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. The introduction of PSA testing has significantly reduced the number of men presenting with metastatic cancers, and most prostate cancers are now either localized or locally advanced at diagnosis, with no evidence of spread beyond the pelvis.

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, but is also increasingly being used for men with locally advanced, non-metastatic disease.

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), which have prognostic value. Men newly diagnosed with prostate cancer can initially be stratified into those for whom radical treatment is a possibility and those for whom it is not appropriate. 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. The risk of recurrence of prostate cancer after definitive local treatment is the basis for the stratification of men with localized prostate cancer into risk groups: low, intermediate and high (see Table 1). The recommendations for imaging of localized disease are similarly based on these prognostic groups.

Table 1

Level of risk	PSA		Gleason Score		Clinical stage
Low	< 10 ng/ml	And	≤ 6	And	T1-T2a
Intermediate	10-20 ng/ml	Or	7	Or	T2b
High	>20 ng/ml	Or	8-10	Or	≥ T2c

Imaging may inform the choice between different radical treatments (for example by determining whether the cancer has extended beyond the prostatic capsule). It also assists in the identification of metastatic disease thereby leading to more appropriate treatment options.

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The T-stage involves the assessment of the local extent of the primary tumor in the prostate and its relationship to surrounding structures. Using imaging to distinguish between T1 and T2 cancers does not usually affect treatment. But if radical treatment is being considered, it is important to decide whether a tumor is T2 (confined within the prostate) or T3/T4 (spread outside the prostate). MRI is now the commonly used imaging technique for T-staging men with prostate cancer.

It is also important to know the nodal status of men with localized disease, as the spread of cancer to the pelvic lymph nodes will affect the choice of treatment. Imaging is of some value for N-staging because computed tomography (CT) and conventional MRI rely on size criteria to assess the likelihood of metastatic spread to the lymph nodes. Four studies found that MRI imaging resulted in a change in radiotherapy strategy or surgical procedure (range 9% to 44% of patients). In addition, 23 studies reported a change in staging following MRI, with all reporting up-staging of anywhere from 5% to 100% of patients, and some reporting down-staging (5% to 19%).

Isotope bone scans can be used to look for bone metastases at the time of presentation. The positivity rate for bone scans increases with PSA or Gleason score. Both found that serum PSA level and risk of a positive bone scan were strongly correlated, and one found that men with PSA less than 10 ng/ml were unlikely to have a positive bone scan. Similarly, after biochemical relapse, the chance of finding skeletal metastases is best predicted by the absolute PSA level and the rate of rise.

Magnetic resonance imaging scanning may have some value in those with biochemical relapse being considered for further local therapy by detecting significant extracapsular disease, seminal vesicle involvement or lymphadenopathy which might preclude radical salvage therapy.

Positron-emission tomography (PET) imaging using the radiopharmaceutical agent 18-FDG does not reliably show primary prostate cancer. This is because of the relatively low metabolic activity in tumors which are slow-growing and because the radiopharmaceutical agent accumulates in the bladder, obscuring the prostate. Newer positron-emitting tracers are under evaluation.

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.

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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.

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HEALTH EVIDENCE REVIEW COMMISSION (HERC)

COVERAGE GUIDANCE: ADVANCED IMAGING FOR STAGING OF PROSTATE CANCER

CLINICIAN BOTTOM LINE:

For men with a recent diagnosis of prostate cancer, if knowledge of the T or N stage could affect management, an MRI scan is appropriate. Radionuclide bone scanning is not needed if the cancer is low risk and localized. PET imaging is not indicated.

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Minutes

HEALTH EVIDENCE REVIEW COMMISSION
Meridian Park Hospital
Community Health Education Center Room 117B&C
Tualatin, OR 97062
November 13, 2014

Members Present: Som Saha, MD, MPH, Chair; James Tyack, DMD; Mark Gibson; Leda Garside, RN, MBA; Gerald Ahmann, MD, PhD. Via teleconference: Beth Westbrook, PsyD; Wiley Chan, MD; Vern Saboe, DC.

Members Absent: Susan Williams, MD; Irene Croswell, RPh.

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

Also Attending: Alison Little, MD MPH, OHSU CeBP; Jane Stephen & Deirdra Monroe, Allergan; Carrie Phillipi, MD, OHSU-Doernbecher's; Fiona Clement, University of Californian-SF.

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Call to Order

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

Minutes Approval

MOTION: To approve the minutes of the 8/14/2014 meeting as presented. CARRIES 8-0.

