

Minutes

HEALTH EVIDENCE REVIEW COMMISSION
Clackamas Community College
Wilsonville Training Center, Rooms 111-112
Wilsonville, Oregon
January 8, 2015

Members Present: Som Saha, MD, MPH, Chair; James Tyack, DMD; Beth Westbrook, PsyD; Wiley Chan, MD; Vern Saboe, DC; Irene Crosswell, RPh; Mark Gibson; Leda Garside, RN, MBA; Susan Williams, MD; Gerald Ahmann, MD, PhD; Holly Jo Hodges, MD.

Members Absent: None.

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

Also Attending: Chris Labhart, Grant County Commissioner; Val King, MD, Robyn Liu, MD, & Jill Scantlan, OHSU CeBP; Karen Campbell and Jane Stephen, Allergan; Stephen Heitner, MD, OHSU; Mary Hlady, Oregon Physical Therapy Association.

Call to Order

Som Saha, Chair of the Health Evidence Review Commission (HERC), called the meeting to order at 1:35 PM and called role.

Minutes Approval

MOTION: To approve the minutes of the 11/13/2014 meeting as presented. CARRIES 11-0.

Director's Report

Darren Coffman noted the survey is open for coverage guidance topic nominations; we hope to ask for input twice a year. To help align with transformation efforts, Saha asserted he would like to see the CCO Medical Directors weigh in on topic nominations.

Coffman further reported that HERC staff has made the following administrative changes prior to the publication of the January 1, 2015 Prioritized List, meant to represent the intent of the Commission:

1. ICD-9 codes which were located only on deleted lines were identified and the most appropriate placements on the new List were identified.
2. Negative pressure wound therapy guideline wording change: "covered" was changed to "included"
3. Neonatal intensive care CPT codes (CPT 99468 and 99469) were added to all lines with hospital E&M codes (expanded from 25 lines).

4. The E&M codes on the mental health and chemical dependency lines were returned to match the October, 2014 Prioritized List.
5. Intravitreal steroid injections/implants (CPT 67027 and 67028) were added to line 363 CHORIORETINAL INFLAMMATION. At the November, 2014 VBBS meeting, a guideline regarding the use of these codes on this line was approved but the codes themselves were not added to the line in error.

Value-based Benefits Subcommittee (VbBS) Report on Prioritized List Changes
[Meeting materials](#) pages 97-175

Ariel Smits and Cat Livingston reported the VbBS met earlier in the day, 1/8/2015. Each helped to summarize a number of topics discussed.

Recommended code movement includes (effective 10/1/15 unless otherwise noted):

- Add straightforward coding changes and corrections
- Add liver elastography to the covered chronic hepatitis line with a new guideline
- Add diagnosis codes for overweight to the covered and uncovered lines for obesity with a guideline
 - Delete pharmacist management codes and inpatient observation codes from these lines and change the line title to include overweight
- Add diagnosis codes for tonsillar hypertrophy to a covered line
- Delete the diagnosis code for hemangioma of the GI tract from an inappropriate covered line to an appropriate uncovered line
- Add procedure codes for stereotactic body radiation therapy to the lung cancer line with a new guideline
- Add the diagnosis code for retained foreign body in the ear to a covered complications line
- Delete the procedure code for removal of retained tympanostomy tube from several covered lines and added to a covered complications line
- Add the procedure codes for intraocular injections and implants to the diabetic macular edema line for non-steroidal medications only, effective January 1, 2015
- Add procedure codes for wearable cardiac defibrillators to 6 covered lines for cardiac conditions with a new guideline limiting their use

Recommended guideline changes (effective 10/1/15):

- Update the prevention guideline links
- Edit the obesity guideline to include overweight with cardiovascular risk factors as an indication for coverage for intensive nutrition and activity counseling
- Edit the tonsillectomy guideline to specify when unilateral tonsillar hypertrophy are included on an upper, covered line
- Edit the hemangioma guideline to clarify its meaning
- Edit two guidelines referring to tympanostomy tube placements to clarify coverage of removal of these tubes

- Delete the current guideline regarding removal of these tubes as it is no longer necessary
- Add a new guideline specifying when MRI, CT and radionucleotide bone scans are covered for staging of prostate cancer

MOTION: To accept the VbBS recommendations on *Prioritized List changes not related to coverage guidances, as stated. See the VbBS minutes of 1/8/15 for a full description. Carries: 11-0.*

Coverage Guidance Topic: Ablation for Atrial Fibrillation (AF)

[Meeting materials](#), pages 177-214

Robyn Liu, MD of OHSU (family practice & clinical epidemiologist) presented a summary of the evidence:

- Ablation of the AV node or bundle of His in patients with AF results in lower heart rate at 12 months than pharmacologic treatment (moderate strength of evidence {SOE}), although there is no difference in mortality or exercise capacity (low SOE)
- Pulmonary vein isolation (PVI) results in a greater likelihood of maintaining sinus rhythm at 12 months than pharmacologic treatment (high SOE)
 - Most of the evidence for this finding is in patients with AF who have failed at least one antiarrhythmic drug
- PVI also results in lower risk of hospitalization over 12 months (moderate SOE) and improved QOL (moderate SOE), but the evidence is insufficient to assess the impact of PVI on mortality
- The surgical Maze procedure, when done at the time of other cardiac surgery, results in a higher likelihood of maintaining sinus rhythm than not performing the Maze (moderate SOE)
- PVI done at the time of other cardiac surgery results in a higher likelihood of maintaining sinus rhythm than not performing PVI (high SOE), and no apparent difference in all-cause mortality or stroke (low SOE)

Cat Livingston reviewed each element in the GRADE table with the committee, including the EbGS recommendations (see [Meeting materials](#), page 192).

Dr. Eric Stecker, OHSU, and member of EbGS was introduced as the expert on this topic. There were no concerns with the recommendations as presented.

Saha asked why only one of the procedures requires a failure of a course of antiarrhythmic medication. Stecker stated the trials they studied of transcatheter pulmonary vein isolation (PVI) required a failure of antiarrhythmic medication. Saha reiterated that requirement was derived directly from the evidence.

MOTION: To approve the proposed coverage guidance for Ablation for Atrial Fibrillation as presented. Carries 11-0.

Approved Coverage Guidance:

HERC COVERAGE GUIDANCE

AV node ablation is recommended for coverage only in persons with inadequate ventricular rate control resulting in symptoms, left ventricular systolic dysfunction or substantial risk of left ventricular systolic dysfunction. Coverage is recommended only when pharmacological therapy for rate control is ineffective or not tolerated (*weak recommendation*).

Transcatheter pulmonary vein isolation is recommended for coverage for those who remain symptomatic from atrial fibrillation despite rate control medications and antiarrhythmic medications (*strong recommendation*).

Surgical ablation (pulmonary vein isolation or Maze procedure) for atrial fibrillation is recommended for coverage at the time of other cardiac surgery for patients who remain symptomatic despite rate control medications (*weak recommendation*).

MOTION: To approve the proposed ablation procedures for atrial fibrillation guideline and corresponding coding changes for the Prioritized List effective October 1, 2015. Carries 11-0.

Changes for the Prioritized List of Health Services:

Line coding changes:

- 1) Remove procedures used solely for ablation of atrial fibrillation from line 286 LIFE-THREATENING CARDIAC ARRHYTHMIAS
 - a. CPT 33254-33259, 33265, 33266
- 2) Remove 33261 (Operative ablation of ventricular arrhythmogenic focus with cardiopulmonary bypass) from lines 73 ACUTE AND SUBACUTE ISCHEMIC HEART DISEASE, MYOCARDIAL INFARCTION and 193 CHRONIC ISCHEMIC HEART DISEASE
 - a. Arrhythmias being treated by this procedure will be on lines 286 or 350

New guideline note:

GUIDELINE NOTE XXX, ABLATION PROCEDURES FOR ATRIAL FIBRILLATION

Line 350

AV nodal ablation (CPT 33250, 33251, 33261, 93650) pairs with atrial fibrillation (ICD-9 427.31/ICD-10 I48.0, I48.1, I48.2, I48.91) only for patients with inadequate ventricular rate control resulting in symptoms, left ventricular systolic dysfunction or substantial risk of left ventricular systolic dysfunction, when pharmacological therapy for rate control is ineffective or not tolerated

Transcatheter pulmonary vein isolation (93656-93657) pairs with atrial fibrillation (ICD-9 427.31/ICD-10 I48.0, I48.1, I48.2, I48.91) only for patients who remain symptomatic from atrial fibrillation despite rate control medications and antiarrhythmic medications.

Surgical ablation (pulmonary vein isolation or Maze procedure) (CPT 33254-33259, 33265, 33266) only pairs with atrial fibrillation (ICD-9 427.31/ICD-10 I48.0, I48.1, I48.2, I48.91) at the

time of other cardiac surgery for patients who remain symptomatic despite rate control medications.

Coverage Guidance Topic: Nuclear Cardiac Imaging

[Meeting materials](#), pages 306-360

Liu presented a summary of the evidence:

- In asymptomatic individuals at high risk of coronary artery disease (CAD), there is no evidence of benefit for single-photon emission computed tomography (SPECT) screening compared to no screening
- In symptomatic patients at low to intermediate risk of CAD, evidence is conflicting with regard to ability to predict mortality and cardiovascular events
 - one study finding no difference between exercise treadmill test (ETT) and SPECT
 - another finding that stress SPECT and stress Echocardiogram (ECHO) were better predictors than ETT and rest ECHO
- In symptomatic patients at high risk of CAD, evidence is conflicting regarding rates of revascularization in those who undergo ETT compared to SPECT
- Prognostic value does not differ between stress ECHO and stress SPECT
- In populations with mixed risk of CAD, stress SPECT, stress ECHO, stress cardiac MRI perfusion (CMR) and angiography do not differ in subsequent death or patient reported adverse cardiac events
- SPECT and ECHO have similar prognostic abilities, and those tests as well as cardiac MR result in similar proportions of referrals to angiography or change in medical management
- With regard to diagnostic accuracy, SPECT and ECHO have similar sensitivity (83% to 87%) and specificity (64% to 77%)
 - some analyses suggest that ECHO may be slightly more sensitive and SPECT may be slightly more specific
- Extracardiac findings (which may require additional evaluation) are identified rarely with SPECT, and significantly less frequently than cardiac CT (CCTA)
- Comparative evidence on the risks of various testing strategies is very limited, with the only apparent difference being that exercise stress has lower rates of adverse events than pharmacologic stress
- SPECT has the highest radiation exposure of any testing strategy at a range of 7 to 30 mSv
- SPECT appears to perform similarly in
 - men and women
 - Caucasians and African-Americans
 - normal weight and obese patients
 - patients with and without diabetes
 - patients with and without hypertension
- Evidence is conflicting regarding the economic value of ETT compared to SPECT
- In one RCT, direct referral to angiography was a lower-cost strategy than SPECT, ECHO, or cardiac MR
- The evidence pertaining to PET is insufficient to draw conclusions for any outcome.

