croswell, RPh.

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

Also Attending: Kim Wentz, MD, MPH, Kirsten Bird, Laurie Theodorou, and Brian Nieubuurt (Oregon Health Authority); Valerie King, MD, MPH, Adam Obley, MD, MPH, Craig Mosbaek (OHSU Center for Evidence Based Policy); Silke Anderson (Oregon Midwifery Council); Duncan Neilsen, MD (Legacy Health); Carole Levanda; Sharron Fuchs; Laura Jenson (OHSU and American Council of Nurse Midwives); Melissa Cheyney, PhD (OSU).

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

The meeting was called to order at 8:00 am and roll was called. Minutes from the October, 2015 VbBS meeting were reviewed.

MOTION: To approve the October 1, 2015 minutes as presented. CARRIES 6-0.

Smits reviewed the errata that have been found since the last meeting. Smits also discussed that HERC staff are actively working on finding a way to incorporate new ICD-10 errata into the Prioritized List in a timely fashion going forward past the January 1, 2016 Prioritized List publication.

The delay in the implementation in the new back conditions lines was discussed in detail; the back lines approved for January 1, 2016 have been delayed until an unknown future date. HERC staff is planning on publishing a Prioritized List with some type of indication about the older back conditions lines being in place only temporarily. The dental coverage expansion is also temporarily delayed.

Dr. Gary Allen was introduced and welcomed as the new VbBS dental member. Laura Ocker is unfortunately leaving the VbBS and was thanked for her excellent service.

➤ **Topic: Straightforward/Consent Agenda**

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

Recommended Actions:

- 1) Add 33968, 33971 and 33974 (Removal of intra-aortic balloon assist device), 33977 and 33978 (Removal of ventricular assist device; extracorporeal), 33980-33983 (Removal or replacement of ventricular assist device pump(s); implantable intracorporeal) to line 290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
- 2) Remove 44372 (Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with placement of percutaneous jejunostomy tube) from lines 75 NEUROLOGICAL DYSFUNCTION IN BREATHING, EATING, SWALLOWING, BOWEL, OR BLADDER CONTROL, 105 CONGENITAL ANOMALIES OF DIGESTIVE SYSTEM AND ABDOMINAL WALL EXCLUDING NECROSIS; CHRONIC INTESTINAL PSEUDO-OBSTRUCTION and 383 ESOPHAGEAL STRICTURE; ACHALASIA
 - a. Advise Health Systems Division (HSD) to add 44372 to the Ancillary Procedures File
- 3) Remove 44373 (Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with conversion of percutaneous gastrostomy tube to percutaneous jejunostomy tube) from lines 105 CONGENITAL ANOMALIES OF DIGESTIVE SYSTEM AND ABDOMINAL WALL EXCLUDING NECROSIS; CHRONIC INTESTINAL PSEUDO-OBSTRUCTION and 383 ESOPHAGEAL STRICTURE; ACHALASIA
 - a. Advise HSD to add 44373 to the Ancillary Procedures File
- 4) Add Z79.01 (Long term (current) anticoagulation use) to line 285 BUDD-CHIARI SYNDROME, AND OTHER VENOUS EMBOLISM AND THROMBOSIS
- 5) Change the line title for line 422 DISORDERS OF SHOULDER, INCLUDING SPRAINS/STRAINS GRADE ~~3~~4 THROUGH 6
- 6) Add Z68.3x (Body mass index (BMI) 30.0-39.9, adult) and Z68.4x (Body mass index (BMI) 40.0+, adult) and Z68.54 (Body mass index (BMI) pediatric, greater than or equal to 95th percentile for age) to lines 325 and 589 OBESITY (ADULT BMI ≥ 30, CHILDHOOD BMI ≥ 95 PERCENTILE) Treatment: Medical and Surgical Care
 - a. Advise HSD to remove Z68.3x and Z68.4x and Z68.54 from the Informational Diagnosis File
- 7) Place 97010 (Application of a modality to 1 or more areas; hot or cold packs) on line 663 MUSCULOSKELETAL CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENT
- 8) Remove from line 240 LIMB THREATENING VASCULAR DISEASE, INFECTIONS, AND VASCULAR COMPLICATIONS and add to line 354 NON-LIMB THREATENING PERIPHERAL VASCULAR DISEASE.
 - a. I70.20x Unspecified atherosclerosis of native arteries of extremities
 - b. I70.29x Other atherosclerosis of native arteries of extremities

- c. I70.30x Unspecified atherosclerosis of unspecified type of bypass graft(s) of the extremities
 - d. I70.39x Other atherosclerosis of unspecified type of bypass graft(s) of the extremities
 - e. I70.40x Unspecified atherosclerosis of autologous vein bypass graft(s) of the extremities
 - f. I70.49x Other atherosclerosis of autologous vein bypass graft(s) of the extremities
 - g. I70.50x Unspecified atherosclerosis of nonautologous biological bypass graft(s) of the extremities
 - h. I70.59x Other atherosclerosis of nonautologous biological bypass graft(s) of the extremities
 - i. I70.60x Unspecified atherosclerosis of nonbiological bypass graft(s) of the extremities
 - j. I70.69x Other atherosclerosis of nonbiological bypass graft(s) of the extremities
 - k. I70.70x Unspecified atherosclerosis of other type of bypass graft(s) of the extremities
 - l. I70.79x Other atherosclerosis of other type of bypass graft(s) of the extremities
 - m. E11.51 Other specified diabetes mellitus with diabetic peripheral angiopathy without gangrene
- 9) Remove from line 354 NON-LIMB THREATENING PERIPHERAL VASCULAR DISEASE and keep on line 240 LIMB THREATENING VASCULAR DISEASE, INFECTIONS, AND VASCULAR COMPLICATIONS
- a. I70.21x Atherosclerosis of native arteries of extremities with intermittent claudication
 - b. I70.31x Atherosclerosis of unspecified type of bypass graft(s) of the extremities with intermittent claudication
 - c. I70.41x Atherosclerosis of autologous vein bypass graft(s) of the extremities with intermittent claudication
 - d. I70.51x Atherosclerosis of nonautologous biological bypass graft(s) of the extremities with intermittent claudication
 - e. I70.61x Atherosclerosis of nonbiological bypass graft(s) of the extremities with intermittent claudication
 - f. I70.71x Atherosclerosis of other type of bypass graft(s) of the extremities with intermittent claudication
 - g. I70.22x Atherosclerosis of native arteries of extremities with rest pain
 - h. I70.32x Atherosclerosis of unspecified type of bypass graft(s) of the extremities with rest pain
 - i. I70.42x Atherosclerosis of autologous vein bypass graft(s) of the extremities with rest pain
 - j. I70.52x Atherosclerosis of nonautologous biological bypass graft(s) of the extremities with rest pain

- k. I70.62x Atherosclerosis of nonbiological bypass graft(s) of the extremities with rest pain
 - l. I70.72x Atherosclerosis of other type of bypass graft(s) of the extremities with rest pain
 - m. I70.26x Atherosclerosis of native arteries of extremities with gangrene
 - n. I70.36x Atherosclerosis of unspecified type of bypass graft(s) of the extremities with gangrene
 - o. I70.46x Atherosclerosis of autologous vein bypass graft(s) of the extremities with gangrene
 - p. I70.56x Atherosclerosis of nonautologous biological bypass graft(s) of the extremities with gangrene
 - q. I70.66x Atherosclerosis of nonbiological bypass graft(s) of the extremities with gangrene
 - r. I70.76x Atherosclerosis of other type of bypass graft(s) of the extremities with gangrene
- 10) Add the following to line 240 LIMB THREATENING VASCULAR DISEASE, INFECTIONS, AND VASCULAR COMPLICATIONS and keep on current lines:
- a. E08.52 Diabetes mellitus due to underlying condition with diabetic peripheral angiopathy with gangrene
 - b. E10.52 Type 1 diabetes mellitus with diabetic peripheral angiopathy with gangrene
 - c. E11.52 Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene
- 11) Add the following to line 354 NON-LIMB THREATENING PERIPHERAL VASCULAR DISEASE and keep on current lines
- a. E08.51 Diabetes mellitus due to underlying condition with diabetic peripheral angiopathy without gangrene
 - b. E09.51 Drug or chemical induced diabetes mellitus with diabetic peripheral angiopathy without gangrene
 - c. E10.51 Type 1 diabetes mellitus with diabetic peripheral angiopathy without gangrene
- 12) Remove all amputation CPT codes from line 354 NON-LIMB THREATENING PERIPHERAL VASCULAR DISEASE
- a. 24900-24940, 25900-25931, 26910, 26951, 26952, 27025, 27290, 27295, 27590-27598, 27880-28825
- 13) Remove E08.49, E08.610, E09.49, E09.610, E13.4x, E13.610, E13.618 from line 382 DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE LEVEL OF INDEPENDENCE IN SELF- DIRECTED CARE CAUSED BY CHRONIC CONDITIONS THAT CAUSE NEUROLOGICAL DYSFUNCTION.
- 14) Remove E08.41, E08.44, E09.41, E09.44, E10.4x, E11.4x, E13.4x (diabetic neuropathy) from line 515 and 541 PERIPHERAL NERVE DISORDERS, medical and surgical therapy

- 15) Add E08.621, E09.621, E10.621, E13.621, E08.622, E09.622, E10.622, E13.622 (diabetic ulcers) to line 336 ANAEROBIC INFECTIONS REQUIRING HYPERBARIC OXYGEN
 - a. Add all codes from these series to GN 107 HYPERBARIC OXYGEN as shown in Appendix A
- 16) Remove E11.628 (Type 2 diabetes mellitus with other skin complications) from line 336 ANAEROBIC INFECTIONS REQUIRING HYPERBARIC OXYGEN
- 17) Remove E11.623 from GN107 HYPERBARIC OXYGEN as a non-valid code
- 18) Remove E11.51 (Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene) from line 336 ANAEROBIC INFECTIONS REQUIRING HYPERBARIC OXYGEN
 - b. Modify GN107 HYPERBARIC OXYGEN to reflect this change as shown in Appendix A
- 19) Add E08.52, E09.52, E10.52, E13.52 (diabetic gangrene) to line 336 ANAEROBIC INFECTIONS REQUIRING HYPERBARIC OXYGEN
 - c. Add code series to GN107 HYPERBARIC OXYGEN as shown in Appendix A

The following recommended changes are to the new lines involving conditions of the back and spine that are being delayed and will take effect when that delay is lifted:

- 1) Add 99291-99292 (Critical care, evaluation and management of the critically ill or critically injured patient) to lines 351 CONDITIONS OF THE BACK AND SPINE WITH URGENT SURGICAL INDICATIONS, 366 SCOLIOSIS, and 532 CONDITIONS OF THE BACK AND SPINE WITHOUT URGENT SURGICAL INDICATIONS
- 2) Advise HSD to remove M54.3x (Sciatica) and M54.4x (Lumbago) from the Diagnostic Workup File as they are currently on line 407 CONDITIONS OF THE BACK AND SPINE
- 3) Remove M41.xx series (Scoliosis) from line 407 CONDITIONS OF THE BACK AND SPINE. Keep only on line 366 SCOLIOSIS.
- 4) Add line 366 SCOLIOSIS to Guideline Note 56 NON-INTERVENTIONAL TREATMENTS FOR CONDITIONS OF THE BACK AND SPINE

MOTION: To approve the recommendations stated in the consent agenda. CARRIES 6-0.

➤ **Topic: 2016 CPT/HCPCS code review**

Discussion: Most code placements and guideline changes were approved as recommended in the meeting materials with no or minimal discussion. Of note, some of the new codes were discussed previously at the October, 2015 VBBS meeting. Specific codes which had substantive discussion at the current meeting were:

61650-61651 (Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement diagnostic angiography, and imaging guidance) were suggested for lines on the Prioritized List based on older code placement. However, VbBS did not feel that there was evidence to support the use of these codes and instead placed these codes on the Services Recommended for Non-Coverage Table. Additionally, it was mentioned that the use of this procedure for treatment of CNS/brain cancers is controversial. These codes can be re-evaluated if providers request review and provide evidence of effectiveness.

78265 Gastric emptying study with small bowel transit and **78266** Gastric emptying study with small bowel and colon transit, multiple days were discussed. VBBS members agreed with placement of 78266 on the Services Recommended for Non-Coverage Table; however, members also felt that 78265 should not be placed on the Diagnostic List, but should be on the Services Recommended for Non-Coverage Table as well.

81432-81433 (Breast and ovarian cancer syndrome testing) were discussed. There was considerable discussion regarding coverage of panels versus BRCA genes alone. The VbBS felt that the panels contained many genetic mutations without evidence that finding these mutations would be meaningful or would affect treatment plans or monitoring. The group decided to only cover the BRCA mutation code (81162) and to place the panels (81432-81433) on the Services Recommended for Non-Coverage Table. These codes were not added to the Non-Prenatal Genetic Testing Guideline as had been suggested in the meeting materials.

The prenatal genetic testing guideline was further modified to include CPT codes used for CVS and amniocentesis. HERC staff will need to further evaluate the CPT codes used for amniocentesis and CVS and will ensure that these codes are complete and will bring back to a future meeting.

Recommended Actions:

- 1) Approve 2016 CPT code placements as shown in Appendix B
- 2) Modify Ancillary Guideline A1 as shown in Appendix A
- 3) Add ICD-10 T88.8xx (Other specified complications of surgical and medical care, not elsewhere classified) to line **428** COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
 - Advise HSD to remove T88.8xx from the Diagnostic Workup File
- 4) Move E04.1 (Nontoxic single thyroid nodule) from line **656** ENDOCRINE AND METABOLIC CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY to line **634** CYST, HEMORRHAGE, AND INFARCTION OF THYROID
- 5) Adopt a new guideline regarding sclerotherapy for fluid collection as shown in Appendix C
- 6) Adopt a new guideline regarding fetal MRI as shown in Appendix C

- 7) Modify the prenatal and non-prenatal genetic testing guidelines as shown in Appendix A
- 8) Adopt a new guideline regarding use of the marker test for cardiac transplant rejection as shown in Appendix C

MOTION: To recommend the code and guideline note placements/adoption/changes as presented or modified. CARRIES 6-0.

➤ **Topic: Adjustment disorder**

Discussion: Smits reviewed the meeting materials. There was clarification that the current conduct disorders line is limited to children 18 and younger; therefore, the new guideline was modified to remove the reference to adults.

Recommended Actions:

- 1) Delete the coding specification from line 449 ADJUSTMENT DISORDERS
- 2) Delete Z71.89 (Other specified counseling) from line 449 ADJUSTMENT DISORDERS
 - a. Advise HSD to add Z71.89 to the Informational Diagnosis File
- 3) Add Z62.8x (Parent-child conflict) and Z63.8 (Other specified problems related to primary support group) and F98.9 (Unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence) to line 449 ADJUSTMENT DISORDERS
 - a. Advise HSD to remove Z62.8x and Z63.8 from the Informational Diagnosis File
 - b. Advise HSD to remove F98.9 from the Unspecified File
- 4) Add F91.9 (Conduct disorder, unspecified) to line 425 OPPOSITIONAL DEFIANT DISORDER and keep on line 483 CONDUCT DISORDER, AGE 18 OR UNDER
- 5) Adopt a new guideline limiting the use of F91.9 to children 5 and younger as shown in Appendix C

MOTION: To recommend the code and adoption of the new guideline note as modified. CARRIES 6-0.

➤ **Topic: Thromboangiitis obliterans**

Discussion: There was minimal discussion of this topic. It was stressed that the intention was that medications and/or other therapies to directly treat Buerger's disease are not intended for coverage on the upper line, as only smoking cessation is effective for treatment of the underlying disease. The placement on the upper line is only for treatment of complications of the disease such as ulcers and gangrene, not for treatment of the actual Buerger's disease itself.

Recommended Actions:

- 1 Add ICD-10 I73.1 (Buerger's disease) to line 240 LIMB THREATENING VASCULAR DISEASE, INFECTIONS, AND VASCULAR COMPLICATIONS and keep on line 657

CARDIOVASCULAR CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY

- 2 Adopt a new guideline note for Buerger's disease as shown in Appendix C

MOTION: To recommend the code and new guideline note adoption as presented. CARRIES 6-0.

➤ **Topic: Acupuncture guideline**

Discussion: Smits reviewed the meeting materials. Williams expressed concern about removing the requirement for referral for acupuncture, feeling that the PCP should be involved to help coordinate care. Ocker replied that the referral requirement delays care, and that some PCPs are not aware of this as an effective treatment and may not offer it when it is appropriate. Olson asked if there is a concern that acupuncture is overused or abused; the response was that this was not entirely clear but abuse potential was probably low. Ocker noted that acupuncturists are required to submit prior authorization for visits beyond the first visit, so therefore appropriateness of diagnosis and utilization could be controlled. The general consensus was that the referral requirement could be removed.

There was further discussion about the number of covered visits allowed for treatment of breech fetal presentation. The proposed 12 visits was felt to be too high. The group felt that 6 visits should be adequate for treatment of this condition.

Recommended Actions:

- 1) Modify the acupuncture guideline as shown in Appendix A

MOTION: To recommend the guideline note changes as presented. CARRIES 5-1 (Opposed: Williams).

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

Discussion: Livingston reviewed the meeting materials. There was minimal discussion. The reference to the Patient Protection and Affordable Care Act in the proposed guideline was changed to the complete name of the law.

Recommended Actions:

- 1) Modify Guideline Note 4 regarding tobacco cessation coverage as shown in Appendix A
- 2) Add a new multisector intervention statement for tobacco cessation as shown in Appendix D

- 3) Modify the treatment description of line 5 TOBACCO DEPENDENCE Treatment: MEDICAL THERAPY/~~BRIEF BEHAVIORAL~~ COUNSELING ~~NOT TO EXCEED 10 FOLLOW-UP VISITS OVER 3 MONTHS~~

MOTION: To recommend the code and guideline note changes and new guideline note adoption as presented. CARRIES 6-0.

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

Discussion: Livingston reviewed the meeting materials. There was discussion about requiring tobacco cessation prior to penile erectile dysfunction procedures. It was pointed out that these procedures are not on a covered line, but such procedures might be covered through the comorbidity rule. With regard to all elective surgeries, Williams suggested requiring cessation rather than just have an intervention prior to elective surgery as is required in the current proposed guideline. Livingston reviewed that the evidence supports the intervention alone may be successful in improving outcomes, and there was a discussion about whether requiring cessation prior to elective surgery was an overly arduous (versus appropriate) pre-surgical requirement. Olson felt that proposed guideline needs be further wordsmithing and recommended having QHOC review it.

The decision was to delay a decision on the proposed guideline until a future meeting.

Recommended Actions:

- 1) This topic will be reviewed further and brought back to a future meeting.

➤ **Topic: Coverage Guidance—Planned out of hospital births**

Discussion: Livingston reviewed the changes made to the proposed Prioritized List guideline, based on the October VbBS meeting discussion. Concerns have been raised in the interim repeatedly about the lack of inclusion of Group B strep (GBS) screening or positivity. There was an extensive discussion about GBS carrier status and whether or not it is appropriate to be a criteria included in the list guideline. And if it is, whether it should include positivity alone, positivity with inadequate prophylaxis, unknown GBS carrier status, or refusal of antibiotics when indicated.

