Summary Documents from 5/9/13 VBBS Meeting

Cervicobrachial syndrome

Question: Should cervicobrachial syndrome (ICD-9 723.3) remain on a funded line or be moved to the same priority line as other neck pain conditions?

Question source: Dr. John Sattenspiel, OHP medical director

Issue: Cervicobrachial syndrome (ICD-9 723.3) currently appears on line 441 PERIPHERAL NERVE ENTRAPMENT. Other neck pain syndromes, such as 723.1 (Cervicalgia), 723.8 (Other syndromes affecting cervical region), 723.9 (Unspecified musculoskeletal disorders and symptoms referable to neck), and 847.0 (Sprain of neck), are located on line 562 ACUTE AND CHRONIC DISORDERS OF SPINE WITHOUT NEUROLOGIC IMPAIRMENT.

From http://www.mdguidelines.com/cervicobrachial-syndrome

> Cervicobrachial syndrome is a nonspecific term describing some combination of pain, numbness, weakness, and swelling in the region of the neck and shoulder. These cases included the rare conditions of objectively verifiable vascular compression or neurologic compression due to thoracic outlet syndrome, and the common condition of objectively unexplainable similar symptoms. The term "cervicobrachial syndrome" should therefore denote a collection of neck and arm symptoms for which there is no known cause. If a particular patient can be proven to have cervical radiculopathy or vascular compression in the thoracic outlet, then the specific and objectively documented diagnosis should be used. The term "cervicobrachial syndrome" is used by some physicians to describe symptoms they suspect come from cervical nerve root irritation that cannot be documented, whereas other physicians reserve the term for patients whose symptoms may come from undocumentable thoracic outlet syndrome. The definition of "cervicobrachial syndrome" is probably unique to the doctor who uses the term. It may be that an alternate, objectively documentable diagnosis is present, but most often the diagnosis of "cervicobrachial syndrome" refers to symptoms for which there is no proven diagnosis.

Recommendation:

1) Move 723.3 (cervicobrachial syndrome) from line 441 PERIPHERAL NERVE ENTRAPMENT to line 562 ACUTE AND CHRONIC DISORDERS OF SPINE WITHOUT NEUROLOGIC IMPAIRMENT

Chronic Pelvic Inflammatory Conditions

Question: Where should chronic pelvic inflammatory conditions be located on the Prioritized List?

Question source: Don Thieman, MD, OHP Medical Director

Issue: Currently, a series of chronic pelvic inflammatory conditions are located on line 56 ACUTE PELVIC INFLAMMATORY DISEASE. A similar diagnosis (614.1 Chronic salpingitis and oophoritis) is located on line 552 PELVIC PAIN SYNDROME, DYSPAREUNIA. The HERC has been asked to review placement of the chronic pelvic inflammatory conditions. These conditions were reviewed as part of the OB/Gyn ICD-10 review process, and no changes were made to their placement.

From Dr. Thieman

> We need to know that inclusion of codes like 615.1 (for chronic endometritis) and 614.4 (for chronic PID) in apparent ATL[above the line] pairs for surgery, in Line 56 "Acute Pelvic Inflammatory Disease", which seems by title to clearly NOT intend this, is an error; or if the title is the "error" and it is truly intended to cover surgery for these codes (without any accompanying Guideline Note). We have an instant case where the gynecologist submitted endometritis in someone with no active clinical findings ("chronic" at best; historical most likely) in a request for hysterectomy where the only other diagnosis is menorrhagia with menstrual pain, without anemia, so a clear denial unless the Line 56 issue is an unwelcome surprise.

Evidence

Chronic endometritis and chronic pelvic inflammatory disease are listed in various literature sources as possible causes of chronic pelvic pain. Multiple articles discussed treatment of acute pelvic inflammatory disease, but treatment of chronic disease was usually discussed with treatment of other chronic pelvic pain conditions.

Expert Input:

Michelle Berlin, MD, OHSU OB/Gyn

> Chronic endometritis can present as unexpected/irregular vaginal bleeding – if no other cause of such bleeding is found, some folks do endometrial biopsy and if evidence of infection found then treat with antibiotics. I would agree w/this management. On the other hand chronic PID is more characterized by pain due to adhesions etc. In other words, chronic PID does not tend to manifest as infection per se but as signs/symptoms of sequelae of PID.
>
> Dr. Berlin assisted with the recommended line placements in the tables below.

Chronic Pelvic Inflammatory Conditions

Recommendations:

1) Move ICD-9 and ICD-10 codes specifying chronic conditions to line 552 PELVIC PAIN SYNDROME, DYSPAREUNIA (see following tables)
2) Change the name of line 552 to CHRONIC PELVIC INFLAMMATORY DISEASE, PELVIC PAIN SYNDROME, DYSPAREUNIA
3) Add ICD-9 codes which could be used for acute or chronic disease to line 552 and keep on line 56 ACUTE PELVIC INFLAMMATORY DISEASE (see following tables)
    a. Add the following guideline to specify that chronic disease is located on the lower line

GUIDELINE NOTE XXX CHRONIC PELVIC INFLAMMATORY CONDITIONS
Lines 56, 552
Chronic pelvic inflammatory conditions (ICD-9 614.2, 614.4, 614.5, 614.8, 614.9, 615.9) are included on the lower line only; acute conditions are included on the upper line.

GUIDELINE NOTE XXX CHRONIC PELVIC INFLAMMATORY CONDITIONS
Lines 56, 552
Chronic pelvic inflammatory conditions (ICD-10 N70.91-N70.93, N71.9, N73.2, N73.4, N73.5, N73.8, N73.9, N74) are included on the lower line only; acute conditions are included on the upper line.

Chronic Pelvic Inflammatory Conditions

ICD-9 Code	Code Description	Current Line	Recommended Line(s)	Notes/Comments
614.1	Chronic salpingitis and oophoritis	**552** PELVIC PAIN SYNDROME, DYSPAREUNIA	**552**	
614.2	Salpingitis and oophoritis not specified as acute, subacute, or chronic	**56** ACUTE PELVIC INFLAMMATORY DISEASE	**56, 552**	Includes tubo-ovarian abscess, salpingitis, oophoritis
614.3	Acute parametritis and pelvic cellulitis	**56**	**56**	Pelvic cellulitis is a synonym for parametritis
614.4	Chronic or unspecified parametritis and pelvic cellulitis	**56**	**56, 552**	Includes abscess of the broad ligament, parametrim or pelvis, chronic PID
614.5	Acute or unspecified pelvic peritonitis, female	**56**	**56, 552**	
614.6	Pelvic peritoneal adhesions, female (postoperative) (postinfection)	**552**	**552**	
614.7	Other chronic pelvic peritonitis, female	**56**	**552**	No sub-diagnoses listed
614.8	Other specified inflammatory disease of female pelvic organs and tissues	**56**	**56, 552**	No sub-diagnoses listed
614.9	Unspecified inflammatory disease of female pelvic organs and tissues	**56**	**56, 552**	Includes PID NOS and PID
615.0	Acute inflammatory diseases of uterus, except cervix	**56**	**56**	
615.1	Chronic inflammatory diseases of uterus, except cervix	**56**	**552**	
615.9	Unspecified inflammatory disease of uterus	**56**	**56, 552**	Includes endometritis, myometritis, myometra, uterine abscess

Chronic Pelvic Inflammatory Conditions

ICD-10 Code	Code Description	Current Line	Recommended Line(s)	Notes/Comments
N70.0x	Acute salpingitis and/or oophoritis	**56**	**56**	
N70.1x	Chronic salpingitis and/or oophoritis	**552**	**552**	
N70.91	Salpingitis, unspecified	**56**	**56, 552**	
N70.92	Oophoritis, unspecified	**56**	**56, 552**	
N70.93	Salpingitis and oophoritis, unspecified	**56**	**56, 552**	
N71.0	Acute inflammatory disease of uterus	**56**	**56**	
N71.1	Chronic inflammatory disease of uterus	**56**	**552**	
N71.9	Inflammatory disease of uterus, unspecified	**56**	**56, 552**	
N73.0	Acute parametritis and pelvic cellulitis	**56**	**56**	
N73.1	Chronic parametritis and pelvic cellulitis	**56**	**552**	
N73.2	Unspecified parametritis and pelvic cellulitis	**56**	**56, 552**	
N73.3	Female acute pelvic peritonitis	**56**	**56**	
N73.4	Female chronic pelvic peritonitis	**56**	**56, 552**	
N73.5	Female pelvic peritonitis, unspecified	**56**	**56, 552**	
N73.6	Female pelvic peritoneal adhesions (postinfective)	**552**	**552**	
N73.8	Other specified female pelvic inflammatory diseases	**56**	**56, 552**	
N73.9	Female pelvic inflammatory disease, unspecified	**56**	**56, 552**	
N74	Female pelvic inflammatory disorders in diseases classified elsewhere	**56**	**56, 552**	

Therapeutic Apheresis

Question: Where should therapeutic apheresis (CPT 36514-36516) be located on the Prioritized List

Question source: HERC staff, DMAP

Issue: DMAP requested that HERC staff review pairing 36514 with multiple sclerosis and myasthenia gravis. On review of indications for therapeutic apheresis, multiple indications for this procedure were identified. Currently, 36514 is on line 157 ACQUIRED HEMOLYTIC ANEMIAS while 36515 and 36516 are on the Ancillary file.

36514 Therapeutic apheresis; for plasma pheresis
36515 Therapeutic apheresis; with extracorporeal immunoadsorption and plasma reinfusion
36516 Therapeutic apheresis; with extracorporeal selective adsorption or selective filtration and plasma reinfusion

Indications for therapeutic apheresis found in the literature (see **Balogun 2010**) include those listed in the following table.

Recommendations:

1) Add 36514-36516 to lines shown in table below
    a. 100, 117, 136, 138, 140, 142, 150, 151, 157, 183, 199, 223, 225, 249, 308, 338, 366, 479
2) Advise DMAP to remove 36515 and 36516 from the Ancillary List

Therapeutic Apheresis

Indication	ICD-9	Line
Anti-GBM nephritis/Goodpasture's disease	446.21	117 GIANT CELL ARTERITIS, KAWASAKI DISEASE, THROMBOANGIITIS OBLITERANS
Systemic lupus erythematosus	710.0	151 SYSTEMIC LUPUS ERYTHEMATOSUS, OTHER DIFFUSE DISEASES OF CONNECTIVE TISSUE
IgA nephritis/Henoch–Schonlein purpura	287.0	338 DISORDERS INVOLVING THE IMMUNE SYSTEM
Antiphospholipid antibody syndrome	289.81	199 HEREDITARY ANEMIAS, HEMOGLOBINOPATHIES, AND DISORDERS OF THE SPLEEN
Pauci-immune rapidly progressive glomerulonephritis	580.4	138 ACUTE GLOMERULONEPHRITIS: WITH LESION OF RAPIDLY PROGRESSIVE GLOMERULONEPHRITIS
Hyperviscosity syndromes: Cryoglobulinemia Paraproteinemia, Waldenström macroglobulinemia	273.1 273.2 273.3	479 DISORDERS OF PLASMA PROTEIN METABOLISM
Focal segmental glomerulosclerosis	582.1	366 NEPHROTIC SYNDROME AND OTHER RENAL DISORDERS
Multiple myeloma	203.0	249 ACUTE LYMPHOCYTIC LEUKEMIAS (ADULT) AND MULTIPLE MYELOMA
Thrombotic thrombocytopenic purpura/hemolytic uremic syndrome	283.11	157 ACQUIRED HEMOLYTIC ANEMIAS
Guillain-Barre Syndrome	357.0	100 GUILLAIN-BARRE SYNDROME
Wegener's granulomatosis	446.4	140 WEGENER'S GRANULOMATOSIS
Myasthenia Gravis	358.00	150 MYASTHENIA GRAVIS
Lambert-Eaton Syndrome	358.30	150 MYASTHENIA GRAVIS
Microscopic polyangiitis	446.0	183 POLYARTERITIS NODOSA AND ALLIED CONDITIONS
Graves' disease in infants and neonates	242.0	136 THYROTOXICOSIS WITH OR WITHOUT GOITER, ENDOCRINE EXOPHTHALMOS; CHRONIC THYROIDITIS
Pemphigus vulgaris	694.4	223 BULLOUS DERMATOSES OF THE SKIN
Rhabdomyolysis	728.88	142 CRUSH INJURIES OTHER THAN DIGITS; COMPARTMENT SYNDROME
Toxic Epidermal Necrolysis	695.15	225 TOXIC EPIDERMAL NECROLYSIS AND STAPHYLOCOCCAL SCALDED SKIN SYNDROME
Transplantation complications/organ rejection	996.83	308 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT

Corneal Pachymetry

Question: what conditions should be treated with corneal pachymetry (CPT 76514)

Question source: DMAP

Issue: DMAP requested that HERC staff review placement of corneal pachymetry. Currently this procedure is only found on line 149 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE. Corneal Pachymetry is the measurement of corneal thickness and commonly uses either ultrasonic or optical methods. Measurement of corneal thickness in individuals presenting with increased intraocular pressure assists in determining if there is a risk of glaucoma or if the individual's increased eye pressure is the result of abnormal corneal thickness.

Indications found for this procedure

1) **Aetna 2012**
    a. Bullous keratopathy
    b. Corneal edema
    c. Corneal refractive surgery (pre- and post-operative evaluation)
    d. Corneal transplant (penetrating keratoplasty) (pre- and post-operative evaluation)
    e. Evaluation of complications of corneal refractive surgery (once)
    f. Evaluation of corneal rejection post penetrating keratoplasty
    g. Fuchs' endothelial dystrophy
    h. Persons with glaucoma or glaucoma suspects (testing is considered medically necessary once per lifetime)
    i. Posterior polymorphous dystrophy
2) **CMS 2010**
    a. 364.22 Glaucomatocyclitic crises
    b. 364.77 Recession of chamber angle of eye
    c. 365 Glaucoma
    d. 371.23 Bullous keratopathy
    e. 371.48 Peripheral degenerations of cornea
    f. 371.57 Endothelial corneal dystrophy
    g. 371.58 Other posterior corneal dystrophies
    h. 371.6 Keratoconus
    i. 996.51 Mechanical complications of prosthetic corneal graft

Recommendation:
Add corneal pachymetry (CPT 76514) to lines

1) **149** GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
2) **258** PRIMARY ANGLE-CLOSURE GLAUCOMA
3) **282** ACUTE, SUBACUTE, CHRONIC AND OTHER TYPES OF IRIDOCYCLITIS
4) **308** COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
5) **337** CORNEAL OPACITY AND OTHER DISORDERS OF CORNEA
6) **362** RUBEOSIS IRIDIS

Intra-aortic Balloon Devices

Question: Where should intra-aortic balloon devices be located on the Prioritized List?

Question source: HERC staff, DMAP

Issue: DMAP requested review of the placement of intra-aortic balloon pumps (IABPs), specifically whether this procedure should pair with 428.0 Congestive heart failure, unspecified. On review of this question, HERC staff found that the CPT codes for Insertion of intra-aortic balloon assist device (CPT 33967, 33973, and 33975) are on varying lines which results in inconsistency in the Prioritized List. For reference, Ventricular Assist Devices (VADs) are on lines 90 MYOCARDITIS (NONVIRAL), PERICARDITIS (NONVIRAL) AND ENDOCARDITIS, 108 HEART FAILURE, 279 CONGESTIVE HEART FAILURE, CARDIOMYOPATHY, TRANSPOSITION OF GREAT VESSELS, HYPOPLASTIC LEFT HEART SYNDROME treatment CARDIAC TRANSPLANT; HEART/KIDNEY TRANSPLANT, 367 IDIOPATHIC OR VIRAL MYOCARDITIS AND PERICARDITIS.

Indications for intra-aortic balloon devices found in the medical literature include left ventricular failure from acute myocardial infarction, myocarditis, cardiomyopathy, or cardiogenic shock; mechanical complications from an acute MI, unstable angina refractory to medical therapy; bridge to transplant.

Per Howard Song, MD, OHSU Cardiothoracic surgery, the indications for IABP use are the same regardless of the route of insertion. The indications for balloon pumps include the same indications as for VADs, as well as LM stenosis, AMI, acute coronary syndrome, acute mitral regurgitation, etc.

Current line placement is shown on the attached table.

Additional expert input:
The CT surgeons who participated in the ICD10 review expressed concern about overuse and lack of evidence of effectiveness of IABPs in use after acute STEMI and in cases of cardiogenic shock. They forwarded two articles which examined IABP effectiveness compared to optimal medical management. HERC staff research found several additional evidence based review articles examining the effectiveness of IABPs for use in STEMI.

Input from DMAP:
48 claims for the CPT series 33967-33974 were made over the past year for a total of $2,914 paid on a total billing of $15,014 (many were dual eligible patients and claims were paid by Medicare). CPT code 33973/33974 were not billed in the past year. The vast majority of claims were for CPT 33967.

Intra-aortic Balloon Devices

Evidence:

1) **Unverzagt 2011**, Cochrane review of IABPs for acute MI with cardiogenic shock
    a. N=6 studies and 2 ongoing trials
        i. N=3 comparing IABP to standard treatment
        ii. N=3 comparing IABP to VAD
        iii. N=190 patients including in meta-analysis (105 IABP, 85 control [40 with medical treatment, 45 with VAD])
    b. All-cause 30-day mortality of 1.04 (95% CI 0.62 to 1.73) provides no evidence for a survival benefit. While differences in survival were comparable in patients treated with IABP, with and without LVAD, haemodynamics and incidences of device related complications show heterogeneous results.
    c. **Authors' conclusions**: Available evidence suggests that IABP may have a beneficial effect on the haemodynamics, however there is no convincing randomized data to support the use of IABP in infarct related cardiogenic shock.
2) **Sjauw 2009**, systematic review of IABP for STEMI
    a. 7 RCTs comparing IABP vs no IABP for STEMI (n=1009)
        i. IABP showed neither a 30-day survival benefit nor improved left ventricular ejection fraction, while being associated with significantly higher stroke and bleeding rates.
    b. 9 cohort studies of STEMI patients with cardiogenic shock (N=10,529)
        i. In patients treated with thrombolysis, IABP was associated with an 18% [95% confidence interval (CI), 16–20%; P , 0.0001] decrease in 30 day mortality, albeit with significantly higher revascularization rates compared to patients without support. Contrariwise, in patients treated with primary percutaneous coronary intervention, IABP was associated with a 6% (95% CI, 3–10%; P , 0.0008) increase in 30 day mortality.
    c. Conclusion The pooled randomized data do not support IABP in patients with high-risk STEMI. The meta-analysis of cohort studies in the setting of STEMI complicated by cardiogenic shock supported IABP therapy adjunctive to thrombolysis. In contrast, the observational data did not support IABP therapy adjunctive to primary PCI. All available observational data concerning IABP therapy in the setting of cardiogenic shock is importantly hampered by bias and confounding.
3) **Bahekar 2012**, meta-analysis of IABP for STEMI with and without cardiogenic shock
    a. N=16 studies
    b. Meta-analysis revealed that in-hospital mortality of patients with AMI with and without cardiogenic shock did not differ between IABP group as compared to no IABP group (RR: 1.11; confidence interval [CI]: 0.69-1.78; P ¼ .67).
    c. Analysis of patients with AMI with cardiogenic shock showed statistically significant improvement in mortality (RR: 0.72; CI:0.60-0.86; P < .0004).

d. There was no significant reduction in the rate of reinfarction (RR: 0.81; CI: 0.30-2.17; P ¼ .67) o recurrent ischemia (RR: 0.78; CI: 0.34-1.78; P ¼ .55) using IABP.
e. Intra-aortic balloon pump was found to significantly increase the risk of moderate bleeding (RR: 1.71; CI: 1.03-2.85; P ¼ .04) and major bleeding (RR: 4.01; CI: 2.66-6.06; P< .0001).
f. Conclusion: The present meta-analysis suggests that patients with high-risk AMI without cardiogenic shock do not seem to benefit from the use of IABP as measured by in-hospital mortality, rate of reinfarction, and recurrent angina. However, in patients with AMI with cardiogenic shock (systolic blood pressure [SBP] < 90), there was significant reduction in mortality using IABP. The use of IABP is associated with increase in the rate of both moderate and severe bleeding.