Cat Livingston reviewed each element in the GRADE table with the committee, including the EbGS recommendations (see [Meeting materials](#) page 330).

The members discussed a desire to make the coverage guidance title more specific and settled on, “Nuclear Cardiac Imaging for screening, diagnosis or risk stratification of coronary artery disease”.

Appointed ad hoc expert Dr. Steven Heitner, OHSU, participated by phone. He offered his agreement with the proposed coverage guidance language.

Average costs, depending on setting (in-patient or outpatient), were suggested be in the following ranges:

- SPECT \$1,000-3,000
- Stress ECHO \$500–1,500

The subcommittee concluded the tests are equivalent in efficacy, but ECHO is less expensive and has less exposure to radiation. If ECHO is not available (for various reasons), SPECT is a reasonable alternative.

The VbBS recommendations were presented (see [Meeting materials](#) page 349), which would make no change in current non-coverage of cardiac PET scan (CPT 78459, 78491 & 78492), but add entries to the non-covered table for these CPT codes. It is further recommended to keep SPECT on the Diagnostic List, adopting the new diagnostic guideline for SPECT imaging (see below).

Heitner added SPECT is used for some other purposes, such as for determining viability without stress.

MOTION: To approve the proposed coverage guidance for Nuclear Cardiac Imaging for screening, diagnosis or risk stratification of coronary artery disease as amended. Carries 11-0.

Approved Coverage Guidance:

HERC COVERAGE GUIDANCE

PET is not recommended for coverage for screening or diagnosis of coronary artery disease (CAD) (*strong recommendation*).

Single photon emission computed tomography (SPECT) is not recommended for coverage for screening for CAD in asymptomatic patients (*strong recommendation*).

Stress SPECT is not recommended for coverage for diagnosis or risk stratification of CAD (*strong recommendation*)—except in patients for whom stress ECHO is contraindicated, is unavailable or would provide suboptimal imaging.*

**i.e. pre-existing cardiomyopathy, baseline regional wall motion abnormalities, left bundle branch block, paced rhythm, unsuitable acoustic windows due to body habitus, inability to utilize*

dobutamine in a setting where exercise is not possible or when the target workload is not achievable.

MOTION: To approve the proposed diagnostic SPECT guideline and coding change recommendations for the Prioritized List as proposed. Carries 11-0.

Changes for the Prioritized List of Health Services:

New guideline note:

DIAGNOSTIC GUIDELINE DXX, SPECT

SPECT (CPT 78451, 78452) is not covered for screening for coronary artery disease in asymptomatic patients.

Stress SPECT (78451, 78452 in conjunction with stress testing) is only covered for diagnosis or risk stratification of coronary artery disease when a stress ECHO is contraindicated, is unavailable or would provide suboptimal imaging (i.e. pre-existing cardiomyopathy, baseline regional wall motion abnormalities, left bundle branch block, paced rhythm, unsuitable acoustic windows due to body habitus, or inability to exercise with inability to utilize dobutamine).

Coverage Guidance Topic: Advanced Imaging in Staging of Prostate Cancer

[Meeting materials](#), pages 267-305

Liu presented a summary of the evidence:

- When determining when and how to image an individual, men with localized prostate cancer should be stratified into risk groups based on:
 - PSA level (blood test)
 - Gleason score (biopsy)
 - Clinical staging of cancer
- There is insufficient evidence to support the routine use of CT of the pelvis in men with low- or intermediate-risk localized prostate cancer
 - CT is considered inferior to MRI in this clinical situation
- The evidence is insufficient to determine whether staging with MRI improve outcomes in men with prostate cancer
- There is low strength of evidence (SOE) that staging with MRI can result in change in management and a very low SOE that MRI results in up-staging or down-staging a highly variable proportion of patients
- Most studies found staging with MRI more sensitive than staging with DRE or TRUS, but not consistently more specific or accurate
- Two systematic reviews on role of radioisotope bone scans in staging of newly diagnosed prostate cancer.
 - One review found that serum PSA level and risk of a positive bone scan were strongly correlated.

- The other review concluded that PSA level was the best means of identifying those at risk of a positive bone scan and that men with PSA < 10 ng/ml were unlikely to have a positive bone scan.
- No direct evidence about influence of radioisotope bone scans on timing of systemic treatment or frequency of clinical follow-up in men for whom radical treatment is not intended.
 - Two small case series found extensive disease on bone scan was an adverse prognostic factor for survival.
 - There is observational evidence that extensive disease on bone scan is an independent risk factor for spinal cord compression in men without functional neurological impairment.
- There is insufficient evidence to support the use of PET for any stage of prostate cancer

Dr. Wally Shaffer reviewed each element in the GRADE table with the committee, including the HTAS recommendations (see [Meeting materials](#) page 283).

Saha wondered how HTAS got to a strong recommendation with low quality of evidence. Members had a brief discussion about the limitations for the current algorithm. A revised algorithm developed by Chan will be discussed at the HERC meeting in the afternoon. The coverage guidance as proposed was crafted using the currently approved methodology/algorithm. Saha clarified the algorithm is a tool to guide us but we need not rigidly subscribe to its conclusion.

Members discussed aspects of the proposed coverage guidance, including what defined “low” and “intermediate” risk. Shaffer added the Choosing Wisely topic that prompted this coverage guidance did not differentiate between risk levels. Liu agreed and stated the NICE evidence specified only “low” or “not low” risk.

The members spent time working on rewording the proposed coverage guidance (original proposal found in [Meeting materials](#) page 275).

Ahmann mentioned ultrasound works well for staging.

VbBS recommendations were presented, which is to not add PET scans for staging of prostate cancer to the Prioritized List, but to add a diagnostic guideline note (see below) on the use of CT, MRI and radionuclide scans (see also [Meeting materials](#) page 299).

Saha reminded the members that the VbBS coverage decision does not have to match the HERC proposed coverage guidance. It was noted that VbBS added a statement about defining low risk as PSA less than 10 at their meeting earlier in the day. There was minimal discussion.

MOTION: To approve the proposed coverage guidance for xxx as amended or as presented. Carries 10-0. Abstained: Ahmann)

Approved Coverage Guidance (shown in new format begun with this topic):

HERC Coverage Guidance

To determine risk status and treatment options, prostate cancer clinical staging that includes PSA level and prostate biopsy with Gleason score is recommended for coverage.

MRI is recommended for coverage for men with histologically proven prostate cancer if knowledge of the T or N stage could affect management. (*weak recommendation*)

CT of the pelvis is not recommended for coverage in men with low- to intermediate-risk prostate cancer (*strong recommendation*), unless MRI is contraindicated.

Radionuclide bone scanning is not recommended for routine coverage in men with low-risk prostate cancer. (*weak recommendation*)

Radionuclide bone scanning is recommended for coverage when hormone therapy is being deferred (through watchful waiting) in asymptomatic men who have high or intermediate risk prostate cancer. (*weak recommendation*) Risk levels are defined in Table 1.

PET imaging is not recommended for coverage in prostate cancer. (*strong recommendation*)

MOTION: To approve the proposed diagnostic guideline” Advanced Imaging for Staging of Prostate Cancer” for the Prioritized List as proposed. Carries 11-0.

Changes for the Prioritized List of Health Services:

New guideline note:

DIAGNOSTIC GUIDELINE DXX, ADVANCED IMAGING FOR STAGING OF PROSTATE CANCER

MRI is covered for men with histologically proven prostate cancer if knowledge of the T or N stage could affect management. CT of the pelvis is covered only when MRI is contraindicated.

Radionuclide bone scanning is not covered in men with low risk prostate cancer. Low risk is defined as PSA < 10 ng/ml and Gleason score ≤ 6 and clinical stage T1-T2a.

Coverage Guidance Topic: Percutaneous Interventions for Cervical Spine Pain

[Meeting materials](#), pages 215-266

Liu presented a summary of the evidence:

- There is no evidence of benefit of epidural steroid injections (ESI) compared with placebo injections for neck pain in patients either with or without disc herniation and radiculitis, post-surgery syndrome or cervical spinal stenosis
- Epidural injections appear to be superior to intramuscular injections in patients with disc compression and radiculitis

- Conclusions regarding the efficacy of ESI from other sources are mixed, but suggest if they are effective, it is likely only short-term
- One study suggests that ESI may result in a decreased risk of cervical surgery
- There is no apparent difference in efficacy based on differing approaches for administering cervical epidural steroids
- There is limited evidence of benefit of radio frequency (RF) neurotomy in patients with confirmed facet joint pain
- Major complications are rare following injections into the cervical spine but can include:
 - A life-threatening generalized anaphylactic reaction
 - Grand-mal seizure
 - Dural and subarachnoid puncture
 - Paralysis
 - Death
- Expert opinion in one review notes multiple reports of potentially catastrophic complications using a transforaminal injection approach and recommends against their use, despite similar or better efficacy compared to intralaminar approaches
- An outbreak in fungal infections and deaths that resulted from the use of contaminated steroid preparations when delivering epidural steroid injections occurred in 2012
- Minor complications are more common but are generally transient in nature
- No major complications of RF neurotomy have been reported

Dr. Wally Shaffer reviewed each element in the GRADE table with the committee, including the HTAS recommendations (see [Meeting materials](#) page 235).

Discussion focused on the recommendation to cover ESI. Saha noted there is low to very-low evidence that it does not work.

Gibson spoke about VbBS's discussion earlier in the day a motion to not cover ESI for OHP failed to pass by a margin of 4 yes, 1 no and 3 abstentions (HERC bylaws stipulate a motion must receive support from a majority of the members present to pass). The controversy was over the quality of evidence used to justify a coverage recommendation. Gibson stated if we had accepted this low quality of evidence during the viscosupplementation of the knee topic, then that service would now be covered. Gibson asserted his convictions we should be consistent in our decisions and acceptance of quality of evidence.

Saha and Gibson clarified, historically, for VbBS to add a service to the Prioritized List, there must be clear evidence of benefit. To remove a service, there must be clear evidence of no benefit. To move a service from the Ancillary File (where ESI now resides) to the Prioritized List would require the same level of evidence as if it were a new service, that is to say, there must be clear evidence of benefit.