There was public testimony received from Silke Akerson, representing the Oregon Midwifery Council. She stated that inclusion of group B strep (GBS) as a criteria for noncoverage would have a major impact on informed choice and informed refusal. That making treatment of GBS positivity would require provision of IV antibiotics in order for the birth to be covered. She also described enhance monitoring by midwives when mom is a GBS carrier, in which babies are more closely monitored, they see all patients within the first 24 hours after delivery, and they provide focused education about monitoring the baby to the parents. She is especially concerned about the term

“adequate prophylaxis,” given that a precipitous delivery may make prophylaxis inadequate, when all involved were trying to do the right thing by providing antibiotics. Akerson also informed the subcommittee that guidance on GBS is not in rule. Midwives just got training on the CDC GBS Guidelines from 2010. Management of GBS was just recently added to scope of practice.

The discussion included an acknowledgement that knowing GBS carrier status was important in order to determine if prophylaxis was indicated, as well as the need for enhanced monitoring.

Akerson’s further testimony included that she was pleased with the coverage guidance in general. Additional detailed points of concern included maternal anemia with hemoglobin <10.5. She stated this is a frequent occurrence, and they easily recommend iron rich foods and supplements, and consult and refer a patient if it doesn’t resolve. The subcommittee decided to modify it by adding “unresponsive to treatment” to the consultation criteria “maternal anemia with hemoglobin < 10.5 g/dL.”

The next point of discussion was around some of the subtypes of infection included in the maternal transfer criteria. Urinary tract infection (UTI) and breast infection rarely occur in the intrapartum setting, and postpartum or antepartum infection could potentially be managed in the outpatient primary care setting, rather than requiring a hospital transfer. It was thought the key pertinent infections were: Maternal infection requiring hospital treatment (e.g. endometritis or wound infection).

Next, the subcommittee discussed the issue of “failure to progress” as being a vague description. Thus ensued a lengthy discussion about the challenge of defining failure to progress and that there are changing definitions within the obstetric literature as well. There were strong preferences to have a clear, available, and consistent definition of failure to progress. The subcommittee settled on referring to the recent ACOG (2014) standards as described in: <http://www.acog.org/Resources-And-Publications/Obstetric-Care-Consensus-Series/Safe-Prevention-of-the-Primary-Cesarean-Delivery>

The last two criteria which Akerson had raised potential concern over were: history of a baby over 9 lbs 4 oz, and BMI >35. After a brief discussion, the subcommittee decided to make no changes to the current recommendations.

Recommended Actions:

- 1) Adopt a new guideline for planned out-of-hospital birth as shown in Appendix C.

MOTION: To approve the recommended changes to the Prioritized List with modifications as shown in Appendix C, based on the draft Planned Out-of-Hospital Birth coverage guidance scheduled for review by HERC at their November 12, 2015 meeting. CARRIES 5-1 (Opposed: Hodges).

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

Discussion: This topic was tabled to the next VBBS meeting.

➤ **Public Comment:**

No additional public comment was received.

➤ **Issues for next meeting:**

- Tobacco cessation and elective surgeries
- Coverage Guidance for Indications for proton beam therapy
- Review placement of vestibular tests
- Review all intestinal motility studies including wireless capsule endoscopy
- Intra-arterial balloon angioplasty and intracranial intravascular stenting
- Modifications to the prenatal testing guideline for CPT codes for use for CVS and amniocentesis
- MRI for low back conditions guideline
- Barrett's esophagus and esophageal dysplasia
- Anemia due to disease
- Review coverage of PT modalities

➤ **Next meeting:**

January 14, 2016 at Clackamas Community College, Wilsonville Training Center, Wilsonville Oregon, Rooms 111-112.

➤ **Adjournment:**

The meeting adjourned at 1:43 PM.

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ANCILLARY GUIDELINE A1, NERVE BLOCKS

The Health Evidence Review Commission intends that single injection and continuous nerve blocks (CPT 64400-64450, [64461-64463](#)) should be covered services if they are required for successful completion of perioperative pain control for, or post-operative recovery from a covered operative procedure when the diagnosis requiring the operative procedure is also covered. Additionally, nerve blocks are covered services for patients hospitalized with trauma, cancer, or intractable pain conditions, if the underlying condition is a covered diagnosis.

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 C.1 unless otherwise specified below.~~

- A Genetic tests are covered as diagnostic, unless they are listed below in section F1 as excluded or have other restrictions listed in this guideline. To be covered, initial screening (e.g. physical exam, medical history, family history, laboratory studies, imaging studies) must indicate that the chance of genetic abnormality is > 10% and results would do at least one of the following:
 - 1 Change treatment,
 - 2 Change health monitoring,
 - 3 Provide prognosis, or
 - 4 Provide information needed for genetic counseling for patient; or patient's parents, siblings, or children
- B Pretest and posttest genetic counseling is required for presymptomatic and predisposition genetic testing. Pretest and posttest genetic evaluation (which includes genetic counseling) is covered when provided by a suitable trained health professional with expertise and experience in genetics.
 - 1 "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.
- C A more expensive genetic test (generally one with a wider scope or more detailed testing) is not covered if a cheaper (smaller scope) test is available and has, in this clinical context, a substantially similar sensitivity. For example, do not cover CFTR gene sequencing as the first test in a person of Northern European Caucasian ancestry because the gene panels are less expensive and provide substantially similar sensitivity in that context.
- D 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, endometrial and other cancers associated with Lynch syndrome) services (CPT 81288, 81292-81300, 81317-

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- 81319, 81435, 81436) and familial adenomatous polyposis (FAP) services (CPT 81201-81203) should be provided as defined by the NCCN Clinical Practice Guidelines in Oncology. Genetic/Familial High-Risk Assessment: Colorectal V.2.2014⁵ (5/19/14 5/4/15). www.nccn.org.
- b **BRCA1/BRCA2 Breast and ovarian cancer syndrome genetic** testing services (CPT [81162](#), 81211-81217) for women without a personal history of breast, ovarian and other associated cancers should be provided to high risk women as defined by the US Preventive Services Task Force or according to the NCCN Clinical Practice Guidelines in Oncology: Genetic/Familial High-Risk Assessment: Breast and Ovarian. V2.2014⁵ (9/23/2014 6/25/15). www.nccn.org.
 - c **BRCA1/BRCA2 Breast and ovarian cancer syndrome genetic** testing services (CPT [81162](#), 81211-81217) for women with a personal history of breast, 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. V2.2014⁵ (9/23/2014 6/25/15). 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.1.2013⁵ (5/13/13 5/1/15). www.nccn.org.
- 2 Genetic counseling should precede genetic testing for hereditary cancer whenever possible.
- a Pre and post-test genetic counseling should be covered when provided by a suitable trained health professional with expertise and experience in cancer genetics. [Genetic counseling is recommended for cancer survivors when test results would affect cancer screening.](#)
 - 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.
 - 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 Post-test genetic counseling should be performed as soon as is practical.
- 3 If the mutation in the family is known, only the test for that mutation is covered. For example, if a mutation for BRCA 1 has been identified in a family, a single site mutation analysis for that mutation is covered (CPT 81215), while a full sequence BRCA 1 and 2 (CPT 81211) analyses is not. There is one exception, for individuals of Ashkenazi Jewish ancestry with a known mutation in the family, the panel for Ashkenazi Jewish BRCA mutations is covered (CPT 81212).
- 4 Costs for rush genetic testing for hereditary breast/ovarian and colon/endometrial cancer is not covered.

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- E Related to diagnostic evaluation of individuals with intellectual disability (defined as a full scale or verbal IQ < 70 in an individual > age 5), developmental delay (defined as a cognitive index <70 on a standardized test appropriate for children < 5 years of age), Autism Spectrum Disorder, or multiple congenital anomalies:
- 1 CPT 81228, Cytogenomic constitutional microarray analysis for copy number variants for chromosomal abnormalities: Cover for diagnostic evaluation of individuals with intellectual disability/developmental delay; multiple congenital anomalies; or, Autism Spectrum Disorder accompanied by at least one of the following: dysmorphic features including macro or microcephaly, congenital anomalies, or intellectual disability/developmental delay in addition to those required to diagnose Autism Spectrum Disorder.
 - 2 CPT 81229, Cytogenomic constitutional microarray analysis for copy number variants for chromosomal abnormalities; plus cytogenetic constitutional microarray analysis for single nucleotide polymorphism (SNP) variants for chromosomal abnormalities: Cover for diagnostic evaluation of individuals with intellectual disability/developmental delay; multiple congenital anomalies; or, Autism Spectrum Disorder accompanied by at least one of the following: dysmorphic features including macro or microcephaly, congenital anomalies, or intellectual disability/developmental delay in addition to those required to diagnose Autism Spectrum Disorder; only if (a) consanguinity and recessive disease is suspected, or (b) uniparental disomy is suspected, or (c) another mechanism is suspected that is not detected by the copy number variant test alone.
 - 3 CPT 81243, 81244, Fragile X genetic testing is covered for individuals with intellectual disability/developmental delay. Although the yield of Fragile X is 3.5-10%, this is included because of additional reproductive implications.
 - 4 A visit with the appropriate specialist (often genetics, developmental pediatrics, or child neurology), including physical exam, medical history, and family history is covered. Physical exam, medical history, and family history by the appropriate specialist, prior to any genetic testing is often the most cost-effective strategy and is encouraged.
- F Related to other tests with specific CPT codes:
- 1 The following tests are not covered:
 - a CPT 81225, CYP2C9 (cytochrome P450, family 2, subfamily C, polypeptide 9) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *5, *6)
 - b CPT 81226, CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *5, *6, *9, *10, *17, *19, *29, *35, *41, *1XN, *2XN, *4XN).
 - c CPT 81227, CYP2C9 (cytochrome P450, family 2, subfamily C, polypeptide 9) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *5, *6)
 - d CPT 81287, MGMT (O-6-methylguanine-DNA methyltransferase) (eg, glioblastoma multiforme), methylation analysis

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- e CPT 81291, MTHFR (5,10-methylenetetrahydrofolate reductase) (eg, hereditary hypercoagulability) gene analysis, common variants (eg, 677T, 1298C)
 - f CPT 81330, SMPD1(sphingomyelin phosphodiesterase 1, acid lysosomal) (eg, Niemann-Pick disease, Type A) gene analysis, common variants (eg, R496L, L302P, fsP330)
 - g CPT 81350, UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1) (eg, irinotecan metabolism), gene analysis, common variants (eg, *28, *36, *37)
 - h CPT 81355, VKORC1 (vitamin K epoxide reductase complex, subunit 1) (eg, warfarin metabolism), gene analysis, common variants (eg, -1639/3673)
 - i CPT 81417, re-evaluation of whole exome sequencing
CPT 81425-81427, Genome sequence analysis
 - k CPT 81470, 81471, X-linked intellectual disability (XLID) genomic sequence panels
 - l CPT 81504, Oncology (tissue of origin), microarray gene expression profiling of > 2000 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as tissue similarity scores
- 2 The following tests are covered only if they meet the criteria [in section A above](#) ~~for the Non-Prenatal Genetic Testing Algorithm~~ AND the specified situations:
- a CPT 81205, BCKDHB (branched-chain keto acid dehydrogenase E1, beta polypeptide) (eg, Maple syrup urine disease) gene analysis, common variants (eg, R183P, G278S, E422X): Cover only when the newborn screening test is abnormal and serum amino acids are normal
 - b Diagnostic testing for cystic fibrosis (CF)
 - i CFTR, cystic fibrosis transmembrane conductance regulator tests. CPT 81220, 81223, 81222: For infants with a positive newborn screen for cystic fibrosis or who are symptomatic for cystic fibrosis, or for clients that have previously been diagnosed with cystic fibrosis but have not had genetic testing, CFTR gene analysis of a panel containing at least the mutations recommended by the American College of Medical Genetics* (CPT 81220) is covered. If two mutations are not identified, CFTR full gene sequencing (CPT 81223) is covered. If two mutations are still not identified, duplication/deletion testing (CPT 81222) is covered. These tests may be ordered as reflex testing on the same specimen.
 - c Carrier testing for cystic fibrosis
 - i CFTR gene analysis of a panel containing at least the mutations recommended by the American College of Medical Genetics* (CPT 81220) is covered [once in a lifetime](#).
 - d [CPT 81224, CFTR \(cystic fibrosis transmembrane conductance regulator\) \(eg, cystic fibrosis\) gene analysis; intron 8 poly-T analysis \(eg, male infertility\): Covered only after genetic counseling.](#)
 - e CPT 81240. F2 (prothrombin, coagulation factor II) (eg, hereditary hypercoagulability) gene analysis, 20210G>A variant: Factor 2 20210G>A testing

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should not be covered for adults with idiopathic venous thromboembolism; for asymptomatic family members of patients with venous thromboembolism and a Factor V Leiden or Prothrombin 20210G>A mutation; or for determining the etiology of recurrent fetal loss or placental abruption.

- f CPT 81241. F5 (coagulation Factor V) (eg, hereditary hypercoagulability) gene analysis, Leiden variant: Factor V Leiden testing should not be covered for: adults with idiopathic venous thromboembolism; for asymptomatic family members of patients with venous thromboembolism and a Factor V Leiden or Prothrombin 20210G>A mutation; or for determining the etiology of recurrent fetal loss or placental abruption.
- g CPT 81256, HFE (hemochromatosis) (eg, hereditary hemochromatosis) gene analysis, common variants (eg, C282Y, H63D): Covered for diagnostic testing of patients with elevated transferrin saturation or ferritin levels. Covered for predictive testing ONLY when a first degree family member has treatable iron overload from HFE.
- h CPT 81221 SERPINA1 (serpin peptidase inhibitor, clade A, alpha-1 antiproteinase, antitrypsin, member 1) (eg, alpha-1-antitrypsin deficiency), gene analysis, common variants (eg, *S and *Z): The alpha-1-antitrypsin protein level should be the first line test for a suspected diagnosis of AAT deficiency in symptomatic individuals with unexplained liver disease or obstructive lung disease that is not asthma or in a middle age individual with unexplained dyspnea. Generic testing or the alpha-1 phenotype test is appropriate if the protein test is abnormal or borderline. The genetic test is appropriate for siblings of people with AAT deficiency regardless of the AAT protein test results.
- i CPT 81415-81416, exome testing: A genetic counseling/geneticist consultation is required prior to ordering test
CPT 81430-81431, Hearing loss (eg, nonsyndromic hearing loss, Usher syndrome, Pendred syndrome); genomic sequence analysis panel: Testing for mutations in GJB2 and GJB6 need to be done first and be negative in non-syndromic patients prior to panel testing.
- k CPT 81440, 81460, 81465, mitochondrial genome testing: A genetic counseling/geneticist or metabolic consultation is required prior to ordering test.
- l [CPT 81412 Ashkenazi Jewish carrier testing panel: panel testing is only covered when the panel would replace and would be of similar or lower cost than individual gene testing including CF carrier testing.](#)
- ~~m Do not cover a more expensive genetic test (generally one with a wider scope or more detailed testing) if a cheaper (smaller scope) test is available and has, in this clinical context, a substantially similar sensitivity. For example, do not cover CFTR gene sequencing as the first test in a person of Northern European Caucasian ancestry because the gene panels are less expensive and provide substantially similar sensitivity in that context.~~

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* American College of Medical Genetics Standards and Guidelines for Clinical Genetics Laboratories. 2008 Edition, Revised 3/2011 and found at <https://www.acmg.net/StaticContent/SGs/CFTR%20Mutation%20Testing.pdf>

DIAGNOSTIC GUIDELINE D17, PRENATAL GENETIC TESTING

The following types of prenatal genetic testing and genetic counseling are covered for pregnant women:

1. Genetic counseling (CPT 96040, HPCPS S0265) for high risk women who have family history of inheritable disorder or carrier state, ultrasound abnormality, previous pregnancy with aneuploidy, or elevated risk of neural tube defect.
2. Genetic counseling (CPT 96040, HPCPS S0265) prior to consideration of CVS, amniocentesis, microarray testing, Fragile X, and spinal muscular atrophy screening
3. Validated questionnaire to assess genetic risk in all pregnant women
4. Screening high risk ethnic groups for hemoglobinopathies (CPT 83020, 83021)
5. Screening for aneuploidy with any of five screening strategies [first trimester (nuchal translucency, beta-HCG and PAPP-A), integrated, serum integrated, stepwise sequential, and contingency] (CPT 76813, 76814, 81508-81511)
6. Cell free fetal DNA testing (CPT 81507) for evaluation of aneuploidy in women who have an elevated risk of a fetus with aneuploidy (maternal age >34, family history or elevated risk based on screening).
7. Ultrasound for structural anomalies between 18 and 20 weeks gestation (CPT 76811, 76812)
8. CVS or amniocentesis (CPT 59000, 59015, [88235](#), [88269](#), [88285](#), [82106](#), [88280](#), [88267](#)) for a positive aneuploidy screen, maternal age >34, fetal structural anomalies, family history of inheritable chromosomal disorder or elevated risk of neural tube defect.
9. Array CGH (CPT 81228) when major fetal congenital anomalies apparent on imaging, and karyotype is normal
10. FISH testing (CPT 88271, 88275) only if karyotyping is not possible due a need for rapid turnaround for reasons of reproductive decision-making (i.e. at 22w4d gestation or beyond)
11. Screening for Tay-Sachs carrier status (CPT 81255) in high risk populations. First step is hex A, and then additional DNA analysis in individuals with ambiguous Hex A test results, suspected variant form of TSD or suspected pseudodeficiency of Hex A
12. Screening for cystic fibrosis carrier status once in a lifetime (CPT 81220-81224)
13. Screening for fragile X status (CPT 81243, 81244) in patients with a personal or family history of
 - a. fragile X tremor/ataxia syndrome
 - b. premature ovarian failure
 - c. unexplained early onset intellectual disability
 - d. fragile X intellectual disability
 - e. unexplained autism through the pregnant woman's maternal line

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14. Screening for spinal muscular atrophy (CPT 81401) once in a lifetime
15. Screening those with Ashkenazi Jewish heritage for Canavan disease (CPT 81200), familial dysautonomia (CPT 81260), and Tay-Sachs carrier status (CPT 81255). [Ashkenazi Jewish carrier panel testing \(CPT 81412\) is covered if the panel would replace and would be of similar or lower cost than individual gene testing including CF carrier testing.](#)
16. Expanded carrier screening only for those genetic conditions identified above

The following genetic screening tests are not covered:

1. Serum triple screen
2. Screening for thrombophilia in the general population or for recurrent pregnancy loss
3. Expanded carrier screening which includes results for conditions not explicitly recommended for coverage

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

GUIDELINE NOTE 4, TOBACCO DEPENDENCE

Line 5

~~Persons are eligible for tobacco dependence counseling if a documented quit date has been established.~~ [Pharmacotherapy and behavioral counseling are included on this line, alone or in combination, for at least 2 quit attempts per year. A minimum of four counseling sessions of at least 10 minutes each \(group or individual, telephonic or in person\) are included for each quit attempt. More intensive interventions and group therapy are likely to be the most effective behavioral interventions.](#)

[Inclusion on this line follows the minimum standard criteria as defined in the Oregon Public Health Division "Standard Tobacco Cessation Coverage" based on the Patient Protection and Affordable Care Act\),, available here:](#)
<https://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Pages/pubs.aspx>

For January 1, 2016 Prioritized List, but referencing October 1, 2015 back lines due to implementation delay.

