

# HEALTH EVIDENCE REVIEW COMMISSION (HERC)

## COVERAGE GUIDANCE: CORONARY ARTERY REVASCULARIZATION FOR STABLE ANGINA

Approved 5/7/2015

### HERC COVERAGE GUIDANCE

Coronary revascularization (with percutaneous coronary intervention (PCI) or coronary artery bypass surgery (CABG)) is recommended for coverage in patients with stable angina whose symptoms are not controlled with optimal medical therapy<sup>1</sup> or who cannot tolerate such therapy (*weak recommendation*).

CABG is recommended for coverage for patients with stable angina who have left main coronary artery stenosis or three-vessel coronary artery stenosis, with or without a trial of optimal medical therapy (*strong recommendation*).

<sup>1</sup>Optimal medical therapy for angina symptom control is defined as two or more antianginals (in addition to standard treatment for coronary artery disease). Antianginals are defined as: beta-blocker, nitrate, calcium channel blocker, or ranolazine.

Note: Definitions for strength of recommendation are provided in Appendix A GRADE Element Description

### RATIONALE FOR GUIDANCE DEVELOPMENT

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

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

Coverage guidance development follows to translate the evidence review to a policy decision. Coverage guidance may be based on an evidence-based guideline developed by the Evidence-based Guideline Subcommittee or a health technology assessment developed by the Health Technology Assessment Subcommittee. In addition, coverage guidance may utilize an existing evidence report produced by one of HERC's trusted sources, generally within the last three years.

# HEALTH EVIDENCE REVIEW COMMISSION (HERC)

## COVERAGE GUIDANCE: PLANNED OUT-OF-HOSPITAL BIRTH

**DRAFT for VbBS meeting materials 8/13/15**

### HERC COVERAGE GUIDANCE

Planned out-of-hospital (OOH) birth is recommended for coverage for women who do not have high-risk coverage exclusion criteria as outlined below (*weak recommendation*). This coverage recommendation is based on the performance of appropriate risk assessments<sup>1</sup> and the OOH birth attendant's compliance with the consultation and transfer criteria as outlined below.

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

#### High-risk coverage exclusion criteria:

##### *Complications in a previous pregnancy:*

- Cesarean section or other hysterotomy
- Unexplained stillbirth/neonatal death or previous death related to intrapartum difficulty
- Baby with neonatal encephalopathy
- HELLP syndrome
- Placental abruption with adverse outcome
- Pre-eclampsia requiring preterm birth
- Eclampsia
- Uterine rupture
- Retained placenta requiring surgical removal
- Fourth-degree laceration without satisfactory functional recovery

##### *Complications of current pregnancy:*

- Gestational age - preterm or postdates (defined as gestational age < 37 weeks + 0 days or > 41 weeks + 6 days)
- [Pre-existing](#) chronic hypertension
- Pregnancy-induced hypertension with diastolic blood pressure greater than or equal to 90 mmHg or systolic blood pressure greater than or equal to 140 mmHg on two consecutive readings taken [at least](#) 30 minutes apart
- Multiple gestation
- Non-cephalic fetal presentation
- Low lying placenta within 2 cm or less of cervical os at term; placenta previa, vasa previa
- Eclampsia or pre-eclampsia
- Placental abruption/abnormal bleeding
- Anemia – hemoglobin less than 8.5 g/dL

- Induction of labor
- [Drug or alcohol use with high risk for adverse effects to fetal or maternal health](#)
- Recurrent antepartum hemorrhage
- IUGR (defined as fetal weight less than fifth percentile using ethnically-appropriate growth tables, or concerning reduced growth velocity on ultrasound)
- Abnormal fetal heart rate/Doppler/surveillance studies
- Oligohydramnios or polyhydramnios
- Blood group incompatibility with atypical antibodies, or Rh sensitization
- Prelabor rupture of membranes > 24 hours
- Life-threatening congenital anomalies
- Unknown HIV or Hepatitis B status
- Current active infection of varicella at the time of labor
- Rubella infection anytime during pregnancy
- Active infection (outbreak) of genital herpes [at the time of labor](#)
- Refractory hyperemesis gravidarum
- Thrombosis/thromboembolism/ thrombocytopenia (platelets <100,000), or other maternal bleeding disorder
- Uteroplacental insufficiency
- Molar pregnancy
- Maternal mental illness requiring inpatient care
- Diabetes, type I or II, uncontrolled gestational diabetes, or gestational diabetes controlled with medication