Further discussion on the coverage guidance was tabled until VbBS completes its back pain line reorganization work.

Retreat Follow-up:

Coffman reported on subcommittee changes. Given the imbalance of representation and physical members between the subcommittees, he stated Saha will move from EbGS to HTAS

and chair HTAS temporarily. Pending new member Labhart has accepted an assignment to HTAS. Coffman is in talks with other members involving movement but nothing is official.

Two CCO medical directors have volunteered to work on subcommittees:

- Dr. Mark Bradshaw, All Care for HTAS
- Dr. Katherine Leukin, WVP Health Authority for EbGS

MOTION: To appoint Bradshaw and Leukin to HTAS and EbGS respectively. Carries: 11-0.

The work plan and algorithm revision discussions were tabled due to time constraints.

Public Comment

There was no public comment at this time.

Adjournment

Meeting adjourned at 4:40 pm. Next meeting will be from 1:30-4:30 pm on Thursday, March 12, 2015 at Clackamas Community College Wilsonville Training Center, Rooms 111-112, Wilsonville, Oregon.

Value-based Benefits Subcommittee Recommendations Summary For Presentation to: Health Evidence Review Commission in January 2015

For specific coding recommendations and guideline wording, please see the text of the 1-8-2015 VbBS minutes.

RECOMMENDED CODE MOVEMENT (effective 10/1/15 unless otherwise noted)

- Make various straightforward coding changes and corrections
- Add liver elastography to the covered chronic hepatitis line with a new guideline
- Add diagnosis codes for overweight to the funded and unfunded lines for obesity with a guideline. Remove pharmacist management codes and inpatient observation codes from these lines. Change line titles to include overweight.
- Add diagnosis codes for tonsillar hypertrophy to a funded line
- Remove the diagnosis code for hemangioma of the GI tract from an inappropriate funded line to an appropriate unfunded line
- Added procedure codes for stereotactic body radiation therapy to the lung cancer line with a new guideline
- Add the diagnosis code for retained foreign body in the ear to a funded complications line
- Remove the procedure code for removal of retained tympanostomy tube from several funded lines and add it to a nonfunded complications line
- Add the procedure codes for intraocular injections and implants to the diabetic macular edema line for non-steroidal medications only, effective January 1, 2015
- Add the procedure codes for wearable cardiac defibrillators to six funded lines for cardiac conditions with a new guideline limiting their use

ITEMS CONSIDERED BUT NO RECOMMENDATIONS FOR CHANGES MADE

- No recommendation to add fever of unknown origin (FUO) and prostate cancer staging as indications for PET scan
- No recommendation to add catheter thrombolysis for treatment of pulmonary embolism
- No recommendation to remove codes for cervical epidural steroid injections from funded lines

RECOMMENDED GUIDELINE CHANGES (effective 10/1/15 unless otherwise noted)

- Various straightforward guideline note changes
- Update links to external documents in the prevention guideline note
- Modify the obesity guideline to include overweight with cardiovascular risk factors as an indication for coverage for intensive nutrition and activity counseling
- Modify the tonsillectomy guideline to specify when unilateral tonsillar hypertrophy is included on an upper, funded line
- Modify the hemangioma guideline to clarify its meaning

- Modify two guidelines referring to tympanostomy tube placements to clarify coverage of removal of these tubes. Delete the current guideline regarding removal of these tubes.
- Add a new guideline specifying when MRI, CT and radionuclide bone scans are covered for staging of prostate cancer

DRAFT

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

Members Present: Kevin Olson, MD, Chair; James Tyack, DMD; David Pollack, MD; Susan Williams, MD; Mark Gibson; Irene Crowell, RPh; Holly Jo Hodges, MD; Laura Ocker, LAc.

Members Absent: None

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

Also Attending: Wally Shaffer, DMAP; Mary Hlady, PT, Cathy Zarosinsky, Nora Stern and Susan Bamberger, OR PT Association; Vern Saboe, DC, OR Chiropractic Association; Karen Campbell and Jane Stephen, Allergan; Catriona Buist; Valerie King, Jill Scantlan, and Robyn Liu, Center for Evidence Based Policy (CEbP).

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

The meeting was called to order at 8:35 am and roll was called. Minutes from the November, 2014 VbBS meeting were reviewed and approved. Staff will post the minutes on the website as soon as possible.

Smits reviewed multiple administrative coding changes done by staff before the publication of the January 1, 2015 ICD-9/ICD-10 Prioritized List. These changes did not require a vote and there was no discussion.

Smits also reported on further staff research into transverse abdominis plane (TAP) blocks. These blocks were reviewed as part of the 2015 CPT code review. There was concern that high cost catheters might be used for these blocks; staff was directed to look into this and compose a guideline if this was the case. Staff reviewed this topic and found that these blocks are done with low cost catheters or simple injections and therefore no guideline note is needed.

➤ **Topic: Straightforward/Consent Agenda**

Discussion: There was minimal discussion about the consent agenda items.

Recommended Actions:

- 1) Change the title of GN 117 to INTRAOCULAR STEROID IMPLANTS FOR ~~CENTRAL~~ RETINAL VEIN OCCLUSION
- 2) Add 50820 (Ureteroileal conduit (ileal bladder), including intestine anastomosis (Bricker operation)) to line 274 CANCER OF BLADDER AND URETER
- 3) Remove 54408, 54410, 54411, 54416, 54417 (Removal of penile prosthesis components) from lines 290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT and 413 GENDER DYSPHORIA
- 4) Remove 54406 and 54415 (Removal of penile prosthesis components) from line 413 GENDER DYSPHORIA
- 5) Move V49.71 (Below knee amputation status) from line 534 DEFORMITIES OF UPPER BODY AND ALL LIMBS to line 381 DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE LEVEL OF INDEPENDENCE IN SELF- DIRECTED CARE CAUSED BY CHRONIC CONDITIONS THAT CAUSE NEUROLOGICAL DYSFUNCTION
- 6) Add 28446 (Open osteochondral autograft, talus) to line 359 RHEUMATOID ARTHRITIS, OSTEOARTHRITIS, OSTEOCHONDRITIS DISSECANS, AND ASEPTIC NECROSIS OF BONE
- 7) Amend GN 106 Preventive Services as shown in Appendix A
- 8) Add inpatient E&M codes to Line 313 AUTISM SPECTRUM DISORDERS
- 9) Remove 96127 (Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument) from all current Prioritized List lines
- 10) Advise DMAP to place 96127 on the Ancillary List

MOTION: To approve the recommendations stated in the consent agenda. CARRIES 8-0.

➤ **Topic: Liver Elastography**

Discussion: Smits introduced a summary document. There was some discussion about limited availability of liver elastography in non-Portland metro areas of the state. There was discussion about whether the evidence supported the staff recommendation to adopt liver elastography for those cases in which it would replace liver biopsy for determination of eligibility for medications for hepatitis C. Smits indicated that the evidence supported use of the test for

distinguishing cirrhosis from non-cirrhosis, but not for distinguishing less severe levels of liver damage/disease. The current guideline does not specify that this would be the major use of this test; however, current fee-for-service PA criteria under consideration only allows use of hepatitis C medications in those patients with cirrhosis. These PA criteria may change and the test would be allowed to be used to differentiate other stages of liver disease with the current guideline wording. The group felt that the groups making these PA criteria would be reviewing this use and leaving the guideline as written would allow faster changes in prescribing for hepatitis C drugs as evidence changes. Olson felt that the staff recommendation achieved the triple aim of lower cost, better care, and better outcomes.

Hodges recommended addition of commercial insurance guideline wording limiting use of liver elastography to every 6 months and not within 6 months of a liver biopsy. This change was accepted.

Recommended Actions:

- 1) Place liver elastography (CPT 91200) on line 202 CHRONIC HEPATITIS; VIRAL HEPATITIS)
- 2) Adopt a new guideline for line 202 as shown in Appendix B

MOTION: To recommend the code placement as presented and adopt the new guideline note as amended. CARRIES 8-0.

➤ **Topic: Biennial Review: Low Back Pain Line Revisions**

Discussion: Smits reviewed the recommendations from the Low Back Pain Task Force. VbBS members asked staff about the origin/rationale for the old back pain line structure. Coffman replied that when these lines were created, the HSC felt that most patients with back pain would get better without treatment, so treatment was not necessary and two of the lines therefore were scored in the non-funded region. The old line structure was created prior to the addition of guidelines to the Prioritized List. At the time of line creation, there was no concern for the risks of opiate therapy. The current Back Pain Line Reorganization Task Force is the first multi-specialty group to specifically look at coverage of back pain and the evidence to support various treatments.

Staff reviewed that there is currently a disconnect between the coverage guidances that have been adopted that recommend various treatments for back pain and the current back pain line structure. The treatments recommended in the coverage guidance are not available to most patients due to the low prioritization of their diagnosis.

Hodges spoke of the OHP Medical Directors' concern for the increased cost for the coverage in the new back pain line recommendations, and for the ability for plans in more rural areas to access the types of care included on the proposed medical line. For example, acupuncturists may not be on a smaller health plan panel. Staff indicated that the new line structure, if adopted, would not take effect until January 1, 2016. There will be actuarial review and the increased costs should be factored into the contracts with the CCOs. There was discussion that interventions such as acupuncture can be one option, but may not be required. Also, acupuncture is currently covered for many conditions on the Prioritized List and the plans have not found this coverage to be an issue. Hodges requested that staff work with the task force to change the guideline wording to indicate that modalities such as yoga are available, but not required.

Testimony was heard from Vern Saboe, DC, representing the Oregon Chiropractic Association (Dr. Saboe is also a HERC member). Dr. Saboe testified that the chiropractic association recommended that 12 visits of chiropractic care be covered, as the evidence shows that the optimal spinal manipulation number of visits is 12. This number is less than the proposed number of visits of 30 for all types of interventions. It was noted that the 30 visit number was for chiropractic care plus multiple other types of care.

Williams brought up that the evidence for the Start Back tool was to offer low risk patients just office education, not 4 visits of PT, CMT, or any other types of care; however, the task force felt that the proposed 4 visits supported the need for early education, as this type of education was better done by PTs than by busy primary care clinicians. Williams also requested that staff consider the back MRI guideline as part of the back pain task force effort.

Nora Stern, PT, testified that the biopsychosocial approach to back pain is much more effective than treatment with opiates. The older model which limited services in non-acute back pain is not accepted anymore. She also supported the addition of the 4 visits for acute low-risk back pain.