GUIDELINE NOTE 92, ACUPUNCTURE

Lines 1, 2078,374, 4145, 4687,545, 5463

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

Line 1 PREGNANCY

Acupuncture pairs on Line 1 for the following conditions and codes.

Hyperemesis gravidarum

ICD-10-CM code: O21.0, O21.1

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Acupuncture pairs with hyperemesis gravidarum when a diagnosis is made by the maternity care provider and referred for acupuncture treatment for up to ~~2~~ 12 sessions of acupressure/acupuncture.

Breech presentation

ICD-10-CM code: O32.1xx0, O32.8xx0

Acupuncture (and moxibustion) is paired with breech presentation 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~~ 6 visits.

Back and pelvic pain of pregnancy

ICD-10-CM code: O33.0

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

Line 20~~7~~8 DEPRESSION AND OTHER MOOD DISORDERS, MILD OR MODERATE

Acupuncture is paired with 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~~ 12 total sessions, with documentation of meaningful improvement.

From October 1, 2015 Prioritized List Line 374 DISORDERS OF SPINE WITH NEUROLOGIC IMPAIRMENT

Acupuncture is included on Line 374 only for pairing with disorders of the spine with myelopathy and/or radiculopathy represented by the diagnosis codes G83.4, ~~M47.1x, M47.2x, M50.0x, M50.1x, M51.0x, M51.1x, M54.1x~~ M51.0x, ~~with referral~~, for up to 12 sessions.

Line 41~~4~~5 MIGRAINE HEADACHES

Acupuncture pairs on Line 41~~4~~5 for ~~G43.9~~ Migraine (ICD-10-CM code G43.0xx, G43.1xx, G43.5xx, G43.7xx, G43.8xx, G43.9xx), ~~when referred~~, for up to 12 sessions.

Line 46~~8~~7 OSTEOARTHRITIS AND ALLIED DISORDERS

Acupuncture pairs on Line 46~~8~~7 for osteoarthritis of the knee only (ICD-10 code M17.xx), ~~when referred~~, for up to 12 sessions.

** From October 1, 2015 Prioritized List* Line 545 ACUTE AND CHRONIC DISORDERS OF SPINE WITHOUT NEUROLOGIC IMPAIRMENT

Acupuncture pairs on Line 545 with the low back diagnoses (ICD-10-CM codes ~~G83.4, M47.1x, M47.2x, M50.0x, M50.1x, M51.1x, M54.1x, M51.36, M51.86, M54.5, M99.03, S33.5xxx, S33.9xxx, S39.092x, S39.82xx, S39.92xx~~), ~~when referred~~, for up to 12 sessions. Acupuncture pairs with chronic (>90 days) neck pain diagnoses (ICD-10-CM M53.82, M54.2, S13.4XXX, S13.8XXX), ~~when referred~~, for up to 12 sessions.

**Line* 54~~6~~3 TENSION HEADACHES

Acupuncture is included on Line 54~~6~~3 for treatment of tension headaches (ICD-10-CM G44.2x), ~~when referred~~, for up to 12 sessions.

The development of this guideline note was informed by a HERC evidence-based guideline. See <http://www.oregon.gov/oha/herc/Pages/blog-low-back-non-pharmacologic-intervention.aspx>

[*Below the current funding line.](#)

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For future Prioritized List with back line changes when implemented.

GUIDELINE NOTE 92, ACUPUNCTURE

Lines 1, 20~~78,374,~~ 407, 41~~45,~~ 46~~87,545,~~ 54~~63~~

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

Line 1 PREGNANCY

Acupuncture pairs on Line 1 for the following conditions and codes.

Hyperemesis gravidarum

ICD-10-CM code: O21.0, O21.1

Acupuncture pairs with hyperemesis gravidarum when a diagnosis is made by the maternity care provider and referred for acupuncture treatment for up to ~~2~~ 12 sessions of acupressure/acupuncture.

Breech presentation

ICD-10-CM code: O32.1xx0, O32.8xx0

Acupuncture (and moxibustion) is paired with breech presentation 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~~ 6 visits.

Back and pelvic pain of pregnancy

ICD-10-CM code: O33.0

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

Line 20~~78~~ DEPRESSION AND OTHER MOOD DISORDERS, MILD OR MODERATE

Acupuncture is paired with 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~~ 12 total sessions, with documentation of meaningful improvement.

Line 407 CONDITIONS OF THE BACK AND SPINE

Acupuncture is included on line 407 for pairing with visit limitations as in GUIDELINE NOTE ~~92~~, NON-INTERVENTIONAL TREATMENTS FOR CONDITIONS OF THE BACK AND SPINE

Line 41~~45~~ MIGRAINE HEADACHES

Acupuncture pairs on Line 41~~45~~ for ~~G43.9~~ Migraine (ICD-10-CM code G43.0xx, G43.1xx, G43.5xx, G43.7xx, G43.8xx, G43.9xx), ~~when referred~~, for up to 12 sessions.

Line 46~~87~~ OSTEOARTHRITIS AND ALLIED DISORDERS

Acupuncture pairs on Line 46~~87~~ for osteoarthritis of the knee only (ICD-10 code M17.xx), ~~when referred~~, for up to 12 sessions.

*Line 54~~63~~ TENSION HEADACHES

Acupuncture is included on Line 54~~63~~ for treatment of tension headaches (ICD-10-CM G44.2x), ~~when referred~~, for up to 12 sessions.

The development of this guideline note was informed by a HERC evidence-based guideline. See <http://www.oregon.gov/oha/herc/Pages/blog-low-back-non-pharmacologic-intervention.aspx>

*Below the current funding line.

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GUIDELINE NOTE 107, HYPERBARIC OXYGEN

Lines 336,373

Hyperbaric oxygen is a covered service only under the following circumstances:

- when paired with ICD-10-CM codes ~~E11.5x~~ and ~~E11.621, E11.622 and E11.623~~ E08.52, E09.52, E10.52, E11.52, E13.52, E08.621, E09.621, E10.621, E11.621, E13.621, E08.622, E09.622, E10.622, E11.622, E13.622 for diabetic wounds with gangrene OR diabetic wounds of the lower extremities in patients who meet the all of the following criteria:
 - Patient has Type 1 or Type 2 diabetes and has a lower extremity wound that is due to diabetes, AND
 - Patient has a wound classified as Wagner grade III or higher, AND
 - Patient has failed an adequate course of standard wound therapy including arterial assessment, with no measurable signs of healing after at least thirty days, AND
 - Wounds must be evaluated at least every 30 days during administration of hyperbaric oxygen therapy. Continued treatment with hyperbaric oxygen therapy is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment.
- when paired with ICD-10-CM codes M27.8 for osteoradionecrosis of the jaw only
- when paired with ICD-10-CM codes O08.0, M60.000-M60.09 only if the infection is a necrotizing soft-tissue infection
- when paired with ICD-10 CM codes S07.xxx, S17.xxx, S38.xxx, S47.1xxA-S47.1xxD, S47.2xxA-S47.2xxD, S47.9xxA-S47.9xxD, S57.xxx, S67.xxx, S77.xxx, S87.xxx, S97.xxx, T79.Axx only for posttraumatic crush injury of Gustilo type III B and C
- when paired with ICD-10--CM codes T66.xxxA only for osteoradionecrosis and soft tissue radiation injury
- when paired with ICD-10-CM codes T86.820-T86.829, T82.898A/T82.898D, T82.9xxA/T82.9xxD, T83.89xA/T83.89xD, T83.9xxA/T83.9xxD, T84.89xA/T84.89xD, T84.9xxA/T84.9xxD, T85.89xA/T85.89xD, T859xxA/T859xxD only for compromised myocutaneous flaps

Appendix B

Code	Code description	List/Line Placement
99415	Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour each additional 30 minutes	E&M Lines
99416	each additional 30 minutes (List separately in addition to code for prolonged service)	E&M Lines
10035	Placement of soft tissue localization device(s) (eg, clip, metallic pellet, wire/needle, radiative seeds), percutaneous, including imaging guidance; first lesion	Diagnostic Procedures File
10036	each additional lesion (List separately in addition to code for primary procedure)	Diagnostic Procedures File
31652	Bronchoscopy with endobrochial ultrasound (EBUS) guided transtracheal and/or transbrochial sampling (eg, aspiration[s]/biopsy([ies])), one or two mediastinal and/or hilar lymph node stations or structures	Diagnostic Procedures File
31653	Bronchoscopy with endobrochial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy([ies])), 3 or more mediastinal and/or hilar lymph node stations or structures	Diagnostic Procedures File
31654	Bronchoscopy with transendoscopic endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s) (List separately in addition to code for primary procedure[s])	Diagnostic Procedures File
33477	Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed	73 ACUTE AND SUBACUTE ISCHEMIC HEART DISEASE, MYOCARDIAL INFARCTION 86 MYOCARDITIS, PERICARDITIS, AND ENDOCARDITIS 115 CONGENITAL HEART BLOCK; OTHER OBSTRUCTIVE ANOMALIES OF HEART 190 RHEUMATIC MULTIPLE VALVULAR DISEASE 193 CHRONIC ISCHEMIC HEART DISEASE 262 DISEASES OF MITRAL, TRICUSPID, AND PULMONARY VALVES 290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT

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Code	Code description	List/Line Placement
37252	Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial noncoronary vessel	Diagnostic Procedures File
37253	each additional noncoronary vessel (List separately in addition to code for primary procedure)	Diagnostic Procedures File
39401	Mediastinoscopy; includes biopsy(ies) of mediastinal mass (eg, lymphoma), when performed	Diagnostic Procedures File
39402	with lymph node biopsy(ies) (eg, lung cancer staging)	Diagnostic Procedures File
43210	Esophagogastroduodenoscopy with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed	60 ULCERS, GASTRITIS, DUODENITIS, AND GI HEMORRHAGE
47531	Injection procedure for cholangiography, percutaneous, complete diagnostic procedure including imaging guidance (eg, ultrasound and/or fluoroscope) and all associated radiological supervision and interpretation; existing access	Diagnostic Procedures File
47532	new access(eg, percutaneous transhepatic cholangiogram)	Diagnostic Procedures File
47533	Placement of biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; external	59 COMPLICATED STONES OF THE GALLBLADDER AND BILE DUCTS; CHOLECYSTITIS 84 INJURY TO INTERNAL ORGANS 105 CONGENITAL ANOMALIES OF DIGESTIVE SYSTEM AND ABDOMINAL WALL EXCLUDING NECROSIS; CHRONIC INTESTINAL PSEUDO-OBSTRUCTION 298 ANOMALIES OF GALLBLADDER, BILE DUCTS, AND LIVER 320 CANCER OF LIVER 439 CANCER OF GALLBLADDER AND OTHER BILIARY
47534	internal - external	59 COMPLICATED STONES OF THE GALLBLADDER AND BILE DUCTS; CHOLECYSTITIS 105 CONGENITAL ANOMALIES OF DIGESTIVE SYSTEM AND ABDOMINAL WALL EXCLUDING NECROSIS; CHRONIC INTESTINAL PSEUDO-OBSTRUCTION 298 ANOMALIES OF GALLBLADDER, BILE DUCTS, AND LIVER 320 CANCER OF LIVER 439 CANCER OF GALLBLADDER AND OTHER BILIARY

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Code	Code description	List/Line Placement
47535	Conversion of external biliary drainage catheter to internal-external biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation	59 COMPLICATED STONES OF THE GALLBLADDER AND BILE DUCTS; CHOLECYSTITIS 105 CONGENITAL ANOMALIES OF DIGESTIVE SYSTEM AND ABDOMINAL WALL EXCLUDING NECROSIS; CHRONIC INTESTINAL PSEUDO-OBSTRUCTION 298 ANOMALIES OF GALLBLADDER, BILE DUCTS, AND LIVER 439 CANCER OF GALLBLADDER AND OTHER BILIARY
47536	Exchange of biliary drainage catheter (eg, external, internal-external, or conversion of internal-external to external only), percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation	59 COMPLICATED STONES OF THE GALLBLADDER AND BILE DUCTS; CHOLECYSTITIS 105 CONGENITAL ANOMALIES OF DIGESTIVE SYSTEM AND ABDOMINAL WALL EXCLUDING NECROSIS; CHRONIC INTESTINAL PSEUDO-OBSTRUCTION 298 ANOMALIES OF GALLBLADDER, BILE DUCTS, AND LIVER 320 CANCER OF LIVER 428 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT 439 CANCER OF GALLBLADDER AND OTHER BILIARY
47537	Removal of biliary drainage catheter, percutaneous, requiring fluoroscopic guidance (eg, with concurrent indwelling biliary stents), including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation	59 COMPLICATED STONES OF THE GALLBLADDER AND BILE DUCTS; CHOLECYSTITIS 84 INJURY TO INTERNAL ORGANS 105 CONGENITAL ANOMALIES OF DIGESTIVE SYSTEM AND ABDOMINAL WALL EXCLUDING NECROSIS; CHRONIC INTESTINAL PSEUDO-OBSTRUCTION 298 ANOMALIES OF GALLBLADDER, BILE DUCTS, AND LIVER 320 CANCER OF LIVER 428 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT 439 CANCER OF GALLBLADDER AND OTHER BILIARY
47538	Placement of stent(s) into bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation, each stent; existing access	59 COMPLICATED STONES OF THE GALLBLADDER AND BILE DUCTS; CHOLECYSTITIS 105 CONGENITAL ANOMALIES OF DIGESTIVE SYSTEM AND ABDOMINAL WALL EXCLUDING NECROSIS; CHRONIC INTESTINAL PSEUDO-OBSTRUCTION 298 ANOMALIES OF GALLBLADDER, BILE DUCTS, AND LIVER 320 CANCER OF LIVER 439 CANCER OF GALLBLADDER AND OTHER BILIARY

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Code	Code description	List/Line Placement
47539	new access, without placement of separate biliary drainage catheter	59 COMPLICATED STONES OF THE GALLBLADDER AND BILE DUCTS; CHOLECYSTITIS 105 CONGENITAL ANOMALIES OF DIGESTIVE SYSTEM AND ABDOMINAL WALL EXCLUDING NECROSIS; CHRONIC INTESTINAL PSEUDO-OBSTRUCTION 298 ANOMALIES OF GALLBLADDER, BILE DUCTS, AND LIVER 320 CANCER OF LIVER 439 CANCER OF GALLBLADDER AND OTHER BILIARY
47540	new access, with placement of separate biliary drainage catheter (eg, external or internal - external)	59 COMPLICATED STONES OF THE GALLBLADDER AND BILE DUCTS; CHOLECYSTITIS 105 CONGENITAL ANOMALIES OF DIGESTIVE SYSTEM AND ABDOMINAL WALL EXCLUDING NECROSIS; CHRONIC INTESTINAL PSEUDO-OBSTRUCTION 298 ANOMALIES OF GALLBLADDER, BILE DUCTS, AND LIVER 320 CANCER OF LIVER 439 CANCER OF GALLBLADDER AND OTHER BILIARY
47541	Placement of access through the biliary tree and into small bowel to assist with an endoscopic biliary procedure (eg, rendezvous procedure), percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation, new access	Diagnostic Procedures File
47542	Balloon dilation of biliary duct(s) or of ampulla (sphincteroplasty), percutaneous, including imaging guidance (eg, Fluoroscopy), and all associated radiological supervision and interpretation, each duct (List separately in addition to code for primary procedure)	59 COMPLICATED STONES OF THE GALLBLADDER AND BILE DUCTS; CHOLECYSTITIS 105 CONGENITAL ANOMALIES OF DIGESTIVE SYSTEM AND ABDOMINAL WALL EXCLUDING NECROSIS; CHRONIC INTESTINAL PSEUDO-OBSTRUCTION 194 NEOPLASMS OF ISLETS OF LANGERHANS 199 ACUTE PANCREATITIS 255 CHRONIC PANCREATITIS 290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT 298 ANOMALIES OF GALLBLADDER, BILE DUCTS, AND LIVER 320 CANCER OF LIVER 321 CANCER OF PANCREAS 439 CANCER OF GALLBLADDER AND OTHER BILIARY 645 GALLSTONES WITHOUT CHOLECYSTITIS

Code	Code description	List/Line Placement
47543	Endoluminal biopsy(ies) of biliary tree, percutaneous, and method(s) (eg, brush, forceps, and/or needle), including imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation, single or multiple (List separately in addition to code for primary procedure)	Diagnostic Procedures File
47544	Removal of calculi/debris from biliary duct(s) and/or gallbladder, percutaneous, including destruction of calculi by method (eg, mechanical, electrohydraulic lithotripsy) when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)	59 COMPLICATED STONES OF THE GALLBLADDER AND BILE DUCTS; CHOLECYSTITIS 105 CONGENITAL ANOMALIES OF DIGESTIVE SYSTEM AND ABDOMINAL WALL EXCLUDING NECROSIS; CHRONIC INTESTINAL PSEUDO-OBSTRUCTION 298 ANOMALIES OF GALLBLADDER, BILE DUCTS, AND LIVER
49185	Sclerotherapy of a fluid collection (eg, lymphocele, cyst, or seroma), percutaneous, including contrast injection(s) sclerosant injection(s), diagnostic study, imaging guidance (eg, ultrasound, fluoroscopy) and radiological supervision and interpretation when performed	229 DISORDERS OF PARATHYROID GLAND; BENIGN NEOPLASM OF PARATHYROID GLAND; DISORDERS OF CALCIUM METABOLISM 298 ANOMALIES OF GALLBLADDER, BILE DUCTS, AND LIVER 427 LYMPHEDEMA 427 LYMPHEDEMA 428 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT 484 BREAST CYSTS AND OTHER DISORDERS OF THE BREAST 547 HYDROCELE 559 CYST OF KIDNEY, ACQUIRED 569 PLEURISY 596 GANGLION 607 DISORDERS OF SOFT TISSUE 634 CYST, HEMORRHAGE, AND INFARCTION OF THYROID
50430	Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; new access	Diagnostic Procedures File
50431	existing access	Diagnostic Procedures File