Director's Report

Darren Coffman reported he expects an official announcement of governor appointments for two new Commissioners. Senate confirmation is in December and, if all goes well, seating in January.

He offered appreciation for the good discussion we had at the October retreat and noted a survey is forthcoming to gather feedback and address follow-up questions.

Coffman noted some technical corrections to previously approved coverage guidances:

- Add diabetic education codes to Self-Monitoring of Blood Glucose for Type 1 & 2 Diabetes coverage guidance
- Adjust CPT codes for the Prenatal Genetic Testing coverage guidance

Value-based Benefits Subcommittee (VbBS) Report on Prioritized List Changes
Meeting materials pages 92-107

Ariel Smits and Cat Livingston reported the VbBS met earlier in the day, 11/13/14. Each helped to summarize a number of topics discussed.

Recommended code movement includes:

- Add a number of codes previously found in the DMAP Excluded File to the Prioritized List
- Add recommended placements of the 2015 CPT, CDT, and HCPCS codes
- Add several colonoscopy and sigmoidoscopy codes to several covered lines with gastrointestinal diagnoses
- Remove several procedure codes for arthrocentesis from one or more inappropriate lines, but left on other, covered lines
- Move negative pressure wound therapy procedure codes from the Ancillary File to several covered lines on the Prioritized List
- Move several diagnoses for eye inflammation from one covered line to another
- Delete procedure codes for surgical treatments for atrial fibrillation from one or two covered lines but leave on another covered line
- Add various oral and facial surgery procedures back to the sleep apnea lines for use in patients with craniofacial anomalies only
- Add various straightforward coding changes and corrections

Recommended guideline changes (effective 1/1/15 unless otherwise noted):

- Edit the non-prenatal genetic testing guideline to reflect the new genetic testing CPT placements (noting non-covered codes and placing restrictions on use of some codes). Update the references to expert documents.
- Edit the negative pressure wound therapy guideline, changing it from an ancillary guideline to be a standard guideline as the CPT codes involved were moved from the Ancillary File to the Prioritized List
- Edit the high risk for breast cancer guideline to require women without a history of breast cancer to have services determined based on NCCN requirements and to specify that contralateral mastectomy is a covered service for women with breast cancer
- Delete the denture guideline. DMAP rules will be used to determine eligibility for dentures in the future.
- Edit the intraocular steroid for chronic non-infectious uveitis guideline to allow treatment for intermediate and pan-uveitis as well as posterior uveitis
- Edit the intraocular steroid implants for central retinal vein occlusion to allow treatment for macular edema resulting from branch retinal vein occlusion in certain circumstances
- Edit the sinus surgery guideline to clarify when adenoidectomy is appropriate
- Edit the sleep apnea guideline to clarify when adenoidectomy is appropriate and to specify that oral/facial surgery codes are included on the line only for patients with craniofacial anomalies
- Add a new guideline regarding surgical treatments for atrial fibrillation (effective date pending HERC approval along with related coverage guidance)
- Add a new diagnostic guideline for SPECT imaging (effective date pending HERC approval along with related coverage guidance)

DRAFT

Liver elastoplasty/Fibroscan
Wally Shaffer, MAP Medical Director, commented about the proposed placement of liver elastoplasty (CPT code 91200) on the Non-Covered Table. He explained Fibroscan, a test to see how fibrotic or stiff a liver is to help determine the level of cirrhosis, is part of the hepatitis C drug protocol for OHP recommended by the hepatology group in Portland advising CareOregon. Non-coverage presents a problem, as the hepatologists who informed CareOregon's process see this scan as a way of avoiding a liver biopsy to categorize patient treatment needs. If the clinical picture and the scan are concordant then you can avoid biopsies. Previously, there was no code to bill. OHP is currently set up to accept this protocol, as it accepts the results of the test. Now that there is a code, perhaps it should not be excluded for payment.

Previously this year, the Commission tabled discussion of use of the expensive new hepatitis C drugs. Coffman discussed how the condition falls in the funded region and CCOs have developed their own treatment protocols but the fee-for-service side may need direction. Gibson asserted that CCOs can and should pay for services considered cost-savings; it is in their purview to do so.

After much discussion, the members decided to have further discussion about the technology at their January meeting for potential placement on the October 1, 2015 Prioritized List. Fee-for-service and CCOs may use the code as they see fit until then.