4) **Thiele 2012**, trial of IABP for MI with cardiogenic shock
   a. Randomized, prospective, open-label, multicenter trial, N=600 pts with AMI with cardiogenic shock
   b. IABP (N=300) vs no IABP (N=298)
   c. All patients underwent early revascularization
   d. At 30 days, 119 patients in the IABP group(39.7%) and 123 patients in the control group (41.3%) had died (relative risk with IABP, 0.96; 95% confidence interval, 0.79 to 1.17; P = 0.69). There were no significant differences in secondary end points or in process-of-care measures, including the time to hemodynamic stabilization, the length of stay in the intensive care unit, serum lactate levels, the dose and duration of catecholamine therapy, and renal function. The IABP group and the control group did not differ significantly with respect to the rates of major bleeding (3.3% and 4.4%, respectively; P = 0.51), peripheral ischemic complications (4.3% and 3.4%, P = 0.53), sepsis (15.7% and 20.5%, P = 0.15), and stroke (0.7% and 1.7%, P = 0.28).
   e. **Conclusions**: The use of intraaortic balloon counterpulsation did not significantly reduce 30-day mortality in patients with cardiogenic shock complicating acute myocardial infarction for whom an early revascularization strategy was planned.
5) **Ouweneel 2012,** review
   a. Limited evidence of effectiveness of IABPs for cardiogenic shock
   b. European Society of Cardiology/European Association for Cardio-Thoracic Surgery guideline
      i. Class 1 (level of evidence C)
      ii. IABP insertion is recommended in patients with haemodynamic instability (particularly those in cardiogenic shock and with mechanical complications)
   c. American College of Cardiology Foundation/American Heart Association/Society for Cardiovascular Angiography and Interventions guideline

Intra-aortic Balloon Devices

i. Class 1 (level of evidence B)
ii. A haemodynamic support device is recommended for patients with cardiogenic shock after STEMI who do not quickly stabilise with pharmacological therapy

Summary:
The current literature does not find evidence for effectiveness for use of IABPs in acute MI without cardiogenic shock. However, the evidence for use in acute MI with cardiogenic shock is somewhat more mixed. Recent meta-analyses and a large trial failed to find benefit of IABPs for MI with cardiogenic shock. Large professional group guidelines in the US and Europe continue to recommend use of IABPs for cases of hemodynamic instability. Expert input recommends inclusion of IABPs for diagnoses which has VADs as a treatment option. The majority of use of IABPs appears to be for cardiogenic shock.

Recommendation

1) Place all intra-aortic balloon device placement and removal codes (CPT 33967-33974) on the following line and remove from all other lines/Lists:
    a. **108** HEART FAILURE
    b. This is the only line containing VAD placement CPT codes which also has IABP codes 33967 (the most frequently billed code) currently
    c. Consider removal, as major use of IABPs appears to be for cardiogenic shock, which is located on line 76
2) Consider placement of IABP codes on line **76** ACUTE AND SUBACUTE ISCHEMIC HEART DISEASE, MYOCARDIAL INFARCTION
    a. Consider removal: no evidence of effectiveness in treatment of acute MI without cardiogenic shock and mixed evidence (generally trending toward no improvement) in treatment of acute MI with cardiogenic shock
    b. If continue to include IABPs for use in cardiogenic shock on line 76, adopt the following guideline:

GUIDELINE NOTE XXX, INTRA-AORTIC BALLOON PUMPS
Line 76
Intra-aortic balloon pumps (CPT 33967-33974) are included on this line only for use in cardiogenic shock.

Intra-aortic Balloon Devices

CPT code	Code Description	Current Line Placement
33967	Insertion of intra-aortic balloon assist device, percutaneous	**76** ACUTE AND SUBACUTE ISCHEMIC HEART DISEASE, MYOCARDIAL INFARCTION **108** HEART FAILURE **195** CHRONIC ISCHEMIC HEART DISEASE
33968	Removal of intra-aortic balloon assist device, percutaneous	**Excluded**
33970	Insertion of intra-aortic balloon assist device through the femoral artery, open approach	**76** **195**
33971	Removal of intra-aortic balloon assist device including repair of femoral artery, with or without graft	**76** **195**
33973	Insertion of intra-aortic balloon assist device through the ascending aorta	**76** **109** CARDIOMYOPATHY, HYPERTROPHIC MUSCLE **192** MULTIPLE VALVULAR DISEASE **195** **237** DISEASES AND DISORDERS OF AORTIC VALVE **274** DISEASES OF MITRAL, TRICUSPID, AND PULMONARY VALVES **304** LIFE-THREATENING CARDIAC ARRHYTHMIAS **354** COCCIDIOIDOMYCOSIS, HISTOPLASMOSIS, BLASTOMYCOTIC INFECTION, OPPORTUNISTIC AND OTHER MYCOSES **376** CARDIAC ARRHYTHMIAS **385** ANEURYSM OF PULMONARY ARTERY
33974	Removal of intra-aortic balloon assist device from the ascending aorta, including repair of the ascending aorta, with or without graft	**76,109,192,195,237,274,304,354,376,385**

Acupuncture for Knee Osteoarthritis

Question: Should acupuncture be added for treatment of knee osteoarthritis?

Question source: Laura E. Ocker, LAc, President, OAAOM

Issue: Acupuncture for knee osteoarthritis was discussed at the March, 2013 VbBS meeting. At that time, several articles were presented with evidence for the effectiveness of acupuncture for treatment of knee arthritis. The evidence presented at the March meeting is included at the end of this summary.

At the VbBS meeting, There was considerable discussion about the strength of the data around acupuncture for knee osteoarthritis. The commissioners were concerned that there was not a significant clinical improvement with acupuncture vs. sham acupuncture or PT, although there was a statistical difference. There were clinically significant differences in outcomes between the acupuncture group and the wait list group. There was discussion about what was the appropriate comparison group for acupuncture studies (sham acupuncture vs. wait list vs. medical care vs. other). Williams pointed out that there was not much difference in the clinical outcomes between viscosupplementation and acupuncture for this condition, and viscosupplementation had been not approved. Olson agreed that there seemed to be a somewhat lower evidence standard being considered. There was a suggestion that this could be related to the lower risk of harm than surgery, and the difficulty of having alternatives with harms (e.g. narcotics). There was considerable discussion about the Vickers study, and the group decided that they did not understand the magnitude of impact or the outcome measure value for this study. HERC staff was asked to further investigate the Vickers study, perhaps with statistical experts, and bring back a better understanding of this study to a future meeting.

Ms. Ocker has provided HERC staff with additional information regarding the protocol for the Vickers 2012 study, which was the most discussed article at the March meeting. The VbBS requested information on what the statistics in the Vickers study represented in the meta-analysis comparing acupuncture to no acupuncture. The values were presented on a scale from -0.5 to 1.0. It was unclear what the absolute value of the effect was in this study.

According to the protocol paper (Vickers 2010), "the meta-analytic statistics are created by weighting each coefficient by the reciprocal of the variance, summing and dividing by the sum of the weights. Meta-analysis will be accomplished using the metan command in Stata." The methods section of the Vickers 2012 article states "Each RCT was reanalyzed by analysis ofcovariance with the standardized principal end point (scores divided by pooled standard deviation) as the dependent variable, and the baseline measure of the principal end point and variables used to stratify randomization as covariates."

The Vickers study utilized effect sizes, as a method of demonstrating whether a clinical significance between acupuncture and no acupuncture existed (rather than a statistical difference). These effect size numbers shows the strength and direction of the difference

between the outcome measures (reduced pain, increased quality of life, etc.). The use of effect size allowed the researchers to combine varied study endpoints (pain, function, etc.).

The effect size of 0.57 (95% CI, 0.50-0.64) for knee osteoarthritis and usual care or other no-acupuncture controls is considered a "medium" effect size (0.2 is small, 0.5 medium, 0.8 large effect size). The effect size of 0.16 (95% CI, 0.07-0.25) for knee acupuncture in comparison with sham acupuncture controls is considered a "small" effect size. One analysis of the article noted that "the favorable effect=0.57 SD of acupuncture for osteoarthritis would denote an improvement of roughly a 1/2 standard deviation on the end-point measurement scale used to assess pain, functionality, or something else."

From an analysis by Leavitt 2012 [http://updates.pain-topics.org/2012/09/acupuncture-aids-chronic-pain-sort-of.html]

> "Vickers et al. believe that their overall observed estimate of roughly 0.50 SD favoring acupuncture over usual care is of clear clinical importance, but Avins observes that this is difficult to substantiate. The clinical relevance of this would vary with the outcome being assessed (eg, pain, functionality, mood, etc.), how it is being measured, and the standard deviation. For example, given a hypothetical average baseline osteoarthritis pain score of 60mm on a 0-to-100mm VAS and a standard deviation of 20mm, acupuncture might exert an 18% improvement of about 11mm (0.57 effect size *X* 20mm) and patients would still have moderate pain measuring 49mm on the VAS. A recent *UPDATE* discussed research finding that 12mm denotes the Minimum Clinically Significant Difference (MCSD) in a VAS score that is perceived by patients as being of any consequence."

Vickers et al give an example in their 2012 paper to try to explain the effect size: "To give an example of what these effect sizes mean in real terms, a baseline pain score on a 0 to 100 scale for a typical RCT might be 60. Given a standard deviation of 25, follow- up scores might be 43 in a no-acupuncture group, 35 in a sham acupuncture group, and 30 in patients receiving true acupuncture. If response were defined in terms of a pain reduction of 50% or more, response rates would be approximately 30%, 42.5%, and 50%, respectively.

From the commentary by Avins in the same issue of the Archives of Internal Medicine (Avins 2012):

> "Most important, the choice of outcome measure is at once reasonable and problematic. The authors chose the standardized effect size, that is, the magnitude of change expressed in standard deviation units. Using this metric is a rational approach for establishing a common outcome that enables synthesizing data measured on different scales and in different populations. It becomes much more problematic when assigning it an absolute measure of effect: the authors state that the overall observed estimate of approximately 0.5 SD "is of clear clinical relevance," but this assertion is difficult to substantiate. Determining a clinically relevant effect size is a contentious exercise, and the clinical relevance of an average 0.5 SD change is uncertain and likely varies with the measure used and the outcome being assessed."

Acupuncture for Knee Osteoarthritis

Recommendation:

1) Discuss the addition of acupuncture (CPT 97810-4) to line 489 OSTEOARTHRITIS AND ALLIED DISORDERS Treatment MEDICAL THERAPY, INJECTIONS
    a. If added, the acupuncture guideline would need to be modified as noted below. Modify the acupuncture guideline as shown in the separate document titled "Acupuncture Guideline" and excerpted below

Line 489 OSTEOARTHRITIS AND ALLIED DISORDERS

Acupuncture pairs on line 489 for treatment of osteoarthritis of the knee only, when referred, for up to 12 sessions.

Acupuncture for Knee Osteoarthritis

Evidence (previously presented at the March 2013 meeting)

1) **Vickers 2012**; patient level meta-analysis of high quality RCTs
    a. N=9 studies for osteoarthritis
        i. N=8 for knee pain, N=1 for hip pain)
    b. Acupuncture was superior to both sham and no acupuncture control for each pain condition (*P*<.001 for all comparisons).
    c. Osteoarthritis: pain reduced 0.16 (95% CI, 0.07-0.25) vs sham control and 0.57 (95% CI, 0.50-0.64) vs no acupuncture control
2) **NICE 2008,** systematic review of acupuncture for osteoarthritis (knee, hip, thumb)
    a. The studies which have shown superiority of acupuncture over placebo have shown this only in the short term (6–12 weeks).
    b. Recommended against coverage for electro-acupuncture, but made no recommendation on traditional acupuncture
3) **Manheimer 2010**, Cochrane systematic review of acupuncture for peripheral osteoarthritis
    a. N=16 trials, 3498 patients
        i. N=12 OA of knee
        ii. N=3 OA of hip
        iii. N=1 OA of hip or knee
    b. In comparison with a sham control, acupuncture showed statistically significant, short-term improvements in osteoarthritis pain (standardized mean difference -0.28, 95% confidence interval -0.45 to -0.11; 0.9 point greater improvement than sham on 20 point scale; absolute percent change 4.59%; relative percent change 10.32%; 9 trials; 1835 participants) and function (-0.28, -0.46 to -0.09; 2.7 point greater improvement on 68 point scale; absolute percent change 3.97%; relative percent change 8.63%); however, these pooled short-term benefits did not meet our predefined thresholds for clinical relevance (i.e. 1.3 points for pain; 3.57 points for function) and there was substantial statistical heterogeneity. Additionally, restriction to sham-controlled trials using shams judged most likely to adequately blind participants to treatment assignment (which were also the same shams judged most likely to have physiological activity), reduced heterogeneity and resulted in pooled short-term benefits of acupuncture that were smaller and non-significant.
    c. In comparison with sham acupuncture at the six-month follow-up, acupuncture showed borderline statistically significant, clinically irrelevant improvements in osteoarthritis pain (-0.10, -0.21 to 0.01; 0.4 point greater improvement than sham on 20 point scale; absolute percent change 1.81%; relative percent change 4.06%; 4 trials;1399 participants) and function (-0.11, -0.22 to 0.00; 1.2 point greater improvement than sham on 68 point scale; absolute percent change 1.79%; relative percent change 3.89%).
    d. In a secondary analysis versus a waiting list control, acupuncture was associated with statistically significant, clinically relevant short-term improvements in osteoarthritis pain (-0.96, -1.19 to -0.72; 14.5 point greater improvement than sham on 100 point scale; absolute percent change 14.5%; relative percent change 29.14%; 4 trials; 884 participants) and function (-0.89, -1.18 to -0.60; 13.0 point

greater improvement than sham on 100 point scale; absolute percent change 13.0%; relative percent change 25.21%).

e. In the head-on comparisons of acupuncture with the "supervised osteoarthritis education" and the "physician consultation" control groups, acupuncture was associated with clinically relevant short- and long-term improvements in pain and function. In the head on comparisons of acupuncture with 'home exercises/advice leaflet' and 'supervised exercise', acupuncture was associated with similar treatment effects as the controls. Acupuncture as an adjuvant to an exercise based physiotherapy program did not result in any greater improvements than the exercise program alone.

f. **Authors' conclusions** Sham-controlled trials show statistically significant benefits; however, these benefits are small, do not meet our pre-defined thresholds for clinical relevance, and are probably due at least partially to placebo effects from incomplete blinding. Waiting list-controlled trials of acupuncture for peripheral joint osteoarthritis suggest statistically significant and clinically relevant benefits, much of which may be due to expectation or placebo effects.

4) **Hopton 2010,** review of pooled data from meta-analyses
   a. N=4 meta-analyses
   b. The collated results indicate that in the short term, acupuncture provided statistically significant effective pain relief compared with sham controls in…chronic osteoarthritis of the knee…These differences remained statistically significant in the longer term at 6 to 12 months, for knee pain

5) **Kwon 2006**, meta-analysis
   a. N=18 RCTs (10 manual acupuncture, 8 electroacupuncture)
   b. Overall, ten studies demonstrated greater pain reduction in acupuncture groups compared with controls. The meta-analysis of homogeneous data showed a significant effect of manual acupuncture compared with sham acupuncture (standardized mean difference 0.24, 95% confidence interval 0.01–0.47, P¼0.04, n¼329), which is supported by data for knee OA. The extent of heterogeneity in trials of electro-acupuncture prevented a meaningful meta-analysis.

Specialty society recommendations

1) American College of Rheumatology (ACR), (**Hochberg 2012**)
   a. Conditionally recommend acupuncture for knee OA
      i. Only when the patient with knee osteoarthritis (OA) has chronic moderate to severe pain and is a candidate for total knee arthroplasty but either is unwilling to undergo the procedure, has comorbid medical conditions, or is taking concomitant medications that lead to a relative or absolute contraindication to surgery or a decision by the surgeon not to recommend the procedure.

Other policies

1) Aetna 2012
   a. Covers acupuncture for treatment of pain from osteoarthritis of the knee or hip (adjunctive therapy; if no clinical benefit is appreciated after 4 weeks, then the treatment plan should be reevaluated)

Acupuncture for Knee Osteoarthritis

2) Cigna 2012

a. Covers acupuncture for neck pain and osteoarthritic knee pain

Tonsillectomy/CPAP/Sleep Apnea Guideline for Children

Question: How can we best modify the existing tonsillectomy and sleep apnea guidelines for children?

Question Source: HOSC/HSC; HERC staff; OHP Medical Directors; DMAP; Drs. Holger Link and Kyle Johnson, OHSU Sleep Medicine

Issues:
The current Sleep Apnea guideline was reviewed at the January and May, 2011 HOSC meetings. At that time, HOSC members raised many concerns and requested further input from specialists. Since that meeting, there has been considerable concern about the current guideline raised by OHP plans as well as by sleep specialists. There is general consensus that the current guideline is inadequate.

Diagnosis of OSA in children

1) The current guideline requires that obstructive sleep apnea (OSA) be diagnosed by either 1) nocturnal polysomnography, 2) sleep questionnaire or 3) consultation with a sleep medicine specialist.
    a. The OHP plans find that sleep studies are too expensive and are approving surgery based on clinical symptoms alone. The plans are concerned because there are no local providers of polysomnography testing in many communities, necessitating patients to travel and adding expense; there is also concern that the tests done to date have all been positive. Additionally, appropriate criteria for diagnosis OSA by sleep study are unclear in children (note: updated guidelines have been issues since 2011). At the May, 2011 meeting, Carla McKelvey noted that she had no problems obtaining sleep studies in her practice in Coos Bay, and found sleep medicine specialist consultations helpful.
    b. Additionally, many of the OHP plans are reporting great difficulty with use of a "validated questionnaire" as is currently required in our tonsillectomy guideline for diagnosis of OSA. These questionnaires are either proprietary or not useful or not easily located. No commercial plans currently recommend their use for diagnosis of OSA.
2) The benefits of home sleep study instead of sleep lab study has been raised by the OHP Medical Directors. Specifically, the McGill Oximetry Score (MOS) has been used by several plans, and they claim it has better validity that the OSA-18, is objective, and inexpensive ($22.81 per one plan)
3) At the HOSC meetings, it was determined that certain high risk children should likely go straight to adenotonsillectomy, rather than getting a sleep study

Other issues

1) Use of non-FDA approved CPAP devices (no devices are approved for children under 7 or less than 40 lbs).
2) When CPAP should be covered for children, and whether the current CPAP guideline should apply to children

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3) Whether the guideline should refer to children 18 and younger or some other age group (12 and younger, to line up with most national guidelines)
4) Should there be a definition of what constitutes a positive sleep study
5) Concern about overuse of adenotonsillectomy for treatment of OSA
6) Concerns about lack of evidence for long term benefit on neurocognitive outcomes

Current guidelines:

GUIDELINE NOTE 27, SLEEP APNEA
Line 211
Surgery for sleep apnea for adults is only covered after documented failure of both CPAP and an oral appliance.

GUIDELINE NOTE 36, TONSILLECTOMY
Lines 49,83,211,392,564
Tonsillectomy is an appropriate treatment in a case with:

1. 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;
2. Peritonsillar abscess requiring surgical drainage;
3. Moderate or severe obstructive sleep apnea (OSA) in children 18 and younger, or mild OSA in children with daytime symptoms and/or other indications for surgery. For children 3 and younger or for children with significant co-morbidities, OSA must be diagnosed by nocturnal polysomnography. For children older than 3 who are otherwise healthy, OSA must be diagnosed by either nocturnal polysomnography, use of a validated questionnaire (such as the Pediatric Sleep Questionnaire or OSA 18), or consultation with a sleep medicine specialist; or,
4. Unilateral tonsillar hypertrophy in adults; unilateral tonsillar hypertrophy in children with other symptoms suggestive of malignancy.