Code	Code description	List/Line Placement
50432	Placement of nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation	184 URETERAL STRICTURE OR OBSTRUCTION; HYDRONEPHROSIS; HYDROURETER 235 URINARY FISTULA 357 URINARY SYSTEM CALCULUS
50433	Placement of nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, new access	184 URETERAL STRICTURE OR OBSTRUCTION; HYDRONEPHROSIS; HYDROURETER 235 URINARY FISTULA 357 URINARY SYSTEM CALCULUS
50434	Convert nephrostomy catheter to nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, via pre-existing nephrostomy tract	184 URETERAL STRICTURE OR OBSTRUCTION; HYDRONEPHROSIS; HYDROURETER 235 URINARY FISTULA 357 URINARY SYSTEM CALCULUS
50435	Exchange nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation	184 URETERAL STRICTURE OR OBSTRUCTION; HYDRONEPHROSIS; HYDROURETER 235 URINARY FISTULA 290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT 357 URINARY SYSTEM CALCULUS
50606	Endoluminal biopsy of ureter and/or renal pelvis, non-endoscopic, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)	Diagnostic Procedures File
50693	Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation ; pre-existing nephrostomy tract	51 DEEP ABSCESSSES, INCLUDING APPENDICITIS AND PERIORBITAL ABSCESS 53 CONGENITAL HYDRONEPHROSIS 84 INJURY TO INTERNAL ORGANS 184 URETERAL STRICTURE OR OBSTRUCTION; HYDRONEPHROSIS; HYDROURETER 275 CANCER OF BLADDER AND URETER 357 URINARY SYSTEM CALCULUS

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Code	Code description	List/Line Placement
50694	new access, without separate nephrostomy catheter	51 DEEP ABSCESSSES, INCLUDING APPENDICITIS AND PERIORBITAL ABSCESS 53 CONGENITAL HYDRONEPHROSIS 84 INJURY TO INTERNAL ORGANS 184 URETERAL STRICTURE OR OBSTRUCTION; HYDRONEPHROSIS; HYDROURETER 275 CANCER OF BLADDER AND URETER 357 URINARY SYSTEM CALCULUS
50695	new access with separate nephrostomy catheter	51 DEEP ABSCESSSES, INCLUDING APPENDICITIS AND PERIORBITAL ABSCESS 53 CONGENITAL HYDRONEPHROSIS 84 INJURY TO INTERNAL ORGANS 184 URETERAL STRICTURE OR OBSTRUCTION; HYDRONEPHROSIS; HYDROURETER 275 CANCER OF BLADDER AND URETER 357 URINARY SYSTEM CALCULUS
50705	Ureteral embolization or occlusion, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)	Services Recommended for Non-Coverage Table
50706	Balloon dilation, ureteral stricture, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)	184 URETERAL STRICTURE OR OBSTRUCTION; HYDRONEPHROSIS; HYDROURETER 332 FUNCTIONAL AND MECHANICAL DISORDERS OF THE GENITOURINARY SYSTEM INCLUDING BLADDER OUTLET OBSTRUCTION
54437	Repair of traumatic corporeal tear(s)	212 DEEP OPEN WOUND, WITH OR WITHOUT TENDON OR NERVE INVOLVEMENT 332 FUNCTIONAL AND MECHANICAL DISORDERS OF THE GENITOURINARY SYSTEM INCLUDING BLADDER OUTLET OBSTRUCTION
54438	Replantation, penis, complete amputation including urethral repair	212 DEEP OPEN WOUND, WITH OR WITHOUT TENDON OR NERVE INVOLVEMENT 332 FUNCTIONAL AND MECHANICAL DISORDERS OF THE GENITOURINARY SYSTEM INCLUDING BLADDER OUTLET OBSTRUCTION

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Code	Code description	List/Line Placement
61645	Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)	Services Recommended for Non-Coverage Table
61650	Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement diagnostic angiography, and imaging guidance, initial vascular territory	Services Recommended for Non-Coverage Table
61651	each additional vascular territory (List separately in addition to code for primary procedure)	Services Recommended for Non-Coverage Table
64461	Paravertebral block (PVB) (paraspinal block), thoracic; single injection site (includes imaging guidance, when performed)	Ancillary List
64462	second and any additional injection site(s) (includes imaging guidance, when performed) (List separately in addition to code for primary procedure)	Ancillary List
64463	continuous infusion by catheter (includes imaging guidance, when performed)	Ancillary List
65785	Implantation of intrastromal corneal ring segments	Services Recommended for Non-Coverage Table
69209	Removal impacted cerumen using irrigation/lavage, unilateral	316 HEARING LOSS - AGE 5 OR UNDER 395 ACUTE OTITIS MEDIA 432 NON-MALIGNANT OTITIS EXTERNA 450 HEARING LOSS - OVER AGE OF FIVE 479 CHRONIC OTITIS MEDIA; OPEN WOUND OF EAR DRUM 503 CERUMEN IMPACTION
72081	Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); one view	Diagnostic Procedures File
72082	2 or 3 views	Diagnostic Procedures File
72083	4 or 5 views	Diagnostic Procedures File
72084	minimum of 6 views	Diagnostic Procedures File

Appendix B

Code	Code description	List/Line Placement
73501	Radiologic examination, hip, unilateral, with pelvis when performed; 1 view	Diagnostic Procedures File
73502	2 - 3 views	Diagnostic Procedures File
73503	minimum of 4 views	Diagnostic Procedures File
73521	Radiologic examination, hips, bilateral, with pelvis when performed; 2 views	Diagnostic Procedures File
73522	3-4 views	Diagnostic Procedures File
73523	minimum of 5 views	Diagnostic Procedures File
73551	Radiologic examination, femur; 1 view	Diagnostic Procedures File
73552	minimum 2 views	Diagnostic Procedures File
74712	Magnetic resonance (eg, proton) imaging, fetal, including placental and maternal pelvic imaging when performed; single or first gestation	1 PREGNANCY
74713	each additional gestation (List separately in addition to code for primary procedure)	1 PREGNANCY
77767	Remote afterloading high dose rate radionuclide skin surface brachytherapy, includes basic dosimetry, when performed, lesion diameter up to 2.0 cm or 1 channel	Services Recommended for Non-Coverage Table
77768	Lesion diameter over 2.0 cm or 2 or more channels, or multiple lesions	Services Recommended for Non-Coverage Table

Appendix B

Code	Code description	List/Line Placement
77770	Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 1 channel	<p>130 BENIGN NEOPLASM OF THE BRAIN AND SPINAL CORD</p> <p>137 CANCER OF CERVIX</p> <p>161 CANCER OF COLON, RECTUM, SMALL INTESTINE AND ANUS</p> <p>195 CANCER OF BREAST; AT HIGH RISK OF BREAST CANCER</p> <p>204 CANCER OF SOFT TISSUE</p> <p>213 CANCER OF UTERUS</p> <p>263 CANCER OF PENIS AND OTHER MALE GENITAL ORGANS</p> <p>266 CANCER OF RETROPERITONEUM, PERITONEUM, OMENTUM AND MESENTERY</p> <p>267 CANCER OF LUNG, BRONCHUS, PLEURA, TRACHEA, MEDIASTINUM AND OTHER RESPIRATORY ORGANS</p> <p>275 CANCER OF BLADDER AND URETER</p> <p>291 CANCER OF VAGINA, VULVA, AND OTHER FEMALE GENITAL ORGANS</p> <p>292 CANCER OF ORAL CAVITY, PHARYNX, NOSE AND LARYNX</p> <p>299 CANCER OF BRAIN AND NERVOUS SYSTEM</p> <p>319 CANCER OF ESOPHAGUS</p> <p>334 CANCER OF PROSTATE GLAND</p> <p>377 BENIGN NEOPLASM OF RESPIRATORY AND INTRATHORACIC ORGANS</p> <p>595 SECONDARY AND ILL-DEFINED MALIGNANT NEOPLASMS</p>

Appendix B

Code	Code description	List/Line Placement
77771	2-12 channels	<p>130 BENIGN NEOPLASM OF THE BRAIN AND SPINAL CORD</p> <p>137 CANCER OF CERVIX</p> <p>161 CANCER OF COLON, RECTUM, SMALL INTESTINE AND ANUS</p> <p>195 CANCER OF BREAST; AT HIGH RISK OF BREAST CANCER</p> <p>204 CANCER OF SOFT TISSUE</p> <p>213 CANCER OF UTERUS</p> <p>263 CANCER OF PENIS AND OTHER MALE GENITAL ORGANS</p> <p>266 CANCER OF RETROPERITONEUM, PERITONEUM, OMENTUM AND MESENTERY</p> <p>267 CANCER OF LUNG, BRONCHUS, PLEURA, TRACHEA, MEDIASTINUM AND OTHER RESPIRATORY ORGANS</p> <p>275 CANCER OF BLADDER AND URETER</p> <p>291 CANCER OF VAGINA, VULVA, AND OTHER FEMALE GENITAL ORGANS</p> <p>292 CANCER OF ORAL CAVITY, PHARYNX, NOSE AND LARYNX</p> <p>299 CANCER OF BRAIN AND NERVOUS SYSTEM</p> <p>319 CANCER OF ESOPHAGUS</p> <p>334 CANCER OF PROSTATE GLAND</p> <p>377 BENIGN NEOPLASM OF RESPIRATORY AND INTRATHORACIC ORGANS</p> <p>595 SECONDARY AND ILL-DEFINED MALIGNANT NEOPLASMS</p>

Appendix B

Code	Code description	List/Line Placement
77772	over 12 channels	<p>130 BENIGN NEOPLASM OF THE BRAIN AND SPINAL CORD</p> <p>137 CANCER OF CERVIX</p> <p>161 CANCER OF COLON, RECTUM, SMALL INTESTINE AND ANUS</p> <p>195 CANCER OF BREAST; AT HIGH RISK OF BREAST CANCER</p> <p>204 CANCER OF SOFT TISSUE</p> <p>213 CANCER OF UTERUS</p> <p>263 CANCER OF PENIS AND OTHER MALE GENITAL ORGANS</p> <p>266 CANCER OF RETROPERITONEUM, PERITONEUM, OMENTUM AND MESENTERY</p> <p>267 CANCER OF LUNG, BRONCHUS, PLEURA, TRACHEA, MEDIASTINUM AND OTHER RESPIRATORY ORGANS</p> <p>275 CANCER OF BLADDER AND URETER</p> <p>291 CANCER OF VAGINA, VULVA, AND OTHER FEMALE GENITAL ORGANS</p> <p>292 CANCER OF ORAL CAVITY, PHARYNX, NOSE AND LARYNX</p> <p>299 CANCER OF BRAIN AND NERVOUS SYSTEM</p> <p>319 CANCER OF ESOPHAGUS</p> <p>334 CANCER OF PROSTATE GLAND</p> <p>377 BENIGN NEOPLASM OF RESPIRATORY AND INTRATHORACIC ORGANS</p> <p>595 SECONDARY AND ILL-DEFINED MALIGNANT NEOPLASMS</p>
78265	Gastric emptying study with small bowel transit	Services Recommended for Non-Coverage Table
78266	Gastric emptying study with small bowel and colon transit, multiple days	Services Recommended for Non-Coverage Table

Appendix B

Code	Code description	List/Line Placement
80081	Obstetrics panel (includes HIV testing) This panel must include the following: Blood count , complete (CBC) and automated differential WBC count (85025 or 85027 and 85009) OR Blood count, complete (CBC) and automated (85027) and appropriate manual differential WBC count (85007 or 85009) Hepatitis B surface antigen (HBsAg) (87340) HIV-1 antigen(s) , with HIV-1 and HIV-2 antibodies, single result (87389) Antibody , rubella (86762) Syphilis test, non-treponemal antibody; qualitative (eg, VDRL, RPR, ART) (86592) Antibody screen, RBC, each serum technique (86850) Blood typing, ABO (86900) AND Blood typing, Rh (D) (86901) (When syphilis screening is performed using a treponemal antibody approach [86780], do not use 80081. Use the individual codes for the tests performed in the Obstetric panel)	1 PREGNANCY
81170	<i>ABL 1 (ABL proto-oncogene 1 , non-receptor tyrosine kinase)</i> (eg, acquired imatinib tyrosine kinase inhibitor resistance), gene analysis, variants in the kinase domain	Diagnostic Procedures File
81162	BRCA1, BRCA2 (breast cancer 1 and 2) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and full duplication/deletion analysis	Diagnostic Procedures File
81218	<i>CEBPA (CCAAT/enhancer binding protein [C/EBP], alpha)</i> (eg, acute myeloid leukemia), gene analysis, full gene sequence	Diagnostic Procedures File
81219	<i>CALR (calreticulin)</i> (eg, myeloproliferative disorders), gene analysis, common variants in exon 9	Services Recommended for Non-Coverage Table
81272	<i>KIT (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog)</i> (eg, gastrointestinal stromal tumor [GIST], acute myeloid leukemia, melanoma), gene analysis, targeted sequence analysis (eg, exons 8, 11, 13, 17, 18,)	Diagnostic Procedures File
81273	<i>KIT (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog)</i> (eg, mastocytosis, gene analysis, D816 variant(s))	Services Recommended for Non-Coverage Table
81276	KRAS (v-Ki-ras2 Kirsten rat sarcoma viral oncogene) (eg, carcinoma) gene analysis additional variants(s) (eg, codon 61, codon 146)	Diagnostic Procedures File

Appendix B

Code	Code description	List/Line Placement
81311	<i>NRAS (neuroblastoma RAS viral [v-ras] oncogene homolog)</i> (eg, colorectal carcinoma), gene analysis, variants in exon 2 (eg, codons 12 and 13) and exon 3 (eg, codon 61)	Services Recommended for Non-Coverage Table
81314	<i>PDGFRA (platelet-derived growth factor receptor, alpha polypeptide)</i> (eg, gastrointestinal stromal tumor [GIST], gene analysis, targeted sequence analysis (eg, exons 12, 18)	Diagnostic Procedures File
81412	<i>Ashkenazi Jewish associated disorders</i> (eg, Bloom syndrome, Canavan disease, cystic fibrosis, familial dysautonomia, Fanconi anemia group C, Gaucher disease, Tay-Sachs disease), genomic sequence analysis panel must include sequencing of at least 9 genes, including <i>ASPA, BLM, CFTR, FANCC, GBA, HEXA, IKBKAP, MCOLN1</i> and <i>SMPD1</i>	Diagnostic Procedures File
81432	Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer); genomic sequence analysis panel, must include sequencing of at least 14 genes, including <i>ATM, BRCA1, BRCA2, BRIP1, CDH1, MLH1, MSH2, MSH6, NBN, PALB2, PTEN, RAD51C, STK11</i> AND <i>TP53</i>	Services Recommended for Non-Coverage Table
81433	duplication/deletion analysis panel, must include analyses for <i>BRCA1, BRCA2, MLH1, MSH2, AND STK11</i>	Services Recommended for Non-Coverage Table
81434	Hereditary retinal disorders (eg, retinitis pigmentosa, Leber congenital amaurosis, cone-rod dystrophy), genomic sequence analysis panel, must include sequencing of at least 15 genes, including <i>ABCA4, CNGA1, CRB1, EYS, PDE6A, PRPF31, PRPH2, RDH12, RHO, RP1, RP2, RPE65, RPGR,</i> and <i>USH2A</i>	Diagnostic Procedures File
81437	Hereditary neuroendocrine tumor disorders (eg, medullary thyroid carcinoma, parathyroid carcinoma, malignant pheochromocytoma or paraganglioma; genomic sequence analysis panel, must include sequencing of at least 6 genes, including <i>MAX, SDHB, SDHC, SDHD, TMEM127,</i> and <i>VHL</i>	Diagnostic Procedures File
81438	duplication/deletion analysis panel, must include analyses for <i>SDHB, SDHC, SDHD,</i> and <i>VHL</i>	Diagnostic Procedures File

Appendix B

Code	Code description	List/Line Placement
81442	Noonan spectrum disorders (eg, Noonan Syndrome, cardio -facio -cutaneous syndrome, Costello syndrome, LEOPARD Syndrome, Noonan-like syndrome), genomic sequence analysis panel , must include sequencing of at least 12 genes, including <i>BRAF</i> , <i>CBL</i> , <i>HRAS</i> , <i>DRAS</i> , <i>MAP2K1</i> , <i>MAP2K2</i> , <i>NRAS</i> , <i>PTPN11</i> , <i>RAF1</i> , <i>RIT1</i> , <i>SHOC2</i> , and <i>SOS1</i>	Diagnostic Procedures File
81490	Autoimmune (rheumatoid arthritis), analysis of 12 biomarkers using immunoassays, utilizing serum, prognostic algorithm reported as a disease activity score	Services Recommended for Non-Coverage Table
81493	Coronary artery disease, mRNA, gene expression profiling by real-time RT-PCR of 23 genes, utilizing whole peripheral blood, algorithm reported as a risk score	Services Recommended for Non-Coverage Table
81525	Oncology (colon), mRNA, gene expression profiling by real-time RT-PCR of 12 genes (7 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a recurrence score	Services Recommended for Non-Coverage Table
81528	Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (<i>KRAS</i> mutations, promoter methylation of <i>NDRG4</i> and <i>BMP3</i>) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result	Services Recommended for Non-Coverage Table
81535	Oncology (gynecologic), live tumor cell culture and chemotherapeutic response by DAPI stain and morphology, predictive algorithm reported as a drug response score; first single drug or drug combination	Services Recommended for Non-Coverage Table
81536	each additional single drug or drug combination (List separately in addition to code for primary procedure)	Services Recommended for Non-Coverage Table
81538	Oncology (lung), mass spectrometric 8-protein signature, including amyloid A, utilizing serum, prognostic and predictive algorithm, reported as good versus poor overall survival	Services Recommended for Non-Coverage Table

Appendix B

Code	Code description	List/Line Placement
81540	Oncology (tumor of unknown origin), mRNA, gene expression profiling by real-time RT-PCR of 92 genes (87 content and 5 housekeeping) to classify tumor into main cancer type and subtype, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a probability of a predicted main cancer type and subtype	Services Recommended for Non-Coverage Table
81545	Oncology (thyroid), gene expression analysis of 142 genes, utilizing fine needle aspirate, algorithm reported as a categorical result (eg, benign or suspicious)	Services Recommended for Non-Coverage Table
81595	Cardiology (heart transplant), mRNA, gene expression profiling by real-time quantitative PCR of 20 genes (11 content and 9 housekeeping), utilizing subfraction of peripheral blood, algorithm reported as rejection risk score	245 CONDITIONS REQUIRING HEART-LUNG AND LUNG TRANSPLANTATION 268 CONGESTIVE HEART FAILURE, CARDIOMYOPATHY, MALIGNANT ARRHYTHMIAS, AND COMPLEX CONGENITAL HEART DISEASE
88350	Immunofluorescence, per specimen, each additional single antibody stain procedure (List separately in addition to code for primary procedure)	Diagnostic Procedures File
90625	Cholera vaccine, live adult dosage, 1 dose schedule, for oral use	Services Recommended for Non-Coverage Table
90620	Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B (MenB), 2 dose schedule for intramuscular use	3 PREVENTION SERVICES WITH EVIDENCE OF EFFECTIVENESS
90621	Meningococcal recombinant lipoprotein vaccine, serogroup B (MenB), 3 dose schedule, for intramuscular use	3 PREVENTION SERVICES WITH EVIDENCE OF EFFECTIVENESS
92537	Caloric vestibular test with recording, bilateral; bithermal (ie, one warm and one cool irrigation in each ear for a total of four irrigations)	297 NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS 422 MENIERE'S DISEASE 515 VERTIGINOUS SYNDROMES AND OTHER DISORDERS OF VESTIBULAR SYSTEM
92538	monothermal (ie, one irrigation in each ear for a total of two irrigations)	297 NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS 422 MENIERE'S DISEASE 515 VERTIGINOUS SYNDROMES AND OTHER DISORDERS OF VESTIBULAR SYSTEM

Appendix B

Code	Code description	List/Line Placement
93050	Arterial pressure waveform analysis for assessment of central arterial pressures, includes obtaining waveform(s), digitization and application of nonlinear mathematical transformations to determine central arterial pressures and augmentation index, with interpretation and report, upper extremity artery, non-invasive	Services Recommended for Non-Coverage Table
96931	Reflection confocal microscopy (RCM) for cellular and sub-cellular imaging of skin ; image acquisition and interpretation and report, , first lesion	Services Recommended for Non-Coverage Table
96932	image acquisition only, first lesion	Services Recommended for Non-Coverage Table
96933	interpretation and report only, first lesion	Services Recommended for Non-Coverage Table
96934	image acquisition and interpretation and report, each additional lesion (List separately in addition to code for primary procedure)	Services Recommended for Non-Coverage Table
96935	image acquisition only, each additional lesion (List separately in addition to code for primary procedure)	Services Recommended for Non-Coverage Table
99177	Instrument based ocular screening (eg, photoscreening, automated-fractions),bilateral; with onsite analysis	Services Recommended for Non-Coverage Table

HCPCS CODES

G0296	Counseling visit to discuss need for lung cancer screening (ldct) using low dose ct scan (service is for eligibility determination and shared decision making)	3 PREVENTION SERVICES WITH EVIDENCE OF EFFECTIVENESS
G0297	Low dose ct scan (ldct) for lung cancer screening	3 PREVENTION SERVICES WITH EVIDENCE OF EFFECTIVENESS
G0298	Hiv antigen/antibody, combination assay, screening	Services Recommended for Non-Coverage Table
G0475	Hiv antigen/antibody, combination assay, screening	Services Recommended for Non-Coverage Table

Appendix C

New Guidelines

GUIDELINE NOTE XXX, SCLEROTHERAPY OF FLUID COLLECTIONS

Lines 172, 229, 298, 427, 428, 484, 547, 559, 569, 596, 607, 634

Sclerotherapy for fluid collections (CPT 49185) is included on these lines only for the treatment of cysts, seromas or lymphoceles which are causing bleeding, infection, severe pain, organ torsion, or organ dysfunction.