Mary Hlady, PT, from the Oregon PT Association testified that the association supports inclusion of the 4 visits for PT or other modalities for acute low back pain, and that the evidence supports this type of care to prevent chronicity of disease.

The final decision was that the VbBS agreed with the basic line structure and contents as presented. HERC staff was directed to work with the OHP Medical Directors as well as the task force and specialists to improve the proposed guidelines. HERC staff will work with the task force and experts to finalize the diagnoses and treatments to include on each line and will review line prioritization.

Recommended Actions:

- 1) A final back pain line recommendation will be brought to the March, 2015 VbBS meeting

➤ **Topic: Intensive counseling for overweight with cardiovascular risk factors**

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

Recommended Actions:

- 1) Place ICD-9 278.02 (Overweight) and E66.3 (Overweight) on Lines 325 OBESITY (ADULT BMI ≥ 30, CHILDHOOD BMI ≥ 95 PERCENTILE) and 594 OBESITY (ADULT BMI ≥ 30, CHILDHOOD BMI ≥ 95 PERCENTILE)
- 2) Advise DMAP to remove 278.02 and E66.3 from the Excluded File
- 3) Rename Line 325 OBESITY (ADULT BMI ≥ 30, CHILDHOOD BMI ≥ 95 PERCENTILE) and OVERWEIGHT IN ADULTS (BMI >25) WITH CARDIOVASCULAR RISK FACTORS
- 4) Rename Line 594 OBESITY (ADULT BMI ≥ 30, CHILDHOOD BMI ≥ 95 PERCENTILE) and OVERWEIGHT IN ADULTS (BMI >25)
- 5) Modify Guideline Note 5 as shown in Appendix A
- 6) Remove CPT 99605-99607 (pharmacist drug management) from Line 325
- 7) Remove CPT 99356 and 99357 (Prolonged service in the inpatient or observation setting) from Line 325

MOTION: To recommend the code, line title, and guideline note changes as presented. CARRIES 8-0.

➤ **Topic: PET scan for fever of unknown origin**

Discussion: There was minimal discussion for this topic.

Recommended Actions:

- 1) No change to current non-pairing of PET scan with fever of unknown origin

MOTION: To recommend no change in non-pairing of codes as presented. CARRIES 8-0.

➤ **Topic: Catheter thrombolysis for pulmonary embolism**

Discussion: There was minimal discussion for this topic.

Recommended Actions:

- 1) Do not add catheter thrombolysis as a treatment for pulmonary embolism.

**MOTION: To recommend no change in the non-pairing as presented.
CARRIES 8-0.**

➤ **Topic: Unilateral tonsillar hypertrophy**

Discussion: Smits introduced the summary document. It was noted that ICD-9 code 474.10 as well as 474.11 should be placed on both line 395 and 574. Rather than add a new guideline, the subcommittee decided to add the proposed wording to existing Guideline Note 36. It was thought that adding the coverage clarification to this guideline would keep all the guidelines around tonsillectomy in one place, which would be easier to find and understand by the plans and other partners.

Recommended Actions:

- 1) Add ICD-9 474.10/ICD-10 J35.3 (Hypertrophy of tonsil with adenoids) to line 395 STREPTOCOCCAL SORE THROAT AND SCARLET FEVER; VINCENT'S DISEASE; ULCER OF TONSIL; UNILATERAL HYPERTROPHY OF TONSIL.
- 2) Modify GN 36 as shown in Appendix A

**MOTION: To recommend the code and guideline note changes as amended.
CARRIES 8-0.**

➤ **Topic: Hemangiomas**

Discussion: There was minimal discussion for this topic.

Recommended Actions:

- 1) Remove 228.04 (Hemangioma of intra-abdominal structures) from line 130 BENIGN NEOPLASM OF THE BRAIN AND SPINAL CORD and add to line 647 BENIGN NEOPLASMS OF DIGESTIVE SYSTEM
- 2) Modify GN13 as shown in appendix A

MOTION: To recommend the code and guideline note changes as presented. CARRIES 8-0.

➤ **Topic: Stereotactic Body Radiation Therapy (SBRT)**

Discussion: Livingston introduced a summary document. The subcommittee felt the option to add SBRT to the lung cancer line alone with a guideline was the preferred strategy. There was discussion about whether to include “peripheral lesions” in the guideline. It was felt that it would be beyond the ability of OHP medical directors to determine what lesions were peripheral vs central. This portion of the guideline was struck. There was also discussion about whether wording should be added to the guideline to allow use for patients who refuse surgery. It was felt that “inoperable” should be interpreted to include patients who refuse surgery as well as patients who are not surgical candidates.

Recommended Actions:

- 1) Add CPT 32701, 77373, and 77435 (Stereotactic body radiation therapy) to line 266 CANCER OF LUNG, BRONCHUS, PLEURA, TRACHEA, MEDIASTINUM AND OTHER RESPIRATORY ORGANS
- 2) Add a new guideline to line 266 as shown in Appendix B

MOTION: To recommend the code and guideline note changes as amended. CARRIES 8-0.

➤ **Topic: Cochlear implant guidelines**

Discussion: Smits introduced the summary document. The subcommittee requested clarification of what various levels of hearing loss represent. Unable to hear sounds below 70db means that a person cannot hear speech. Unable to hear sounds below 90db means that a person effectively has no hearing (profoundly deaf). Hearing aids may not be effective for persons with hearing loss of 70db. The subcommittee requested that HERC staff work with Dr. Warren and/or other community ENTs to determine why 70db is used as a cut-off for cochlear implants in some guidelines/FDA approval and why 90db is used as a cut off for implants in other guidelines, specifically the NICE guideline reviewed at the meeting. Specifically, the subcommittee wanted additional information on why NICE chose 90db as a cut off and whether NICE considered the 70-90 db range in their guideline. Staff was also charged with finding other evidence regarding the effectiveness of cochlear implants for persons with hearing thresholds between 70-90db.

There was discussion about why the current guideline differentiates between pre- and post-lingual adults. Livingston indicated that the ICD-10 ENT group reviewed the cochlear implant guideline and specifically made changes to differentiate pre- and postlingual adults. HERC staff will review these meeting notes to determine the rationale, and will discuss this with Dr. Warren and/or other community ENTs.

Recommended Actions:

- 1) HERC staff will review ICD-10 ENT meeting notes, confer with Dr. Warren and other experts, and look for evidence for use of cochlear implants between 70-90 db and will bring this topic back to a future VbBS meeting
-

➤ **Topic: Retained tympanostomy tube guideline**

Discussion: Livingston reviewed the summary document in the meeting materials. There was minimal discussion.

Recommended Actions:

- 1) Remove CPT 69424 (Ventilating tube removal requiring general anesthesia) from all current lines (lines 174, 290, 317, 379, 394 and 481).
- 2) Add CPT 69424 to Line 427 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
- 3) Remove ICD-9 385.83 (RETAINED FOREIGN BODY OF MIDDLE EAR) from line 379 CHOLESTEATOMA; INFECTIONS OF THE PINNA and add to Line 427
- 4) Add ICD-10 H74.8xX (Other specified disorders of middle ear and mastoid) to Line 427
- 5) Delete Guideline Note 76 RETAINED TYMPANOSTOMY TUBES
- 6) Modify Guideline Notes 29 and 51 as shown in Appendix A

MOTION: To recommend the code and guideline note changes as presented. CARRIES 8-0.

➤ **Topic: Intraocular steroid implants**

Discussion: Smits introduced the summary materials. Ms. Campbell and Ms. Stephens from Allergan gave testimony regarding their concerns with no coverage of the CPT code for intraocular injections for use with any medication (i.e. anti-VEGF). Delaying a change will mean that patients will not receive needed treatments and may suffer further vision damage. However, the subcommittee members felt that this topic should be dealt with in the context of reviewing intraocular steroids for diabetic macular edema, which is scheduled for the March VBBS meeting. Staff indicated that any changes made prior to August will go into effect October 1, 2015. Several suggestions were made to the proposed guideline, including adding “injections” as well as implants, as some steroid medications are delivered by injection.

The subcommittee decided that the injection/implant CPT codes should be added to line 100 instead as an errata to allow non-steroidal medications to be used immediately. It is the intent of the VbBS to not cover steroid medications for

conditions on line 100, but no formal guideline was adopted at this meeting. Staff will further research the use of steroids for diabetic macular edema and bring back revised recommendations and a revised guideline regarding intraocular steroids for the next VBBS meeting.

Recommended Actions:

- 1) Add CPT 67027 (Implantation of intravitreal drug delivery system) and 67028 (Intravitreal injection of a pharmacologic agent) to line 100 DIABETIC AND OTHER RETINOPATHY as an errata effective January 1, 2015
- 2) It is the intent of the VbBS that these codes not be used for steroidal medications until further review
- 1) HERC staff will further research intraocular steroids for diabetic eye conditions and bring back recommendations and a revised guideline note (if applicable) to the next VbBS meeting

MOTION: To recommend the code changes as discussed. CARRIES 8-0.

➤ **Topic: Wearable cardiac defibrillators**

Discussion: Smits introduced the summary document on wearable cardiac defibrillators (WCDs). The subcommittee felt that the guideline that seemed to best fit the evidence was the 2nd option in the summary. They clarified the last sentence by removing reference to “other situations in which ICDs are not indicated.”

Recommended Actions:

- 1) Add CPT 93745 (Initial set-up and programming by a physician or other qualified health care professional of wearable cardioverter-defibrillator includes initial programming of system, establishing baseline electronic ECG, transmission of data to data repository, patient instruction in wearing system and patient reporting of problems or events) and HCPCS K0606-K0609 (DME items for wearable cardioverter-defibrillator) to the following lines with implantable cardiac defibrillators:
 - a. 73 ACUTE AND SUBACUTE ISCHEMIC HEART DISEASE, MYOCARDIAL INFARCTION
 - b. 103 CARDIOMYOPATHY, HYPERTROPHIC MUSCLE
 - c. 115 CONGENITAL HEART BLOCK; OTHER OBSTRUCTIVE ANOMALIES OF HEART
 - d. 193 CHRONIC ISCHEMIC HEART DISEASE
 - e. 286 LIFE-THREATENING CARDIAC ARRHYTHMIAS
 - f. 350 CARDIAC ARRHYTHMIAS
- 2) Advise DMAP to remove CPT 93745 and HCPCS K0606-K0609 from the Ancillary File

- 3) Adopt a new guideline regarding wearable cardiac defibrillators as shown in Appendix B

MOTION: To recommend the code and guideline note changes as amended. CARRIES 8-0.