Summary of evidence presented at January and May 2011 meetings
First line treatment for OSA in children is tonsillectomy and adenoidectomy, and weight control in overweight children. Residual OSA is not uncommon after surgery, and CPAP is the second-line treatment with surgical failure. There are issues with compliance with CPAP in children. There are some data suggesting that intranasal steroids are of short-term benefit, although the data are limited. Currently, the FDA does not approve CPAP use for children under 40lb or under 7 years of age.

There is evidence that pediatric OSA questionnaires are of questionable usefulness. Questionnaires were found to have poor sensitivity and poor negative predictive values for diagnosing OSA in children.

Tonsillectomy/CPAP/Sleep Apnea Guideline for Children

New evidence reviewed since 2011 HOSC meetings

MED report 2011

1) Review of evidence for ages 2-12, diagnostic testing of OSA in children
    a. Lab polysomnography is rated A for diagnosing OSA
    b. Home PSG and video recording is rated C (potential but unproven benefit)
    c. Clinical history and physical exam is rated D (no proven benefit or not considered safe)
    d. OSA morbidity is 18-34%, morbidity highest in children under 3, and in those with severe OSA. Obesity a risk factor for OSA in adolescents only, not in younger children
    e. Tonsillectomy improves neurocognitive outcomes at 1 year
    f. Lab PSG costs $540.28
    g. PA for CPAP is for 3 months, then have to prove that it is being used with downloaded data, rental goes towards purchase.
    h. Guidelines
        i. Clinical findings alone insufficient
        ii. Nap polysomnography and unattended portable monitoring not recommended
        iii. Need training in pediatric sleep disorders for children under 13. Children under 3 need to be done at a pediatric sleep center.
    i. Recommendations
        i. Require documentation of OSA symptoms with excessive daytime somnolence/behavior disorder
        ii. Recommend PSGs when indications for adenotonsillectomy are equivocal
        iii. CPAP is indicated without PSG testing is adenotonsillectomy fails to relieve symptoms or is contraindicated
        iv. PSGs are indicated to titrate CPA and provide follow up evaluation
        v. High risk children (i.e. cranio-facial abnormalities, neuromuscular disorders, Down syndrome, etc.) were not included in the report

Other guidelines

1) American Academy of Pediatrics 2012
    a. Polysomnography should be performed in children/adolescents with snoring and symptoms/signs of OSAS; if polysomnography is not available, then alternative diagnostic tests or referral to a specialist for more extensive evaluation may be considered.
    b. Adenotonsillectomy is recommended as the first-line treatment of patients with adenotonsillar hypertrophy.
    c. Patients should be reevaluated postoperatively to determine whether further treatment is required. Objective testing should be performed in patients who are high risk or have persistent symptoms/signs of OSAS after therapy.
    d. Continuous positive airway pressure is recommended as treatment if adenotonsillectomy is not performed or if OSAS persists postoperatively.

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e. Weight loss is recommended in addition to other therapy in patients who are overweight or obese.
f. Intranasal corticosteroids are an option for children with mild OSAS in whom adenotonsillectomy is contraindicated or for mild postoperative OSAS.

2) American Academy of Head and Neck Surgeons 2011

a. Before determining the need for tonsillectomy, the clinician should refer children with sleep-disordered breathing for polysomnography if they exhibit certain complex medical conditions such as obesity, Down syndrome, craniofacial abnormalities, neuromuscular disorders, sickle cell disease, or mucopolysaccharidoses.
b. The clinician should advocate for polysomnography prior to tonsillectomy for sleep-disordered breathing in children without any of the comorbidities listed in statement 1 for whom the need for surgery is uncertain or when there is discordance between tonsillar size on physical examination and the reported severity of sleep-disordered breathing.
c. In children for whom polysomnography is indicated to assess sleep-disordered breathing prior to tonsillectomy, clinicians should obtain laboratory-based polysomnography, when available.

3) **American Academy of Sleep Medicine 2011**

a. Polysomnography is indicated when the clinical assessment suggests the diagnosis of obstructive sleep apnea syndrome (OSAS) in children. (Standard)
b. Children with mild OSAS preoperatively should have clinical evaluation following adenotonsillectomy to assess for residual symptoms. If there are residual symptoms of OSAS, polysomnography should be performed. (Standard)
c. Polysomnography is indicated following adenotonsillectomy to assess for residual OSAS in children with preoperative evidence for moderate to severe OSAS, obesity, craniofacial anomalies that obstruct the upper airway, and neurologic disorders (e.g., Down syndrome, Prader-Willi syndrome, and myelomeningocele). (Standard)
a. Polysomnography is indicated for positive airway pressure (PAP) titration in children with obstructive sleep apnea syndrome. (Standard)
b. Polysomnography is indicated when the clinical assessment suggests the diagnosis of congenital central alveolar hypoventilation syndrome or sleep related hypoventilation due to neuromuscular disorders or chest wall deformities. It is indicated in selected cases of primary sleep apnea of infancy. (Guideline) Polysomnography is indicated when there is clinical evidence of a sleep related breathing disorder in infants who have experienced an apparent life-threatening event (ALTE). (Guideline)
c. Polysomnography is indicated in children being considered for adenotonsillectomy to treat obstructive sleep apnea syndrome (Guideline)
d. Follow-up PSG in children on chronic PAP support is indicated to determine whether pressure requirements have changed as a result of the

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child's growth and development, if symptoms recur while on PAP, or if additional or alternate treatment is instituted. (Guideline)

e. Polysomnography is indicated after treatment of children for OSAS with rapid maxillary expansion to assess for the level of residual disease and to determine whether additional treatment is necessary. (Option)
f. Children with OSAS treated with an oral appliance should have clinical follow-up and polysomnography to assess response to treatment. (Option)
g. Nap (abbreviated) polysomnography is not recommended for the evaluation of obstructive sleep apnea syndrome in children. (Option)

4) **AASM 2012**, Guidelines for Scoring Sleep Studies
   a. For children (<18 years, although <13 years is an option)
   b. Apnea is scored when peak signal excursions drop by ≥ 90% of pre-event baseline using an oronasal thermal sensor (diagnostic study), PAP device flow (titration study), or an *alternative* sensor; and the event meets duration and respiratory effort criteria for an obstructive, mixed, or central apnea. A central apnea is scored in children when the event meets criteria for an apnea, there is an absence of inspiratory effort throughout the event, and at least one of the following is met: (1) the event is ≥ 20 seconds in duration, (2) the event is associated with an arousal or ≥ 3% oxygen desaturation, (3) (infants under 1 year of age only) the event is associated with a decrease in heart rate to less than 50 beats per minute for at least 5 seconds or less than 60 beats per minute for 15 seconds.
   c. A hypopnea is scored in children when the peak signal excursions drop is ≥ 30% of pre-event baseline using nasal pressure (diagnostic study), PAP device flow (titration study), or an *alternative* sensor, for ≥ the duration of 2 breaths in association with either ≥ 3% oxygen desaturation or an arousal. In children and adults, surrogates of the arterial PCO2 are the end-tidal PCO2 or transcutaneous PCO2 (diagnostic study) or transcutaneous PCO2 (titration study).
   d. For pediatric patients hypoventilation is scored when the arterial PCO2 (or surrogate) is > 50 mm Hg for > 25% of total sleep time. In adults Cheyne-Stokes breathing is scored when both of the following are met: (1) there are episodes of ≥ 3 consecutive central apneas and/or central hypopneas separated by a crescendo and decrescendo change in breathing amplitude with a cycle length of at least 40 seconds (typically 45 to 90 seconds), and (2) there are fi ve or more central apneas and/or central hypopneas per hour associated with the crescendo/decrescendo breathing pattern recorded over a minimum of 2 hours of monitoring.

Materials submitted by experts

5) **Kaditis 2012**
   a. Proposed algorithm for the diagnosis and treatment of OSA in children

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Commercial Plans

A. Aetna 2013

1. Diagnosis
    1. Aetna considers nocturnal polysomnography (NPSG) for children and adolescents younger than 18 years of age with habitual snoring during sleep medically necessary when performed in a healthcare facility to differentiate primary snoring versus obstructive sleep apnea syndrome (OSAS).
    2. Aetna considers NPSG for children medically necessary when performed in a healthcare facility after an adenotonsillectomy or other pharyngeal surgery for OSAS when *any* of the following is met (study should be delayed 6 to 8 weeks post-operatively):
        1. Age younger than 3 years; or
        2. Cardiac complications of OSAS (e.g., right ventricular hypertrophy); or
        3. Craniofacial anomalies; or
        4. Failure to thrive; or
        5. Neuromuscular disorders; or
        6. Obesity; or
        7. Prematurity; or
        8. Recent respiratory infection; or
        9. Severe OSAS was present on pre-operative PSG (a respiratory disturbance index of 19 or greater); or
        10. Symptoms of OSAS persist after treatment.
    3. Aetna considers the use of abbreviated or screening techniques, such as videotaping, nocturnal pulse oximetry, daytime nap PSG, or unattended home PSG, experimental and investigational for diagnosis of OSAS in children because their effectiveness for this indication has not been established.
2. Treatment

    Aetna considers the following treatments for OSAS in children with habitual snoring medically necessary when the apnea index is greater than 1 on a NPSG.
    1. Aetna considers adenotonsillectomy medically necessary for treatment of OSAS in children. Childhood OSAS is usually associated with adenotonsillar hypertrophy, and the available medical literature suggests that the majority of cases will benefit from adenotonsillectomy.
    2. Aetna considers continuous positive airway pressure (CPAP) medically necessary for treatment of OSAS in children when *any* of the following is met:
        1. Adenotonsillectomy is contraindicated; *or*
        2. Adenotonsillectomy is delayed; *or*
        3. Adenotonsillectomy is unsuccessful in relieving symptoms of OSAS.

        Aetna considers CPAP medically necessary for treatment of tracheomalacia.

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3. Aetna considers oral appliances or functional orthopedic appliances medically necessary in the treatment of children with craniofacial anomalies with signs and symptoms of OSAS.

Healthnet 2011

1) Overnight polysomnography (PSG) in a sleep lab setting for children is considered medically necessary for the diagnosis of Obstructive Sleep Apnea in Children
2) Indications for overnight polysomnography in a sleep lab setting for children where obstructive sleep-disordered breathing is suspected, include **any** of the following:
    a. Habitual (nightly) snoring associated with any of the following:
        i. Restless or disturbed sleep
        ii. Behavioral disturbance, or learning disorders including deterioration in academic performance, hyperactivity, or attention deficit disorder
        iii. Unexplained enuresis at an inappropriate age
        iv. Frequent awakenings
        v. Failure to thrive or growth impairment
    b. Witnessed apnea for greater than 2 respiratory cycle times (inspiration and expiration
    c. Excessive daytime somnolence, or altered mental status unexplained by other conditions or etiologies
    d. Polycythemia unexplained by other conditions or etiologies
    e. Cor pulmonale unexplained by other conditions or etiologies
    f. Hypertrophy of tonsils and adenoids associated with noisy daytime respirations where surgical removal poses a significant risk and would be avoided in the absence of sleep disordered breathing
3) diagnosis of OSA can be made when the following are met in children 12 and under:
    a. Apnea-hypopnea index >1 in children 12 and under
    b. Minimum oxygen saturation <92%
4) Repeat overnight polysomnography in a sleep lab setting for children is considered medically necessary in any of the following circumstances:
    a. Initial polysomnography is inadequate or non-diagnostic and the accompanying caregiver reports that the child's sleep and breathing patterns during the testing were not representative of the child's sleep at home
    b. A child with previously diagnosed and treated obstructive sleep apnea who continues to exhibit persistent snoring or other symptoms of sleep disordered breathing. In the case of adenotonsillectomy, repeat polysomnography should also be performed if the pre-operative obstructive sleep apnea was severe (RDI or AHI greater than 19). If the treatment was surgical, testing should be deferred for 6 to 8 weeks post-operatively.

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c. To periodically re-evaluate the appropriateness of continuous positive airway pressure (CPAP) setting based on the child's growth pattern or the presence of recurrent symptoms while on CPAP
d. If obesity was a major contributing factor and significant weight loss has been achieved, repeat testing may be indicated to determine the need for continued therapy.

5) CPAP is indicated when **all** of the following criteria are met:
   a. OSA diagnosis has been established by PSG; and
   b. Adenotonsillectomy has been unsuccessful or is contraindicated, or when definitive surgery is indicated but must await complete dental and facial development.
6) Health Net, Inc. considers **any** of the following not medically necessary, because the peer- reviewed medical literature does not support their use:
   a. Repeat polysomnography in the follow-up of patients with obstructive sleep apnea treated with CPAP when symptoms attributable to sleep apnea have resolved; or
   b. Polysomnography in children for **any** of the following:
      i. Routine evaluation of adenotonsillar hypertrophy alone without other clinical signs or symptoms suggestive of obstructive sleep disordered breathing
      ii. Routine follow-up for children whose symptoms have resolved post-adenotonsillectomy.
7) Health Net, Inc. considers home home/portable sleep studies for the diagnosis of OSA in children (less than 18 years of age) investigational.
   a. Limited portable studies, or studies in the home, are not sufficient to exclude OSA in a child with suggestive symptoms, nor can they reliably assess the severity of the disorder which is important in planning treatment. Overnight polysomnography remains the diagnostic "gold standard" in children with OSA.

<u>Expert Input</u>

Dr. Holger Link, OHSU Sleep Medicine

General comments: I had a look at PSG interpretations of my Medicaid patients with big tonsils from January first to now and 8 out of 32 patients (23%) did not go on to surgery per my records. I am therefore not sure why OHP states that all children with large tonsils that undergo PSGT have surgery and that the sleep study therefore is not indicated. One of our concerns is that the Willamette Valley had decided that all children with big tonsils and symptoms of OSA should go directly for surgery. Most patients that are seen at OHSU never have a sleep study. However, I think that it is very important that physicians and other clinical practitioners have the ability to use clinical judgment and to order a sleep study if thought to be indicated for a particular patient.

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Regarding what age should the guideline apply to (12 and younger or 18 and younger): Hard to define a scientifically based cut off. The recent AASM Scoring Guidelines for respiratory events suggest a cut off <18 years but also acknowledges that some sleep specialist choose to score children > 13 years with adult criteria. One approach is to choose and age at which most children will have completed puberty, maybe around 16 years. Alternatively could use 13 -14 years.

Regarding specific criteria to determine if a PSG is positive: It is very important for the treating physician to be able to incorporate the clinical impression and overall clinical picture in the decision making. Defining a positive PSG is usually fairly easy when the AHI is > 5/hour and much more challenging when the AHI is lower. I always look at the composition of the AHI (i.e. how many obstructive apnea, hypopneas or central and severity of desaturations.). I would suggest to consider adenotonsillectomy or CPAP in the 2-5 AHI patients if they have disrupted sleep or daytime behavior problems or decreased energy and sleepiness.

Summary

1) General issues
    a. For the diagnosis and treatment of OSA, "child" is defined as a person 12 years of age or younger by nearly all specialty groups
    b. High risk children (i.e. cranio-facial abnormalities, neuromuscular disorders, Down syndrome, etc.) should be considered separately
2) Diagnosis of OSA in children
    a. Polysomnography is considered the standard for diagnosis of OSA; some expert groups require it prior to diagnosis and others recommend it for equivocal diagnoses or high risk children or when there is discordance between tonsillar size on physical examination and the reported severity of sleep-disordered breathing.
        i. Sleep testing other than overnight polysomnography in a sleep lab (i.e. nap testing, home testing) should not be done
    b. Can be made with documentation of OSA symptoms with excessive daytime somnolence/behavior disorder
    c. Can be made via referral to specialist
3) Treatment of OSA
    a. Adenotonsillectomy is effective at treating OSA
    b. CPAP is indicated if adenotonsillectomy fails to relieve symptoms or is contraindicated
        i. Groups vary on recommendations for PSG prior to initiating CPAP
    c. PSGs are indicated to titrate CPAP and provide follow up evaluation
    d. Weight loss is recommended in addition to other therapy in patients who are overweight or obese.
    e. Intranasal corticosteroids are an option for children with mild OSAS in whom adenotonsillectomy is contraindicated or for mild postoperative OSAS.

Tonsillectomy/CPAP/Sleep Apnea Guideline for Children

Recommendations:

1) Adopt a new guideline for pediatric sleep apnea diagnosis and treatment as shown below
    a. Reference to a validated questionnaire is removed
    b. Sleep disruption must be documented; however, whether this documentation is by nocturnal polysomnography, clinical history, or other method is left open
2) Modify the existing Tonsillectomy Guideline and Sleep Apnea Guideline as shown below

GUIDELINE NOTE XXX, OBSTRUCTIVE SLEEP APNEA DIAGNOSIS AND TREATMENT FOR CHILDREN

Line 211

Obstructive sleep apnea (OSA) in children (12 and younger) must be diagnosed by either 1) documented sleep disruption (by history, nocturnal polysomnography, or other method) AND daytime sleepiness and/or behavior problems, or 2) consultation with a pediatric sleep medicine specialist. High risk children (i.e. children with cranio-facial abnormalities, neuromuscular disorders, Down syndrome, etc.) and children with equivocal indications for adenotonsillectomy should have nocturnal polysomnography prior to surgery.

Adenotonsillectomy is an appropriate first line treatment for children with OSA. Weight loss is recommended in addition to other therapy in patients who are overweight or obese. Intranasal corticosteroids are an option for children with mild OSA in whom adenotonsillectomy is contraindicated or for mild postoperative OSA.

CPAP is covered for a 3 month trial for those who have

1) undergone surgery (or are not candidates for surgery), AND
2) have documented residual sleep apnea symptoms (sleep disruption and/or significant desaturations) with residual daytime symptoms (daytime sleepiness and behavior problems)

CPAP will be covered on an ongoing basis if:

1) There is documentation for improvement in sleep disruption and daytime sleepiness and behavior problems
2) Annual re-evaluation for CPAP demonstrates ongoing need and compliance with use

GUIDELINE NOTE 36, <u>ADENOTONSILLECTOMY FOR INDICATIONS OTHER THAN OBSTRUCTIVE SLEEP APNEA</u>

Lines 49,83,211,392,564

Tonsillectomy/adenotonsillectomy is an appropriate treatment for patients with:

1. 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

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positive culture/screen and where an appropriate course of antibiotic therapy has been completed;
2. Peritonsillar abscess requiring surgical drainage;
~~3. Moderate or severe obstructive sleep apnea (OSA) in children 18 and younger, or mild OSA in children with daytime symptoms and/or other indications for surgery. For children 3 and younger or for children with significant co-morbidities, OSA must be diagnosed by nocturnal polysomnography. For children older than 3 who are otherwise healthy, OSA must be diagnosed by either nocturnal polysomnography, use of a validated questionnaire (such as the Pediatric Sleep Questionnaire or OSA 18), or consultation with a sleep medicine specialist; or,~~
~~4.~~ 3. Unilateral tonsillar hypertrophy in adults; unilateral tonsillar hypertrophy in children with other symptoms suggestive of malignancy.

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

GUIDELINE NOTE 27, SLEEP APNEA
Line 211
Surgery for sleep apnea for adults (13 and older) is only covered after documented failure of both CPAP and an oral appliance.

CG - Diagnosis of sleep apnea in adults

Question: Should the Diagnostic Testing for Obstructive Sleep Apnea Guideline be modified?

Question source: Managed Care Medical Directors

Issue:
At the 3/14/13 VBBS meeting, the following new diagnostic guideline on testing for obstructive sleep apnea (OSA) was approved:

> **DIAGNOSTIC GUIDELINE XX DIAGNOSTIC TESTING FOR OBSTRUCTIVE SLEEP APNEA (OSA)**
>
> The following diagnostic tests for OSA are covered for adults:
> 1. Type I PSG is covered when used to aid the diagnosis of OSA in patients who have clinical signs and symptoms indicative of OSA if performed attended in a sleep lab facility.
> 2. Type II or Type III sleep testing devices are covered when used to aid the diagnosis of OSA in patients who have clinical signs and symptoms indicative of OSA if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility.
> 3. Type IV sleep testing devices measuring three or more channels, one of which is airflow, are covered when used to aid the diagnosis of OSA in patients who have signs and symptoms indicative of OSA if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility.
> 4. Sleep testing devices measuring three or more channels that include actigraphy, oximetry, and peripheral arterial tone, are covered when used to aid the diagnosis of OSA in patients who have signs and symptoms indicative of OSA if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility.