GUIDELINE NOTE XXX, FETAL MRI

Line 1

Fetal MRI (CPT 74712-74713) is included on this line only when all of the following conditions are met:

- 1) Abnormalities are found on fetal ultrasound performed by an experienced sonologist which cannot be adequately further evaluated by 2D or 3D ultrasound
- 2) The information obtained by fetal MRI is necessary for decisions about fetal or neonatal therapy, delivery planning, or to advise a family about prognosis
- 3) The fetus is 18 weeks gestational age or older
- 4) The MRI is performed and interpreted at a center with technicians and radiologists who are either trained or highly experienced in fetal MRI and which has appropriate MRI equipment, with a minimum of a 1.5 Tesla magnet

GUIDELINE NOTE XXX, CARDIAC TRANSPLANT GENETIC TESTING FOR TRANSPLANT REJECTION

Lines 245,268

Genetic testing for cardiac transplant rejection (CPT 81595) is included on these lines only for patients at least 1 year post transplant who are without clinical signs of rejection.

GUIDELINE NOTE XXX, UNSPECIFIED CONDUCT DISORDER

Lines 425, 483

ICD-10 F91.9 (Conduct disorder, unspecified) is included on line 425 only for children ages 5 and younger who cannot be diagnosed with a more specific mental health diagnosis. This diagnosis is included on line 483 for older children and adolescents.

GUIDELINE NOTE XXX, BUERGER'S DISEASE

Lines 240, 657

Buerger's disease (ICD-10 I73.1) is included on line 240 only when ulceration or gangrene is present. Otherwise, this diagnosis is included on line 657. T173.1 does not pair on line 240 with revascularization procedures, bypass graft procedures, or angioplasty.

Appendix C New Guidelines

Guideline Note XXX, PLANNED OUT-OF-HOSPITAL BIRTH

Lines 1, 2

Planned out-of-hospital birth is included on these lines when appropriate risk assessments are performed, and the consultation and transfer criteria are followed, and no high risk coverage exclusion criteria exist. Risk assessment should be done initially when planning the location of birth, and updated throughout pregnancy, labor, and delivery to determine if out-of-hospital birth is still appropriate.

The clinical and/or diagnostic assessment of each criterion, with the exception of those marked with an asterisk, is necessary for planned out-of-hospital birth to be included on these lines. (Criteria marked with an asterisks may not be known or not be pertinent if there is no clinical indication for concern and additional diagnostic testing is not indicated.)

An ultrasound is required to rule out certain risk criteria (e.g. multiple gestation, placenta previa, and life threatening congenital anomalies). Certain risk criteria require serial measurements such as fundal height and blood pressure.

If a woman refuses a required clinical or diagnostic assessment, then ascertainment of her risk status is unknowable and she does not meet criteria for coverage for an out-of-hospital birth.

Documentation of continuing appropriate risk assessment and routine prenatal care is required.

High-risk coverage exclusion criteria:

Complications in a previous pregnancy:

Maternal surgical history

- Cesarean section or other hysterotomy
- Uterine rupture
- Retained placenta requiring surgical removal
- Fourth-degree laceration without satisfactory functional recovery

Maternal medical history

- Pre-eclampsia requiring preterm birth
- Eclampsia
- HELLP syndrome

Fetal and placental

- Unexplained stillbirth/neonatal death or previous death related to intrapartum difficulty
- Baby with neonatal encephalopathy
- Placental abruption with adverse outcome

Appendix C

New Guidelines

Complications of current pregnancy:

Maternal

- Induction of labor
- Prelabor rupture of membranes > 24 hours
- Pre-existing chronic hypertension; Pregnancy-induced hypertension with diastolic blood pressure greater than or equal to 90 mmHg or systolic blood pressure greater than or equal to 140 mmHg on two consecutive readings taken at least 30 minutes apart
- Unknown group B strep carrier state
- Lack of informed consent on group B strep prophylaxis, if mother is Group B strep positive.
- Eclampsia or pre-eclampsia
- Anemia – hemoglobin less than 8.5 g/dL
- Thrombocytopenia (platelets <100,000)
- Thrombosis/thromboembolism or other maternal bleeding disorder*
- Maternal mental illness requiring inpatient care*
- Drug or alcohol use with high risk for adverse effects to fetal or maternal health
- Unknown, or positive, syphilis, HIV, or Hepatitis B status
- Current active infection of varicella at the time of labor; rubella infection anytime during pregnancy; active infection (outbreak) of genital herpes at the time of labor*
- Refractory hyperemesis gravidarum*
- Diabetes, type I or II, uncontrolled gestational diabetes, or gestational diabetes controlled with medication

Placental

- Low lying placenta within 2 cm or less of cervical os at term; placenta previa, vasa previa
- Placental abruption/abnormal bleeding
- Recurrent antepartum hemorrhage
- Uteroplacental insufficiency*

Fetal

- Gestational age - preterm or postdates (defined as gestational age < 37 weeks + 0 days or > 41 weeks + 6 days)
- Multiple gestation
- Non-cephalic fetal presentation
- IUGR (defined as fetal weight less than fifth percentile using ethnically-appropriate growth tables, or concerning reduced growth velocity on ultrasound)*
- Oligohydramnios or polyhydramnios*
- Abnormal fetal heart rate/Doppler/surveillance studies
- Blood group incompatibility with atypical antibodies, or Rh sensitization
- Molar pregnancy

Appendix C

New Guidelines

Transfer criteria:

If out-of-hospital birth is planned, certain intrapartum and postpartum complications may necessitate transfer to a hospital to meet coverage criteria. For these indications, an attempt should be made to transfer the mother and/or her newborn; however, imminent fetal delivery may delay or preclude actual transfer prior to birth.

Maternal

- Temperature ≥ 38.0 C
- Maternal infection requiring hospital treatment (e.g. endometritis or wound infection)
- Hemorrhage (hypovolemia, shock, need for transfusion)
- Retained placenta > 60 minutes
- Laceration requiring hospital repair (e.g., extensive vaginal, cervical or third- or fourth-degree trauma)
- Enlarging hematoma
- Bladder or rectal dysfunction

Fetal and uterine

- Repetitive or persistent abnormal fetal heart rate pattern
- Thick meconium staining of amniotic fluid
- Prolapsed umbilical cord
- Failure to progress (as defined by the American Congress of Obstetricians and Gynecologists, March 2014, found at <http://www.acog.org/Resources-And-Publications/Obstetric-Care-Consensus-Series/Safe-Prevention-of-the-Primary-Cesarean-Delivery>)/failure of head to engage in active labor
- Chorioamnionitis or other serious infection (including toxoplasmosis, rubella, CMV, HIV, etc.)
- Uterine rupture, inversion or prolapse

If the infant is delivered out-of-hospital, the following complications require transfer to a hospital for the out-of-hospital birth to meet coverage criteria:

- Low Apgar score (< 5 at 5 minutes, < 7 at 10 minutes)
- Weight less than 5th percentile for gestational age
- Unexpected significant or life-threatening congenital anomalies
- Respiratory or cardiac irregularities, cyanosis, pallor
- Temperature instability, fever, suspected infection or dehydration
- Hyperglycemia/hypoglycemia unresponsive to treatment
- Hypotonia, tremors, seizures, hyperirritability
- Excessive bruising, enlarging cephalohematoma, significant birth trauma
- Vomiting/diarrhea

Appendix C

New Guidelines

Consultation criteria:

Certain high risk conditions require consultation (by a provider of maternity care who is credentialed to admit and manage pregnancies in a hospital) for coverage of a planned out-of-hospital birth to be recommended. These complications include (but are not limited to) patients with:

Complications in a previous pregnancy:

Maternal

- More than three first trimester spontaneous abortions, or more than one second trimester spontaneous abortion
- More than one preterm birth, or preterm birth less than 34 weeks 0 days in most recent pregnancy
- Pre-eclampsia, not requiring preterm birth
- Cervical insufficiency/prior cerclage
- Third degree laceration; fourth-degree laceration with satisfactory functional recovery
- Life-threatening congenital anomalies (unless fatal anomalies with nonresuscitation planned)
- Postpartum hemorrhage requiring additional pharmacologic treatment or blood transfusion
- Retained placenta requiring manual removal

Fetal

- Child with congenital and/or hereditary disorder
- Baby > 4.5 kg or 9 lbs 14 oz
- Shoulder dystocia, with or without fetal clavicular fracture
- Unexplained stillbirth/neonatal death or previous death unrelated to intrapartum difficulty
- Unresolved intrauterine growth restriction (IUGR) or small for gestational age (defined as fetal or birth weight less than fifth percentile using ethnically-appropriate growth tables)
- Blood group incompatibility, and/or Rh sensitization

Complications of current pregnancy:

Maternal

- Inadequate prenatal care (defined as less than five prenatal visits or care began in the third trimester)
- Body mass index at first prenatal visit of greater than 35 kg/m²
- History of maternal seizure disorder (excluding eclampsia)
- Gestational diabetes, diet-controlled
- Maternal mental illness with suspicion for psychosis or potential harm to self or infant under outpatient psychiatric care
- Maternal anemia with hemoglobin < 10.5 g/dL, unresponsive to treatment
- Third-degree laceration not requiring hospital repair
- Laparotomy during pregnancy

Fetal

- Fetal macrosomia (estimated weight >4.5 kg or 9 lbs 14 oz)
- Confirmed intrauterine death
- Family history of genetic/heritable disorders that would impact labor, delivery or newborn care

Appendix D

New Multisector Interventions

MULTISECTOR INTERVENTIONS: TOBACCO PREVENTION AND CESSATION

Benefit coverage for smoking cessation on Line 5 and in GUIDELINE NOTE 4, *TOBACCO DEPENDENCE* is intended to be offered with minimal barriers, in order to encourage utilization. To further prevent tobacco use and help people quit, additional evidence-based policy and programmatic interventions from a population perspective are available here:

- Oregon Public Health Division's Health Promotion and Chronic Disease Prevention Section: Evidence-Based Strategies for Reducing Tobacco Use A Guide for CCOs <https://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Documents/evidence-based-strategies-reduce-tob-use-guide-cco.pdf>
- Community Preventive Services Task Force (supported by the CDC) - What Works: Tobacco Use <http://www.thecommunityguide.org/about/What-Works-Tobacco-factsheet-and-insert.pdf>

The Community Preventive Services Task Force identified the following evidence-based strategies:

Appendix D

New Multisector Interventions

TASK FORCE FINDINGS ON TOBACCO USE

The Community Preventive Services Task Force (Task Force) has released the following findings on what works in public health to prevent tobacco use. These findings are compiled in The Guide to Community Preventive Services (The Community Guide) and listed in the table below. Use the findings to identify strategies and interventions you could use for your community.

Legend for Task Force Findings:  Recommended  Insufficient Evidence  Recommended Against (See reverse for detailed descriptions.)

Intervention	Task Force Finding
Reducing Tobacco Use Initiation	
Increasing the unit price of tobacco products	
Mass media campaigns when combined with other interventions	
Smoke-free policies	
Increasing Tobacco Use Cessation	
Increasing the unit price of tobacco products	
Mass media campaigns when combined with other interventions	
Mass-reach health communication interventions	
Mobile phone-based interventions	
Multicomponent interventions that include client telephone support	
Smoke-free policies	
Provider reminders when used alone	
Provider reminders with provider education	
Reducing client out-of-pocket costs for cessation therapies	
Internet-based interventions	
Mass media – cessation contests	
Mass media – cessation series	
Provider assessment and feedback	
Provider education when used alone	

Intervention	Task Force Finding
Reducing Exposure to Environmental Tobacco Smoke	
Smoke-free policies	
Community education to reduce exposure in the home	
Restricting Minors' Access to Tobacco Products	
Community mobilization with additional interventions	
Sales laws directed at retailers when used alone	
Active enforcement of sales laws directed at retailers when used alone	
Community education about youth's access to tobacco products when used alone	
Retailer education with reinforcement and information on health consequences when used alone	
Retailer education without reinforcement when used alone	
Laws directed at minors' purchase, possession, or use of tobacco products when used alone	
Decreasing Tobacco Use Among Workers	
Smoke-free policies	
Incentives and competitions to increase smoking cessation combined with additional interventions	
Incentives and competitions to increase smoking cessation when used alone	

Visit the "Tobacco Use" page of The Community Guide website at www.thecommunityguide.org/tobacco to find summaries of Task Force findings and recommendations on tobacco use. Click on each topic area to find results from the systematic reviews, included studies, evidence gaps, and journal publications.

The Centers for Disease Control and Prevention provides administrative, research, and technical support for the Community Preventive Services Task Force.

Minutes

HEALTH EVIDENCE REVIEW COMMISSION
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Wilsonville, Oregon
November 12, 2015

Members Present: Som Saha, MD, MPH, Chair; Gary Allen, DMD; Beth Westbrook, PsyD; Wiley Chan, MD; Vern Saboe, DC; Mark Gibson; Leda Garside, RN, MBA; Susan Williams, MD; Gerald Ahmann, MD, PhD; Derrick Sorweide, DO; Mark Gibson; Chris Labhart; Holly Jo Hodges, MD.

Members Absent: Irene Crowell, RPh

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

Also Attending: Kim Wentz, MD, MPH, Brian Nieubuurt (Oregon Health Authority); Erica Pettigrew, MD, Karen Kovak (OHSU); Valerie King, MD MPH, Adam Obley, MD, MPH, Craig Mosbaek (OHSU Center for Evidence Based Policy); Silke Akerson (Oregon Midwifery Council); Sharron Fuchs; Duncan Neilson, MD (Legacy Health); Melissa Cheyney, PhD (OSU); Pam Keuneke (Providence); Laura Jenson (OHSU, American Council of Nurse Midwives).

Call to Order

Som Saha, Chair of the Health Evidence Review Commission (HERC), called the meeting to order and role was called.

Minutes Approval

MOTION: To approve the minutes of the 10-1-2015 meeting as presented. CARRIES 12-0.

Director's Report

Membership

Darren Coffman introduced Gary Allen, DMD, newly appointed dental representative. Dr. Allen is a native Oregonian who served in the military and is currently the dental director at Advantage Dental. He has been involved in many health policy commissions and taskforces over the last two decades and is interested in furthering oral health in Oregon.

At the end of December, some Commissioner's terms are expiring. Mark Gibson (consumer representative) and Dr. Derrick Sorweide (osteopathic physician) are on track to be reappointed directly. Replacement of Drs. Saboe (complementary and alternative medicine) and Ahmann (oncologist) is delayed; incumbents will continue to attend until replaced. Irene Crowell (retail pharmacists) is leaving

the Commission after an employment change but will remain until another pharmacist can be recruited and appointed.

ICD-10-CM update

Staff have been publishing errata to the ICD-10 list implemented October 1, 2015 every 2 weeks since September. When the January 1, 2016 List is published, any errors that are not straightforward and can't be changed by errata may need to wait until the next interim modification date of October 1, 2016. Staff are working with OHA Health Systems to develop a plan to handle these types of issues. One option proposed is to have a March 1, 2016 List update. Another suggestion is to more liberally define what may be included in an errata.

Biennial review changes related to conditions of the back and spine

Implementation of these biennial changes approved by HERC in March are being delayed by OHA leadership to ensure that rate adjustments accurately reflect projected new costs and savings resulting from these changes in benefits. The January 1, 2016 List will reflect all the changes approved with the exception of these involving conditions of the back and spine, which will be notated clearly in a fashion still being developed by staff. Hodges asked that the new list represent only what is being implemented at that time to the degree possible.

Coverage Guidance Topic: Planned Out-of-hospital birth

[Meeting materials](#), pages 63-226

Dr. Cat Livingston gave a brief summation of the evidence presentation and discussion held at the October 1, 2015 meeting ([meeting materials](#) pages 168-173).

Minor changes were made to the box language at the same time the high risk coverage exclusion, transfer and consultation criteria were reorganized into categories according to whether they impact the mother, fetus or placenta.

Jason Gingerich introduced the appointed ad-hoc experts, Duncan Neilson, MD, and Melissa Cheyney, PhD, who assisted the subcommittee as they developed their recommendations, announced their stated conflicts of interest and outlined their role in the process.

Members discussed a mother's known strep Group B status at the time of birth. While very rare, an active infection can pass to the infant with sometimes devastating effects, with a near 50% mortality rate. Some mothers refuse the test and would reject the prophylactic IV antibiotics recommended during labor to prevent the passage of the infection. Cheyney added midwives are currently taking training to allow IV antibiotics used in home births as that has become part of their scope of practice.

Gibson noted the difficulty of demanding tests for Group B strep, stating if a mother wanted to have an out-of-hospital birth that the test should be completed as well as a risk assessment and informed consent about the pros and cons of the prophylaxis treatment. Only then should a mom be able to say no to antibiotics.

Hodges shared, before 1996, every year 7,500 babies were born through the bacteria and would contract the disease, with half of the infants dying of sepsis.

Saha asked how the situation differed between hospital and an out-of-hospital birth. Duncan explained the baby gets the advantages of a neonatal team dedicated to its care 24/7 with at least a 48 hour stay. At home, midwives look in at 24 then 48 hours.