➤ **Topic: Coverage Guidance—Percutaneous interventions for cervical spine pain**

Discussion: Smits introduced the summary document, and reviewed the history of discussion on this topic at VbBS and HERC. Shaffer discussed the HTAS deliberations on this coverage guidance. He noted that HTAS decided to recommend coverage of cervical epidural steroid injections based on one RCT which showed benefit versus intramuscular injection. Shaffer acknowledged that the literature did find evidence of short term harm for epidural steroid injections and no long term benefit (all benefits seen were short term). One paper reviewed found lower surgery rates in patients receiving epidural steroid injections. Expert testimony from Dr. David Sibell was also found to be convincing, as was additional literature that Dr. Sibell supplied to HTAS. The HTAS decision to support epidural steroid injections was based on the short term benefits seen compared to intramuscular injections and reduced surgery rates. HTAS also looked at other guidelines, including WA HTA and Medicare guidelines, and come up with restrictive criteria for coverage.

Gibson felt that basing the majority of the HTAS decision on one retrospective cohort study was not acceptable. Hodges expressed concern about how the evidence for cervical epidural steroid injections compared to the evidence for other treatments under consideration for coverage in the back pain line review. Livingston noted that based on her brief review, PT, CMT and several other modalities under consideration had at least moderate quality and strength of evidence to support them.

The subcommittee was in agreement on not covering facet joint injections or medial branch blocks for the cervical spine. The other modalities under consideration (radiofrequency neurotomy and epidural steroid injection) should be considered as part of the back pain line restructuring effort. HERC staff was directed to make a summary of the level of evidence supporting various treatments for back pain, such as PT, CBT, CMT, etc. and bring this summary back to the next meeting for consideration as part of the back pain line restructuring effort.

Recommended Actions:

- 1) Add 63210 (Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement,

- includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic) to the Non-Covered Table
- 2) Advise DMAP to remove 63210 from the Ancillary List
 - 3) Keep 64490-64492 (Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (flouro or CT), cervical) and 64633 and 64634 (Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single or additional facet joints) on the Non-Covered List
 - 4) Add an entry to the new Non-Covered Table for CPT 63210, 64633-64634, 64479-64480, 64490-64495

MOTION: To approve the recommended changes to the Prioritized List as presented based on the draft August 2014 coverage guidance scheduled for review by HERC at their January 1, 2015 meeting. FAILED 4-1 (Nay: Pollack; Abstained (3): Croswell, Ocker, Williams) [Note: HERC bylaws state that motions must pass with a majority of votes of members present; therefore, this motion failed]

➤ **Topic: Coverage Guidance—Advanced imaging for staging of prostate cancer**

Discussion: Smits introduced the summary document. The subcommittee agreed with the recommendation to not add prostate cancer as an indication for PET imaging. The subcommittee added a definition of low risk prostate cancer, based on Table 1 from the coverage guidance. There was some concern about the low level of evidence supporting the use of some of the imaging modalities. However, it was noted that coverage for these imaging modalities was already part of the Prioritized List and therefore evidence of lack of effectiveness or harm was required to remove coverage.

Recommended Actions:

- 1) Do not add PET imaging to line 333 CANCER OF PROSTATE GLAND.
- 2) Adopt a new diagnostic guideline regarding imaging for staging of prostate cancer as shown in Appendix B

MOTION: To approve the recommended changes to the Prioritized List as amended based on the draft November 2014 coverage guidance scheduled for review by HERC at their January, 2105 meeting. CARRIES 8-0.

➤ **Public Comment:**

No additional public comment was received.

➤ **Issues for next meeting:**

- Intraocular steroids for diabetic macular edema
- Tobacco cessation coverage guideline
- Prenatal testing guideline
- Incentivizing wellness
- PPIs for treatment of GERD
- Craniofacial anomaly codes and OSA tx failure
- Benign joint conditions
- Unilateral hearing loss
 - BAHA hearing aid guideline
- Intraocular steroids for diabetic macular edema
- Cochlear implant guidelines
- Back pain line reorganization

➤ **Next meeting:**

March 12, 2015 at Clackamas Community College, Wilsonville Training Center, Wilsonville Oregon, Rooms 111-112.

➤ **Adjournment:**

The meeting adjourned at 1:25 PM.

Appendix A

Revised Guideline Notes

GUIDELINE NOTE 5, OBESITY AND OVERWEIGHT

Line 325

Medical treatment of overweight (with known cardiovascular risk factors) and obesity is limited to accepted intensive counseling on nutrition and ~~exercise~~physical activity, provided by health care professionals. Intensive counseling is defined as face to face contact more than monthly. Visits are not to exceed more than once per week. Intensive counseling visits (once every 1-2 weeks) are covered for 6 months. Intensive counseling visits may continue for longer than 6 months as long as there is evidence of continued weight loss or improvement in cardiovascular risk factors based on the intervention. Maintenance visits are covered no more than monthly after this intensive counseling period.

Known cardiovascular risk factors in overweight persons for which this therapy is effective include: hypertension, dyslipidemia, impaired fasting glucose, or the metabolic syndrome.

Pharmacological treatments are not intended to be included as services on this line.

GUIDELINE NOTE 13, HEMANGIOMAS, COMPLICATED

Lines 326, 636

Dermatologic Hemangiomas (ICD-9 228.01) are ~~covered~~ included on ~~this~~ line 326 when they are ulcerated, infected, recurrently hemorrhaging, or function-threatening (e.g. eyelid hemangioma). Otherwise, they are included on line 636.

GUIDELINE NOTE 29, TYMPANOSTOMY TUBES IN ACUTE OTITIS MEDIA

Line 394

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

Appendix A

Removal of retained tympanostomy tubes requiring anesthesia (CPT code 69424) or as an office visit, is included on line 427 as a complication, pairing with 385.83/ H74.8xX.

GUIDELINE NOTE 36, ADENOTONSILLECTOMY FOR INDICATIONS OTHER THAN OBSTRUCTIVE SLEEP APNEA

Lines 49,84,395,574

Tonsillectomy/adenotonsillectomy is an appropriate treatment for patients with:

- A) Five documented attacks of strep tonsillitis in a year or 3 documented attacks of strep tonsillitis in each of two consecutive years where an attack is considered a positive culture/screen and where an appropriate course of antibiotic therapy has been completed;
- B) Peritonsillar abscess requiring surgical drainage; or,
- C) Unilateral tonsillar hypertrophy in adults; unilateral tonsillar hypertrophy in children with other symptoms suggestive of malignancy.

See Guideline Note 118 for diagnosis and treatment of obstructive sleep apnea in children.

ICD-9 474.10 and 474.11/ICD-10 J35.1 and J35.3 are included on line 395 only for 1) unilateral tonsillar hypertrophy in adults and 2) unilateral tonsillar hypertrophy in children with other symptoms suggestive of malignancy. Bilateral tonsillar hypertrophy and unilateral tonsillar hypertrophy in children without other symptoms suggestive of malignancy are included only on line 574.

GUIDELINE NOTE 51, CHRONIC OTITIS MEDIA WITH EFFUSION

Line 481

Antibiotic and other medication therapy (including antihistamines, decongestants and nasal steroids) are not indicated for children with chronic otitis media with effusion (OME) (without another appropriate diagnosis).

There should be a 3 to 6 month watchful waiting period after diagnosis of otitis media with effusion, and if documented hearing loss is greater than or equal to 25dB in the better hearing ear, tympanostomy surgery may be indicated given short but not long-term improvement in hearing. Formal audiometry is indicated for children with chronic OME present for 3 months or longer. Children with language delay, learning problems, or significant hearing loss should have hearing testing upon diagnosis. Children with chronic OME who are not at risk for language or developmental delay should be reexamined at 3- to 6-month intervals until the effusion is no longer present, significant hearing loss is identified, or structural abnormalities of the eardrum or middle ear are suspected.

Appendix A

For the child who has had chronic OME and who has a hearing deficiency in the better-hearing ear of 25 dB or greater, myringotomy with tube insertion is recommended after a total of 4 to 6 months of effusion with a documented hearing deficit.

Adenoidectomy is not indicated at the time of first pressure equalization tube insertion. It may be indicated in children over 3 years who are having their second set of tubes.

Tube insertion should be covered for patients with craniofacial anomalies, Down's syndrome, cleft palate and patients with speech and language delay along with co-morbid hearing loss.

Removal of retained tympanostomy tubes requiring anesthesia (CPT code 69424) or as an office visit, is included on line 427 as a complication, pairing with 385.83/ H74.8xX.

~~GUIDELINE NOTE 76, RETAINED TYMPANOSTOMY TUBES~~

~~—Lines 174,290,379,394,481~~

~~Removal of retained tympanostomy tubes under anesthesia, if indicated (CPT code 69424 Ventilating tube removal requiring general anesthesia) or as part of an office visit, are intended to be covered for Line 481 diagnoses with the Line 379 ICD-9 code 385.83 Retained foreign body of middle ear.~~

GUIDELINE NOTE 106, PREVENTIVE SERVICES

Line 3

Included on this line are the following preventive services:

1. US Preventive Services Task Force (USPSTF) “A” and “B” Recommendations (as of May 2012):
<http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>
2. American Academy of Pediatrics (AAP) Bright Futures Guidelines (published 2008):
~~http://brightfutures.aap.org/pdfs/Guidelines_PDF/20-Appendices_PeriodicitySchedule.pdf~~
http://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf
3. Health Resources and Services Administration (HRSA) Women's Preventive Services - Required Health Plan Coverage Guidelines: (approved with Affordable Care Act on March 23, 2010)
<http://www.hrsa.gov/womensguidelines/>
4. Immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP) ~~and approved for the Oregon Immunization Program:~~
~~<http://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/ImmunizationProviderResources/Documents/DMA Pvactable.pdf>~~
<http://www.cdc.gov/vaccines/schedules/hcp/index.html>

Appendix B

New Guideline Notes

GUIDELINE XXX LIVER ELASTOGRAPHY

Line 202

Liver elastography (CPT 91200) is included on this line only when the non-invasive test would replace liver biopsy for determination of eligibility for medications for chronic hepatitis C. Performance of liver elastography more than twice per year or within six months following a liver biopsy is not included on this line.

GUIDELINE NOTE XXX STEREOTACTIC BODY RADIATION THERAPY

Line 266

Stereotactic body radiation therapy (CPT 32701, 77373, 77435) is included on Line 266 only for early stage non-small cell lung cancer in medically inoperable patients.