This guideline was presented as part of the VBBS minutes to the Managed Care Medical Directors April 8th who raised several concerns about the language:

1) Many of the medical directors had concerns about the coverage language requiring coverage for all types of sleep testing devices. Some felt strongly that CCOs should have their choice of covering which one depending on what made sense for the plan, and their local providers.
2) Concerns were raised about having two sleep studies performed on each patient, one for diagnosis and one for cpap titration. They recommended language to the effect of titration being performed at the time of the diagnostic testing (i.e. split-night polysomnography)

CG - Diagnosis of sleep apnea in adults

HERC Staff Recommendations:
Modify the Diagnostic Guideline on OSA as follows:

DIAGNOSTIC GUIDELINE XX DIAGNOSTIC TESTING FOR OBSTRUCTIVE SLEEP APNEA (OSA)

At least one of the following diagnostic tests for OSA are covered for adults:
1. Type I PSG is covered when used to aid the diagnosis of OSA in patients who have clinical signs and symptoms indicative of OSA if performed attended in a sleep lab facility.
2. Type II or Type III sleep testing devices are covered when used to aid the diagnosis of OSA in patients who have clinical signs and symptoms indicative of OSA if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility.
3. Type IV sleep testing devices measuring three or more channels, one of which is airflow, are covered when used to aid the diagnosis of OSA in patients who have signs and symptoms indicative of OSA if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility.
4. Sleep testing devices measuring three or more channels that include actigraphy, oximetry, and peripheral arterial tone, are covered when used to aid the diagnosis of OSA in patients who have signs and symptoms indicative of OSA if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility.

Titration should be performed on the diagnostic study, if possible.

CG - Continuous blood glucose monitoring in diabetes mellitus

Question: Should the guideline on *Continuous blood glucose monitoring in diabetes mellitus* be modified?

Question source: HTAS and Managed Care Medical Directors

Issue: At the March 14, 2013 VBBS meeting, the Coverage Guidance on Continuous blood glucose monitoring was reviewed and a recommendation was made for applying a guideline to the Prioritized List. When this was presented to the Managed Care Medical Directors, they had some concerns and suggestions about modifying the guideline for more appropriate implementation. There were 2 key concerns, the first that the AND and OR language was confusing, and they wanted language added that a1c was > 8.0% "despite compliance with treatment." If a patient is noncompliant, additional testing is not helpful. Additionally, the VBBS decision on retrospective monitors was brought back to the HTAS subcommittee, who therefore made changes to their Coverage Guidance.

Initial HTAS Coverage Guidance 11/26/12:

> Real-time continuous glucose monitoring systems should be covered for Type 1 diabetes mellitus patients with HbA1c levels greater than 8.0% or a history of recurrent hypoglycemia, for whom insulin pump management is being considered, initiated, or utilized.
>
> Real-time continuous glucose monitoring systems should not be covered for Type 2 diabetes mellitus patients.
>
> Retrospective continuous glucose monitoring systems should be covered for Type 1 diabetes mellitus and should not be covered for Type 2 diabetes mellitus.

VBBS REVIEW 3/14/13

From the VBBS minutes:

> Discussion: Livingston presented a summary document. There were concerns raised about clinically insignificant changes in blood glucose levels. An ancillary guideline was discussed. The lack of data on retrospective monitors was mentioned and a discussion ensued about whether the retrospective monitors should be permitted for all type 1 diabetics with no limitations, or if the same limitations should apply as with real-time continuous blood glucose monitors. The decision was made to go with the more restrictive option, because it was more aligned with the evidence.
>
> MOTION: To approve a new guideline on continuous blood glucose monitoring with either: Option 1-No limitations for type 1 diabetics using retrospective monitors, or Option 2-Same limitations (>8.0% HbA1c) on use of both retrospective and real-time monitors by type 1 diabetics.
> The subcommittee voted, with five votes for option 2, one vote (Pollack) for option 1 and one abstention (Ocker). Option 2 CARRIES 5-1-1.
>
> A discussion ensued about what to do when subcommittees recommend different language. The GRADE process has modified decision making as well as the greater incorporation of experts. The VBBS decided to recommend a slightly different version, and this would be an example for HERC to give feedback to the

CG - Continuous blood glucose monitoring in diabetes mellitus

subcommittees as to how GRADE analysis should be applied to the Prioritized List.

VBBS Approved guideline 3/14/13

GUIDELINE NOTE XXX CONTINUOUS BLOOD GLUCOSE MONITORING
Line 10

Continuous blood glucose monitoring *(CPT codes 95250-95251, HCPCS codes S1030-S1031)* with real-time or retrospective continuous glucose monitoring systems are only included on Line 10 for Type 1 diabetics with HbA1c levels greater than 8.0% OR a history of recurrent hypoglycemia, AND for whom insulin pump management is being considered, initiated, or utilized.

Coverage Guidance Revised by HTAS 4/22/13

The VBBS decision was brought back to HTAS. HTAS modified their Coverage Guidance as follows:

Continuous blood glucose monitoring with real-time or retrospective continuous glucose monitoring systems should only be covered for Type 1 diabetes mellitus patients for whom insulin pump management is being considered, initiated, or utilized and who also have one of the following:

- HbA1c levels greater than 8.0%, or
- a history of recurrent hypoglycemia.

Real-time and retrospective continuous glucose monitoring systems should not be covered for Type 2 diabetes mellitus patients.

HERC Staff Recommendations:

1) Modify the Continuous blood glucose monitoring Guideline Note as follows including HTAS recommendations and Medical Director recommendations:

GUIDELINE NOTE XXX CONTINUOUS BLOOD GLUCOSE MONITORING
Line 10

Continuous blood glucose monitoring *(CPT codes 95250-95251, HCPCS codes S1030-S1031)* with real-time or retrospective continuous glucose monitoring systems are only included on Line 10 for Type 1 diabetics ~~with HbA1c levels greater than 8.0% OR a history of recurrent hypoglycemia, AND~~ for whom insulin pump management is being considered, initiated, or utilized and who also have one of the following:

- HbA1c levels greater than 8.0% (despite compliance with treatment), or
- a history of recurrent hypoglycemia.

CG – Neuroimaging for Headache Issue Summary

Question: How should the revised Coverage Guidance on Neuroimaging for Headache be incorporated into the Prioritized List?

Question source: Health Evidence Review Commission

Issue: HERC approved the Coverage Guidance: Neuroimaging for Headache on August 9, 2012. VBBS and HERC approved a modification to the current diagnostic guideline relating to neuroimaging for headache on October 11, 2012. After feedback from DMAP, there were some language concerns that prohibited effective implementation of the guideline (e.g. “visual disturbances”, “cognitive disturbance”). EbGS rereviewed the evidence and the coverage guidance language, reposted the revised language for public comment, and approved a revised Coverage Guidance document. The basis of this was still the SIGN review, but had some additional indications such as cluster headache, and more specific language (removing cognitive disturbance, visual disturbance, reference to aura, objectifying neck stiffness, etc). This revised Coverage Guidance needs to be evaluated for application within the Prioritized List.

Current Prioritized List Status:

The current diagnostic guideline addressing neuroimaging for headache is as follows:

DIAGNOSTIC GUIDELINE D5, NEUROIMAGING FOR HEADACHE

Neuroimaging is not indicated in patients with a clear history of migraine, without red flag features for potential secondary headache, and a normal neurological examination. Neuroimaging is only covered for patients with “red flag features” defined as:

A) New onset or change in headache in patients who are aged over 50
B) Thunderclap headache: rapid time to peak headache intensity (seconds to 5 minutes)
C) Focal neurological symptoms (e.g. limb weakness, aura <5 min or >1 hr)
D) Non-focal neurological symptoms (e.g. cognitive disturbance/altered mental status)
E) Abrupt change in headache frequency, characteristics or associated symptoms
F) Unexplained abnormal findings on neurological examination
G) Headache that changes with posture
H) Headache wakening the patient up (NB migraine is the most frequent cause of morning headache)
I) Headache precipitated by physical exertion or valsalva maneuver (e.g. coughing, laughing, straining)
J) Patients with risk factors for cerebral venous sinus thrombosis
K) Jaw claudication or visual disturbance
L) Neck stiffness accompanying headache
M) Fever accompanying headache
N) New onset headache in a patient with a history of human immunodeficiency virus (HIV) infection
O) New onset headache in a patient with a history of cancer

CG – Neuroimaging for Headache Issue Summary

Revised HERC Coverage Guidance approved by EbGS 4/4/13:

HERC COVERAGE GUIDANCE

Neuroimaging is not recommended for coverage in patients with a defined tension or migraine type of headache, or a variation of their usual headache (e.g. more severe, longer in duration, or not responding to drugs).

Neuroimaging is recommended for coverage with headache when a red flag* is present.

*The following represent red flag conditions for underlying abnormality with headache:

- new onset or change in headache in patients who are aged over 50
- thunderclap headache: rapid time to peak headache intensity (seconds to 5 min)
- focal neurologic symptoms (e.g. limb weakness)
- non-focal neurological symptoms (e.g. altered mental status)
- abnormal neurological examination
- headache that changes with posture
- headache wakening the patient up
- headache precipitated by physical exertion or Valsalva maneuver (e.g. coughing, laughing, straining)
- patients with risk factors for cerebral venous sinus thrombosis
- jaw claudication
- nuchal rigidity
- new onset headache in a patient with a history of human immunodeficiency virus (HIV) infection
- new onset headache in a patient with a history of cancer
- headache with a history of dizziness, lack of coordination, numbness or tingling
- cluster headache, paroxysmal hemicrania or Short-lasting unilateral neuralgiform headache attacks with conjunctival injection and tearing) (SUNCT), or short-lasting unilateral neuralgiform headache attacks with cranial autonomic features (SUNA)

HERC Staff Recommendations:

1. Modify the current diagnostic guideline as follows:

CG – Neuroimaging for Headache Issue Summary

DIAGNOSTIC GUIDELINE D5, NEUROIMAGING FOR HEADACHE

~~Neuroimaging is not indicated in patients with a clear history of migraine, without red flag features for potential secondary headache, and a normal neurological examination. Neuroimaging is only covered for patients with "red flag features" defined as:~~

Neuroimaging is not covered in patients with a defined tension or migraine type of headache, or a variation of their usual headache (e.g. more severe, longer in duration, or not responding to drugs).

Neuroimaging is covered for headache when a red flag* is present.

*The following represent red flag conditions for underlying abnormality with headache:

A. New onset or change in headache in patients who are aged over 50
B. Thunderclap headache: rapid time to peak headache intensity (seconds to 5 minutes)

C. Focal neurological symptoms (e.g. limb weakness~~, aura <5 min or >1 hr~~)
D. Non-focal neurological symptoms (e.g. ~~cognitive disturbance/~~altered mental status)
~~E. Abrupt change in headache frequency, characteristics or associated symptoms~~
F. ~~Unexplained~~ Abnormal ~~findings on~~ neurological examination
G. Headache that changes with posture
~~H.~~ Headache wakening the patient up ~~(NB migraine is the most frequent cause of morning headache)~~
I. Headache precipitated by physical exertion or valsalva maneuver (e.g. coughing, laughing, straining)
J. Patients with risk factors for cerebral venous sinus thrombosis
K. Jaw claudication ~~or visual disturbance~~
L. ~~Neck stiffness accompanying headache~~ Nuchal rigidity
~~M. Fever accompanying headache~~
N. New onset headache in a patient with a history of human immunodeficiency virus (HIV) infection
O. New onset headache in a patient with a history of cancer

P. Headache with a history of dizziness, lack of coordination, numbness or tingling

Q. Cluster headache, paroxysmal hemicrania or Short-lasting unilateral neuralgiform headache attacks with conjunctival injection and tearing) (SUNCT), or short-lasting unilateral neuralgiform headache attacks with cranial autonomic features (SUNA)

CG - Induction of Labor

Question: How should the revised Coverage Guidance on Induction of Labor be incorporated into the Prioritized List?

Question source: Evidence-based Guideline Subcommittee

Issue: At the January 10, 2013 HERC meeting, the HERC decided that Induction of Labor was a good Coverage Guidance to take through the revised coverage guidance process that is based on components of GRADE methodology and involves expert input. The EbGS then reexamined the Induction of Labor Coverage Guidance at the February 7, 2013 meeting. Invited experts included Drs. Caughey, Tomlinson, and Neilson. Significant feedback was received about a cutoff of 39 weeks versus 41 weeks for elective induction of labor. Additional evidence was sought on this area. The CG was revised and sent out for public comment, and at the April 4, 2013 EbGS meeting a revised Coverage Guidance was approved that had the following major changes:

- A new GRADE table
- New coverage recommendation language consistent with revised process was incorporated
- Individualized treatment plan language was removed
- A change in recommendation regarding elective induction between 39 and 41 weeks (previously not recommended for coverage, now recommended for coverage if the cervix is favorable)
- The recommendation against induction for breech was removed from the recommendations
- Recommendations for coverage were made for many conditions with insufficient evidence

Current Prioritized List Induction of Labor Guideline:

GUIDELINE NOTE 85, INDUCTION OF LABOR

Line 1

Elective induction of labor without medical or obstetrical indication is covered only for gestational age beyond 41 and 0/7 weeks, prelabor rupture of membranes, maternal diabetes (pre-existing or gestational), or other medical or obstetrical indications. Induction of labor is not covered at any gestational age for fetal macrosomia in the absence of maternal diabetes, for breech presentation or for elective purposes without a medical or obstetrical indication.

Previous IOL Coverage Guidance – HERC Approved 6/14/12

Induction of labor *should be* covered for the following indications:

- Gestational age beyond 41 0/7 weeks
- Prelabor rupture of membranes at term
- Diabetes, pre-existing and gestational

Induction of labor *should not* be covered for:

CG - Induction of Labor

- Macrosomia (in the absence of maternal diabetes)
- Elective purposes (without a medical or obstetrical indication)
- Breech

For those indications for which there is insufficient evidence of clear benefit over harm*, coverage may be based on an individualized treatment plan taking into account maternal and infant health.

Revised IOL Coverage Guidance EbGS Approved 4/4/13

Induction of labor is recommended for coverage for the following indications *(strong recommendation)*:

- Gestational age beyond 41 weeks 0 days
- Prelabor rupture of membranes, term
- Fetal demise

- Preeclampsia, term (severe or mild)
- Eclampsia
- Chorioamnionitis

Induction of labor is recommended for coverage for the following indications *(weak recommendation)*:

- Diabetes, pre-existing and gestational

- Placental abruption
- Preeclampsia, preterm (severe or mild)
- Severe preeclampsia, preterm
- Cholestasis of pregnancy
- Preterm, prelabor rupture of membranes;
- Gastroschisis
- Twin gestation
- Maternal medical conditions (e.g., renal disease, chronic pulmonary disease, chronic hypertension, cardiac disease, antiphospholipid syndrome)
- Gestational hypertension
- Fetal compromise (e.g. isoimmunization, oligohydramnios)

- Intrauterine growth restriction/Small for gestational age, term
- Elective purposes, >39 weeks 0 days to <41 weeks 0 days (without a medical or obstetrical indication) with a favorable cervix (for example, with a Bishop score ≥6)

Induction of labor is not recommended for coverage for the following indications *(weak recommendation):*

- Macrosomia (in the absence of maternal diabetes)

CG - Induction of Labor

- Elective purposes, >39 weeks 0 days to <41 weeks 0 days (without a medical or obstetrical indication) with an unfavorable cervix (for example, a Bishop score <6)
- Intrauterine growth restriction/Small for gestational age, preterm (without other evidence of fetal compromise)

Induction of labor is not recommended for coverage for the following indications *(strong recommendation):*
Elective purposes <39 weeks (without a medical or obstetrical indication)

HERC Staff Recommendations:

Modify the current Guideline on Induction of Labor as follows:

GUIDELINE NOTE 85, INDUCTION OF LABOR

Line 1

~~Elective induction of labor without medical or obstetrical indication is covered only for gestational age beyond 41 and 0/7 weeks, prelabor rupture of membranes, maternal diabetes (pre-existing or gestational), or other medical or obstetrical indications. Induction of labor is not covered at any gestational age for fetal macrosomia in the absence of maternal diabetes, for breech presentation or for elective purposes without a medical or obstetrical indication.~~

Induction of labor is covered for:

- Gestational age beyond 41 weeks 0 days
- Prelabor rupture of membranes, term
- Fetal demise

- Preeclampsia, term (severe or mild)
- Eclampsia
- Chorioamnionitis

- Diabetes, pre-existing and gestational

- Placental abruption
- Preeclampsia, preterm (severe or mild)
- Severe preeclampsia, preterm
- Cholestasis of pregnancy
- Preterm, prelabor rupture of membranes;
- Gastroschisis
- Twin gestation
- Maternal medical conditions (e.g., renal disease, chronic pulmonary disease, chronic hypertension, cardiac disease, antiphospholipid syndrome)
- Gestational hypertension
- Fetal compromise (e.g. isoimmunization, oligohydramnios)

- Intrauterine growth restriction/Small for gestational age, term

CG - Induction of Labor

- Elective purposes, >39 weeks 0 days to <41 weeks 0 days (without a medical or obstetrical indication) with a favorable cervix (for example, with a Bishop score ≥6)

Induction of labor is not covered for the following:

- Macrosomia (in the absence of maternal diabetes)
- Elective purposes, >39 weeks 0 days to <41 weeks 0 days (without a medical or obstetrical indication) with an unfavorable cervix (for example, a Bishop score <6)
- Elective purposes <39 weeks (without a medical or obstetrical indication)
- Intrauterine growth restriction/Small for gestational age, preterm (without other evidence of fetal compromise)

CG PET for Breast Cancer

Question: How should the Coverage Guidance - PET for Breast Cancer – be applied to the Prioritized List?

Question source: Health Technology Assessment Subcommittee

Current Prioritized List status:

Line:	**197**
Condition:	CANCER OF BREAST (See Guideline Notes 1,3,7,11,12,26,64,65,76,79,88)
Treatment:	MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY, RADIATION THERAPY AND BREAST RECONSTRUCTION
ICD-9:	174.0-174.9,175.0-175.9,233.0,238.3,284.11,611.83,612.0-612.1,V10.3,V45.71, V50.41-V50.42,V51.0,V52.4,V58.0,V58.11
CPT:	11970,13153,14000,14001,15200,15201,19110,19120-19126,19290-19298,19301-19307,19318,19328-19369,32553,38740,38745,49411,58300,58301,58661,58940, 77014,77261-77295,77300-77370,77402-77421,77427,77431,77470,77600-77790, 79005-79445,96150-96154,96405,96406,96420-96450,96542-96571,98966-98969, 99051,99060,99070,99078,99201-99360,99366,99374,99375,99379-99412,99429-99444,99468-99480,99487-99496,99605-99607
HCPCS:	G0396,G0397,G0406-G0408,G0425-G0427,S0270-S0274,S2066-S2068,S9537, S9560

GUIDELINE NOTE 19, PET SCAN GUIDELINES

Lines 125,144,165,166,170,182,207,208,220,221,243,276,278,292, 312,339

PET Scans are covered for diagnosis of the following cancers only:

- Solitary pulmonary nodules and non-small cell lung cancer
- Evaluation of cervical lymph node metastases when CT or MRI do not demonstrate an obvious primary tumor.

For diagnosis, PET is covered only when it will avoid an invasive diagnostic procedure, or will assist in determining the optimal anatomic location to perform an invasive diagnostic procedure.