Dr. Val King mentioned that approximately 25% of the Medicaid population are Group B strep carriers.

Dr. Kim Wentz added that death or brain damage can occur in the few hours it takes to get IV antibiotics started in a home setting. She further stated surveillance at home cannot be the same as surveillance in the hospital. She also shared the many instances she's seen where true informed consent isn't documented or where patients did not understand the context of the risks.

MOTION: To approve the VbBS recommendation on the requirement of testing for Group B strep carrier status in order to receive coverage for a planned out-of-hospital birth in the guideline note. CARRIES: 11-1 (Opposed: Hodges)

MOTION: To approve the proposed planned out-of-hospital guideline note for the Prioritized List as recommended by VbBS. Carries 12-0.

MOTION: To include the the requirement of testing for Group B strep carrier status in order to receive coverage for a planned out-of-hospital birth in the coverage guidance. CARRIES: 12-0.

MOTION: To approve the proposed coverage guidance for planned out-of-hospital birth as presented, including the recommendations of EbGS and subsequent amendments. (Abstained: Hodges)

Sharron Fuchs offered testimony, thanking the Commission for taking these steps to help ensure newborn safety in an out-of-hospital setting.

Approved Coverage Guidance:

HERC COVERAGE GUIDANCE

Planned out-of-hospital OOH birth is recommended for coverage for women who do not have high-risk coverage exclusion criteria as outlined below (*weak recommendation*). This coverage recommendation is based on the performance of appropriate risk assessments¹ and the OOH birth attendant's compliance with the consultation and transfer criteria as outlined below.

Planned OOH birth is not recommended for coverage for women who have high risk coverage exclusion criteria as outlined below, or when appropriate risk assessments are not performed, or where the attendant does not comply with the consultation and transfer criteria as outlined below (*strong recommendation*).

High-risk coverage exclusion criteria:

Complications in a previous pregnancy:

Maternal surgical history

- Cesarean section or other hysterotomy

- Uterine rupture
- Retained placenta requiring surgical removal
- Fourth-degree laceration without satisfactory functional recovery

Maternal medical history

- Pre-eclampsia requiring preterm birth
- Eclampsia
- HELLP syndrome

Fetal

- Unexplained stillbirth/neonatal death or previous death related to intrapartum difficulty
- Baby with neonatal encephalopathy
- Placental abruption with adverse outcome

Complications of current pregnancy:

Maternal

- Induction of labor
- Prelabor rupture of membranes > 24 hours
- Pre-existing chronic hypertension Pregnancy-induced hypertension with diastolic blood pressure greater than or equal to 90 mmHg or systolic blood pressure greater than or equal to 140 mmHg on two consecutive readings taken at least 30 minutes apart
- Unknown group B strep carrier state
- Lack of informed consent on group B strep prophylaxis, if mother is Group B strep positive.
- Eclampsia or pre-eclampsia
- Anemia hemoglobin less than 8.5 g/dL
- Thrombosis/thromboembolism/ thrombocytopenia platelets <100,000 , or other maternal bleeding disorder
- Drug or alcohol use with high risk for adverse effects to fetal or maternal health
- Maternal mental illness requiring inpatient care
- Unknown or positive HIV, syphilis or Hepatitis B status
- Current active infection of varicella at the time of labor rubella infection anytime during pregnancy active infection outbreak of genital herpes at the time of labor
- Refractory hyperemesis gravidarum
- Diabetes, type I or II, uncontrolled gestational diabetes, or gestational diabetes controlled with medication

Placental

- Low lying placenta within 2 cm or less of cervical os at term placenta previa, vasa previa
- Placental abruption/abnormal bleeding
- Recurrent antepartum hemorrhage
- Uteroplacental insufficiency

Fetal

- Gestational age - preterm or postdates defined as gestational age < 37 weeks 0 days or > 41 weeks 6 days
- Multiple gestation
- Non-cephalic fetal presentation
- IUGR defined as fetal weight less than fifth percentile using ethnically-appropriate growth tables, or concerning reduced growth velocity on ultrasound
- Abnormal fetal heart rate/Doppler/surveillance studies
- Oligohydramnios or polyhydramnios
- Blood group incompatibility with atypical antibodies, or Rh sensitization
- Molar pregnancy

Transfer criteria:

If out-of-hospital birth is planned, certain intrapartum and postpartum complications may necessitate transfer to a hospital to meet coverage criteria. For these indications, an attempt should be made to transfer the mother and/or her newborn however, imminent fetal delivery may delay or preclude actual transfer prior to birth.

Maternal

- Temperature ≥ 38.0 C
- Maternal infection requiring hospital treatment e.g. endometritis or wound infection
- Hemorrhage hypovolemia, shock, need for transfusion
- Retained placenta > 60 minutes
- Laceration requiring hospital repair e.g., extensive vaginal, cervical or third- or fourth-degree trauma
- Enlarging hematoma
- Bladder or rectal dysfunction

Fetal and uteroplacental

- Repetitive or persistent abnormal fetal heart rate pattern
- Thick meconium staining of amniotic fluid
- Prolapsed umbilical cord
- Failure to progress/failure of head to engage in active labor
- Chorioamnionitis or other serious infection including toxoplasmosis, rubella, CMV, HIV, etc.
- Uterine rupture, inversion or prolapse

If the infant is delivered out-of-hospital, the following complications require transfer to a hospital for the out-of-hospital birth to meet coverage criteria

- Low Apgar score < 5 at 5 minutes, < 7 at 10 minutes
- Weight less than 5th percentile for gestational age
- Unexpected significant or life-threatening congenital anomalies
- Respiratory or cardiac irregularities, cyanosis, pallor
- Temperature instability, fever, suspected infection or dehydration

- Hyperglycemia/hypoglycemia unresponsive to treatment
- Hypotonia, tremors, sei ures, hyperirritability
- Excessive bruising, enlarging cephalohematoma, significant birth trauma
- Vomiting/diarrhea

Consultation criteria:

Certain high risk conditions require consultation by a provider of maternity care who is credentialed to admit and manage pregnancies in a hospital for coverage of a planned out-of-hospital birth to be recommended. These complications include but are not limited to patients with

Complications in a previous pregnancy:

Maternal

- More than three first trimester spontaneous abortions, or more than one second trimester spontaneous abortion
- More than one preterm birth, or preterm birth less than 34 weeks 0 days in most recent pregnancy
- Pre-eclampsia, not requiring preterm birth
- Cervical insufficiency/prior cerclage
- Third degree laceration fourth-degree laceration with satisfactory functional recovery
- Postpartum hemorrhage requiring additional pharmacologic treatment or blood transfusion
- Retained placenta requiring manual removal

Fetal

- Child with congenital and/or hereditary disorder
- Baby > 4.5 kg or 9 lbs 14 o
- Shoulder dystocia, with or without fetal clavicular fracture
- Unexplained stillbirth/neonatal death or previous death unrelated to intrapartum difficulty
- Unresolved intrauterine growth restriction IUGR or small for gestational age defined as fetal or birth weight less than fifth percentile using ethnically-appropriate growth tables
- Blood group incompatibility, and/or Rh sensitization

Complications of current pregnancy:

Maternal

- Inadequate prenatal care defined as less than five prenatal visits or care began in the third trimester
- Body mass index at first prenatal visit of greater than 35 kg/m²
- History of maternal sei ure disorder excluding eclampsia
- Gestational diabetes, diet-controlled
- Maternal mental illness under outpatient psychiatric care with suspicion for psychosis or potential harm to self or infant
- Maternal anemia with hemoglobin < 10.5 g/dL, unresponsive to treatment

- Third-degree laceration not requiring hospital repair
- Laparotomy during pregnancy

Fetal

- Fetal macrosomia estimated weight >4.5 kg or 9 lbs 14 o
- Confirmed intrauterine death
- Life-threatening congenital anomalies unless non resuscitation planned
- Family history of genetic/heritable disorders that would impact labor, delivery or newborn care

¹Risk assessment should be done initially when planning the location of birth and updated throughout pregnancy, labor, and delivery to determine if out-of-hospital birth is still appropriate (*weak recommendation*).

Approved Changes for the Prioritized List of Health Services:

Guideline Note XXX, PLANNED OUT-OF-HOSPITAL BIRTH

Lines 1, 2

Planned out-of-hospital birth is included on these lines when appropriate risk assessments are performed, and the consultation and transfer criteria are followed, and no high risk coverage exclusion criteria exist. Risk assessment should be done initially when planning the location of birth, and updated throughout pregnancy, labor, and delivery to determine if out-of-hospital birth is still appropriate. The clinical and/or diagnostic assessment of each criterion, with the exception of those marked with an asterisk (*), is necessary for planned out-of-hospital birth to be included on these lines. (Criteria marked with an asterisks may not be known or not be pertinent if there is no clinical indication for concern and additional diagnostic testing is not indicated.) An ultrasound is required to rule out certain risk criteria (e.g. multiple gestation, placenta previa, and life threatening congenital anomalies). Certain risk criteria require serial measurements such as fundal height and blood pressure. If a woman refuses a required clinical or diagnostic assessment, then ascertainment of her risk status is unknowable and she does not meet criteria for coverage for an out-of-hospital birth. Documentation of continuing appropriate risk assessment and routine prenatal care is required.

High-risk coverage exclusion criteria:

Complications in a previous pregnancy:

Maternal surgical history

- Cesarean section or other hysterectomy
- Uterine rupture
- Retained placenta requiring surgical removal
- Fourth-degree laceration without satisfactory functional recovery

Maternal medical history

- Pre-eclampsia requiring preterm birth
- Eclampsia
- HELLP syndrome

Fetal and placental

- Unexplained stillbirth/neonatal death or previous death related to intrapartum difficulty
- Baby with neonatal encephalopathy

- Placental abruption with adverse outcome

Complications of current pregnancy:

Maternal

- Induction of labor
- Prelabor rupture of membranes > 24 hours
- Pre-existing chronic hypertension; Pregnancy-induced hypertension with diastolic blood pressure greater than or equal to 90 mmHg or systolic blood pressure greater than or equal to 140 mmHg on two consecutive readings taken at least 30 minutes apart
- Unknown group B strep carrier state
- Lack of informed consent on group B strep prophylaxis, if mother is Group B strep positive.
- Eclampsia or pre-eclampsia
- Anemia – hemoglobin less than 8.5 g/dL
- Thrombocytopenia (platelets <100,000)
- Thrombosis/thromboembolism or other maternal bleeding disorder*
- Maternal mental illness requiring inpatient care*
- Drug or alcohol use with high risk for adverse effects to fetal or maternal health
- Unknown, or positive, syphilis, HIV, or Hepatitis B status
- Current active infection of varicella at the time of labor; rubella infection anytime during pregnancy; active infection (outbreak) of genital herpes at the time of labor*
- Refractory hyperemesis gravidarum*
- Diabetes, type I or II, uncontrolled gestational diabetes, or gestational diabetes controlled with medication

Placental

- Low lying placenta within 2 cm or less of cervical os at term; placenta previa, vasa previa
- Placental abruption/abnormal bleeding
- Recurrent antepartum hemorrhage
- Uteroplacental insufficiency*

Fetal

- Gestational age - preterm or postdates (defined as gestational age < 37 weeks + 0 days or > 41 weeks + 6 days)
- Multiple gestation
- Non-cephalic fetal presentation
- IUGR (defined as fetal weight less than fifth percentile using ethnically-appropriate growth tables, or concerning reduced growth velocity on ultrasound)*
- Oligohydramnios or polyhydramnios*
- Abnormal fetal heart rate/Doppler/surveillance studies
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If out-of-hospital birth is planned, certain intrapartum and postpartum complications may necessitate transfer to a hospital to meet coverage criteria. For these indications, an attempt should be made to transfer the mother and/or her newborn; however, imminent fetal delivery may delay or preclude actual transfer prior to birth.

Maternal

- Temperature \geq 38.0 C
- Maternal infection requiring hospital treatment (e.g. endometritis or wound infection)

- Hemorrhage (hypovolemia, shock, need for transfusion)
- Retained placenta > 60 minutes
- Laceration requiring hospital repair (e.g., extensive vaginal, cervical or third- or fourth-degree trauma)
- Enlarging hematoma
- Bladder or rectal dysfunction

Fetal and uterine

- Repetitive or persistent abnormal fetal heart rate pattern
- Thick meconium staining of amniotic fluid
- Prolapsed umbilical cord
- Failure to progress (as defined by the American Congress of Obstetricians and Gynecologists, March 2014, found at <http://www.acog.org/Resources-And-Publications/Obstetric-Care-Consensus-Series/Safe-Prevention-of-the-Primary-Cesarean-Delivery/>)/failure of head to engage in active labor
- Chorioamnionitis or other serious infection (including toxoplasmosis, rubella, CMV, HIV, etc.)
- Uterine rupture, inversion or prolapse

If the infant is delivered out-of-hospital, the following complications require transfer to a hospital for the out-of-hospital birth to meet coverage criteria:

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- Temperature instability, fever, suspected infection or dehydration
- Hyperglycemia/hypoglycemia unresponsive to treatment
- Hypotonia, tremors, seizures, hyperirritability
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Maternal

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- More than one preterm birth, or preterm birth less than 34 weeks 0 days in most recent pregnancy
- Pre-eclampsia, not requiring preterm birth
- Cervical insufficiency/prior cerclage
- Third degree laceration; fourth-degree laceration with satisfactory functional recovery
- Life-threatening congenital anomalies (unless fatal anomalies with nonresuscitation planned)
- Postpartum hemorrhage requiring additional pharmacologic treatment or blood transfusion
- Retained placenta requiring manual removal

Fetal

- Child with congenital and/or hereditary disorder
- Baby > 4.5 kg or 9 lbs 14 oz
- Shoulder dystocia, with or without fetal clavicular fracture
- Unexplained stillbirth/neonatal death or previous death unrelated to intrapartum difficulty

- Unresolved intrauterine growth restriction (IUGR) or small for gestational age (defined as fetal or birth weight less than fifth percentile using ethnically-appropriate growth tables)
- Blood group incompatibility, and/or Rh sensitization

Complications of current pregnancy:

Maternal

- Inadequate prenatal care (defined as less than five prenatal visits or care began in the third trimester)
- Body mass index at first prenatal visit of greater than 35 kg/m²
- History of maternal seizure disorder (excluding eclampsia)
- Gestational diabetes, diet-controlled
- Maternal mental illness with suspicion for psychosis or potential harm to self or infant under outpatient psychiatric care
- Maternal anemia with hemoglobin < 10.5 g/dL, unresponsive to treatment
- Third-degree laceration not requiring hospital repair
- Laparotomy during pregnancy

Fetal

- Fetal macrosomia (estimated weight >4.5 kg or 9 lbs 14 oz)
- Confirmed intrauterine death
- Family history of genetic/heritable disorders that would impact labor, delivery or newborn care

Value-based Benefits Subcommittee (VbBS) Report on Prioritized List Changes

[Meeting materials](#), pages 228-329

Ariel Smits, reported that the VbBS met earlier in the day, 11-12-2015. The recommendations are mostly about coding changes.

RECOMMENDED CODE MOVEMENT (effective 1/1/16)

- Add or delete various codes related to straightforward changes
- Add the 2016 CPT and HCPCS codes to various lines/Health Systems Division files
- Add various diagnosis codes to a covered line for conditions which might affect young children placed on foster care or who have otherwise had early childhood trauma
- Add the diagnosis code for Buerger's disease to a covered line and remain on an uncovered line with a new guideline specifying that it is only on the covered line for treatment of ulcers and/or gangrene and does not pair with revascularization procedures

RECOMMENDED GUIDELINE CHANGES (effective 1/1/16)

- Modify the nerve block ancillary guideline to add new 2016 nerve block CPT codes
- Modify the non-prenatal genetic testing guideline to incorporate the current figure D1 (which will be removed), to update NCCN references, to add new BRCA testing CPT codes, to add a section recommending genetic counseling and indicated testing of cancer survivors, to add back a deleted section regarding a cystic fibrosis (CF) testing code, to limit CF testing to once per lifetime, and to move a requirement for the least costly/broad testing which would give the required information
- Modify the prenatal genetic testing guideline to allow panel testing for Ashkenazi Jewish patients, to limit CF testing to the 2 CPT codes most commonly used for this, and to add CPT

codes to the chorionic villus sampling (CVS)/amniocentesis entry to better capture the range of codes intended for coverage

- Modify the hyperbaric oxygen guideline to include all the appropriate ICD-10 codes for diabetic ulcers and gangrene
- Add new guidelines to limit use of 2016 CPT codes, including sclerotherapy, fetal MRI, and genetic testing for cardiac transplant rejection
- Add a new guideline to limit the use of a non-specific conduct disorder diagnosis to children 5 and younger
- Modify the acupuncture guideline to remove the requirement for referrals for non-pregnancy related indications, standardize the number of visits for various conditions to 12 (6 for breach fetal presentation), and correct ICD-10 codes for various conditions
- Modify the tobacco cessation guideline to clarify alignment of the recommended services for coverage with ACA requirements
- Add a new multisector intervention statement regarding tobacco cessation practices
- Tobacco cessation and elective surgery
 - Consider requirement of intensive intervention prior to surgery
 - This will come back later for further consideration

MOTION: To accept the VbBS recommendations on Prioritized List changes not related to coverage guidances, as stated. [See the VbBS minutes of 11-12-2015](#) for a full description. Carries: 12-0.

Coverage Guidance Topic: Proton beam therapy

[Meeting materials](#), pages 330-445

Topic tabled until the January 14, 2016 meeting.

Adjournment

Meeting adjourned at 4:15 pm. Next meeting will be from 1:30-4:30 pm on Thursday, January 14, 2016 at Clackamas Community College Wilsonville Training Center, Rooms 111-112, Wilsonville, Oregon.