Breast Pumps:
Livingston outlined a new guideline recommended by VbBS covering breast pumps and supplies for postpartum women when a pump is necessary to establish or maintain milk production in order to maximize availability of breast milk to the baby and that lactation support services are covered for pregnant and postpartum women for 6 months postpartum

- The proposed language changed from the VbBS meeting materials.
- Livingston expressed concern that the CCO medical directors might not be in support of the new language, but Holly Jo Hodges expressed full support of the proposal.
- Carrie Phillipi, MD, general pediatrician and lactation consultant, testified about the disparity between private insurance and OHP clients for access to high quality electric breast pumps. She supported the new proposed language.
- Discussion centered on providing tools necessary to support breast-feeding.

The guideline recommended by VbBS was amended to read as follows:

GUIDELINE NOTE 140, BREASTFEEDING PUMPS AND SUPPLIES

Line 3

Breast pumps and supplies are covered for postpartum women when a pump is necessary to establish or maintain milk production in order to maximize availability of breast milk to the baby.

For cases in which there is a medical indication for breast pumps, the pumps should be supplied whenever possible within 24 hours to allow for continued milk production.

Lactation support services (including education and counseling by trained providers) are covered for pregnant and postpartum women (for six months postpartum).

MOTION: To approve the breast feeding guideline as amended: Carries: 8-0.

DRAFT

MOTION: To accept the all other VbBS recommendations on *Prioritized List changes* as stated other than those related to coverage guidances or liver elastography. See the VbBS minutes of 11/13/14 for a full description. Carries: 8-0.

Coverage Guidance Topic: Indications for Hyperbaric Oxygen Therapy (HBOT)
Meeting materials, pages 208-277

Wally Shaffer presented the proposed coverage guidance from HTAS:

- Systemic administration of 100% oxygen in treatment chamber under pressures > 1 atmosphere
- No standard protocol (frequency, duration, dose)
- Considered established treatment for
  - Decompression illness
  - Air or gas embolism
  - Acute CO poisoning
  - Cyanide poisoning
- Primary evidence source was Washington State Health Care Authority Health Technology Assessment Program 2013 report (retrieved from http://www.hca.wa.gov/hta/documents/021513_hbot_final_report.pdf)
  - Supplemented by 9 additional reviews from core sources and two documents provided by expert including Underwater and Hyperbaric Medical Society (UHMS) guideline

Evidence Review

Diabetic non-healing wounds, including foot ulcers

- HBOT effective in improved wound healing and limb salvage (moderate quality of evidence (QOE))
- NICE guideline recommends against provision of HBOT, despite concluding that HBOT results in:
  - Fewer surgical interventions (moderate QOE)
  - Fewer major amputations (low QOE)
  - No difference in minor amputations or improved wound healing up to 6 weeks (moderate QOE)
  - No difference in reduction in ulcer surface area (low QOE)
  - Cost effectiveness analysis ~ £ 25,000

Venous ulcers

- Short-term reductions in wound area; no evidence for complete wound healing or superior results after 30 days (low QOE)
- UHMS does not recommend HBOT

Surgical reconstruction (without grafts and flaps)

- Limited evidence for improvements in wound healing, lower risk of infection for HBOT group (very low QOE)
- UHMS does not address this indication

Compromised grafts and flaps

- Mixed results – Improved healing/graft survival (low QOE)
- UHMS recommends HBOT

Crush injuries

- No difference in healing time, amputations, length of hospital stay; improved complete healing (low QOE)
- UHMS recommends HBOT

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Thermal burns
- Mixed results – no difference in length of hospital stay, additional surgeries, mortality; improvement in healing time (very low QOE)
- UHMS does not address this indication

Refractory osteomyelitis
- No RCTs – mixed results regarding relapse rate, cure (very low QOE)
- UHMS recommends HBOT

Late radiation tissue injury
- Improved outcomes in bone and soft tissue damage; decreased risk of developing osteoradionecrosis following tooth extraction (moderate QOE)
- UHMS does not address this indication

Traumatic Brain injury
- Possible improved outcomes at 1 month, but unclear clinical significance (moderate QOE)
- UHMS does not address this indication

Cerebral palsy
- Mixed results regarding motor function (low QOE)
- UHMS does not address this indication

Multiple sclerosis
- No benefit on MS-related outcomes (moderate QOE)
- UHMS does not address this indication