GUIDELINE NOTE XXX WEARABLE CARDIAC DEFIBRILLATORS

Lines 73,103,115,193,286,350

Wearable cardiac defibrillators (WCDs; CPT 93745, HCPCS E0617, K0606-K0609) are included on these lines for patients at high risk for sudden cardiac death who meet the medical necessity criteria for an implantable cardioverter defibrillator (ICD) but are unable to have an ICD implanted due to medical condition (e.g. ICD explanted due to infection with waiting period before ICD reinsertion or current medical condition contraindicates surgery). WCDs are not included on these lines for use during the waiting period for ICD implantation after myocardial infarction, coronary bypass surgery, or coronary artery stenting.

DIAGNOSTIC GUIDELINE DXX, ADVANCED IMAGING FOR STAGING OF PROSTATE CANCER

MRI is covered for men with histologically proven prostate cancer if knowledge of the T or N stage could affect management. CT of the pelvis is covered only when MRI is contraindicated. Radionuclide bone scanning is not covered in men with low risk localized prostate cancer. Low risk is defined as PSA <10 ng/ml and Gleason score ≤6 and clinical stage T1-T2a.

Back Pain Lines and Guidelines

Medical line: This line includes all diagnoses from the old back pain lines (lines 374,412,545,588) as well as several diagnoses currently on the Diagnostic List (sciatica, lumbago, etc.). Procedures on this line include primary care and specialty office visits, ER visits, SNF care, patient education, medications, OMT/CMT, acupuncture, PT/OT, and cognitive behavioral therapy. These services are governed by a new guideline. No percutaneous interventions, such as epidural steroid injections or surgeries, appear on this line. Inpatient hospital care and ICU care are not included on this line.

Line: XXX

CONDITION: CONDITIONS OF THE BACK AND SPINE

TREATMENT: RISK ASSESSMENT, PHYSICAL MODALITIES, COGNITIVE BEHAVIORAL THERAPY, MEDICAL THERAPY

ICD-9: 336.0,344.60-344.61,349.2,720.2,720.81,721.0-721.9,722.0-722.9,723.0,723.1,723.4,723.6-723.9,724.0-724.9,731.0,732.0,737.0-737.2,737.40-737.42,737.8-737.9,738.4-738.5,739.0-739.9,742.59,754.2,756.10-756.19,839.20-839.21,847.0-847.9,V57.1,V57.2,V57.81-V57.89

ICD-10: G83.4,G95.0,M24.08,M25.78,M40.x,M42.0x,M43.00-M43.28,M43-M43.9,M45.0-M45.8,M46.1,M46.40-M46.49,M46.81-M46.89,M46.91-M46.99,M47.011-M47.16,M47.20-M47.28,M47.811-M47.9,M48.00-M48.27,M48.30-M48.38,M48.9,M49.80-M49.89,M50.00-M50.93,M51.04-M51.9,M53.2x1-M53.2x8, M53.3,M53.80-M53.9,M54.0,M54.11-M54.6,M54.81-M54.9,M62.830,M96.1,M96.2-M96.5, M99.00-M99.09, M99.12-M99.13,M99.20-M99.79,M99.83-M99.84,Q06.0-Q06.3,Q06.8-Q06.9, Q67.5, Q76.0-Q76.4,Z47.82,S13.0xxA-S13.0xxD, S13.4xxA-S13.4xxD,S13.8xxA-S13.8xxD, S13.9xxA-S13.9xxD,S16.1xxA-S16.1xxD,S23.0xxA-S23.0xxD, S23.100A-S23.100D, S23.101A-S23.101D,S23.110A-S23.110D,S23.111A-S23.111D,S23.120A-S23.120D, S23.121A-S23.121D,S23.122A-S23.122D,S23.123A-S23.123D,S23.130A-S23.130D, S23.131A-S23.131D,S23.132A-S23.132D,S23.133A-S23.133D,S23.140A-S23.140D, S23.141A-S23.141D,S23.142A-S23.142D,S23.143A-S23.143D,S23.150A-S23.150D, S23.151A-S23.151D,S23.152A-S23.152D,S23.153A-S23.153D,S23.160A-S23.160D, S23.161A-S23.161D,S23.162A-S23.162D,S23.163A-S23.163D,S23.170A-S23.170D, S23.171A-S23.171D,S23.3xxA-S23.3xxD,S23.8xxA-S23.8xxD,S23.9xxA-S23.9xxD, S33.0xxA-S33.0xxD, S33.100A-S33.100D,S33.101A-S33.101D,S33.110A-S33.110D, S33.111A-S33.111D,S33.120A-S33.120D,S33.121A-S33.121D,S33.130A-S33.130D, S33.131A-S33.131D,S33.140A-S33.140D,S33.141A-S33.141D,S33.5xxA-S33.5xxD, S33.9xxA-S33.9xxD,S34.3xxA-S34.3xxD, S39.092A-S39.092D,S39.82xA-S39.82xD, S39.92xA-S39.92xD

CPT: 90785,90832-90838,90853 (mental health visits, counseling), 96150-4 (health and behavior assessment codes), 97001-97004, 97022, 97110-97124, 97140, 97150, 97530, 97535 (PT/OT evaluation and treatment), 97810-97814 (acupuncture), 98925-98929, 98940-98942 (OMT/CMT), 98966-98968, 98969, 99051, 99060, 99070,99078,99201-99215 (outpatient medical visits), 99281-99285 (ER), 99304-99337 (SNF care), 99340-99359, 99366-99404 (risk factor reduction intervention), 99408, 99409, 99411, 99412, 99441-99449, 99487-99490, 99605-99607

HPCPS: G0157-G0160 (PT/OT), G0396-G0397 (SBRT), G0425-G0427 (telehealth), G0463, G0466, G0467, G0469, G0470 (FQHC)

Back Pain Lines and Guidelines

Surgical lines: There are 2 surgical lines, with the higher priority line containing those diagnoses with urgent/emergent surgical indications and those conditions with good evidence that surgery is an effective treatment. The lower priority line contains diagnoses without good evidence of effective surgical treatment, or with evidence that surgery is equally effective to non-surgical care but with greater expense and risk. This lower line is scored to the unfunded region. Both surgical lines include office visits, medications, ER visits, inpatient and ICU care and SNF care, spinal surgical treatments and percutaneous interventions. The surgical lines contain the majority of conditions found on the medication line, with the exception of those diagnoses generally seen as symptoms, such as 724.x (pain in spine, lumbago, sciatica). The two surgical lines generally have unique diagnoses from each other; a couple of diagnoses are duplicated and the placement determined by the surgical guideline.

Line: AAA

CONDITION: CONDITIONS OF THE BACK AND SPINE WITH URGENT SURGICAL INDICATIONS

TREATMENT: SURGICAL THERAPY

ICD-9: 344.60-344.61 (cauda equina), 721.1, 721.41-721.42, 721.91 (spondylosis with myelopathy); 722.7x (intervertebral disc disorder with myelopathy), 723.0 (spinal stenosis), 724.0x (spinal stenosis), 738.4, 756.11-756.12 (spondylolisthesis)

ICD-10: G83.4 (cauda equina), M43.1x (spondylolisthesis), M47.0x, M47.1x (spondylosis with myelopathy), M48.0x (spinal stenosis), M50.0x, M51.0x (intervertebral disc disorder with myelopathy), M53.2x (spinal instabilities), Q76.2 (spondylolisthesis), Z47.82 (aftercare after scoliosis surgery)

CPT: 20660-20665, 20930-20938, 21720, 21725, 22206-22226, 22532-22855, 29000-29046, 29710-29720, 62287, 62311 (epidural injection), 62355-62370, 63001-63091, 63170, 63180-63200, 63270-63273, 63295-63610, 63650, 63655, 63685 [all surgical codes from lines 374 and 412], 64483, 64484 (epidural injection), 97001-97004, 97022, 97110-97124, 97140, 97150, 97530, 97535 (PT/OT evaluation and treatment), 96150-4 (health and behavior assessment codes), 98966-98968, 98969, 99051, 99060, 99070, 99078, 99201-99215 (outpatient medical visits), 99217-99239 (hospital), 99281-99285 (ER), 99304-99337 (SNF care), 99401-99404 (risk factor reduction intervention), 99408, 99409, 99411, 99412, 99441-99444, 99446-99449 (critical care), 99605-99607

HPCPS: G0157-G0160 (PT/OT), G0396-G0397 (SBRT), G0406-G0408 (inpatient consultation), G0425-G0427 (telehealth), G0463, G0466, G0467 (FQHC), S2350-S2351 (discectomy with decompression of spinal cord)

Back Pain Lines and Guidelines

Line: BBB

CONDITION: CONDITIONS OF THE BACK AND SPINE

TREATMENT: SURGICAL THERAPY

ICD-9: [all from lines 374,412, limited from 545 and 588] 336.0, 349.2,720.81,721.0, 721.2,721.3,721.5-721.8,721.90,722.0,722.10-722.2,722.4-722.6,722.8-722.93, 723.0, 723.1,723.3-723.9, 724.0x,731.0,732.0,737.0-737.2,737.40-737.42,737.8-737.9,738.4-738.5,742.59,754.2,756.10-756.12,839.20-839.21,V57.1,V57.2,V57.81-V57.89,V57.1, V57.21-V57.22,V57.81-V57.89

ICD-10: [hand reviewed] G95.0, M40.xx,M42.xx,M43.0x, M43.1x, M43.2x, M43.5x, M43.8x, M45.x, M46.0x-M46.9x,M47.2x,M47.8x,M47.9,M48.0x (spinal stenosis), M48.1, M48.3, M48.8, M48.9, M49.8x,M50.1x-M50.9x, M51.1x-M51.9,M53.8x,M53.9,M54.1x, M96.1-M96.5,M99.2x-M99.8x,Q67.5,Q76.0-Q76.3,Q76.4x,S13.0x,S23.0x, S23.1x, S33.0x, S33.1x,S34.3x

CPT: 20660-20665, 20930-20938,21720,21725,22206-22226,22532-22865, 27035,29000-29046,29710-29720,62287,62311 (epidural injection),62355-62370,63001-63091,63170,63180-63200, 63270-63273,63295-63610,63650,63655,63685, 64483, 64484 (epidural injection), 96150-96154 (health and behavior assessment codes), 97001-97004, 97022, 97110-97124, 97140, 97150, 97530, 97535 (PT/OT evaluation and treatment), 98966-98968, 98969, 99051, 99060, 99070,99078,99201-99215 (outpatient medical visits), 99217-99239 (hospital), 99281-99285 (ER), 99304-99337 (SNF care), 99401-99404 (risk factor reduction intervention), 99408, 99409, 99411, 99412, 99441-99444, 99446-99449 (critical care), 99605-99607