Behavioral and Physical Health Integration Standards Update

Amy Harris, MPH
Program Analyst
Patient-Centered Primary Care Home Program



Presentation Overview

- Patient-Centered Primary Care Home (PCPCH) Standards Advisory Committee
- Senate Bill (SB) 832
- Committee's work related to integration standards
 - Conceptual framework
 - Proposed Behavioral Health Home (BHH) model
 - Integration standard in the PCPCH model
- Implementation/Next Steps
 - BHH and Certified Community Behavioral Health Clinic (CCBCH) demonstration



PCPCH Standards Advisory Committee

- Established in 2009 following House Bill 2009
- Comprised of diverse stakeholders
- Advises Oregon Health Authority (OHA) on policy and technical expertise for the PCPCH model of care delivery
- Has reconvened in 2012, 2013 and 2015 to refine the PCPCH model



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Senate Bill (SB) 832

- Enacted by the Oregon legislature in 2015
- Charged OHA with developing standards for “achieving integration of behavioral health services and physical health services in Patient-Centered Primary Care Homes and Behavioral Health Homes”
- Included in the scope of work for 2015 PCPCH advisory committee



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Committee Composition

- Given the scope of work for developing integration standards, there was greater representation from behavioral health stakeholder groups, including:
 - National Alliance on Mental Illness (NAMI) Oregon
 - Institute for Behavioral Health Integration
 - Greater Oregon Behavioral Health, Inc. (GOBHI)
 - Western Psychological & Counseling Services
 - Mid-Valley Behavioral Care Network
- Committee met 10 times from June to December 2015

Conceptual Framework: Physical health integration into behavioral health settings

- There is no one door to care
 - Physical and behavioral health needs coordinated or provided no matter what “home” a person chooses
- Transformation as a journey
 - Flexible model that provides an opportunity for practice improvement
- Be our partner over time
 - Standards should apply to organizations that serve a population that would benefit most from ongoing integrated care
- Coordination, co-location, integration

Behavioral Health Home Model

- Proposed BHH model presented to committee
 - Based on the current PCPCH model and the Certified Community Behavioral Health Clinic standards.
 - Informed by SAMHSA-HRSA Center for Integrated Health Solutions Behavioral Health home model
- Six core attributes and standards and measures related to the provision of both physical and behavioral health services; 3 levels or tiers of recognition
- The committee reviewed each measure and recommended revisions were incorporated into the final version of the proposed BHH model

BHH Model Standard 3.C.- Coordination and Integration with Primary Care

- 3.C.1 – (Required for Tier 1 BHH) BHH conducts screenings, links clients to PCPs and coordinates primary care with PCP. BHH has designated staff that serves as bridge between client, BH providers and primary care provider. BHH has a cooperative referral process with primary care providers.
- 3.C.2 – (Required for Tier 2 BHH) BHH is co-located with primary care and provides access to primary care services during a defined percentage of hours that the clinic is open.
- 3.C.3 – (Required for Tier 3 BHH) BHH is integrated with primary care and provides access to primary care services during all clinic hours of operation.

PCPCH Model Standard 3C. - Mental Health, Substance Abuse & Developmental Services

- 3.C.0 – (Must Pass) PCPCH has a screening strategy for mental health, substance use, **and** developmental conditions and documents on-site, local referral resources, **and processes**.
- 3.C.2 - PCPCH has a cooperative referral process with specialty mental health, substance abuse, **and** developmental providers including a mechanism for co-management as needed **or is co-located with specialty mental health, substance abuse, or developmental providers**.
- 3.C.3 - **PCPCH provides integrated behavioral health services, including population-based, same-day consultations by behavioral health providers specially trained in assessing and addressing psychosocial aspects of health conditions.**

* revisions in bold



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Next Steps/Implementation

- SB832 did not provide operational funding for program implementation
- Work will move forward through the Certified Community Behavioral Health Clinic (CCBHC) demonstration project.
- If a program is implemented, the BHH model will need further refinement including the development of technical specifications for each measure



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Certified Community Behavioral Health Clinic (CCBHC) Overview

- *Excellence in Mental Health Act* - improve quality and access to behavioral health services through the creation of federal criteria for Certified Community Behavioral Health Clinics (CCBHC)
- Oregon awarded a 1-year planning grant from SAMHSA to develop an application for a 2-year CCBHC demonstration program
- During planning grant year, Oregon is required to identify clinics meeting the CCBHC criteria
 - Minimum requirement is 2 clinics; one must be rural

Certified Community Behavioral Health Clinic (CCBHC) Overview *(continued)*

- During the planning grant year Oregon is required to develop a prospective payment plan for Medicaid reimbursable behavioral health services provided by CCBHCs
- There are no direct funds available in the grant to assist clinics with meeting the CCBHC criteria, however technical assistance will be available as grant funded positions are filled
- 25 states have been awarded the planning grant; 8 will be selected to participate in the demonstration program

CCBHC Timeline *

- Jan 2016: Requirements for CCBHC participation announced
- Mar 2016: CCBHC application cycle open (online application)
- Mar-May 2016: OHA staff conduct site visits to CCBHC applicants
- June 2016: OHA selects CCBHC applicants for participation in the demonstration program
- Oct 2016: CCBHC demonstration program application due to SAMHSA
- Jan 2017: CCBHC demonstration program begins (if Oregon is awarded the grant)

*Timeline is still in development, this is a draft only.



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CCBHC Criteria and BHH Standards

- Align the CCBHC demonstration with the development of the BHH standards
- To participate in the 2-year CCBHC demonstration, (if Oregon is selected) behavioral health service organizations must:
 - meet the CCBHC criteria developed by SAMHSA
 - meet specific measures in the proposed BHH model (not yet determined)



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Additional Information and Resources

PCPCH Standards Advisory Committee

<http://www.oregon.gov/oha/pcpch/Pages/SAC.aspx>

CCBHC Demonstration Program (including criteria)

<http://www.samhsa.gov/grants/grant-announcements/sm-16-001>

PCPCH or BHH questions, contact amy.harris@state.or.us

CCBHC questions, contact micheal.n.morris@state.or.us



Statewide CCO Learning Collaborative:

Quality and Health Outcomes Committee Meeting
500 Summer Street NE, Salem, OR 97301, Room 137 A-D
January 11, 2016 11:00 a.m. – 12:30 p.m.

Toll-free conference line: 888-278-0296
Participant code: 310477

Behavioral and Physical Health Integration for Persons with Serious Behavioral Health Conditions: Emerging Standards and Strategies

Session Objectives

Participants will:

- 1) Understand emerging standards for Behavioral Health Homes
- 2) Understand key findings from the Behavioral Health Home Learning Collaborative.
- 3) Understand the Certified Community Behavioral Health Clinics planning grant process and the implications for CCOs.

Introduction and reflection (Summer Boslaugh, Dan Reece, Mark Bradshaw, MD) (5 minutes)

1. **Panel discussion: Key Findings from Oregon’s Behavioral Health Home Learning Collaboratives**
(Facilitator: Dan Reece) (45 minutes)

- **The Oregon Behavioral Health Home Learning Collaborative – Rita Moore & Mark Remiker**
Funded by a CMS Adult Medicaid Quality Improvement grant, OHA, ORPRN and OHSU have led a 2-year state-wide behavioral health learning collaborative.
 - *Rita Moore, PhD, OHA Policy Analyst*
Rita Moore has a PhD in Political Science from Columbia University and has been a Policy Analyst in the Office of Health Policy and Analytics of the Oregon Health Authority since 2014. She is project manager for the Behavioral Health Home Learning Collaborative and grant manager for the Adult Medicaid Quality Grant that supports it. She helped staff the Child & Family Well-Being Measures Workgroup that recently completed its recommendations for monitoring and accountability measures across the health care and early learning sectors. She has extensive experience in the US and Europe in program evaluation and policy analysis to support transformation within and across complex systems, focusing in particular on health care, education, and social services.
 - *Mark Remiker, MA, CCRP, Practice Enhancement Research Specialist, Oregon Rural Practice-Based Research Network*
Mark has been part of the Behavioral Health Home Learning Collaborative since its inception in 2014, working with five of the participating 10 sites. Before joining ORPRN, Mark worked as a research coordinator for the Wisconsin Research and Education Network (WREN), a PBRN based at University of Wisconsin-Madison. His past research experience focused on implementing evidence-based guidelines for chronic kidney disease in primary care settings and validating EHR selection criteria for asthma and diabetes. Mark holds a BA in psychology from University of Wisconsin-Eau Claire and a

MA in biological anthropology from Washington State University. He is originally from Milwaukee, Wisconsin.

- **La Clinica Birch Grove Health Center – Kerri Hecox**

La Clinica FQHC, Jackson County Mental Health, On-Track Recovery and the Addictions Recovery Center have collaborated to provide an integrated Behavioral Health Home. The Birch Grove Health Center has been participating in the Oregon BHH Learning Collaborative.

- *Kerri Hecox, MD, LA Clinica FQHC, Medford, OR*

Kerri Hecox earned her medical degree at the University of Colorado and a master's degree in public health policy and administration at the University of North Carolina in Chapel Hill. She completed her residency in family medicine at Moses H. Cone Memorial Hospital in Greensboro, North Carolina, where she received the George T. Wolff Outstanding Resident Award and the Resident Teacher Award. Dr. Hecox serves on the boards of the Family Nurturing Center and the YMCA, and believes that strong family and social connections are keys to well-being. She has extensive training in the recognition and treatment of child abuse and served as the child abuse physician for Jackson County at the Children's Advocacy Center from 2008 to 2013. She currently works at the La Clinica Birch Grove Health Center in Medford as the site medical director.

- **Pearl Street Health – Carrie Suiter**

The Center for Family Development and Springfield Family Medicine, in Collaboration with Trillium Health Plans have created the Pearl Street Health BHH. Pearl Street Health is participating in both the Oregon BHH Learning Collaborative and the Trilliums Integration Incubator Project.

- *Carrie Suiter, BA, CADC Health Services Coordinator, Center for Family Development*

Carrie Suiter has been working in healthcare reform initiatives, specifically with integrating behavioral health in primary care, for the past four years. Carrie Suiter has worked closely with Springfield Family Physicians, Trillium Coordinated Care Organization, Oregon Health and Sciences University, Oregon Rural Practice-Based Research Network, and Oregon Health Authority related to several health integration programs that Center for Family Development is engaged in. Carrie Suiter was awarded a slot within Oregon Health Authority's 2014-2015 Council of Clinical Innovators program highlighting her work in behavioral health integration. Previously, Carrie Suiter was a program coordinator for at-risk youth in the juvenile justice system and provided individual and family based treatment to individual's enrolled in the program.

- **Trillium Integration Incubator Project (TIIP)– Lynnea Lindsey-Pengelly**

In 2014, Trillium approved eight proposals to develop integrated care settings, four of which were behavioral health home sites. TIIP sites used a standards data set and reporting process. They participated in monthly learning sessions. A care management PMPM supported non-billable components of the care model.

- *Lynnea Lindsey-Pengelly, PhD, MSCP, Medical Director for Trillium Behavioral Health and Trillium Community Health Plans*

2. **Small group discussion** – four groups (OHA staff and panel pairs lead each session) (Facilitator: Dan Reece) (20 minutes)

Each CCO shares with the group the answers to the following questions:

- a. How are the health needs of persons with serious behavioral health disorders currently being met in your community?
- b. What are the most promising strategies for your community to better meet the needs of persons with serious behavioral disorders?

3. Group debrief (Facilitator: Dan Reece) (10 minutes)

- Facilitators share general comments
- Group to share any other comments, thoughts, barriers
- Final remarks

4. Next steps (Summer Boslaugh) (5 minutes)

- a. March 14, 2016 QHOC meeting: Transgender Health
- b. Evaluation

LESSONS FROM THE BEHAVIORAL HEALTH HOME LEARNING COLLABORATIVE

CCO Learning
Collaborative

1/11/2016

Rita Moore, PhD

Policy Analyst, Oregon Health Authority
Project Manager, Behavioral Health Home Learning
Collaborative

Mark Remiker, MA

Research Associate, ORPRN



PRESENTATION OBJECTIVES

- Behavioral health homes within Oregon's health system transformation
- Describe the evolution of the Behavioral Health Home Learning Collaborative (BHH LC)
- Share early findings of promising practices

BEHAVIORAL HEALTH HOMES IN OREGON

- Part of broader integration efforts, focused on underserved SMI and SUD sub-populations

“Behavioral health home” means a mental health disorder or substance use disorder treatment organization...that provides integrated health care to individuals whose primary diagnoses are mental health disorders or substance use disorders. Oregon Senate Bill 832 (SB 832-C, 2015)

- PCPCH Standards Advisory Committee recommendations for Behavioral Health Homes
- CCBHCs

RATIONALE FOR BEHAVIORAL HEALTH HOMES

- SMI populations have higher rates of chronic conditions (De Hert 2011)
 - Diabetes rates 2-3x higher than general population
 - Cardiovascular disease 2-3x higher than general population
 - Smoking rates typically 80% or higher (de Leon and Diaz 2005)
- About half of individuals with SUD have chronic conditions (De Alba 2004)
 - Asthma/COPD - 20%
 - Hypertension - 16%
 - Current or past smoking - 89%
- On average SMI populations die 25-30 years earlier than general population, mostly due to high blood pressure, high cholesterol, heart disease and diabetes (Parks 2006, Olfson et al 2015)

RATIONALE FOR BEHAVIORAL HEALTH HOMES

- **SMI populations generate higher costs:**
 - 2x more likely to utilize ER (Hackman et al 2009)
 - 2x more likely to be hospitalized (Crump et al 2014, Crump et al 2013)
 - \$317B estimated economic burden of serious mental illness including health care expenditures, loss of earnings, and disability benefit in 2002 (Insel 2008)
- **Emerging evidence that co-located primary care in mental health settings may reduce costs**
 - Massachusetts study demonstrated 24% reduction in ED visits when NP added to mental health site (Boardman 2006)

RATIONALE FOR BEHAVIORAL HEALTH HOME

- **Setting designed to serve hard to reach, often stigmatized populations**
 - *“Most of the patients that I ...see for the first time...have this naked fear in their eyes, because they have been judged at a lot of other clinics ...because they carry a diagnosis of a drug addiction or mental illness.” (MD)*
 - *“Being in relationship with a patient is as critical as the prescriptions that [clinicians] write.” (MD)*
 - *“You need a medical provider who’s really comfortable hanging out with mental health professionals and talking the mental health lingo, and it’s hard to find the right people who fit [that description] in primary care.” (MD)*

BHH LEARNING COLLABORATIVE

BEHAVIORAL HEALTH HOME LEARNING COLLABORATIVE

- OHA started in 2014, supported by AMQ Grant
- Oregon Rural Practice-based Research Network (ORPRN) provides practice facilitation, data collection and analysis
- 13 behavioral health settings using variety of integration models



CCO REPRESENTATION

- AllCare Health Plan
- FamilyCare, Inc.
- Health Share of Oregon (Tri-County Medicaid Collaborative)
- Jackson Care Connect
- Pacific Source Community Solutions -- Columbia Gorge
- Trillium Community Health Plan
- Umpqua Health Alliance
- Willamette Valley Community Health, LLC

BHH LC ACTIVITIES AND DATA COLLECTION

		Year 1	Year 2	Year 3
Activities	In-person learning sessions	3	2	2
	Practice facilitation for rapid cycle improvement projects; TA for PCPCH/CCBHC status	Monthly	Bi-weekly	Bi-weekly
	Webinars	3	3	2-3
	Care Management Plus Training		√	
Data Collection (Qualitative & Quantitative)	Pre-work: Self-Assessment	√	√	√
	BH Integration Capacity Assessment (BHICA)	√	√	√
	Formal Kick-off meeting		√	√
	Focus Group Interviews		√	
	Process measures (utilization, services, etc.)			√
	Population-level Adult Core Measures			√
	Exit Interviews with project champions	√	√	√

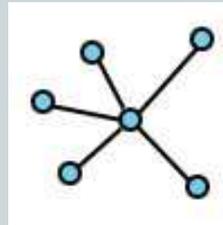
PRACTICE FACILITATION

Practice facilitators from Oregon Rural Practice-based Research Network (ORPRN) worked with agencies on-site

Work with practices “to make meaningful changes designed to improve patients’ outcomes. [They] help physicians and improvement teams develop the skills they need to adapt clinical evidence to the specific circumstance of their practice environment.” (DeWalt, Powell, Mainwaring, et al., 2010)

Support includes:

- Meetings, huddles
- PDSA cycles
- Workflow analysis
- HIT assistance
- Connect practices/share best practices
- Collect and analyze data



BEHAVIORAL HEALTH INTEGRATION CAPACITY ASSESSMENT (BHICA)

Tool includes 5 sections

Understanding your population

Assessing your infrastructure

Identifying the population and matching care

Assessing the optimal integration approach

Financing integration

<https://www.resourcesforintegratedcare.com/tool/bhica>

PROJECT GUIDELINES

SAMHSA core elements for PBHCI

- Screening/referral for needed physical health prevention
- Registry/tracking system for physical health needs
- Care management
- Prevention and wellness support services

CMS adult core quality metrics

- Controlling high blood pressure
- Diabetes: A1C
- BMI
- Smoking cessation

OVERVIEW OF PROJECTS

- **Focus on building capacity and infrastructure**
 - Registries
 - Empanelment
 - Workflows
- **Focus on a specific population/condition**
 - Populations: 2nd generation antipsychotics; dual diagnosis
 - Conditions:
 - Hypertension
 - Diabetes
 - Anxiety
- **Focus on a process**
 - Shared Care Plans
 - Referral Coordination
 - Health Information Exchange

PRELIMINARY FINDINGS

FROM PROGRESS REPORTS, FOCUS GROUPS, KEY
INFORMANT INTERVIEWS

EARLY IMPACT OF BHH

- **Approximately 2,500 clients across 9 participating sites received integrated primary care in last year**
 - **Co-located, integrated clinics**
 - **Part-time, co-located care**
 - **Coordinated care**

WHAT SEEMS TO WORK

Multi-disciplinary team based care is essential

- Co-location helpful, but not sufficient or required
- Top to bottom commitment to new model
- Medical services available every day, especially same day
- Record-sharing, especially common EHR
- Intentional, frequent cross-disciplinary communication
- New workflows on both BH and PH sides
- “Right fit” staff and cross-training

- Regardless of payment model, need panel size sufficient to cover costs of delivering services

- Case management and robust ancillary services to provide whole person care

PRACTICE FACILITATION PROMOTES TRANSFORMATION

- Targeted technical assistance specific to each site
 - Meet practices where they are
 - Especially useful when working with multiple organizations at different stages of integration

- Practice facilitators create space, structure and focus for integration work
 - Define and articulate actionable goals, assess resources, identify organizational strengths and needs
 - Connect agencies with peers and resources as appropriate
 - External observer can help team see unrecognized barriers (e.g., unproductive team dynamics, misaligned or missing procedures or workflow, absence of critical actors in the integration team)

MOVING FORWARD

- **Our sites have laid groundwork over 2 years; just now implementing**
 - State and federal agencies providing funds to expand this model of care
 - Research suggests BHHs can serve SMI/SUD populations better
- **Next Steps for BHH LC: Assess BHH impact and value**
 - Track outcomes
 - Track costs
 - Document promising models of integration
 - Support CCBHC certification effort
- **Request for Collaboration with CCOs:**
 - CCO participation in BHH LC Year 3
 - Share data

Birch Grove Health Center Medford, OR

Kerri Hecox, MD
January 11, 2016

Birch Grove Collaborative

- ▶ Birch Grove Health Center (BGHC) opened March 2014 as new access point FQHC in La Clinica Health System, opened in collaboration with Jackson County Mental Health, and two substance abuse agencies: Addictions Recovery Center and OnTrack
- ▶ Clinic designed to target patient population primarily with substance abuse and/or mental health diagnoses through referrals from partner agencies

Target Population Identification & Referral

- ▶ Substance Abuse: clients of ARC and OnTrack residential facilities are offered to establish primary care at BGHC when enter SA treatment—try to enroll pt at “point of change” in their lives
- ▶ La Clinica Mobile Health Center goes to each residential site 2 times per month for both medical & dental visits
- ▶ JCMH is co-located with BGHC and refers established clients & Crisis Services clients without PCP