#### Transfer criteria:

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

- Non-cephalic fetal presentation
- Eclampsia or pre-eclampsia
- Placental abruption/abnormal bleeding
- ~~Anemia — hemoglobin less than 8.5 g/dL~~
- ~~Current active infection of varicella at the time of labor~~
- ~~Current active infection (outbreak) of genital herpes at the time of labor~~
- Repetitive or persistent abnormal fetal heart rate pattern
- Thick meconium staining of amniotic fluid
- ~~Pregnancy-induced hypertension with diastolic blood pressure greater than or equal to 90 mmHg or raised systolic blood pressure greater than or equal to 140 mmHg on two consecutive readings taken at least 30 minutes apart~~
- Chorioamnionitis or other serious infection (including toxoplasmosis, rubella, CMV, HIV, etc.)
- Failure to progress/failure of head to engage in active labor
- Prolapsed umbilical cord
- Uterine rupture, inversion or prolapse
- Hemorrhage (hypovolemia, shock, need for transfusion)
- Retained placenta > 60 minutes
- Temperature  $\geq 38.0$  C

- Laceration requiring hospital repair (e.g., extensive vaginal, cervical or third- or fourth-degree trauma)
- Enlarging hematoma
- Infection (endometritis, UTI, wound, breast)
- ~~Thrombophlebitis/thromboembolism~~
- Bladder or rectal dysfunction

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

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

#### Consultation criteria:

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

##### *Complications in a previous pregnancy:*

- More than three first trimester spontaneous abortions, or more than one second trimester spontaneous abortion
- Blood group incompatibility, [and/or Rh sensitization](#)
- Pre-eclampsia, not requiring preterm birth
- More than one preterm birth, or preterm birth less than 34 weeks 0 days in most recent pregnancy
- Cervical insufficiency/prior cerclage
- Unresolved intrauterine growth restriction (IUGR) or small for gestational age (defined as fetal or birth weight less than fifth percentile using ethnically-appropriate growth tables)
- Third degree laceration; fourth-degree laceration with satisfactory functional recovery
- ~~Perinatal death~~
- Child with congenital and/or hereditary disorder
- Baby > 4.5 kg or 9 lbs 14 oz
- Unexplained stillbirth/neonatal death or previous death unrelated to intrapartum difficulty
- Shoulder dystocia, with or without fetal clavicular fracture
- Postpartum hemorrhage requiring additional pharmacologic treatment or blood transfusion
- Retained placenta requiring manual removal

##### *Complications of current pregnancy:*

- Fetal macrosomia (estimated weight >4.5 kg or 9 lbs 14 oz)
- Family history of genetic/heritable disorders
- History of maternal seizure disorder (excluding eclampsia)
- Laparotomy during pregnancy
- Cervical dysplasia requiring evaluation
- Gestational diabetes, diet-controlled
- Maternal mental illness under outpatient psychiatric care
- Maternal anemia with hemoglobin < 10.5 g/dL
- Third-degree laceration not requiring hospital repair
- Confirmed intrauterine death
- Inadequate prenatal care (defined as less than five prenatal visits or care began in the third trimester)
- Body mass index at first prenatal visit of greater than 35 kg/m<sup>2</sup>

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

Note: Definitions for strength of recommendation are provided in Appendix B GRADE Element Description

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## EVIDENCE SOURCES

[Note: an additional source search was done at the request of the Evidence-based Guidelines Subcommittee (EbGS) at their April 2, 2015 meeting. A narrative and tabular description of this additional evidence follows that of the initial evidence sources description. A complete listing of the sources included from the new search immediately follows those identified in the initial search below. A full evidence table for these new sources is included in Appendix C.]