Migraine and cluster headaches
- HBOT relieves acute migraine attacks; does not prevent attacks, reduce nausea/vomiting or need for rescue meds (low QOE)
- Insufficient evidence for cluster headaches
- UHMS does not address this indication

Sensorineural hearing loss
- Acute: Mixed results - possible benefit if treated within 2 weeks but clinical significance uncertain (low QOE)
- Chronic: No benefit (very low to moderate QOE)
- UHMS does not address this indication

Delayed/non-healing fractures, Bell's Palsy, Malignant Otitis Externa
- No evidence available
- UHMS does not address these indications

Vascular dementia
- HBOT plus donepezil – possible improvement in cognitive function (very low QOE)
- UHMS does not address this indication

Acute coronary syndrome
- Possible decreased mortality, heart muscle damage, MACE, time to relief of pain – high risk of bias (low QOE)
- UHMS does not address this indication

Gas gangrene
- Possible improved survival rates; fewer amputations (low QOE)
- UHMS does not address this indication

Frequency, Duration, or Dose
- Insufficient evidence to determine optimal frequency, duration, or dose for HBOT
  - No studies reported on duration
  - Mixed results from a subgroup analysis on frequency
  - Significant heterogeneity between studies addressing dose

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Harms

- Harms are generally mild and self-limited
- Most common: barotrauma (ear), visual disturbances, oxygen toxicity
- Additional harms mentioned:
  - Severe pulmonary complications
  - Seizures
  - Claustrophobia
  - 2 deaths attributed to HBOT in patients with gas gangrene

Differential Efficacy/Safety and Costs

Differential efficacy and safety

- Insufficient evidence to determine differential effectiveness and safety of HBOT according to sex, race, ethnicity, disability, wound duration, or treatment setting

Costs

- HBOT may be cost-effective under certain conditions, for certain populations and indications (low QOE – most models not robust)

Discussion:

Dr. Enoch Huong, appointed ad hoc expert, stated he had issues with the recommendation of non-coverage for refractory osteomyelitis, sensorineural hearing loss and thermal burns. He understood the conclusion based on the GRADE methodology and the current existing literature but their conclusions *may* be due to methodological issues. He mentioned UHMS asserted that the evidence *does* support those three indications. Huong hoped we can revisit those conditions when we have more data.

For refractory osteomyelitis: Shaffer explained HTAS drew their conclusions from the low evidence quality and mixed results; more quality studies are needed to support coverage.

For thermal burns: Shaffer stated there was similar, low evidence quality and mixed results. It was hard to find the benefit in burn treatment. Huong added a provider must weigh risks with transport from burn center for HBOT at another location; it is usually not practical.

For sensorineural hearing loss: This addressed sudden hearing loss in otherwise healthy people. There are not a lot of effective treatments. The evidence showed decrease in decibel of hearing loss, but the clinical significance was unclear. The WA HTA review found the evidence inconclusive. There was a fair amount of public comment and discussion; details may be found in the public comment disposition.

Shaffer added HTAS accepted HBOT for carbon monoxide poisoning as standard of care, though there was some controversy in the literature and the evidence review found conflict in the trials, stating it is "presumed appropriate for coverage." However, if you take the current best protocols, there is clearer evidence of benefit. It is currently covered on OHP with no evidence of harms.

MOTION: To approve the proposed coverage guidance for Hyperbaric Oxygen Therapy as presented. Carries 8-0.

DRAFT

Approved Coverage Guidance:

HERC COVERAGE GUIDANCE

Hyperbaric oxygen therapy is recommended for coverage (*strong recommendation*) for diabetic wounds of the lower extremities in patients who meet 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.

Hyperbaric oxygen therapy is recommended for coverage for late radiation tissue injury, and gas gangrene (*strong recommendation*).
Hyperbaric oxygen therapy is recommended for coverage for compromised surgical flaps and grafts, and for crush injuries (*weak recommendation*).
Hyperbaric oxygen therapy is not recommended for coverage for cerebral palsy, multiple sclerosis or chronic sensorineural hearing loss (*strong recommendation*).
Hyperbaric oxygen therapy is not recommended for coverage for the following conditions (*weak recommendation*):

- Venous ulcers,
- Surgical reconstruction without flaps and grafts,
- Refractory osteomyelitis,
- Acute traumatic brain injury,
- Brain injuries other than acute traumatic brain injury,
- Migraines and cluster headaches,
- Acute sensorineural hearing loss,
- Delayed or non-healing fractures,
- Bell's Palsy,
- Malignant otitis externa,
- Vascular dementia,
- Thermal burns, or
- Acute coronary syndrome.