PET scans are covered for the initial staging of the following cancers:

- Cervical cancer only when initial MRI or CT is negative for extra-pelvic metastasis
- Head and neck cancer when initial MRI or CT is equivocal
- Colon cancer
- Esophageal cancer
- Solitary pulmonary nodule
- Non-small cell lung cancer
- Lymphoma
- Melanoma

CG PET for Breast Cancer

For staging, PET is covered when clinical management of the patient will differ depending on the stage of the cancer identified and either:

A) the stage of the cancer remains in doubt after standard diagnostic work up, OR
B) PET replaces one or more conventional imaging studies when they are insufficient for clinical management of the patient.

Restaging is covered only for cancers for which staging is covered and for thyroid cancer if recurrence is suspected and I131 scintography is negative. For restaging, PET is covered after completion of treatment for the purpose of detecting residual disease, for detecting suspected recurrence or to determine the extent of a known recurrence. PET is not covered to monitor tumor response during the planned course of therapy. PET scans are NOT indicated for routine follow up of cancer treatment or routine surveillance in asymptomatic patients.

PET scans are also indicated for preoperative evaluation of the brain in patients who have intractable seizures and are candidates for focal surgery. PET scans are NOT indicated for cardiac evaluation.

Code	Code Description	Current Placement
G0252	Pet imaging, full and partial-ring pet scanners only, for initial diagnosis of breast cancer and/or surgical planning for breast cancer (e. G. Initial staging of axillary lymph nodes)	DMAP Ancillary Codes File

Coverage Guidance Approved by HTAS 2/25/2013

PET scanning is not recommended for coverage in initial staging of breast cancer at low risk for metastasis (asymptomatic individuals with newly identified ductal carcinoma in situ, or clinical stage I or II disease).

PET scanning is not recommended for coverage as a modality to monitor response to treatment of breast cancer.

PET scanning is not recommended for coverage for surveillance testing for asymptomatic individuals who have been treated for breast cancer with curative intent.

HERC Staff Assessment:

Currently, the PET scan guideline does not apply to Line 197 Breast Cancer. The coverage guidance is consistent with what is recommended within the guideline for those conditions for which PET scanning is appropriate (e.g. “PET scans are not indicated for routine follow up of cancer treatment or routine surveillance in

CG PET for Breast Cancer

asymptomatic patients"). In the HTAS discussions, there was an assumption that for those groups not mentioned, e.g. those being diagnosed with breast cancer with a high risk of metastases, and those for whom other imaging was equivocal, that there would still be the possibility of PET scan use. However, clear guidance and evidence on the appropriate use of PET scans in the breast cancer population was not provided in detail as part of the Coverage Guidance.

HERC Staff Recommendations:

OPTION 1

A. Make no change to the PET Scan Guidelines or to Line 197

B. Recommend to DMAP to move code G0252 from the DMAP *Ancillary Codes File* to the *DMAP Excluded File*

OPTION 2

A. Add the PET Scan Guideline to Line 197

B. Make no change to the guideline itself. This would allow for PET scans to be used:

For staging, PET is covered when clinical management of the patient will differ depending on the stage of the cancer identified and either:

A) *the stage of the cancer remains in doubt after standard diagnostic work up, OR*

B) *PET replaces one or more conventional imaging studies when they are insufficient for clinical management of the patient.*

CG-Self Monitoring of blood glucose

Question: How should the Coverage Guidance - Self Monitoring of Blood Glucose - be applied to the Prioritized List?

Question source: Health Technology Assessment Subcommittee

Coverage Guidance Recommendation:

For patients with Type 2 diabetes mellitus not requiring insulin, home blood glucose monitors and related diabetic supplies are recommended for coverage only for those who have initial HbA1c levels greater than 8.0%, and in sufficient quantity to allow once a week testing. Such coverage should include a structured education and feedback program for self-monitoring of blood glucose *(strong recommendation).*

Additional supplies for self-monitoring of blood glucose, up to 100 test strips for 90 days, should be covered for the following patients with Type 2 diabetes (*weak recommendation*):

- Patients newly diagnosed and receiving diabetes education
- Patients changing treatment regimens
- Patients with unexplained or new onset hyperglycemia
- Patients with recent history of hypoglycemia
- Patients with comorbid conditions affecting diabetic control
- Patients with microvascular or macrovascular complications of diabetes
- Patients on basal (once daily) insulin
- Patients on systemic corticosteroid therapy

For patients with insulin-requiring diabetes mellitus, including those with Type 2 diabetes using multiple daily insulin injections, home blood glucose monitors and related diabetic supplies are recommended for coverage and should include a structured education and feedback program for self-monitoring of blood glucose (*strong recommendation*).
Note: This guidance does not apply to pregnant women.

Current Prioritized List Status:

Line:	**10**
Condition:	TYPE I DIABETES MELLITUS (See Guideline Notes 1,64,65,76)
Treatment:	MEDICAL THERAPY
ICD-9:	250.01,250.03,250.11,250.13,250.21,250.23,250.31,250.33,250.51,250.53,250.61, 250.63,250.71,250.73,250.91,250.93,251.3,V53.91,V65.46
CPT:	49435,49436,90935-90947,90989-90997,92002-92014,92227,95250,95251,96150-96154,97802-97804,98966-98969,99051,99060,99070,99078,99201-99360,99366, 99374,99375,99379-99412,99429-99444,99468-99480,99487-99496,99605-99607
HCPCS:	G0108,G0245,G0246,G0396,G0397,G0406-G0408,G0425-G0427,S0270-S0274, S9145,S9353

CG-Self Monitoring of blood glucose

Line:	**33**
Condition:	TYPE II DIABETES MELLITUS (See Coding Specification Below) (See Guideline Notes 1,7,8,64,65,76)
Treatment:	MEDICAL THERAPY, BARIATRIC SURGERY WITH BMI >= 35
ICD-9:	250.00,250.02,250.10,250.12,250.20,250.22,250.30,250.32,250.40,250.42,250.50, 250.52,250.60,250.62,250.70,250.72,250.80,250.82,250.90,250.92,V53.51
CPT:	43644,43645,43770-43775,43846-43848,90935-90947,90989-90997,92002-92014, 92227,96150-96154,97802-97804,98966-98969,99051,99060,99070,99078,99201-99360,99366,99374,99375,99379-99412,99429-99444,99468-99480,99487-99496, 99605-99607
HCPCS:	G0108,G0245,G0246,G0396,G0397,G0406-G0408,G0425-G0427,S0270-S0274, S2083,S9145,S9353,S9537

CPT codes 43644-43645 and 43846-43848 (Roux-En-Y gastric bypass) and 43770-43775 (laparoscopic adjustable gastric banding) are only included on this line as treatment according to the requirements in Guideline Note 8 when paired with:

1) a primary diagnosis of 250.x0 or 250.x2 (Type II Diabetes with or without complication);

2) a secondary diagnosis of 278.00 (Obesity, Unspecified) or 278.01 (Morbid Obesity); AND,

3) a tertiary diagnosis code of V85.35-V85.45 (BMI >= 35).

HERC Staff Recommendations:

1) Add a new guideline

GUIDELINE NOTE XX SELF-MONITORING OF BLOOD GLUCOSE
LINE 33

For patients with Type 2 diabetes mellitus not requiring insulin, home blood glucose monitors and related diabetic supplies are covered only for those who have initial HbA1c levels greater than 8.0%, and in sufficient quantity to allow once a week testing.

Additional supplies for self-monitoring of blood glucose, up to 100 test strips for 90 days, are covered for the following patients with Type 2 diabetes:

- Patients newly diagnosed and receiving diabetes education
- Patients changing treatment regimens
- Patients with unexplained or new onset hyperglycemia
- Patients with recent history of hypoglycemia
- Patients with comorbid conditions affecting diabetic control
- Patients with microvascular or macrovascular complications of diabetes
- Patients on basal (once daily) insulin
- Patients on systemic corticosteroid therapy

For patients with insulin-requiring diabetes mellitus, home blood glucose monitors and related diabetic supplies are covered.

2) Code placement recommendations – for discussion

CG- Carotid Endarterectomy

Question: How should the HTAS-approved Coverage Guidance on Carotid Endarterectomy be applied to the Prioritized List?

Question source: Health Technology Assessment Subcommittee

Current Prioritized List Status:

Line: 440
Condition: TRANSIENT CEREBRAL ISCHEMIA; OCCLUSION/STENOSIS OF PRECEREBRAL ARTERIES WITHOUT OCCLUSION (See Guideline Notes 64,65,76)
Treatment: MEDICAL THERAPY; THROMBOENDARTERECTOMY
ICD-9: 362.34,388.02,433.00,433.10,433.20,433.30,433.80,433.90,435.0-435.9,V12.54
CPT:34001,35301,35390,37202,37215,37216,98966-98969,99051,99060,99070,99078,99201-99360,99366,99374,99375,99379-99412,99429-99444,99468-99480,99487-99496,99605-99607
HCPCS: G0396,G0397,G0406-G0408,G0425-G0427,S0270-S0274

CPT code 35301 *Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision* is currently located on the following lines:

Line	Condition	Treatment
308	COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT	MEDICAL AND SURGICAL TREATMENT
342	STROKE	MEDICAL THERAPY
349	NON-DISSECTING ANEURYSM WITHOUT RUPTURE	SURGICAL TREATMENT
350	ARTERIAL ANEURYSM OF NECK	REPAIR
440	TRANSIENT CEREBRAL ISCHEMIA; OCCLUSION/STENOSIS OF PRECEREBRAL ARTERIES WITHOUT OCCLUSION	MEDICAL THERAPY; THROMBOENDARTERECTOMY

Code	CodeDescription	Current Placement
93880	Duplex scan of extracranial arteries; complete bilateral study	DMAP Diagnostic Procedure File

HTAS Approved Coverage Guidance:

Carotid endarterectomy is recommended for coverage in patients with 70-99% carotid stenosis without near-occlusion (*strong recommendation*).

Carotid endarterectomy is not recommended for coverage for patients with less than 50% carotid stenosis (*strong recommendation*).

CG- Carotid Endarterectomy

Coverage of screening for asymptomatic carotid artery stenosis in the general primary care population is not recommended (*strong recommendation*).

For patients with 50 – 69% carotid stenosis who are symptomatic (recent transient ischemic attack or ischemic stroke), carotid endarterectomy is recommended for coverage only for those who have failed optimal medical management (*weak recommendation*).

Staff Assessment:
No current limitation exists on screening.
No current guideline exists on appropriate indications for carotid endaterectomy.

HERC Staff Recommendations:
1) Add a Diagnostic Guideline

DIAGNOSTIC GUIDELINE XX SCREENING FOR CAROTID ARTERY STENOSIS
Screening for carotid artery stenosis (CPT 93880) in asymptomatic individuals is not a covered service.

2) Add a Guideline

GUIDELINE NOTE XXX CAROTID ENDARTERECTOMY
Carotid endarterectomy is covered in patients with 70-99% carotid stenosis without near-occlusion.

For patients with 50 – 69% carotid stenosis who are symptomatic (recent transient ischemic attack or ischemic stroke), carotid endarterectomy is covered only for those who have failed optimal medical management.

Carotid endarterectomy is not covered for patients with any of the following:

- less than 50% carotid stenosis
- 50-69% stenosis who are asymptomatic
- near occlusion.

Lung Volume Reduction Surgery

Question: Should a guideline be added to specify which patients qualify for lung volume reduction surgery for emphysema?

Question source: DMAP

Issue: In December, 2011, the HOSC added a new 2012 CPT code (32672) to line 306 CHRONIC OBSTRUCTIVE PULMONARY DISEASE; CHRONIC RESPIRATORY FAILURE and moved an existing lung volume reduction surgery (32491) from the Excluded List to Line 306. This change was done as part of the new CPT code review. DMAP is requesting that the HERC review this procedure and consider a guideline to specify which patients qualify for this surgery.

Lung volume reduction surgery (LVRS) or reduction pneumoplasty, also referred to as lung shaving or lung contouring, is performed on patients with severe emphysema in order to allow the remaining compressed lung to expand, and thus, improve respiratory function. However, it has significant peri-operative morbidity and mortality. LVRS is associated with a 5–8% operative mortality, 30–40% morbidity and a cost of $20–35 000 for each surgical procedure (Berger 2005).

December, 2011 HOSC minutes

> 32672 (Thoracoscopy, surgical; with resection-plication for emphysematous lung (bullous or non-bullous) for lung volume reduction (LVRS), unilateral includes any pleural procedure, when performed): Gubler noted that this procedure is used for recurrent pneumothorax in bullous emphysema. Shaffer noted that DMAP gets requests for authorization for this procedure. As the alternative is lung transplant, DMAP is authorizing this procedure as a less costly option. Olson wondered if a guideline should be created to restrict use of this procedure to recurrent pneumothorax. Gubler felt that this procedure was done very rarely and not abused. Price noted that DMAP as authorized 2 requests for this procedure in the past 5 years, so it is a rare procedure. The decision was to place on the COPD line (306) rather than on the Excluded List. The existing similar code (32491) was moved from the Excluded list to line 206 was well.

From DMAP

> It came to the attention of DMAP via the RN Hotline call from a CCO that the CPT 32491 (Lung Volume Reduction Surgery) was to be removed from the Excluded List and placed on line 306 of the OHP Prioritized List based on the 2/14/2012 "Dear Honorables" letter effective 4/1/2012 by HERC. DMAP did not make changes in the Medical Management Information Systems or Med-Surgical Rules at that time (this code continues in rule as not covered OAR 410-130-0220-1 Table).
>
> This was discussed in Medical Management Committee 1/22/2013. While policy can revise the rules and open the code for payment it was thought that it should require prior authorization. EncoderPro indicates that the only allowable diagnoses for this procedure are

Lung Volume Reduction Surgery

492.0 (Emphysematous Bleb) and 492.8 (Other Emphysema). These codes are included on line 306 to pair with the 32491 procedure code. Also included on line 306 are less definitive diagnosis codes such as 496 (COPD) which would not be appropriate and support the need for the procedure. Information was provided by the Transplant Coordinator that this procedure is considered in lieu of or bridge to lung transplants. Line 254 for Lung Transplants includes the specific diagnosis of 492.8 (Other Emphysema) to pair with transplants codes but the CPT code 32491 is not included on this line.

DMAP is requesting feedback on whether this procedure might necessitate a guideline note for specific coverage criteria as paired on line 306 or would a "coding specification" be appropriate to define that this procedure code is included on this line and intended to pair only with the specific diagnosis code(s) as noted above? If a coding specification is appropriate then DMAP can limit that procedure code to be reimbursed only if paired with those specific diagnoses. This would eliminate the need or concern to place a prior authorization requirement on it and define coverage criteria.

Evidence

1) **Berger 2005**, meta-analysis of RCTs
    a. N=6 studies (306 patients)
    b. 3-12 month follow up
    c. The LVRS arm of the meta-analysis population showed better results than the medical cohort in terms of pulmonary function (FEV1 $p < 0.0001$, FVC $p < 0.0001$, residual volume $p < 0.0001$, total lung capactiy $p = 0.004$), gas exchange (arterial partial pressure of oxygen $p < 0.0001$) and exercise capacity (6MWD $p = 0.0002$)
    d. Mortality 6–12 months after random assignment to treatment was similar in the two study arms, suggesting that the operative mortality from LVRS was offset, within months, by deaths in the medical arm.
    e. Conclusions: This meta-analysis showed that a selected subset of patients with advanced, heterogeneous emphysema and low exercise tolerance (6MWD) experienced better outcomes from LVRS than from medical therapy.
2) **Miller 2006**, Canadian RCT LVRS vs best medical care (BMC)
    a. RCT, 2 yr follow up
    b. N=62 patients
    c. Overall surgical mortality was 16% at 2 years while the overall medical mortality was 13% ($p = 0.914$). There were no 30-day postoperative deaths but 2 deaths (6%) occurred within 90 days of randomization.
    d. Surgery reduced the residual volume measured at 6 months by 23% (5,385 mL to 4,322 mL, $p = 0.007$). There was an increase in forced expiratory volume in 1 second (FEV1) of 30% (265 mL, $p = 0.013$) from baseline, an improvement in the six minute walk test (6MWT) of 78 meters ($p = 0.045$), and an increase in Health Utility Index 3 (HUI3) which peaked at 6 months with a difference of 0.16 ($p = 0.129$). There was a gain in QALYs of 0.21 ($p = 0.19$) in the LVRS-arm over the BMC-arm. The LVRS costs an additional $28,119 Canadian dollars (CAD) compared with BMC or $133,900/QALY gained.

3) **Naunheim 2006**, National Emphysema Treatment Trial predictors of morbidity and mortality
    a. N=511 with LVRS
    b. The incidence of operative mortality was 5.5%, major pulmonary morbidity occurred in 29.8% of patients, and cardiovascular morbidity occurred in 20.0% of patients. Predictors for these end points are as follows: Non–upper-lobe predominance predicted operative mortality. Pulmonary morbidity increased in elderly patients with a low DLCO. Cardiovascular morbidity increased in older, steroid dependent patients with non-upper lobe predominance

Other coverage policies

1) CMS 2005
    a. Medicare-covered LVRS approaches are limited to bilateral excision of a damaged lung with stapling performed via median sternotomy or video-assisted thoracoscopic surgery.
    b. Qualifying patients
        i. BMI ≤31.1 kg/m2 (men) or ≤32.3 kg/m 2 (women)
        ii. Stable with ≤20 mg prednisone (or equivalent) qd
        iii. CT evidence of bilateral emphysema
        iv. Forced expiratory volume in one second (FEV_1) ≤ 45% predicted ≥ 15% predicted if age ≥ 70 years)
        v. Total lung capacity (TLC) ≥ 100% predicted post-bronchodilator
        vi. Residual volume (RV) ≥ 150% predicted post-bronchodilator
        vii. PCO_2, ≤ 60 mm Hg (PCO_2, ≤ 55 mm Hg if 1-mile above sea level)
        viii. PO_2, ≥ 45 mm Hg on room air (PO_2, ≥ 30 mm Hg if 1-mile above sea level)
        ix. Post-rehabilitation 6-min walk of ≥ 140 m; able to complete 3 min unloaded pedaling in exercise tolerance test (pre- and post-rehabilitation)
        x. Plasma cotinine level ≤13.7 ng/mL (or arterial carboxyhemoglobin ≤ 2.5% if using nicotine products)
        xi. Nonsmoking for 4 months prior to initial interview and throughout evaluation for surgery
        xii. Severe upper lobe predominant emphysema (as defined by radiologist assessment of upper lobe predominance on CT scan) OR severe non-upper lobe emphysema with low exercise capacity
    c. Performed at an approved facility: certified by the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) under the LVRS Disease Specific Care Certification Program (program standards and requirements as printed in the Joint Commission's October 25, 2004, Disease Specific Care Certification Program packet); or (2) approved as Medicare lung or heart-lung transplantation hospitals.

2) Cigna 2012
    a. Cigna covers lung volume reduction surgery (LVRS) for individuals with severe emphysema when ALL of the following criteria are met:
        i. radiological evidence of bilateral upper-lobe (heterogeneous) emphysema
        ii. smoking cessation for at least six months

Lung Volume Reduction Surgery

iii. low functional capacity after pulmonary rehabilitation
iv. pulmonary function test results showing:
    1. forced expiratory volume in one second (FEV1) ≤ 45% of predicted and, if age 70 or older, FEV1 ≥15% of predicted value
    2. post-bronchodilator total lung capacity (TLC) ≥100% of predicted and residual volume (RV) ≥ 150% of predicted value
v. resting partial pressure of oxygen (PaO2) ≥45 mm Hg and resting partial pressure of carbon dioxide (PaCO2) ≤60 mm Hg on room air
vi. six-minute walk test > 140 meters

Summary: LVRS is a high cost, high mortality and morbidity procedure which is effective only in select patients with bilateral upper lobe predominant emphysema who are not current smoking and have a specific set of test parameters.