HPCPS: G0157-G0160 (PT/OT), G0396-G0397 (SBRT), G0406-G0408 (inpatient consultation), G0425-G0427 (telehealth), G0463, G0466, G0467 (FQHC), S2350-S2351 (discectomy with decompression of spinal cord)

Back Pain Lines and Guidelines

Line: CCC

CONDITION: SCOLIOSIS

TREATMENT: MEDICAL AND SURGICAL THERAPY

ICD-9: 737.3x, 737.43

ICD-10: M41.xx

CPT: 20660-20665, 20930-20938, 21720, 21725, 22206-22226, 22532-22865, 29000-29046, 29710-29720, 62287, 62355-62370, 63001-63091, 63170, 63180-63200, 63210, 63295-63610, 63650, 63655, 63685, 96127, 96150-96154 (health and behavior assessment codes), 97001-97004, 97022, 97110-97124, 97140, 97150, 97530, 97535 (PT/OT evaluation and treatment), 97760, 97762, 98966-98968, 98969, 99051, 99060, 99070, 99078, 99201-99215 (outpatient medical visits), 99217-99239 (hospital), 99281-99285 (ER), 99304-99337 (SNF care), 99401-99404 (risk factor reduction intervention), 99408, 99409, 99411, 99412, 99441-99444, 99446-99449 (critical care), 99605-99607

HPCPS: G0157-G0160 (PT/OT), G0396-G0397 (SBRT), G0406-G0408 (inpatient consultation), G0425-G0427 (telehealth), G0463, G0466, G0467 (FQHC)

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Back Pain Lines and Guidelines

GUIDELINE NOTE XXX NON-INTERVENTIONAL TREATMENTS FOR CONDITIONS OF THE BACK AND SPINE

Line XXX

Patients seeking care for back pain should be assessed for “red flag” symptoms requiring immediate diagnostic testing, as defined in Diagnostic Guideline D4. Patients lacking red flag symptoms should be assessed using a validated assessment tool (such as the Start Back Assessment Tool) in order to determine their risk level.

For patients who score as low risk on the assessment tool, the following services are included on this line:

- Office evaluation and education,
- Up to 4 total visits, consisting of the following treatments: OMT/CMT, acupuncture, and PT/OT. Massage, if available, may be considered.
- First line medications: NSAIDs, acetaminophen, and/or muscle relaxers. Opioids may be considered as a second line treatment, subject to the limitations on coverage of opioids in Guideline Note YYY OPIOID PRESCRIBING FOR CONDITIONS OF THE BACK AND SPINE. See evidence table.

For patients who score as high risk on a validated assessment tool, the following treatments are included on this line:

- Office evaluation and education
- Cognitive behavioral therapy. The necessity for cognitive behavioral therapy should be re-evaluated every 90 days and coverage will only be continued if there is documented evidence of decreasing depression or anxiety symptomatology, improved ability to work/function, increased self-efficacy, or other clinically significant, objective improvement.
- Medications, subject to the limitations on coverage of opioids in Guideline Note YYY OPIOID PRESCRIBING FOR CONDITIONS OF THE BACK AND SPINE. See evidence table.
- The following evidence-based therapies, when available, are encouraged: yoga, massage, supervised exercise therapy, intensive interdisciplinary rehabilitation
- A total of 30 visits per year of any combination of the following evidence-based therapies when available and medically appropriate:
 - 1) Rehabilitative therapy (physical and/or occupational therapy), if provided according to GUIDELINE NOTE 6, REHABILITATIVE SERVICES. Rehabilitation services provided under this guideline also count towards visit totals in Guideline Note 6
 - 2) Chiropractic or osteopathic manipulation and consultation
 - 3) Acupuncture

These therapies are only covered if provided by a provider licensed to provide the therapy. Continued coverage will only be approved when there is documentation of measurable clinically significant progress toward the therapy plan of care goals and objectives using evidence based objective tools (e.g. STarT Back, Pain Catastrophizing Scale, Oswestry, Neck Disability Index, SF-MPQ, and MSPQ).

These coverage recommendations are derived from the State of Oregon Evidence-based Guideline on the Evaluation and Management of Low Back Pain available here:

Back Pain Lines and Guidelines

<http://www.oregon.gov/oha/herc/Pages/blog-low-back-non-pharmacologic-intervention.aspx>

Intervention Category*	Intervention	Acute < 4 Weeks	Subacute & Chronic > 4 Weeks
Self-care	Advice to remain active	●	●
	Books, handout	●	●
	Application of superficial heat	●	
Nonpharmacologic therapy	Spinal manipulation	●	●
	Exercise therapy		●
	Massage		●
	Acupuncture		●
	Yoga		●
	Cognitive-behavioral therapy		●
	Progressive relaxation		●
Pharmacologic therapy (Carefully consider risks/harms)	Acetaminophen	●	●
	NSAIDs	●(▲)	●(▲)
	Skeletal muscle relaxants	●	
	Antidepressants (TCA)		●
	<i>Benzodiazepines**</i>	●(▲)	●(▲)
<i>Tramadol, opioids**</i>	●(▲)	●(▲)	
Interdisciplinary therapy	Intensive interdisciplinary rehabilitation		●
<ul style="list-style-type: none"> ● Interventions supported by grade B evidence (at least fair-quality evidence of moderate benefit, or small benefit but no significant harms, costs, or burdens). No intervention was supported by grade "A" evidence (good-quality evidence of substantial benefit). <p>▲ <i>Carries greater risk of harms than other agents in table.</i></p>			

NSAIDs = nonsteroidal anti-inflammatory drugs; TCA = tricyclic antidepressants.

*These are general categories only. Individual care plans need to be developed on a case by case basis. For more detailed information please see: <http://www.annals.org/content/147/7/478.full.pdf>

**Associated with significant risks related to potential for abuse, addiction and tolerance. This evidence evaluates effectiveness of these agents with relatively short term use studies. Chronic use of these agents may result in significant harms.



Back Pain Lines and Guidelines

GUIDELINE NOTE YYY OPIOID PRESCRIBING FOR CONDITIONS OF THE BACK AND SPINE

Lines XXX, AAA, BBB

The following restrictions on opioid treatment apply to all non-postoperative care for diagnoses included on these lines:

- 1) During the first 30 days after acute injury or flare of chronic pain, opioid treatment is included on this line **ONLY**
 - a. For limited use (e.g. 7-10 day duration), **AND**
 - b. After a trial of at least two first line pharmacologic therapies such as NSAIDs, acetaminophen, and muscle relaxers, **AND**
 - c. After a trial of non-pharmacologic interventions such as PT, acupuncture, and CMT
- 2) Treatment with opioids after 30 days, up to 90 days, requires the following
 - a. Documented evidence of improvement in pain intensity of at least thirty percent as compared to baseline. Pain can be measured using the two item graded chronic pain scale or other validated tools.
 - b. Documented evidence of improvement in function of at least thirty percent as compared to baseline. Function can be measured using the two item graded chronic pain scale or other validated tools.
 - c. Verification that the patient has no contraindication to the use of opioids.
 - d. Documentation from the state's prescription monitoring program data base to ensure that the controlled substance history is consistent with the prescribing record
 - e. Use a validated screening instrument to verify the absence of a current substance use disorder (excluding nicotine) or a history of opioid use disorder.
 - f. Administration of a baseline urine drug test to verify the absence of cocaine, amphetamines, alcohol, and non-prescribed opioids.
 - g. Verification that the patient has no evidence of or is not at high risk for serious adverse outcomes from opioid use.
- 3) Further opioid treatment after 90 days may be considered **ONLY** when there is a significant change in status, such as a clinically significant new injury or surgery. In such cases, use of opioids is limited to a maximum of an additional 90 days and is subject to the criteria in #2 above.

For post-operative care of conditions on line AAA and BBB, the following restrictions on opioid treatment apply:

- 1) Opioid prescriptions should be provided for the shortest reasonable time period, generally not to exceed 30 days
- 2) Opioids prescriptions after 30 days but before 90 days will be covered only when there is documented evidence that opioids are continuing to provide improvement in both pain intensity and function of at least thirty percent as compared to baseline. Pain and function can be measured using the two item graded chronic pain scale or other validated tools.
- 3) Opioid prescriptions after 90 days will only be covered in exceptional circumstances (e.g. significant post-operative complication)

Back Pain Lines and Guidelines

GUIDELINE NOTE ZZZ SURGICAL AND PERCUTANEOUS INTERVENTIONS FOR CONDITIONS OF THE BACK AND SPINE

Lines AAA, BBB

Surgical consultation/consideration for surgical intervention and/or percutaneous interventions are included on lines AAA and BBB only for patients with neurological complications, defined as showing evidence of one or more 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

Spondylolithesis (ICD-9 738.4, 756.11-756.12 / ICD-10 M43.1x, Q76.2) is included on line AAA only when it results in spinal stenosis with signs and symptoms of neurogenic claudication. Otherwise, these diagnoses are included on line BBB.

Surgical correction of spinal stenosis (ICD-9 721.1, 724.0x / ICD-10 M48.0x) is only included on line AAA for patients with:

- 1) MRI evidence of moderate to severe central or foraminal spinal stenosis AND
- 2) A history of neurogenic claudication, or objective evidence of neurologic impairment consistent with MRI findings.

Otherwise, these diagnoses are included on line BBB. Only decompression surgery is covered for spinal stenosis; spinal fusion procedures are not covered for this diagnosis.

For conditions on line BBB:

- 1) Percutaneous interventions may only be considered when the condition has been present for more than 4 weeks duration and only when provided according to Guideline Note 105 EPIDURAL STEROID INJECTIONS, ~~OTHER PERCUTANEOUS INTERVENTIONS~~ FOR ~~LOW~~-BACK PAIN
- 2) Surgical interventions may only be considered after the patient has completed at least 6 months of conservative treatment, provided according to Guideline Note XXX NON-INTERVENTIONAL TREATMENTS FOR CONDITIONS OF THE BACK AND SPINE.

The following interventions are not covered due to lack of evidence of effectiveness for back pain, with or without radiculopathy:

- facet joint corticosteroid injection
- prolotherapy
- intradiscal corticosteroid injection
- local injections
- botulinum toxin injection
- intradiscal electrothermal therapy
- therapeutic medial branch block
- radiofrequency denervation
- sacroiliac joint steroid injection
- coblation nucleoplasty
- percutaneous intradiscal radiofrequency thermocoagulation
- radiofrequency denervation

Back Pain Lines and Guidelines

GUIDELINE NOTE AAA SCOLIOSIS

Lines CCC

Non-surgical treatments of scoliosis (ICD-9 737.3x/ICD-10 M41.) are included on line CCC when

- 1) the scoliosis is considered clinically significant, defined as curvature greater than or equal to 25 degrees or
- 2) there is curvature with a documented rapid progression.