The following indications are presumed to be appropriate for coverage but are excluded from these coverage guidance recommendations: air or gas embolism, acute carbon monoxide poisoning, decompression illness and cyanide poisoning.

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Changes for the Prioritized List of Health Services:
The VbBS recommended text from the meeting materials was slightly changed: The wording "is a covered benefit" was changed to "included on these lines" to be consistent with other Prioritized List guideline wording. This does not change the intent of the guideline.

MOTION: To approve the proposed hyperbaric oxygen guideline and corresponding coding changes for the Prioritized List effective January 1, 2015 as shown in Attachment A. Carries 8-0.

Process Discussion

Smits mentioned a recent instance where VbBS reviewed the coverage guidance for Percutaneous Interventions for Cervical Spine Pain recommendation by HTAS, and disagreed with the conclusion. VbBS believed the supporting evidence to be weak, and based on that conclusion, were disinclined to add the service to the Prioritized List. In this case, VbBS expressed concern that HTAS had seemingly relied heavily on expert testimony; HTAS felt this was the best level of evidence they could find, because studies were not particularly helpful.

She asked, in cases like this, when subcommittees disagree, what protocol to follow.

Chan asserted the coverage guidance GRADE table should be robustly detailed, making it easy to follow the originating subcommittee's logic. Gibson and other VbbS members explained they read and understood the GRADE rationale; they just disagreed with the conclusions, feeling that HTAS relied too heavily on expert testimony. VbBS has to decide if the net benefit justifies the cost of covering a condition. Shaffer contended the HTAS/EbGS process includes the addition of ad hoc experts, who fill in gaps of evidence and provide clinical context and info on subpopulations. VbBS does not hear that as strongly.

Saha agreed GRADE should be used by EbGS/HTAS to give rationale for a *coverage guidance*. The VbBS process and products are different; they, like other payers, should use the coverage guidance to make clinical guideline decisions. VbBS must make a cost-benefit analysis across the entire domain of services to cover for the Medicaid population.

Gibson stated that differentiation between subcommittees is good and is expected but cautioned that these decisions are reached in a public process, governed by a political landscape. Careful consideration of dissent is appropriate.

Coffman summarized the discussion by stating there is no direction to VbBS other than to continue to work as they have always done. VbBS will revisit Percutaneous Interventions for Cervical Spine Pain in January, 2015.

Coverage Guidance Updates

Meeting Materials pages 278-324

Livingston explained the policy for reexamining coverage guidances is to scan for new evidence from trusted sources every two years to determine if the evidence has changed substantively. She asked, what we should do if we note studies are coming out soon? Should we start the re-review as soon as that evidence is available or should we wait until the next official review period 2 years hence?

Gibson weighed in, asserting HERC's credibility counts on us using the best, most recent high quality evidence possible, favoring looking at new evidence, to determine if the new evidence meets the threshold for a new review, as soon as we are able.

Saha argued for striking a balance between daily re-scanning evidence and waiting two years. We should strive to stay up-to-date, whether new evidence comes to us from our scans, the news or the provider community.

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Livingston mentioned the topics up for rescanning were completed under our old process, pre-GRADE, and employed a different language structure. She proposed editing guidances to bring the language in-line with our current nomenclature, noting GRADE was not used in those instances. Coffman added each coverage guidance will include a paragraph to explain what evidence was found, if anything, during the rescan and with details listed in a new appendix.

EbGS Coverage Guidance recommended action:

No changes based on updated evidence review:

- Management of chronic otitis media in children
- Indications for planned cesarean section
- Knee arthroscopy for osteoarthritis
- Routine ultrasound in pregnancy
- Non-pharmacologic interventions for treatment-resistant depression, specifically transcranial magnetic stimulation
    - Discussion centered on confusion about the first line of this coverage guidance, which was added as a concession to concerns about under-representing psychotherapy in the role of treating major depressive disorder. Westbrook argued the evidence shows, in publications she reads, the best treatment is a combination of psychotherapy and pharmaceuticals.
    - Commissioners agreed that the actual question being answered by this coverage guidance is specifically focused on *treatment resistant depression*; the lead-in sentence may add confusion as it discusses treating major depressive disorder. This guidance begins once a condition is deemed "treatment resistant."