Current Patient Base

- ▶ 811 patients with 2.75 full-time providers, one MD, and two mid-levels
- ▶ Substance abuse diagnosis: 319 (33%)
- ▶ Mental health diagnosis: 375 (39%)
- ▶ Dual diagnoses: 464 (48%)*
- ▶ Buprenorphine MAT 72 (7%)

(*includes any SA diagnosis and any MH including anxiety and depression, some duplication in stats)

Patient Demographics

- ▶ AGE < 18: 8%
- ▶ 18–25: 20%
- ▶ 26–64: 69%
- ▶ >65: 2%
- ▶ GENDER 56% female
- ▶ 44% male

- ▶ 48–61% without stable housing (e.g. transitional housing, shelter, living with others or homeless)

Utilization Last 12 Months

- ▶ 2,336 provider visits (average= 3.3 visits/pt/year) *

- ▶ 4,156 visits total , including enabling services (Average= 5.8 visits/pt/year)

(*this includes pts who are seen only once and drop out of care, average # visits for patients who establish slightly higher)

Coding of Established Pt Visits

- ▶ 99212: 2%
- ▶ 99213: 66%
- ▶ 99214: 31%
- ▶ 99215: 1%

Likely undercoding, as not coding based on time. Often significant social service supports/issues

Support/Collaborative Staff

- ▶ Embedded mental health therapist (LCSW) from JCMH works closely with medical providers to provide short-term MH (3 months or less) to clinic patients, and refers back into JCMH when appropriate
- ▶ Case manager for buprenorphine patient
- ▶ CADC in building (not embedded in team) three days/week

Care Coordination

- ▶ Weekly staffings attended by buprenorphine case manager at both residential SA treatment facilities (discuss all mutual clients, not just buprenorphine)
- ▶ Weekly implementation meetings between “on the ground” managerial staff of all agencies (residential facility managers, physical health clinic manager, MD, JCMH outreach coordinator)

Care Coordination

- ▶ Same day clinic access for residential substance abuse facilities for clients in withdrawal for buprenorphine MAT
- ▶ Enhanced access back into treatment for patients who relapse with embedded CADC
- ▶ Faster entry into MH treatment with embedded therapist, therapist able to do short interventions with unstable pts

Patient Barriers that Affect Care

- ▶ STABLE HOUSING—in our population the #1 issue, very high relapse/decompensation without stable living situation
- ▶ Stigma of diagnoses, Lack of trust in health system
- ▶ Employment/education
- ▶ Transportation
- ▶ “Life skills”—knowing how to make/keep appointments, etc.
- ▶ Lack of therapeutic options for family support/couples counseling

Barriers–Care System

- ▶ Cultures of different agencies slow to change, Mental Health in particular with systematic barriers to care coordination (difficult to get psychiatric assessment in timely fashion, not used to collaboration with primary care)
- ▶ Loss of collaboration follow up with transitions of care—patient moves from inpt SA treatment to outpt & communication lost
- ▶ Lack of coordination with legal system/DHS
- ▶ Communication very person–dependent, not systematized (working on this with HIE)

Barriers–Payment

- ▶ Care coordination is not reimbursed, therefore unpaid for a time-intensive process
- ▶ Group visits not reimbursed through medical billing
- ▶ Productivity lower than traditional clinic, longer appointment times needed–risk to sustainability
- ▶ Case management not reimbursed
- ▶ Buprenorphine prior authorization process onerous, intensive staff time
- ▶ High no-show rates with this population, difficulty keeping scheduled appts

Barriers—How We View “Health”

- ▶ Social impact of SA relapse/MH decompensation not factored into medical “cost” e.g.–cost of foster care, incarceration: factors which over long-term affect health
- ▶ Current health metrics reflective of broad population, not as relevant to high-risk subpopulations that we serve (e.g. housing/employment status better predictor of health outcomes than colon cancer screen)

Steps Toward Full Integration

- ▶ Improving coordination with outpatient SA treatment/housing
- ▶ Representation on Jackson County Mental Health Court, patients in MH Court enrolling in Birch Grove
- ▶ Improving coordination with Family Court and DHS
- ▶ Outreach to the Jackson County Work Release Center for care continuity/establishing care for those leaving incarceration



Center for Family Development

Carrie Suiter, Health Services Coordinator
csuiter@c-f-d.org



Collaborating with Trillium CCO

- Start-up funding was provided to begin the process of health integration work (LaneCare Transformation grant dollars prior to TIIP).
- Upon development of TIIP, there was a strong aim for the CCO to be an active participant during the evolutionary process of these TIIP sites.
- Increased support and guidance from the CCO was provided to the sites related to expectations/growth from the community and state.
- CCO provided opportunities to mutually learn from other sites as well as accessing outside resources for further growth in health integration concepts.
- Care Coordination Department: SUPERB!

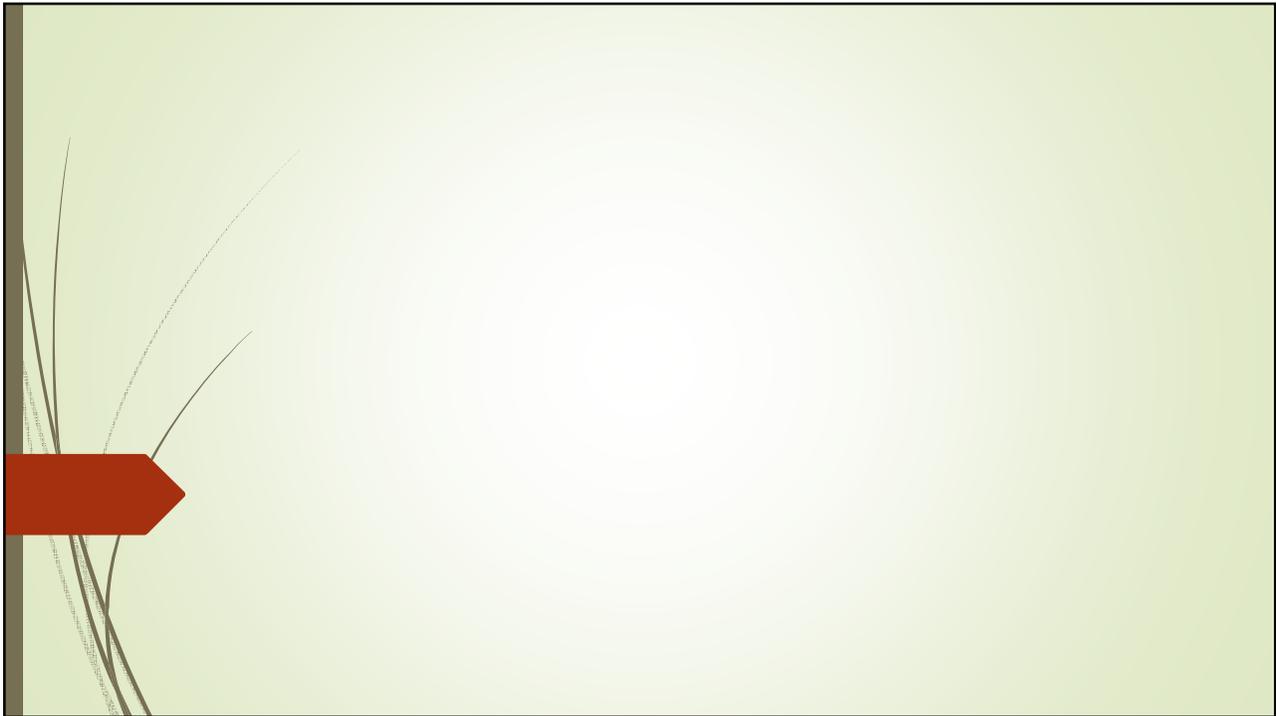
Increased Communication

- Clinicians and health integration programs need to increase communication with the CCO in order to inform what is happening in the community with the members we share.
- Need to create a forum where clinicians in the TIIP sites can voice/listen to the barriers and issues arising in these models of care on a reoccurring basis.
 - Example: Health Behavior track with SPMI population/newly contracted members. (Centennial)
- Quarterly meetings regarding empanelment, issues arising providing necessary treatments for the SPMI population, access issues, etc. (BHH specific)

Payments: Behavioral Health Home (BHH)

- Empanelment sizes & Alternative Payment Model:
 - SPMI patient visits frequently are longer than the typical OV.
 - If empanelment decreased for the provider to meet the patient needs yet the BHH needs an on-site multi-disciplinary team to meet the patient needs, the alternative payment structure needs to match this model of care.





Return on investment, data collection and measuring outcomes

- Return on investment: Lowering emergency department utilization can be impacted by BHH. However, the issue lies that many of the patients/members have significant barriers (e.g. memory issues, substance abuse issues, medical trauma- which results in alienating their healthcare providers or present through avoidant behavior-flight/fight, etc.). Due to these barriers, we have seen that the patients/members struggle with engagement or are needing more time to de-escalate and stabilize in order to address their healthcare needs. Dismissing the patients in a manner to what we are used to is not proving effective.
- Data collection: We believe if we increased our collaboration with our CCO as a BHH, we could work together on impacting the change and outcomes we are seeking for the members we share. The CCO has access to data we do not have.
- Additionally, increased responsivity.



Take-Aways

- Dedication from CCO to guide the TIIP sites has proven to be most helpful.
- Increased collaboration between the CCO and health integration practitioners are requested.
- Redefining success and expectations related to SPMI/SUD population within the health integration sites as well as length of time to review outcomes is proving to be a must when operating in such sites.
- Care Coordination department within Trillium has been very helpful in our process.



Questions?

Thank you!
Carrie Suiter

	<p>Trillium Integration Incubator Project</p> <p> TIIP</p> <p>Oregon - HOC January 11, 2016</p>
 Trillium	

The **TIPP**ing Point
How Little Things Can Make a Big Difference

The tipping point is that magic moment when an idea, trend, or social behavior crosses a threshold, tips, and spreads like wildfire.

- Malcolm Gladwell

 Oregon - HOC JANUARY 11, 2016 2

TIIP – Leadership

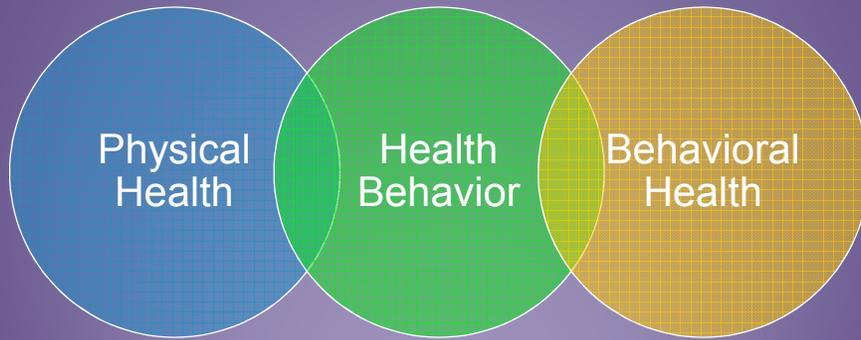
- ▶ Lynnea Lindsey-Pengelly, PhD, MSCP
 - Trillium CHP - CCO
 - Medical Services Director Behavioral Health



What is required to align the work of integrating physical and behavioral health primary care with healthcare transformation



Spectrum of Advanced Care = Requires Integration to Achieve



What is TIIP?

- ▶ Two RFPs issued in Spring 2014 for integrating primary care AND for integrating behavioral health
- ▶ Four submissions for each RFP
- ▶ Review committee met on June 5th 2014 and **ALL** eight projects were chosen
- ▶ Launch date was set for July 1, 2014



Eight TIIP Sites

Primary Care Medical Homes	Behavioral Health Medical Homes
Eugene Pediatrics added Thrive Behavioral Health	Center for Family Development partnered with Springfield Family Physicians
Oregon Medical Group Crescent partnered with Options Counseling, The Child Center and Strong Integrated Behavioral Health	Lane County Behavioral Health moved from co-located model with the Community Health Centers to an integrated model of care
PeaceHealth Medical Group University District and Santa Clara brought in internal BH resources	Peace Health Behavioral Health EASA/Young Adult Hub expanded adding primary care services
Springfield Family Physicians partnered with Center for Family Development	Willamette Family Treatment Services opened an integrated Medical Clinic



What are the essentials...

- ▶ What are the elements that make up an advanced medical home



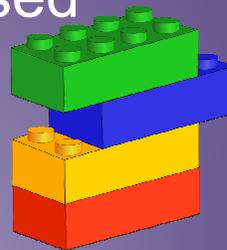
Required Elements

- Financial
- Clinical
- Technological/Data/Measurement



Essential Elements: What is necessary?

1. Medical Home Model
2. Integrated Team-based Care Approach
3. Population Health perspective
4. Data and Outcomes



AND

A supporting payment model APM



Spectrum of Health Care - Physical & Behavioral Health

Primary Care

Day to day non-emergent care for the whole person

Secondary Care

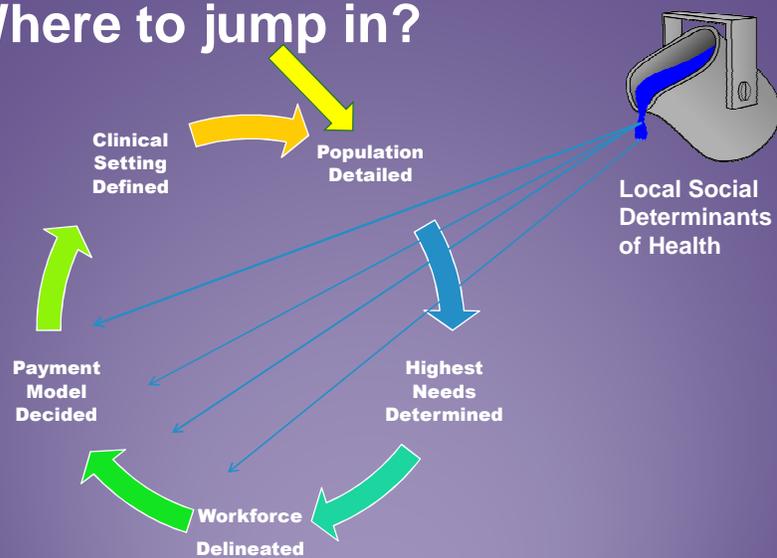
Outpatient Specialty Services

Tertiary Care

Urgent and Emergent Services most often requiring residential and/or inpatient care



Where to jump in?

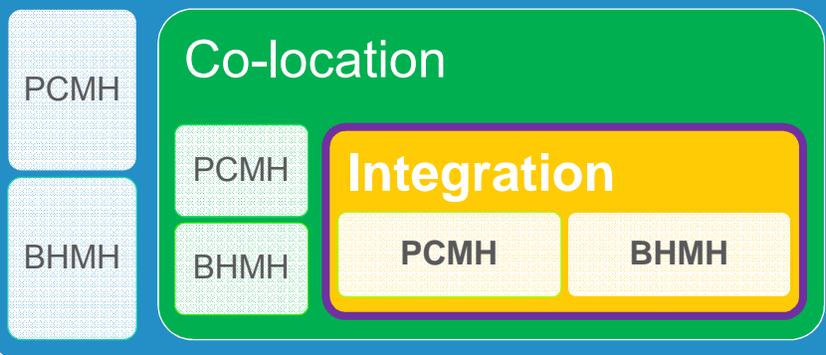


TIIP to TIP TIMELINE



Connecting Physical & Behavioral Health Care

Collaboration



Supporting Early Adoption of Integrated Care

- ▶ Teachable moments
- ▶ Monthly TIIP Learning Collaborative
- ▶ Targeted Learning Opportunities
- ▶ Weekly e-Newsletter TIIP Sheet
 - Brief articles
 - Live Links to research, resources and trainings
- ▶ Experts in PCMH and PCBH
- ▶ TIIP Advisory Committee Community experts
- ▶ Internal learning TIIP Operations



Thank you!

- ▶ drlinpen@trilliumchp.com
- ▶ 541-762-4290



Statewide PIP (Performance Improvement Project)

CCO Members with Diabetes & Schizophrenia or Bipolar Disorder who received both HbA1c test and LDL-C screen (Composite)

The baseline measurement period was 7/1/11 through 6/30/12. Composite: 65.8%

The first re-measurement period was 7/1/13 through 6/30/14. Composite: 66.6%

The second re-measurement period was 7/1/14 through 6/30/15. Composite: 63.7%

 Composite rates are based on claims/encounters: 1) in the OHA MMIS/DSSURS database and 2) CCO revisions provided to OHA in the revision time period that met the measure technical specifications.

For CCOs overall, the PIP composite rate for the second re-measurement was less than the first re-measurement or the baseline. However, for specific CCOs, there were some increases in rates.

Consistency is important when measuring trends. However, due to various circumstances described below, the three measurements differed somewhat from each other in three main areas. First, CCO's were not in existence during the baseline measurement period, second, the time elapsed from the end of the measurement period and data run date varied, and third, the length of time CCOs were allowed to send possible data revisions to OHA varied.

Baseline rates are unique for the following reasons. Since CCOs were not in existence during the baseline measurement period the denominator contains "probable" members derived from predecessor plans and certain (enrollable) FFS clients determined by zip code. Also, HEDIS® continuous enrollment criteria was applied to OHP enrollment overall not by specific CCO. In addition, due to the time that had already elapsed when the PIP was developed, the baseline allowed **10 months** for claims/encounters to enter the data warehouse at the data run date. This was **3 months longer** for claims/encounters to enter the warehouse than the first re-measurement and **6 months longer** than the second re-measurement. This is very important. As more time elapses, more claims/encounters will enter the data warehouse.

Prepared by Susan Arbor, OHA-Health Systems, 12/28/15, Request #3042

First re-measurement rates are unique for the following reasons. As implied above, for the first re-measurement period, seven months elapsed between the end of the measurement period and the data run date. This is 3 months shorter than the baseline and 3 months longer than the second re-measurement.

For the re-measurement periods, OHA determined the patient lists for each CCO. For the first re-measurement period, CCOs were given five weeks to respond with possible revisions. Ten out of sixteen CCOs sent possible revisions. The revisions were accepted if they met the measure technical specifications. The revisions taken as a whole resulted in the overall CCO rate to increase a bit from the initial first re-measurement lists.

Second re-measurement rates are unique for the following reasons. As inferred above, for the second re-measurement period, only 4 months elapsed between the end of the measurement period and the data run date. This is 6 months shorter than the baseline and 3 months shorter than the second re-measurement.

For the second re-measurement period, CCOs were given two weeks to respond with revisions due to timelines needed to write reports for CMS. Four out of sixteen CCOs sent revisions. The revisions taken as a whole resulted in the overall CCO rate to increase slightly from the initial second re-measurement lists.

Summary

The baseline consisted of probable CCO members as the CCOs were not in existence during the baseline measurement period.

Time elapsed between the end of the measurement period and data run date is a major factor of the completeness of the claims/encounters in the OHA MMIS/DSSURS database. Shorter time periods could result in a fewer tests being counted resulting in a lower rates.

CCOs were given more to time respond with data revisions for the first re-measurement period than for the second re-measurement period (due to timelines needed to write reports for CMS.) This could result in fewer tests/screens being counted in the second re-measurement due to claims lags, i.e. the encounter/claim is known to the CCO but has not reached the MMIS/DSSURS database yet.