Surgical treatments of scoliosis are included on line CCC

- 1) only for children and adolescents (age 21 and younger) with
- 2) a spinal curvature of greater than 45 degree

GUIDELINE NOTE 105, EPIDURAL STEROID INJECTIONS, ~~OTHER PERCUTANEOUS INTERVENTIONS~~ FOR ~~LOW~~-BACK PAIN

Lines 75, 159, 297, 374, AAA, BBB

Epidural steroid injections (CPT [62311](#), 64483, 64484) are covered for patients with persistent radiculopathy due to herniated disc, where radiculopathy is defined as [pain as well as showing](#) evidence of one or more 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

One epidural steroid injection is covered; a second epidural steroid injection may be provided after 3-6 months only if objective evidence of 3 months of sustained pain relief was provided by the first injection. It is recommended that shared decision-making regarding epidural steroid injection include a specific discussion about inconsistent evidence showing moderate short-term benefits, and lack of long-term benefits. Epidural steroid injections are not covered for spinal stenosis or for patients with ~~low~~-back pain without radiculopathy.

Back Pain Lines and Guidelines

Recommended Changed to Current Guidelines

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. 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*	Additional studies*
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)	<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

Back Pain Lines and Guidelines

Possible cause	Key features on history or physical examination	Imaging*	Additional studies*
disc with radiculopathy)	<ul style="list-style-type: none"> • Radiculopathic** signs present >1 month • Severe/progressive neurologic deficits (such as foot drop), progressive motor weakness 	MRI***	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**	Consider EMG/NCV

* Level of evidence for diagnostic evaluation is variable

** Radiculopathic signs are defined for the purposes of this guideline is defined as the presence of as in Guideline Note 37 with 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

*** Only if patient is a potential candidate for surgery or epidural steroid injection

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>

GUIDELINE NOTE 72, ELECTRONIC ANALYSIS OF INTRATHECAL PUMPS

Lines 400,562,634 *[needs line edits]*

Electronic analysis of intrathecal pumps, with or without programming (CPT codes 62367-62368), is included on these lines only for pumps implanted prior to April 1, 2009.

GUIDELINE NOTE 92, ACUPUNCTURE

Lines 1,207,~~374~~,414,468,~~545~~,546,~~XXX~~

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

Back Pain Lines and Guidelines

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 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 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 207 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 total sessions, with documentation of meaningful improvement.

~~Line 374 DISORDERS OF SPINE WITH NEUROLOGIC IMPAIRMENT~~

~~Acupuncture is included on Line 374 YYY 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, M51.1x, M54.1x, with referral, for up to 12 sessions.~~

Line XXX-CONDITIONS OF THE BACK AND SPINE

Acupuncture is included on line XXX, with visit limitations as in Guideline Note XXX.

Line 414 MIGRAINE HEADACHES

Acupuncture pairs on Line 414 for ICD-10-CM code G43.9 Migraine, when referred, for up to 12 sessions.

Line 468 OSTEOARTHRITIS AND ALLIED DISORDERS

Acupuncture pairs on Line 468 for osteoarthritis of the knee only, when referred, for up to 12 sessions.

~~Line 545 ACUTE AND CHRONIC DISORDERS OF SPINE WITHOUT NEUROLOGIC IMPAIRMENT~~

~~Acupuncture pairs on Line 545 with the low back diagnoses G83.4, M47.1x, M47.2x, M50.0x, M50.1x, M51.1x, M54.1x, when referred, for up to 12 sessions. Acupuncture pairs with chronic (>90 days) neck pain diagnoses (-), when referred, for up to 12 sessions.~~

Line 546 TENSION HEADACHES

Acupuncture is included on Line 546 for treatment of tension headaches G44.2x, when referred, for up to 12 sessions.

Back Pain Lines and Guidelines

GUIDELINE NOTE 100, SMOKING AND SPINAL FUSION

Lines 51, 154, 204, 258, ~~374, 412~~, 484, 533, ~~588~~, [AAA](#), [BBB](#)

Non-emergent spinal arthrodesis (CPT 22532-22634) is limited to patients who are non-smoking for 6 months prior to the planned procedure. Patients should be given access to appropriate smoking cessation therapy.

GUIDELINE NOTE 101, ARTIFICIAL DISC REPLACEMENT

Lines ~~374, 545~~ [AAA](#), [BBB](#)

Artificial disc replacement (CPT 22856-22865) is included on these lines as an alternative to fusion only when all of the following criteria are met:

Lumbar artificial disc replacement

- 1) Patients must first complete a structured, intensive, multi-disciplinary program for management of pain, if covered by the agency;
- 2) Patients must be 60 years or under;
- 3) Patients must meet FDA approved indications for use and not have any contraindications. FDA approval is device specific but includes:
 - Failure of at least six months of conservative treatment
 - Skeletally mature patient
 - Replacement of a single disc for degenerative disc disease at one level confirmed by patient history and imaging

Cervical artificial disc replacement

- 1) Patients must meet FDA approved indications for use and not have any contraindications. FDA approval is device specific but includes:
 - Skeletally mature patient
 - Reconstruction of a single disc following single level discectomy for intractable symptomatic cervical disc disease (radiculopathy or myelopathy) confirmed by patient findings and imaging.

Back Pain Lines and Guidelines

Deleted Guidelines

~~GUIDELINE NOTE 37, DISORDERS OF SPINE WITH NEUROLOGIC IMPAIRMENT~~

~~Lines 374,545~~

~~Diagnoses are included on Line 374 when objective evidence of neurologic impairment or radiculopathy is present, as defined as:~~

- ~~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~~

~~Otherwise, disorders of spine not meeting these criteria (e.g. pain alone) fall on Line 545.~~

~~GUIDELINE NOTE 41, SPINAL DEFORMITY, CLINICALLY SIGNIFICANT~~

~~Line 412~~

~~Clinically significant scoliosis is defined as curvature greater than or equal to 25 degrees or curvature with a documented rapid progression. Clinically significant spinal stenosis is defined as having MRI evidence of moderate to severe central or foraminal spinal stenosis in addition to a history of neurogenic claudication, or objective evidence of neurologic impairment consistent with MRI findings (see Guideline Note 37).~~

~~GUIDELINE NOTE 56, ACUTE AND CHRONIC DISORDERS OF SPINE WITHOUT NEUROLOGIC IMPAIRMENT~~

~~Line 545~~

~~Disorders of spine without neurologic impairment include any conditions represented on this line for which objective evidence of one or more of the criteria stated in Guideline Note 37 is not available~~

~~GUIDELINE NOTE 60, SPINAL DEFORMITY, NOT CLINICALLY SIGNIFICANT~~

~~Line 588~~

~~Scoliosis not defined as clinically significant included curvature less than 25 degrees that does not have a documented progression of at least 10 degrees~~

~~GUIDELINE NOTE 94, EVALUATION AND MANAGEMENT OF LOW BACK PAIN~~

~~Lines 374,545~~

~~Procedures for the evaluation and management of low back pain are included on these lines when provided subject to the State of Oregon Evidence-based Clinical Guidelines dated 10/2011 located at:~~

~~<http://www.oregon.gov/oha/OHPR/pages/herc/evidence-based-guidelines.aspx>.~~

Back Pain Lines and Guidelines

Line scoring

Scoring—Line XXX medical treatments

Category: 7

HL: 5

Suffering: 3

Population effects: 0

Vulnerable population: 0

Tertiary prevention: 3

Effectiveness: 3

Need for service: 0.9

Net cost: 2

Score: 594

Approximate line placement: 376

Scoring—Line AAA urgent surgical

[scoring for line 374]

Category: 7

HL: 5

Suffering: 3

Population effects: 0

Vulnerable population: 0

Tertiary prevention: 2

Effectiveness: 3

Need for service: 1

Net cost: 2

Score: 600

Approximate line placement: 374

Scoring—Line BBB surgical

[scores from line 545]

Category: 7

HL: 4

Suffering: 2

Population effects: 0

Vulnerable population: 0

Tertiary prevention: 0

Effectiveness: 1

Need for service: 0.8

Net cost: 2

Score: 96

Approximate line placement: 545

Scoring—Line CCC scoliosis

[scoring for line 374]

Category: 7

HL: 5

Suffering: 3

Back Pain Lines and Guidelines

Population effects: 0
Vulnerable population: 0
Tertiary prevention: 2
Effectiveness: 3
Need for service: 1
Net cost: 2
Score: 600
Approximate line placement: 374

DRAFT

Back Pain Lines and Guidelines

HERC Staff Recommendations for the Back Conditions Line Reorganization Proposal

- 1) Miscellaneous coding changes required
 - a. Advise DMAP to remove ICD-9 724.3 (Sciatica), ICD-10 M41.40 (Neuromuscular scoliosis, site unspecified), M41.50 (Other secondary scoliosis, site unspecified), M54.3-M54.4 (Sciatica) from the Diagnostic List
 - b. Advise DMAP to remove 22830 (Exploration of spinal fusion) from the Diagnostic List
 - c. Advise DMAP to remove 63210 (Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic) from the Ancillary List
 - d. Remove ICD-9 754.1/ICD-10 Q68.0 (Congenital musculoskeletal deformities of sternocleidomastoid muscle) from line 545 ACUTE AND CHRONIC DISORDERS OF SPINE WITHOUT NEUROLOGIC IMPAIRMENT and ICD-9 756.3/ICD-10 Q76.6-Q76.9 (Other anomalies of ribs and sternum) and ICD-10 Q68.0 (Congenital musculoskeletal deformities of sternocleidomastoid muscle) from lines 412 SPINAL DEFORMITY, CLINICALLY SIGNIFICANT and 588 SPINAL DEFORMITY, NOT CLINICALLY SIGNIFICANT and place on line 534 DEFORMITIES OF UPPER BODY AND ALL LIMBS
 - e. Note: the Taskforce did not recommend coverage of facet joint injections for the cervical or lumbar spine.
 - i. Keep 64490-64492 (Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (flouro or CT), cervical) and 64633 and 64634 (Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single or additional facet joints) on the Non-Covered List
 - ii. Lumbar facet joint injection currently is on the Non-Covered List
- 2) Approve the new medical and two new surgical lines with line scoring as presented
- 3) Approve the new medical and surgical guidelines as presented
- 4) Approve the changes/deletions to existing guidelines as presented