Lung Volume Reduction Surgery

Recommendation:

1) Consider moving lung volume reduction surgery from line 306 to the Excluded List
    a. High morbidity and mortality
    b. High cost per QALY

    OR
2) Add the following guideline to line 306 CHRONIC OBSTRUCTIVE PULMONARY DISEASE; CHRONIC RESPIRATORY FAILURE

GUIDELINE NOTE XXX LUNG VOLUME REDUCTION SURGERY

Line 306

Lung volume reduction surgery (LVRS, CPT 32491, 32672) is included on line 306 only for treatment of patients with radiological evidence of severe bilateral upper lobe predominant emphysema (ICD-9 492.0, 492.8) and all of the following:

1) BMI ≤31.1 kg/m2 (men) or ≤32.3 kg/m 2 (women)
2) Stable with ≤20 mg prednisone (or equivalent) dose a day
3) Pulmonary function testing showing
    a. Forced expiratory volume in one second (FEV_1) ≤ 45% predicted and, if age 70 or older, FEV_1 ≥ 15% predicted value
    b. Total lung capacity (TLC) ≥ 100% predicted post-bronchodilator
    c. Residual volume (RV) ≥ 150% predicted post-bronchodilator
4) PCO_2, ≤ 60 mm Hg (PCO_2, ≤ 55 mm Hg if 1-mile above sea level)
5) PO_2, ≥ 45 mm Hg on room air (PO_2, ≥ 30 mm Hg if 1-mile above sea level)
6) Post-rehabilitation 6-min walk of ≥ 140 m
7) Non-smoking for 6 months prior to surgery, as shown by cotinine level

The procedure must be performed at an approved facility (1) certified by the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) under the LVRS Disease Specific Care Certification Program or (2) approved as Medicare lung or heart-lung transplantation hospitals. The patient must have approval for surgery by pulmonary physician, thoracic surgeon, and anesthesiologist post-rehabilitation. The patient must have approval for surgery by cardiologist if any of the following are present: unstable angina; left-ventricular ejection fraction (LVEF) cannot be estimated from the echocardiogram; LVEF <45%; dobutamine-radionuclide cardiac scan indicates coronary artery disease or ventricular dysfunction; arrhythmia (>5 premature ventricular contractions per minute; cardiac rhythm other than sinus; premature ventricular contractions on EKG at rest).

Concussion Guideline

Question: Should a guideline be added to the Prioritized List to define when a concussion is on the upper, covered line and when on the lower, uncovered line?

Question source: FamilyCare Inc (OHP plan)

Issue: In December, 2010, concussion ICD-9 codes were added to the upper concussion line based on testimony and submitted evidence that the treatment and evaluation of concussion had changed since the creation of the Prioritized List.

From the December, 2010 HOSC minutes:

> "…When the Prioritized List was created, concussions were graded based on loss of consciousness. Today, concussions are graded on continued symptoms, such as headache, cognitive difficulties, etc…The group wanted to add concussion ICD-9 codes without loss of consciousness (850.0) to a covered line. The location of the diagnosis (line 100 or line 631) will be dependent on whether the patient has continued symptoms. 850.9 (Concussion unspecified) will not be moved to the higher line...Smits asked if a guideline was needed to differentiate when the diagnoses (850.0 and 310.2) were covered on Line 100. The group felt that this was not needed. The line titles would determine which cases are covered on which of the two lines." [note: 850.9 (Concussion unspecified) was later added to line 100.]

In May, 2011, the HOSC moved post-concussive syndrome (ICD-9 310.2) from the concussion lines to line 209 ORGANIC MENTAL DISORDERS INCLUDING DEMENTIAS as the appropriate treatments were included on this line and similar diagnosis were present.

Current List placements:

Line 101 SEVERE/MODERATE HEAD INJURY: HEMATOMA/EDEMA WITH LOSS OF CONSCIOU0SNESS, COMPOUND/DEPRESSED FRACTURES OF SKULL
ICD-9 850.0-850.9 (Entire concussion series)

Line 641 MINOR HEAD INJURY: HEMATOMA/EDEMA WITH NO LOSS OF CONSCIOUSNESS
ICD-9 850.0 Concussion with no loss of consciousness, 850.9 Concussion, unspecified

Expert input

Dr. Jim Chesnutt:

Dr. Chesnutt did not feel that any changes were needed at this time.

Recommendation:

1) Adopt the following guideline:

GUIDELINE NOTE XXX CONCUSSION AND POST CONCUSSION SYNDROME

Lines 101, 209, 641

ICD-9 diagnosis codes 850.0 (Concussion with no loss of consciousness) and 850.9 (Concussion, unspecified) are included on line 101 only for concussions with symptoms that persist for more than 7 days but less than 3 months; otherwise, these diagnoses are included on line 641. When concussion symptoms last for more than 3 months, the diagnosis of post-concussive syndrome (ICD-9 310.2) should be used, which is included on line 209.

Bilateral cochlear implants for sensorineural hearing loss

Question: How should the guidelines on cochlear implantation be clarified with regard to bilateral cochlear implants for sensorineural hearing loss?

Question source: OHP Managed Care Medical Director, Doug Luther

Issue: The guideline is not specific about whether bilateral cochlear implants for sensorineural hearing loss are intended to be covered. Because the person with a single cochlear implant may have corrected hearing, it is not clear if they are eligible to have the guideline applied for the second ear. DMAP has currently been allowing coverage of bilateral cochlear implants. Also, there are no definitions as to "severe" and "profound" hearing loss in the current guideline language.

Prioritized List Status

GUIDELINE NOTE 31, COCHLEAR IMPLANTATION, AGE 5 AND UNDER

Line 298

Children will be considered candidates for cochlear implants if the following criteria are met:

A) Profound sensorineural hearing loss in both ears
B) Child has reached the age of 1
C) Receive little or no useful benefit from hearing aids
D) No medical contraindications
E) High motivation and appropriate expectations (both child, when appropriate, and family)

GUIDELINE NOTE 49, COCHLEAR IMPLANTS, OVER AGE 5

Line 491

Children will be considered candidates for cochlear implants if the following criteria are met:

1) Profound sensorineural hearing loss in both ears
2) Receive little or no useful benefit from hearing aids
3) No medical contraindications
4) High motivation and appropriate expectations (both child, when appropriate, and family)

Postlinguistic adults will be considered candidates for cochlear implants if the following criteria are met:

1) Severe to profound sensorineural hearing loss in both ears
2) Hearing loss acquired after learning oral speech and language development (postlinguistic hearing loss)

Bilateral cochlear implants for sensorineural hearing loss

3) Receive limited benefit from appropriately fit hearing aids; i.e., scores of 40% or less on sentence recognition test in the best-aided listening condition
4) No medical contraindications

Prelinguistic adults will be considered candidates for cochlear implants if the following criteria are met:

1) Profound sensorineural hearing loss in both ears
2) Hearing loss acquired before learning oral speech and language development (prelinguistic hearing loss)
3) Receive no benefit from hearing aids
4) No medical contraindications
5) A desire to be a part of the hearing world

Evidence review

MED Report, 2011 *reviewing bilateral cochlear implants in children*

1) Based on 1 systematic review (Sparreboom 2010) and two Technology Assessments (Bond 2009; Hayes 2009) and a single clinical practice guideline (NICE 2009)
2) The normal hearing range is considered to be from 0 to 140 decibels (dB). Severe hearing loss is defined as the ability to hear loud sounds of 71 to 90 dB, whereas profound loss is regarded as the inability to hear any speech and only loud sounds above 90 dB.
3) Efficacy – bilateral cochlear implants result in improvement in sensitivity to sound (13% improvement ($p<0.0001$) and speech perception (20% improvement, no p value) compared to unilateral implants. Main benefits are in noisy situations. None of the studies included in this report addressed the effects these interventions have on the key patient-oriented outcomes of speech production, educational success, or the quality of life of either deaf children or their parents.
4) Studies funded by device manufacturers and moderate to poor quality.
5) Risks – major complications occur in 7% of cases, including fatal pneumococcal meningitis. 20% have minor complications.
6) Limitations – major limitations about the quality of the evidence including:

   • Small sample size
   • Weak study design
   • Non-randomized study populations
   • No separate control groups (subjects acted as their own controls)
   • Multiple devices used, even in the same patient
   • Funding sources not identified or funded by device manufacturers
   • Variety of follow-up periods presented
   • Diverse outcome measures and testing conditions employed

7) Simultaneous rather than sequential is more cost-effective

Recent study (identified by MED)
Boons, 2012

1) Case-control retrospective study
2) Centers in Belgium and Holland
3) 25 children with 1 cochlear implant matched with 25 children with 2 cochlear implants out of 288 children receiving implants
4) Results: On the receptive language tests (mean difference [95% CI], 9.4 [0.3-18.6]) and expressive language tests (15.7 [5.9-25.4] and 9.7 [1.5-17.9]), children undergoing bilateral implantation performed significantly better than those undergoing unilateral implantation.
5) Simultaneous implantation and narrower interval between sequential implants were both associated with improved language scores

Study on QOL in Adults
Bichey, 2008

1) Prospective case-control study on 23 bilateral cochlear implant patients
2) All postlingually deafened, severe to profound hearing loss bilaterally
3) Data gathered before first implant, before second, and most recent, using validated Ontario Healthy Utility Index measuring 8 domains of quality of life
4) Cost per QALY $17,832 for first implant. Differential of second is $7112.
5) Greatest improvement is after first cochlear implant, but continue to have improvement in QOL after second implant.

Other Payers
Washington state Medicaid

Cochlear implantation is only covered for children 20 years of age and younger.
It is not covered for adults.
Bilateral cochlear implantation is not covered, only unilateral.

Aetna, 2012

Aetna considers uniaural (monaural) or binaural (bilateral) cochlear implantation a medically necessary prosthetic for adults aged 18 years and older with bilateral, pre- or post-linguistic, sensorineural, moderate-to-profound hearing impairment who meet *both* of the following criteria:

1. Member has bilateral severe to profound sensorineural hearing loss determined by a pure tone average of 70 dB or greater at 500 Hz, 1000 Hz, and 2000 Hz; *and*
2. Member has limited benefit from appropriately fitted binaural hearing aids. Limited benefit from amplification is defined by test scores of 40 % correct or less in best-aided listening condition on open-set sentence cognition (e.g., Central Institute for the Deaf (CID) sentences, Hearing in Noise Test sentences (HINT), and consonant-nucleus-consonant (CNC) test.

Aetna considers uniaural (monaural) or binaural (bilateral) cochlear implantation a medically necessary prosthetic for children 12 months of age or older with bilateral sensorineural hearing impairment who meet *all* of the following criteria:

1. Child has profound, bilateral sensorineural hearing loss determined by a pure tone average of 90 dB or greater at 500, 1000 and 2000 Hz; *and*
2. Child has limited benefit from appropriately fitted binaural hearing aids. For children 4 years of age or younger, limited benefit is defined as failure to reach developmentally appropriate auditory milestones measured using the Infant-Toddler Meaningful Auditory Integration Scale, the Meaningful Auditory Integration Scale, or the Early Speech Perception test, or less than 20 % correct on open-set word recognition test (Multisyllabic Lexical Neighborhood Test) in conjunction with appropriate amplification and participation in intensive aural habilitation over a 3 to 6 month period. For children older than 4 years of age, limited benefit is defined as less than 12 % correct on the Phonetically Balanced-Kindergarten Test, or less than 30 % correct on the Hearing in Noise Test for children, the open-set Multi-syllabic Lexical Neighborhood Test (MLNT) or Lexical Neighborhood Test (LNT), depending on the child's cognitive ability and linguistic skills; *and*
3. A 3- to 6-month hearing aid trial has been undertaken by a child without previous experience with hearing aids. Note: When there is radiological evidence of cochlear ossification, this requirement may be waived at Aetna's discretion.

The following additional medical necessity criteria must also be met for uniaural (monaural) or binaural (bilateral) cochlear implantation in adults and children:

1. The member must be enrolled in an educational program that supports listening and speaking with aided hearing; *and*
2. The member must have had an assessment by an audiologist and from an otolaryngologist experienced in this procedure indicating the likelihood of success with this device; *and*
3. The member must have no medical contraindications to cochlear implantation (e.g., cochlear aplasia, active middle ear infection); *and*

The member must have arrangements for appropriate follow-up care including the long-term speech therapy required to take full advantage of this device. (Note: Particular plans may place limits on benefits for speech therapy services. Please consult plan documents for details).

CIGNA, 2012

A) Cigna covers a unilateral or bilateral cochlear implant as medically necessary for an individual with bilateral sensorineural hearing loss when there is reasonable expectation that a significant benefit will be achieved from the device and when the following age-specific criteria are met:
   (i) For an adult (age 18 years or older) with BOTH of the following:
   - bilateral, severe-to-profound sensorineural hearing loss determined by a pure-tone average of 70 dB (decibels) hearing loss or greater at 500 Hz (hertz), 1000 Hz and 2000 Hz
   - limited or no benefit from appropriately fitted hearing aids

(ii) For a child (age 12 months to 17 years, 11 months) with BOTH of the following:
 profound, bilateral sensorineural hearing loss with thresholds of 90 dB or greater at 1000 Hz
 limited or no benefit from a three-month trial of appropriately fitted binaural hearing aids

B) Cigna covers a second cochlear implant in the contralateral (opposite) ear as medically necessary in an individual with an existing unilateral cochlear implant when the hearing aid in the contralateral ear produces limited or no benefit.
C) Cigna covers the replacement of an existing cochlear implant as medically necessary when EITHER of the following criteria is met:
   (i) currently used component is no longer functional and cannot be repaired
   (ii) currently used component renders the implant recipient unable to adequately and/or safely perform his/her age-appropriate activities of daily living

D) Cigna does not cover upgrading of a cochlear implant system or component (e.g., upgrading processor from body-worn to behind-the-ear, upgrading from single- to multi-channel electrodes) of an existing, properly functioning cochlear implant because it is considered not medically necessary.
E) Cigna does not cover a cochlear implant for the treatment of tinnitus in an individual who does not also have profound or severe sensorineural deafness/hearing loss warranting the need for cochlear implantation because such use is considered experimental, investigational or unproven.

Cost: Reimbursement for CPT code 69930 as $21,332.44. The total estimated cost for bilateral cochlear implants in the US is estimated to be around $60,000. The lifetime costs of services, special education, and adaptation related to a child that is deaf before age three, are more than $1 million. Cochlear implants may only partially mitigate the lifetime costs of ongoing significant hearing loss.

For DMAP claims, about 20% are done sequentially, virtually all within a year of the first one.

Summary
There is limited quality data to support that bilateral cochlear implants improve ability to localize sound and speech perception. Most studies do not evaluate patient-oriented outcomes. Currently, DMAP is allowing coverage of bilateral cochlear implants. Simultaneous rather than sequential implantation appears to have more benefit. However, the language of preferring simultaneous to sequential may have operationalization issues however, as some local institutions prefer sequential implants, and sometimes the implants occur many years apart.

Recommendations:

Modify guideline notes 31 and 49 as follows:

GUIDELINE NOTE 31, COCHLEAR IMPLANTATION, AGE 5 AND UNDER

Line 298

Children will be considered candidates for cochlear implants if the following criteria are met:

A) Profound sensorineural hearing loss in both ears (defined as 91dB hearing loss or greater at 500, 1000 and 2000 Hz)
B) Child has reached the age of 1
C) Receive little or no useful benefit from hearing aids
D) No medical contraindications
E) High motivation and appropriate expectations (both child, when appropriate, and family)

Bilateral cochlear implants are covered. Simultaneous implantation appears to be more cost-effective than sequential implantation.

GUIDELINE NOTE 49, COCHLEAR IMPLANTS, OVER AGE 5

Line 491

Children will be considered candidates for cochlear implants if the following criteria are met:

1) Profound sensorineural hearing loss in both ears (defined as 91dB hearing loss or greater at 500, 1000 and 2000 Hz)
2) Receive little or no useful benefit from hearing aids
3) No medical contraindications
4) High motivation and appropriate expectations (both child, when appropriate, and family)

Postlinguistic adults will be considered candidates for cochlear implants if the following criteria are met:

1) Severe to profound sensorineural hearing loss in both ears (defined as 71dB (decibels) hearing loss or greater at 500 Hz (hertz), 1000 Hz and 2000 Hz)
2) Hearing loss acquired after learning oral speech and language development (postlinguistic hearing loss)
3) Receive limited benefit from appropriately fit hearing aids; i.e., scores of 40% or less on sentence recognition test in the best-aided listening condition
4) No medical contraindications

Prelinguistic adults will be considered candidates for cochlear implants if the following criteria are met:

Bilateral cochlear implants for sensorineural hearing loss

1) Profound sensorineural hearing loss in both ears (defined as 91dB (decibels) hearing loss or greater at 500 Hz (hertz), 1000 Hz and 2000 Hz)
2) Hearing loss acquired before learning oral speech and language development (prelinguistic hearing loss)
3) Receive no benefit from hearing aids
4) No medical contraindications
5) A desire to be a part of the hearing world

Bilateral cochlear implants are covered. Simultaneous implantation appears to be more cost-effective than sequential implantation.

Diseases of Lips

Question: Should 528.5 (Diseases of lips) be added to a low line to specify that certain subdiagnoses are not covered?

Question source: HERC staff

Issue: 528.5 (Diseases of lips) is on line 214 SUPERFICIAL ABSCESSES AND CELLULITIS. According to coding specifications, 528.5 includes Abscess of lip(s), Cellulitis of lip(s), Fistula of lip(s), Hypertrophy of lip(s), Cheilitis (inflammation of the lips), Cheilodynia (painful lips) and Cheilosis (fissuring and scaling of the lips).

Recommendation:

1) Add 528.5 to line 688 DERMATOLOGICAL CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY
2) Keep 528.5 on line 214
3) Adopt the following guideline

GUIDELINE NOTE XXX DISEASES OF LIPS

Lines 214, 688

ICD-9 code 528.5 (Diseases of lips) is included on line 214 only for treatment of abscess or cellulitis of the lips. All other sub-diagnoses under this code are included on line 688.

Guideline for Treatment of Cancer Near the End of Life

Issue: HERC staff have identified that the wording/intent of Guideline Note 12 appears to be in conflict with the Affordable Care Act (ACA). Staff would like a discussion with the VbBS/HERC regarding next steps to take to revise this guideline to bring it into compliance with the ACA. Statement of Intent 1 regarding palliative care does not appear to be in conflict with the ACA, but should be examined as well.

> **ACA section 1302**
> CONSIDERATION.—In defining the essential health benefits under paragraph (1), the Secretary shall…
> (B) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;
> (C) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;
> (D) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;

GUIDELINE NOTE 12, TREATMENT OF CANCER WITH LITTLE OR NO BENEFIT PROVIDED NEAR THE END OF LIFE
Lines 102,103,123-125,144,159,165,166,170,181,197,198,207,208,218,220, 221,228,229,231, 243,249,252,275-278,280,287,292,310-312,320,339-341,356,459,586,622

This guideline only applies to patients with advanced cancer who have less than 24 months median survival with treatment.

All patients receiving end of life care, either with the intent to prolong survival or with the intent to palliate symptoms, should have/be engaged with palliative care providers (for example, have a palliative care consult or be enrolled in a palliative care program).

Treatment with intent to prolong survival is not a covered service for patients with any of the following:

- Median survival of less than 6 months with or without treatment, as supported by the best available published evidence
- Median survival with treatment of 6-12 months when the treatment is expected to improve median survival by less than 50%, as supported by the best available published evidence
- Median survival with treatment of more than 12 months when the treatment is expected to improve median survival by less than 30%, as supported by the best available published evidence
- Poor prognosis with treatment, due to limited physical reserve or the ability to withstand treatment regimen, as indicated by low performance status.

Unpublished evidence may be taken into consideration in the case of rare cancers which are universally fatal within six months without treatment.

The Health Evidence Review Commission is reluctant to place a strict $/QALY (quality adjusted life-year) or $/LYS (life-year saved) requirement on end-of-life treatments, as such measurements are only approximations and cannot take into account all of the merits of an individual case. However, cost must be taken into consideration when considering treatment options near the end of life. For example, in no instance can it be justified to spend $100,000 in public resources to increase an individual's expected survival by three months when hundreds of thousands of Oregonians are without any form of health insurance.

Treatment with the goal to palliate is addressed in Statement of Intent 1, Palliative Care.