MOTION: Delete the first sentence of the coverage guidance. CARRIES: 8-0.

Deleted passage: ~~In patients with an episode of major depressive disorder who have failed an initial trial of antidepressants, psychotherapy should be covered.~~

Review once updated trusted sources are available:

- Neuroimaging in dementia
    - WA HTA – expected December 2014
- Advanced imaging for low back pain
    - source report update – expected late 2015/early 2016
- Low Back Pain: pharmacologic interventions
    - source report update – expected late 2015/early 2016
- Low Back Pain: non-pharmacologic, non-invasive interventions
    - source report update – expected late 2015/early 2016
- Percutaneous interventions for low back pain
    - source report update – expected late 2014/early 2015

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HTAS Coverage Guidance recommended actions:

No changes based on updated evidence review:

- Artificial disks
- Lumbar discography
- Hip resurfacing

Review once updated trusted sources are available:

- MRI for breast cancer screening
    - WA HTA expected December 2014; AHRQ report in process – completion date unknown
- Viscosupplementation for osteoarthritis of the knee
    - AHRQ report in process – completion date unknown)

Retreat Follow-up

Staff is creating a work plan and time-line for presentation at the January 8, 2015 meeting that captures many of the action items from the retreat.

Subcommittee restructuring

Coffman reported we are expecting the appointment and potential confirmation of two new Commissioners. Once they are seated, he would like to address the membership inequity in two subcommittees: HTAS and EbGS; EbGS has eight members, while HTAS has four. He would like to work toward an equal balance in terms of membership numbers but also make sure there is a balance between physicians and non-physicians. He will continue to work with leadership after confirmations and hoped Commissioners might be open to switch subcommittees, if that were decided. He mentioned staff would take member's scheduled into account and change meeting dates if necessary.

Coverage guidance review timing

HERC's recent assessment and process improvement project identified an issue with the 2-month gap between the time VbBS reviews a coverage guidance and when HERC completes their review and approvals. This policy seems to cause unnecessary delay. Staff proposed to reduce this delay by having VbBS review the scheduled topic in the morning, and if a recommendation is reached that day, have HERC review both the EbGS/HTAS recommended coverage guidance and VbBS Prioritized List changes on the topic that afternoon. If VbBS does not come to a recommendation, HERC's review would wait for a future meeting.

Motion: To bring coverage guidance recommendation to VbBS and HERC on the same day. CARRIES: 8-0.

Role of experts

Coffman explained staff are working with leadership to look at ways to standardize HERC's use of experts. Areas to address are:

- Defining clear roles
- Early engagement of experts if needed

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- Experts' expectations
- Subcommittees' expectations

Searchable Prioritized List

Staff are creating an interactive web-based tool with a rich keyword search function to aid medical directors (and others) who research condition and treatment pairings and guidelines. Implementing this solution will take a most of 2015.

Clinical bottom line

Livingston reported staff is creating a one-or two-sentence summary for coverage guidances specifically aimed at the provider community.

Public Comment

There was no public comment at this time.

Adjournment

Meeting adjourned at 4:30 pm. Next meeting will be from 1:30-4:30 pm on Thursday, January 8, 2015 at Clackamas Community College Wilsonville Training Center, Rooms 111-112, Wilsonville, Oregon.

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Attachment A

Changes to the Prioritized List Based on Coverage Guidance on Indications for Hyperbaric Oxygen Treatment

Changes reviewed by HERC on 11/13/2014 to become effective as indicated:

1) Add/delete diagnoses on line 336 as shown below effective January 1, 2015:

Line: **336**
Condition: ANAEROBIC INFECTIONS REQUIRING HYPERBARIC OXYGEN (See Guideline Note 107)
Treatment: HYPERBARIC OXYGEN
ICD-9: 040.0, 250.7,250.8,~~526.4~~,526.89,639.0,639.6,670.02-670.04,673.00-673.04,~~686.00-686.09,709.3~~,728.0,730.91-730.99,785.4, 927-929,958.0,990,996.52,996.70-996.79,999.
ICD-10: E11.5x,E11.621,E11.622,E11.628I70.361-I70.369,I70.461-I70.469,I70.561-I70.569,I70.661-I70.669,I70.761-I70.769,I96,M27.8,~~M46.20-M46.39~~,M60.000-M60.005,M60.011-M60.09,M72.6,~~M86.9~~,O08.0,O88.011-O88.03, 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,T66.xxxA-T66.xxxD,T79.0xxA-T79.0xxD, T79.Axx,T80.0xxA-T80.0xxD,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,T85.9xxA-T85.9xxD,T86.820-T86.829
CPT: 98966-98969,99051,99060,99070,99078,99183,99201-99215,99281-99285,99341-99355,99358-99378,99381-99404,99408-99412,99429-99449,99487-99496,99605-99607
HCPCS: G0396,G0397,G0463