STATEMENT OF INTENT 1: PALLIATIVE CARE

It is the intent of the Commission that palliative care services be covered for patients with a life-threatening illness or severe advanced illness expected to progress toward dying, regardless of the goals for medical treatment and with services available according to the patient's expected length of life (see examples below).

Palliative care is comprehensive, specialized care ideally provided by an interdisciplinary team (which may include but is not limited to physicians, nurses, social workers, etc.) where care is particularly focused on alleviating suffering and promoting quality of life. Such interdisciplinary care should include assessment, care planning, and care coordination, emotional and psychosocial counseling for patients and families, assistance accessing services from other needed community resources, and should reflect the patient and family's values and goals.

Some examples of palliative care services that should be available to patients with a life-threatening/limiting illness,

A) without regard to a patient's expected length of life:
- Inpatient palliative care consultation; and,
- Outpatient palliative care consultation, office visits.

B) with an expected median survival of less than one year, as supported by the best available published evidence:
- Home-based palliative care services (to be defined by DMAP), with the expectation that the patient will move to home hospice care.

C) with an expected median survival of six months or less, as supported by peer-reviewed literature:
- Home hospice care, where the primary goal of care is quality of life (hospice services to be defined by DMAP).

It is the intent of the Commission that certain palliative care treatments be covered when these treatments carry the primary goal to alleviate symptoms and improve quality of life, without intending to alter the trajectory of the underlying disease.

Guideline for Treatment of Cancer Near the End of Life

Some examples of covered palliative care treatments include:

A) Radiation therapy for painful bone metastases with the intent to relieve pain and improve quality of life.

B) Surgical decompression for malignant bowel obstruction.

C) Medication therapy such as chemotherapy with low toxicity/low side effect agents with the goal to decrease pain from bulky disease or other identified complications. Cost of chemotherapy and alternative medication(s) should also be considered.

D) Medical equipment and supplies (such as non-motorized wheelchairs, walkers, bandages, and catheters) determined to be medically appropriate for completion of basic activities of daily living, for management of symptomatic complications or as required for symptom control.

E) Acupuncture with intent to relieve nausea.

Cancer treatment with intent to palliate is not a covered service when the same palliation can be achieved with pain medications or other non-chemotherapy agents.

It is NOT the intent of the Commission that coverage for palliative care encompasses those treatments that seek to prolong life despite substantial burdens of treatment and limited chance of benefit. See Guideline Note 12: TREATMENT OF CANCER WITH LITTLE OR NO BENEFIT PROVIDED NEAR THE END OF LIFE.

<u>Recommendations</u>:

1) Convene a workgroup composed of providers/experts in the fields of oncology, palliative care, primary care, medical ethics, and health care law, and disability advocates
2) Discuss possible directions for the workgroup to explore in revising GN12 that focus on the benefits of the treatment rather than the impact on the individual
3) Plan to discuss the workgroup recommendations at a VbBS/HERC meeting later this year

Code	Description	Notes	New placement
A41.01	Sepsis due to Methicillin susceptible Staphylococcus aureus		186 SEPTICEMIA
A41.02	Sepsis due to Methicillin resistant Staphylococcus aureus		186 SEPTICEMIA
A41.02	Sepsis due to Methicillin resistant Staphylococcus aureus		186 SEPTICEMIA
A49.01	Methicillin susceptible Staphylococcus aureus infection, unspecified site		EXCLUDED FILE
A49.02	Methicillin resistant Staphylococcus aureus infection, unspecified site		EXCLUDED FILE
B95.61	Methicillin susceptible Staphylococcus aureus infection as the cause of diseases classified elsewhere		EXCLUDED FILE
B95.62	Methicillin resistant Staphylococcus aureus infection as the cause of diseases classified elsewhere		EXCLUDED FILE
B96.20	Unspecified Escherichia coli [E. coli] as the cause of diseases classified elsewhere		EXCLUDED FILE
B96.21	Shiga toxin-producing Escherichia coli [E. coli] (STEC) O157 as the cause of diseases classified elsewhere		EXCLUDED FILE
B96.22	Other specified Shiga toxin-producing Escherichia coli [E. coli] (STEC) as the cause of diseases classified elsewhere		EXCLUDED FILE
B96.23	Unspecified Shiga toxin-producing Escherichia coli		EXCLUDED FILE
B96.29	Other Escherichia coli [E. coli] as the cause of diseases classified elsewhere		EXCLUDED FILE
C44.00	Unspecified malignant neoplasm of skin of lip		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.01	Basal cell carcinoma of skin of lip		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.02	Squamous cell carcinoma of skin of lip		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.09	Other specified malignant neoplasm of skin of lip		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.101	Unspecified malignant neoplasm of skin of unspecified eyelid, including canthus		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.102	Unspecified malignant neoplasm of skin of right eyelid, including canthus		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.109	Unspecified malignant neoplasm of skin of left eyelid, including canthus		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.111	Basal cell carcinoma of skin of unspecified eyelid, including canthus		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.112	Basal cell carcinoma of skin of right eyelid, including canthus		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.119	Basal cell carcinoma of skin of left eyelid, including canthus		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.121	Squamous cell carcinoma of skin of unspecified eyelid, including canthus		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.122	Squamous cell carcinoma of skin of right eyelid, including canthus		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.129	Squamous cell carcinoma of skin of left eyelid, including canthus		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA

C44.191	Other specified malignant neoplasm of skin of unspecified eyelid, including canthus		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.192	Other specified malignant neoplasm of skin of right eyelid, including canthus		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.199	Other specified malignant neoplasm of skin of left eyelid, including canthus		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.201	Unspecified malignant neoplasm of skin of unspecified ear and external auricular canal		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.202	Unspecified malignant neoplasm of skin of right ear and external auricular canal		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.209	Unspecified malignant neoplasm of skin of left ear and external auricular canal		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.211	Basal cell carcinoma of skin of unspecified ear and external auricular canal		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.212	Basal cell carcinoma of skin of right ear and external auricular canal		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.219	Basal cell carcinoma of skin of left ear and external auricular canal		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.221	Squamous cell carcinoma of skin of unspecified ear and external auricular canal		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.222	Squamous cell carcinoma of skin of right ear and external auricular canal		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.229	Squamous cell carcinoma of skin of left ear and external auricular canal		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.291	Other specified malignant neoplasm of skin of unspecified ear and external auricular canal		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.292	Other specified malignant neoplasm of skin of right ear and external auricular canal		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.299	Other specified malignant neoplasm of skin of left ear and external auricular canal		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.300	Unspecified malignant neoplasm of skin of unspecified part of face		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.301	Unspecified malignant neoplasm of skin of nose		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.309	Unspecified malignant neoplasm of skin of other parts of face		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.310	Basal cell carcinoma of skin of unspecified parts of face		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.311	Basal cell carcinoma of skin of nose		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.319	Basal cell carcinoma of skin of other parts of face		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.320	Squamous cell carcinoma of skin of unspecified parts of face		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.321	Squamous cell carcinoma of skin of nose		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.329	Squamous cell carcinoma of skin of other parts of face		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.390	Other specified malignant neoplasm of skin of unspecified parts of face		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA

C44.391	Other specified malignant neoplasm of skin of nose		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.399	Other specified malignant neoplasm of skin of other parts of face		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.40	Unspecified malignant neoplasm of skin of scalp and neck		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.41	Basal cell carcinoma of skin of scalp and neck		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.42	Squamous cell carcinoma of skin of scalp and neck		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.49	Other specified malignant neoplasm of skin of scalp and neck		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.500	Unspecified malignant neoplasm of anal skin		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.501	Unspecified malignant neoplasm of skin of breast		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.509	Unspecified malignant neoplasm of skin of other part of trunk		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.510	Basal cell carcinoma of anal skin		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.511	Basal cell carcinoma of skin of breast		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.519	Basal cell carcinoma of skin of other part of trunk		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.520	Squamous cell carcinoma of anal skin		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.521	Squamous cell carcinoma of skin of breast		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.529	Squamous cell carcinoma of skin of other part of trunk		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.590	Other specified malignant neoplasm of anal skin		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.591	Other specified malignant neoplasm of skin of breast		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.599	Other specified malignant neoplasm of skin of other part of trunk		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.601	Unspecified malignant neoplasm of skin of unspecified upper limb, including shoulder		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.602	Unspecified malignant neoplasm of skin of right upper limb, including shoulder		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.609	Unspecified malignant neoplasm of skin of left upper limb, including shoulder		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.611	Basal cell carcinoma of skin of unspecified upper limb, including shoulder		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.612	Basal cell carcinoma of skin of right upper limb, including shoulder		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.619	Basal cell carcinoma of skin of left upper limb, including shoulder		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.621	Squamous cell carcinoma of skin of unspecified upper limb, including shoulder		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.622	Squamous cell carcinoma of skin of right upper limb, including shoulder		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.629	Squamous cell carcinoma of skin of left upper limb, including shoulder		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA

C44.691	Other specified malignant neoplasm of skin of unspecified upper limb, including shoulder		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.692	Other specified malignant neoplasm of skin of right upper limb, including shoulder		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.699	Other specified malignant neoplasm of skin of left upper limb, including shoulder		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.701	Unspecified malignant neoplasm of skin of unspecified lower limb, including hip		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.702	Unspecified malignant neoplasm of skin of right lower limb, including hip		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.709	Unspecified malignant neoplasm of skin of left lower limb, including hip		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.711	Basal cell carcinoma of skin of unspecified lower limb, including hip		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.712	Basal cell carcinoma of skin of right lower limb, including hip		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.719	Basal cell carcinoma of skin of left lower limb, including hip		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.721	Squamous cell carcinoma of skin of unspecified lower limb, including hip		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.722	Squamous cell carcinoma of skin of right lower limb, including hip		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.729	Squamous cell carcinoma of skin of left lower limb, including hip		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.791	Other specified malignant neoplasm of skin of unspecified lower limb, including hip		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.792	Other specified malignant neoplasm of skin of right lower limb, including hip		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.799	Other specified malignant neoplasm of skin of left lower limb, including hip		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.80	Unspecified malignant neoplasm of overlapping sites of skin		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.81	Basal cell carcinoma of overlapping sites of skin		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.82	Squamous cell carcinoma of overlapping sites of skin		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.89	Other specified malignant neoplasm of overlapping sites of skin		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.90	Unspecified malignant neoplasm of skin, unspecified		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.91	Basal cell carcinoma of skin, unspecified		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.92	Squamous cell carcinoma of skin, unspecified		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C44.99	Other specified malignant neoplasm of skin, unspecified		279 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
C93.Z2	Other monocytic leukemia, in relapse	See C93.Z1	119 CHRONIC MYELOID LEUKEMIA 424 CHRONIC LEUKEMIAS WITH POOR PROGNOSIS
D17.71	Benign lipomatous neoplasm of kidney	Similar to D30	517 BENIGN NEOPLASM OF KIDNEY AND OTHER URINARY ORGANS
D17.72	Benign lipomatous neoplasm of other genitourinary organ	similar to a variety of D codes, most of which are on 636	636 BENIGN NEOPLASMS OF SKIN AND OTHER SOFT TISSUES

D17.79	Benign lipomatous neoplasm of other sites	Per coding guidelines, refers to neoplasms of the perineum and retroperineum; similar to D20	647 BENIGN NEOPLASMS OF DIGESTIVE SYSTEM
D56.5	Hemoglobin E-beta thalassemia		197 HEREDITARY ANEMIAS, HEMOGLOBINOPATHIES, AND DISORDERS OF THE SPLEEN
D61.810	Antineoplastic chemotherapy induced pancytopenia	should be on equivalent lines to 284.11 (all chemotherapy and bone marrow transplant lines)	All chemotherapy and bone marrow transplant lines
D61.811	Other drug-induced pancytopenia	should be on equivalent of line 408--ICD9 284.12	578 ANEMIAS DUE TO DISEASE
D61.818	Other pancytopenia		DIAGNOSTIC WORKUP FILE
D68.311	Acquired hemophilia		114 COAGULATION DEFECTS
D68.312	Antiphospholipid antibody with hemorrhagic disorder		114 COAGULATION DEFECTS
D68.318	Other hemorrhagic disorder due to intrinsic circulating anticoagulants, antibodies, or inhibitors		114 COAGULATION DEFECTS
F03.90	Unspecified dementia without behavioral disturbance	Similar to F01.5x	75 NEUROLOGICAL DYSFUNCTION IN BREATHING, EATING, SWALLOWING, BOWEL, OR BLADDER CONTROL CAUSED BY CHRONIC CONDITIONS 205 CHRONIC ORGANIC MENTAL DISORDERS INCLUDING DEMENTIAS 297 NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS 349 NEUROLOGICAL DYSFUNCTION IN COMMUNICATION CAUSED BY CHRONIC CONDITIONS 381 DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE
F03.91	Unspecified dementia with behavioral disturbance	Similar to F01.5x	75 NEUROLOGICAL DYSFUNCTION IN BREATHING, EATING, SWALLOWING, BOWEL, OR BLADDER CONTROL CAUSED BY CHRONIC CONDITIONS 205 CHRONIC ORGANIC MENTAL DISORDERS INCLUDING DEMENTIAS 297 NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS 349 NEUROLOGICAL DYSFUNCTION IN COMMUNICATION CAUSED BY CHRONIC CONDITIONS 381 DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE
F48.2	Pseudobulbar affect		409 DISSOCIATIVE DISORDERS
G04.02	Postimmunization acute disseminated encephalitis, myelitis and encephalomyelitis		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT

G04.32	Postimmunization acute necrotizing hemorrhagic encephalopathy	same as G04.31	290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
G04.39	Other acute necrotizing hemorrhagic encephalopathy		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
G13.2	Systemic atrophy primarily affecting the central nervous system in myxedema		75 NEUROLOGICAL DYSFUNCTION IN BREATHING, EATING, SWALLOWING, BOWEL, OR BLADDER CONTROL CAUSED BY CHRONIC CONDITIONS 297 NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS 349 NEUROLOGICAL DYSFUNCTION IN COMMUNICATION CAUSED BY CHRONIC CONDITIONS 381 DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE
G25.83	Benign shuddering attacks	No treatment needed per Medscape	664 NEUROLOGIC CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY
G31.85	Corticobasal degeneration		75 NEUROLOGICAL DYSFUNCTION IN BREATHING, EATING, SWALLOWING, BOWEL, OR BLADDER CONTROL CAUSED BY CHRONIC CONDITIONS 297 NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS 349 NEUROLOGICAL DYSFUNCTION IN COMMUNICATION CAUSED BY CHRONIC CONDITIONS 381 DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE LEVEL OF INDEPENDENCE IN SELF-DIRECTED CARE CAUSED BY CHRONIC CONDITIONS THAT CAUSE NEUROLOGICAL DYSFUNCTION
G32.81	Cerebellar ataxia in diseases classified elsewhere		EXCLUDED FILE
G32.89	Other specified degenerative disorders of nervous system in diseases classified elsewhere		EXCLUDED FILE
G40.802	Other epilepsy, not intractable, without status epilepticus		33 EPILEPSY AND FEBRILE CONVULSIONS
G40.803	Other epilepsy, intractable, with status epilepticus		33 EPILEPSY AND FEBRILE CONVULSIONS
G40.804	Other epilepsy, intractable, without status epilepticus		33 EPILEPSY AND FEBRILE CONVULSIONS
G40.812	Lennox-Gastaut syndrome, not intractable, without status epilepticus	difficult to treat childhood onset epilepsy	33 EPILEPSY AND FEBRILE CONVULSIONS
G40.813	Lennox-Gastaut syndrome, intractable, with status epilepticus		33 EPILEPSY AND FEBRILE CONVULSIONS
G40.814	Lennox-Gastaut syndrome, intractable, without status epilepticus		33 EPILEPSY AND FEBRILE CONVULSIONS

G40.821	Epileptic spasms, not intractable, with status epilepticus		33 EPILEPSY AND FEBRILE CONVULSIONS
G40.822	Epileptic spasms, not intractable, without status epilepticus		33 EPILEPSY AND FEBRILE CONVULSIONS
G40.823	Epileptic spasms, intractable, with status epilepticus		33 EPILEPSY AND FEBRILE CONVULSIONS
G40.824	Epileptic spasms, intractable, without status epilepticus		33 EPILEPSY AND FEBRILE CONVULSIONS
G40.A01	Absence epileptic syndrome, not intractable, with status epilepticus		33 EPILEPSY AND FEBRILE CONVULSIONS
G40.A09	Absence epileptic syndrome, not intractable, without status epilepticus		33 EPILEPSY AND FEBRILE CONVULSIONS
G40.A11	Absence epileptic syndrome, intractable, with status epilepticus		33 EPILEPSY AND FEBRILE CONVULSIONS
G40.A19	Absence epileptic syndrome, intractable, without status epilepticus		33 EPILEPSY AND FEBRILE CONVULSIONS
G40.B01	Juvenile myoclonic epilepsy, not intractable, with status epilepticus		33 EPILEPSY AND FEBRILE CONVULSIONS
G40.B09	Juvenile myoclonic epilepsy, not intractable, without status epilepticus		33 EPILEPSY AND FEBRILE CONVULSIONS
G40.B11	Juvenile myoclonic epilepsy, intractable, with status epilepticus		33 EPILEPSY AND FEBRILE CONVULSIONS
G40.B19	Juvenile myoclonic epilepsy, intractable, without status epilepticus		33 EPILEPSY AND FEBRILE CONVULSIONS
G43.821	Menstrual migraine, not intractable, with status migrainosus		414 MIGRAINE HEADACHES
G43.829	Menstrual migraine, not intractable, without status migrainosus		414 MIGRAINE HEADACHES
G43.831	Menstrual migraine, intractable, with status migrainosus		414 MIGRAINE HEADACHES
G43.839	Menstrual migraine, intractable, without status migrainosus		414 MIGRAINE HEADACHES
G43.A0	Cyclical vomiting, not intractable		535 DISORDERS OF FUNCTION OF STOMACH AND OTHER FUNCTIONAL DIGESTIVE DISORDERS
G43.A1	Cyclical vomiting, intractable		535 DISORDERS OF FUNCTION OF STOMACH AND OTHER FUNCTIONAL DIGESTIVE DISORDERS
G43.B0	Ophthalmoplegic migraine, not intractable		414 MIGRAINE HEADACHES
G43.B1	Ophthalmoplegic migraine, intractable		414 MIGRAINE HEADACHES
G43.C0	Periodic headache syndromes in child or adult, not intractable		414 MIGRAINE HEADACHES
G43.C1	Periodic headache syndromes in child or adult, intractable		414 MIGRAINE HEADACHES
G43.D0	Abdominal migraine, not intractable		535 DISORDERS OF FUNCTION OF STOMACH AND OTHER FUNCTIONAL DIGESTIVE DISORDERS
G43.D1	Abdominal migraine, intractable		535 DISORDERS OF FUNCTION OF STOMACH AND OTHER FUNCTIONAL DIGESTIVE DISORDERS
G44.1	Vascular headache, not elsewhere classified		414 MIGRAINE HEADACHES
G70.80	Lambert-Eaton syndrome, unspecified		144 MYASTHENIA GRAVIS
G70.81	Lambert-Eaton syndrome in disease classified elsewhere		144 MYASTHENIA GRAVIS