2) For the next biennial review List (October 1, 2015 or January 1, 2016 Prioritized List), combine lines 336 and 373, as shown below, with placement of the combined line at line 336.
   a. Diagnoses included on new line as shown below
   b. CPT and HCPCS codes included from both lines
   c. Keep Guideline Note 107 revisions from January 1, 2015 List

Line: **336**
Condition: ~~ANAEROBIC INFECTIONS~~ CONDITIONS REQUIRING HYPERBARIC OXYGEN THERAPY (See Guideline Note 107)
Treatment: HYPERBARIC OXYGEN
ICD-9: 040.0,250.7,250.8,~~526.4~~,526.89,639.0,639.6,670.02-670.04,673.00,673.04, ~~686.00,686.01,686.09,709.3,~~ 728.0, ~~730.91-730.99,~~785.4,927-929,958.0,990,996.52,996.70-996.79, 986,987.0-987.9,993.3, 999.
ICD-10: E11.5x,E11.621,E11.622,E11.628,I70.361-I70.369,I70.461-I70.469,I70.561-I70.569,I70.661-I70.669,I70.761-I70.769,I96, M27.8,~~M46.20-M46.39~~,M60.000-M60.005,M60.011-M60.09,M72.6,~~M86.9,~~O08.0,O88.011-O88.03, 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,T58.01xA-T58.01xD,T58.02xA-T58.02xD,T58.03xA-T58.03xD,T58.04xA-T58.04xD, T58.11xA-T58.11xD,T58.12xA-T58.12xD,T58.13xA-T58.13xD,T58.14xA-T58.14xD,T58.2x1A-T58.2x1D,T58.2x2A-T58.2x2D,T58.2x3A-T58.2x3D,T58.2x4A-T58.2x4D,T58.8x1A-T58.8x1D,T58.8x2A-T58.8x2D,T58.8x3A-T58.8x3D, T58.8x4A-T58.8x4D,T58.91xA-T58.91xD,T58.92xA-T58.92xD,T58.93xA-T58.93xD,T58.94xA-T58.94xD,T59.4x4A-T59.4x4D,T59.93xA-T59.93xD,T66.xxxA-T66.xxxD,T70.3xxA-T70.3xxD,T79.0xxA-T79.0xxD,T79.Axx,T80.0xxA-T80.0xxD,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,T85.9xxA-T85.9xxD,T86.820-T86.829
CPT: 98966-98969,99051,99060,99070,99078,99183,99201-99215,99281-99285, 99291-99404,99341-99355,99358-99378,99381-99404,99408-99412,99429-99449, 99471-99476,99487-99496,99605-99607
HCPCS: G0396,G0397,G0406-G0408,G0425-G0427,G0463

3) Modify GN 107 as shown below effective January 1, 2015:

GUIDELINE NOTE 107, HYPERBARIC OXYGEN

Lines 336~~,373~~ (delete only for biennial review List)

Hyperbaric oxygen is included on these lines only under the following circumstances:

- ~~when paired with ICD-9-CM code 526.4 for osteomyelitis of the jaw only~~
- when paired with ICD-9-CM codes 250.7x and 250.8x/ICD-10-CM E11.5x and E11.621,E11.622,E11.623 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

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- 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-9-CM codes 526.89/ ICD-10--CM codes M27.8 for osteoradionecrosis of the jaw only
- when paired with ICD-9-CM codes 639.0, 670.02, and 670.04/ ICD-10--CM codes O08.0, M60.000-M60.09 only if the infection is a necrotizing soft-tissue infection
- ~~when paired with ICD-9-CM codes 730.10-730.99/ICD-10-CM M46.20-M46.39, M86.9 only for chronic refractory osteomyelitis unresponsive to conventional medical and surgical management~~
- when paired with ICD-9-CM codes 927-929/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-9-CM codes 990/ ICD-10--CM codes T66.xxxA only for osteoradionecrosis and soft tissue radiation injury
- when paired with ICD-9-CM codes 996.52, 996.7/ 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

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