G70.89	Other specified myoneural disorders		144 MYASTHENIA GRAVIS
G89.29	Other chronic pain	G89.4 Chronic pain syndrome is excluded	EXCLUDED FILE
G93.82	Brain death	348.42 (ICD 9 brain death) is currently DWF	DIAGNOSTIC WORKUP FILE
H40.001	Preglaucoma, unspecified, right eye		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.002	Preglaucoma, unspecified, left eye		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.003	Preglaucoma, unspecified, bilateral		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.009	Preglaucoma, unspecified, unspecified eye		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.011	Open angle with borderline findings, low risk, right eye		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.012	Open angle with borderline findings, low risk, left eye		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.013	Open angle with borderline findings, low risk, bilateral		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.019	Open angle with borderline findings, low risk, unspecified eye		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.021	Open angle with borderline findings, high risk, right eye		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.022	Open angle with borderline findings, high risk, left eye		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.023	Open angle with borderline findings, high risk, bilateral		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.029	Open angle with borderline findings, high risk, unspecified eye		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.031	Anatomical narrow angle, right eye		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.032	Anatomical narrow angle, left eye		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.033	Anatomical narrow angle, bilateral		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.039	Anatomical narrow angle, unspecified eye		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.041	Steroid responder, right eye		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.042	Steroid responder, left eye		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.043	Steroid responder, bilateral		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.049	Steroid responder, unspecified eye		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.051	Ocular hypertension, right eye		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.052	Ocular hypertension, left eye		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.053	Ocular hypertension, bilateral		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.059	Ocular hypertension, unspecified eye		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.061	Primary angle closure without glaucoma damage, right eye		247 PRIMARY ANGLE-CLOSURE GLAUCOMA
H40.062	Primary angle closure without glaucoma damage, left eye		247 PRIMARY ANGLE-CLOSURE GLAUCOMA
H40.063	Primary angle closure without glaucoma damage, bilateral		247 PRIMARY ANGLE-CLOSURE GLAUCOMA

H40.069	Primary angle closure without glaucoma damage, unspecified eye		247 PRIMARY ANGLE-CLOSURE GLAUCOMA
H40.10x0	Unspecified open-angle glaucoma, stage unspecified		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.10x1	Unspecified open-angle glaucoma, mild stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.10x2	Unspecified open-angle glaucoma, moderate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.10x3	Unspecified open-angle glaucoma, severe stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.10x4	Unspecified open-angle glaucoma, indeterminate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.11x0	Primary open-angle glaucoma, stage unspecified		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.11x1	Primary open-angle glaucoma, mild stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.11x2	Primary open-angle glaucoma, moderate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.11x3	Primary open-angle glaucoma, severe stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.11x4	Primary open-angle glaucoma, indeterminate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1210	Low-tension glaucoma, right eye, stage unspecified		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1211	Low-tension glaucoma, right eye, mild stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1212	Low-tension glaucoma, right eye, moderate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1213	Low-tension glaucoma, right eye, severe stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1214	Low-tension glaucoma, right eye, indeterminate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1220	Low-tension glaucoma, left eye, stage unspecified		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1221	Low-tension glaucoma, left eye, mild stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1222	Low-tension glaucoma, left eye, moderate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1223	Low-tension glaucoma, left eye, severe stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1224	Low-tension glaucoma, left eye, indeterminate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1230	Low-tension glaucoma, bilateral, stage unspecified		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1231	Low-tension glaucoma, bilateral, mild stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1232	Low-tension glaucoma, bilateral, moderate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1233	Low-tension glaucoma, bilateral, severe stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1234	Low-tension glaucoma, bilateral, indeterminate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1290	Low-tension glaucoma, unspecified eye, stage unspecified		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1291	Low-tension glaucoma, unspecified eye, mild stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1292	Low-tension glaucoma, unspecified eye, moderate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1293	Low-tension glaucoma, unspecified eye, severe stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE

H40.1294	Low-tension glaucoma, unspecified eye, indeterminate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1310	Pigmentary glaucoma, right eye, stage unspecified		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1311	Pigmentary glaucoma, right eye, mild stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1312	Pigmentary glaucoma, right eye, moderate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1313	Pigmentary glaucoma, right eye, severe stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1314	Pigmentary glaucoma, right eye, indeterminate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1320	Pigmentary glaucoma, left eye, stage unspecified		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1321	Pigmentary glaucoma, left eye, mild stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1322	Pigmentary glaucoma, left eye, moderate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1323	Pigmentary glaucoma, left eye, severe stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1324	Pigmentary glaucoma, left eye, indeterminate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1330	Pigmentary glaucoma, bilateral, stage unspecified		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1331	Pigmentary glaucoma, bilateral, mild stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1332	Pigmentary glaucoma, bilateral, moderate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1333	Pigmentary glaucoma, bilateral, severe stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1334	Pigmentary glaucoma, bilateral, indeterminate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1390	Pigmentary glaucoma, unspecified eye, stage unspecified		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1391	Pigmentary glaucoma, unspecified eye, mild stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1392	Pigmentary glaucoma, unspecified eye, moderate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1393	Pigmentary glaucoma, unspecified eye, severe stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1394	Pigmentary glaucoma, unspecified eye, indeterminate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1410	Capsular glaucoma with pseudoexfoliation of lens, right eye, stage unspecified		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1411	Capsular glaucoma with pseudoexfoliation of lens, right eye, mild stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1412	Capsular glaucoma with pseudoexfoliation of lens, right eye, moderate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1413	Capsular glaucoma with pseudoexfoliation of lens, right eye, severe stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1414	Capsular glaucoma with pseudoexfoliation of lens, right eye, indeterminate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1420	Capsular glaucoma with pseudoexfoliation of lens, left eye, stage unspecified		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE

H40.1421	Capsular glaucoma with pseudoexfoliation of lens, left eye, mild stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1422	Capsular glaucoma with pseudoexfoliation of lens, left eye, moderate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1423	Capsular glaucoma with pseudoexfoliation of lens, left eye, severe stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1424	Capsular glaucoma with pseudoexfoliation of lens, left eye, indeterminate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1430	Capsular glaucoma with pseudoexfoliation of lens, bilateral, stage unspecified		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1431	Capsular glaucoma with pseudoexfoliation of lens, bilateral, mild stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1432	Capsular glaucoma with pseudoexfoliation of lens, bilateral, moderate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1433	Capsular glaucoma with pseudoexfoliation of lens, bilateral, severe stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1434	Capsular glaucoma with pseudoexfoliation of lens, bilateral, indeterminate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1490	Capsular glaucoma with pseudoexfoliation of lens, unspecified eye, stage unspecified		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1491	Capsular glaucoma with pseudoexfoliation of lens, unspecified eye, mild stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1492	Capsular glaucoma with pseudoexfoliation of lens, unspecified eye, moderate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1493	Capsular glaucoma with pseudoexfoliation of lens, unspecified eye, severe stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.1494	Capsular glaucoma with pseudoexfoliation of lens, unspecified eye, indeterminate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.20x0	Unspecified primary angle-closure glaucoma, stage unspecified		247 PRIMARY ANGLE-CLOSURE GLAUCOMA
H40.20x1	Unspecified primary angle-closure glaucoma, mild stage		247 PRIMARY ANGLE-CLOSURE GLAUCOMA
H40.20x2	Unspecified primary angle-closure glaucoma, moderate stage		247 PRIMARY ANGLE-CLOSURE GLAUCOMA
H40.20x3	Unspecified primary angle-closure glaucoma, severe stage		247 PRIMARY ANGLE-CLOSURE GLAUCOMA
H40.20x4	Unspecified primary angle-closure glaucoma, indeterminate stage		247 PRIMARY ANGLE-CLOSURE GLAUCOMA
H40.2210	Chronic angle-closure glaucoma, right eye, stage unspecified		247 PRIMARY ANGLE-CLOSURE GLAUCOMA
H40.2211	Chronic angle-closure glaucoma, right eye, mild stage		247 PRIMARY ANGLE-CLOSURE GLAUCOMA
H40.2212	Chronic angle-closure glaucoma, right eye, moderate stage		247 PRIMARY ANGLE-CLOSURE GLAUCOMA
H40.2213	Chronic angle-closure glaucoma, right eye, severe stage		247 PRIMARY ANGLE-CLOSURE GLAUCOMA

H40.2214	Chronic angle-closure glaucoma, right eye, indeterminate stage		247 PRIMARY ANGLE-CLOSURE GLAUCOMA
H40.2220	Chronic angle-closure glaucoma, left eye, stage unspecified		247 PRIMARY ANGLE-CLOSURE GLAUCOMA
H40.2221	Chronic angle-closure glaucoma, left eye, mild stage		247 PRIMARY ANGLE-CLOSURE GLAUCOMA
H40.2222	Chronic angle-closure glaucoma, left eye, moderate stage		247 PRIMARY ANGLE-CLOSURE GLAUCOMA
H40.2223	Chronic angle-closure glaucoma, left eye, severe stage		247 PRIMARY ANGLE-CLOSURE GLAUCOMA
H40.2224	Chronic angle-closure glaucoma, left eye, indeterminate stage		247 PRIMARY ANGLE-CLOSURE GLAUCOMA
H40.2230	Chronic angle-closure glaucoma, bilateral, stage unspecified		247 PRIMARY ANGLE-CLOSURE GLAUCOMA
H40.2231	Chronic angle-closure glaucoma, bilateral, mild stage		247 PRIMARY ANGLE-CLOSURE GLAUCOMA
H40.2232	Chronic angle-closure glaucoma, bilateral, moderate stage		247 PRIMARY ANGLE-CLOSURE GLAUCOMA
H40.2233	Chronic angle-closure glaucoma, bilateral, severe stage		247 PRIMARY ANGLE-CLOSURE GLAUCOMA
H40.2234	Chronic angle-closure glaucoma, bilateral, indeterminate stage		247 PRIMARY ANGLE-CLOSURE GLAUCOMA
H40.2290	Chronic angle-closure glaucoma, unspecified eye, stage unspecified		247 PRIMARY ANGLE-CLOSURE GLAUCOMA
H40.2291	Chronic angle-closure glaucoma, unspecified eye, mild stage		247 PRIMARY ANGLE-CLOSURE GLAUCOMA
H40.2292	Chronic angle-closure glaucoma, unspecified eye, moderate stage		247 PRIMARY ANGLE-CLOSURE GLAUCOMA
H40.2293	Chronic angle-closure glaucoma, unspecified eye, severe stage		247 PRIMARY ANGLE-CLOSURE GLAUCOMA
H40.2294	Chronic angle-closure glaucoma, unspecified eye, indeterminate stage		247 PRIMARY ANGLE-CLOSURE GLAUCOMA
H40.30x0	Glaucoma secondary to eye trauma, unspecified eye, stage unspecified		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.30x1	Glaucoma secondary to eye trauma, unspecified eye, mild stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.30x2	Glaucoma secondary to eye trauma, unspecified eye, moderate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.30x3	Glaucoma secondary to eye trauma, unspecified eye, severe stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.30x4	Glaucoma secondary to eye trauma, unspecified eye, indeterminate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.31x0	Glaucoma secondary to eye trauma, right eye, stage unspecified		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.31x1	Glaucoma secondary to eye trauma, right eye, mild stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.31x2	Glaucoma secondary to eye trauma, right eye, moderate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.31x3	Glaucoma secondary to eye trauma, right eye, severe stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.31x4	Glaucoma secondary to eye trauma, right eye, indeterminate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.32x0	Glaucoma secondary to eye trauma, left eye, stage unspecified		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.32x1	Glaucoma secondary to eye trauma, left eye, mild stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.32x2	Glaucoma secondary to eye trauma, left eye, moderate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.32x3	Glaucoma secondary to eye trauma, left eye, severe stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE

H40.32x4	Glaucoma secondary to eye trauma, left eye, indeterminate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.33x0	Glaucoma secondary to eye trauma, bilateral, stage unspecified		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.33x1	Glaucoma secondary to eye trauma, bilateral, mild stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.33x2	Glaucoma secondary to eye trauma, bilateral, moderate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.33x3	Glaucoma secondary to eye trauma, bilateral, severe stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.33x4	Glaucoma secondary to eye trauma, bilateral, indeterminate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.40x0	Glaucoma secondary to eye inflammation, unspecified eye, stage unspecified		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.40x1	Glaucoma secondary to eye inflammation, unspecified eye, mild stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.40x2	Glaucoma secondary to eye inflammation, unspecified eye, moderate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.40x3	Glaucoma secondary to eye inflammation, unspecified eye, severe stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.40x4	Glaucoma secondary to eye inflammation, unspecified eye, indeterminate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.41x0	Glaucoma secondary to eye inflammation, right eye, stage unspecified		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.41x1	Glaucoma secondary to eye inflammation, right eye, mild stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.41x2	Glaucoma secondary to eye inflammation, right eye, moderate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.41x3	Glaucoma secondary to eye inflammation, right eye, severe stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.41x4	Glaucoma secondary to eye inflammation, right eye, indeterminate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.42x0	Glaucoma secondary to eye inflammation, left eye, stage unspecified		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.42x1	Glaucoma secondary to eye inflammation, left eye, mild stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.42x2	Glaucoma secondary to eye inflammation, left eye, moderate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.42x3	Glaucoma secondary to eye inflammation, left eye, severe stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.42x4	Glaucoma secondary to eye inflammation, left eye, indeterminate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.43x0	Glaucoma secondary to eye inflammation, bilateral, stage unspecified		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.43x1	Glaucoma secondary to eye inflammation, bilateral, mild stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.43x2	Glaucoma secondary to eye inflammation, bilateral, moderate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE

H40.43x3	Glaucoma secondary to eye inflammation, bilateral, severe stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.43x4	Glaucoma secondary to eye inflammation, bilateral, indeterminate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.50x0	Glaucoma secondary to other eye disorders, unspecified eye, stage unspecified		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.50x1	Glaucoma secondary to other eye disorders, unspecified eye, mild stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.50x2	Glaucoma secondary to other eye disorders, unspecified eye, moderate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.50x3	Glaucoma secondary to other eye disorders, unspecified eye, severe stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.50x4	Glaucoma secondary to other eye disorders, unspecified eye, indeterminate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.51x0	Glaucoma secondary to other eye disorders, right eye, stage unspecified		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.51x1	Glaucoma secondary to other eye disorders, right eye, mild stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.51x2	Glaucoma secondary to other eye disorders, right eye, moderate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.51x3	Glaucoma secondary to other eye disorders, right eye, severe stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.51x4	Glaucoma secondary to other eye disorders, right eye, indeterminate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.52x0	Glaucoma secondary to other eye disorders, left eye, stage unspecified		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.52x1	Glaucoma secondary to other eye disorders, left eye, mild stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.52x2	Glaucoma secondary to other eye disorders, left eye, moderate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.52x3	Glaucoma secondary to other eye disorders, left eye, severe stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.52x4	Glaucoma secondary to other eye disorders, left eye, indeterminate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.53x0	Glaucoma secondary to other eye disorders, bilateral, stage unspecified		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.53x1	Glaucoma secondary to other eye disorders, bilateral, mild stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.53x2	Glaucoma secondary to other eye disorders, bilateral, moderate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.53x3	Glaucoma secondary to other eye disorders, bilateral, severe stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.53x4	Glaucoma secondary to other eye disorders, bilateral, indeterminate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.60x0	Glaucoma secondary to drugs, unspecified eye, stage unspecified		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.60x1	Glaucoma secondary to drugs, unspecified eye, mild stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.60x2	Glaucoma secondary to drugs, unspecified eye, moderate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.60x3	Glaucoma secondary to drugs, unspecified eye, severe stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE

H40.60x4	Glaucoma secondary to drugs, unspecified eye, indeterminate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.61x0	Glaucoma secondary to drugs, right eye, stage unspecified		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.61x1	Glaucoma secondary to drugs, right eye, mild stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.61x2	Glaucoma secondary to drugs, right eye, moderate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.61x3	Glaucoma secondary to drugs, right eye, severe stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.61x4	Glaucoma secondary to drugs, right eye, indeterminate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.62x0	Glaucoma secondary to drugs, left eye, stage unspecified		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.62x1	Glaucoma secondary to drugs, left eye, mild stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.62x2	Glaucoma secondary to drugs, left eye, moderate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.62x3	Glaucoma secondary to drugs, left eye, severe stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.62x4	Glaucoma secondary to drugs, left eye, indeterminate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.63x0	Glaucoma secondary to drugs, bilateral, stage unspecified		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.63x1	Glaucoma secondary to drugs, bilateral, mild stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.63x2	Glaucoma secondary to drugs, bilateral, moderate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.63x3	Glaucoma secondary to drugs, bilateral, severe stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H40.63x4	Glaucoma secondary to drugs, bilateral, indeterminate stage		143 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
H43.821	Vitreomacular adhesion, right eye	Treated with 67036, which is on line 304	304 VITREOUS DISORDERS
H43.822	Vitreomacular adhesion, left eye		304 VITREOUS DISORDERS
H43.823	Vitreomacular adhesion, bilateral		304 VITREOUS DISORDERS
H43.829	Vitreomacular adhesion, unspecified eye		304 VITREOUS DISORDERS
I25.84	Coronary atherosclerosis due to calcified coronary lesion		193 CHRONIC ISCHEMIC HEART DISEASE
I26.02	Saddle embolus of pulmonary artery with acute cor pulmonale		217 ACUTE PULMONARY HEART DISEASE AND PULMONARY EMBOLI
I26.92	Saddle embolus of pulmonary artery without acute cor pulmonale		217 ACUTE PULMONARY HEART DISEASE AND PULMONARY EMBOLI
I48.2	Chronic atrial fibrillation		350 CARDIAC ARRHYTHMIAS
I48.3	Typical atrial flutter		350 CARDIAC ARRHYTHMIAS
I48.4	Atypical atrial flutter		350 CARDIAC ARRHYTHMIAS
I48.91	Unspecified atrial fibrillation		350 CARDIAC ARRHYTHMIAS
I48.92	Unspecified atrial flutter		350 CARDIAC ARRHYTHMIAS

I67.81	Acute cerebrovascular insufficiency		75 NEUROLOGICAL DYSFUNCTION IN BREATHING, EATING, SWALLOWING, BOWEL, OR BLADDER CONTROL CAUSED BY CHRONIC CONDITIONS 297 NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS 322 STROKE 349 NEUROLOGICAL DYSFUNCTION IN COMMUNICATION CAUSED BY CHRONIC CONDITIONS 381 DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE LEVEL OF INDEPENDENCE IN SELF-DIRECTED CARE CAUSED BY CHRONIC CONDITIONS THAT CAUSE NEUROLOGICAL DYSFUNCTION 659 INTRACRANIAL CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY
I67.82	Cerebral ischemia		75 NEUROLOGICAL DYSFUNCTION IN BREATHING, EATING, SWALLOWING, BOWEL, OR BLADDER CONTROL CAUSED BY CHRONIC CONDITIONS 297 NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS 322 STROKE 349 NEUROLOGICAL DYSFUNCTION IN COMMUNICATION CAUSED BY CHRONIC CONDITIONS 381 DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE LEVEL OF INDEPENDENCE IN SELF-DIRECTED CARE CAUSED BY CHRONIC CONDITIONS THAT CAUSE NEUROLOGICAL DYSFUNCTION 659 INTRACRANIAL CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY

I67.83	Posterior reversible encephalopathy syndrome		75 NEUROLOGICAL DYSFUNCTION IN BREATHING, EATING, SWALLOWING, BOWEL, OR BLADDER CONTROL CAUSED BY CHRONIC CONDITIONS 297 NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS 322 STROKE 349 NEUROLOGICAL DYSFUNCTION IN COMMUNICATION CAUSED BY CHRONIC CONDITIONS 381 DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE LEVEL OF INDEPENDENCE IN SELF-DIRECTED CARE CAUSED BY CHRONIC CONDITIONS THAT CAUSE NEUROLOGICAL DYSFUNCTION
I67.841	Reversible cerebrovascular vasoconstriction syndrome	treated with calcium channel blockers, may cause stroke like symptoms	75 NEUROLOGICAL DYSFUNCTION IN BREATHING, EATING, SWALLOWING, BOWEL, OR BLADDER CONTROL CAUSED BY CHRONIC CONDITIONS 297 NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS 322 STROKE 349 NEUROLOGICAL DYSFUNCTION IN COMMUNICATION CAUSED BY CHRONIC CONDITIONS 381 DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE LEVEL OF INDEPENDENCE IN SELF-DIRECTED CARE CAUSED BY CHRONIC CONDITIONS THAT CAUSE NEUROLOGICAL DYSFUNCTION

I67.848	Other cerebrovascular vasospasm and vasoconstriction		75 NEUROLOGICAL DYSFUNCTION IN BREATHING, EATING, SWALLOWING, BOWEL, OR BLADDER CONTROL CAUSED BY CHRONIC CONDITIONS 297 NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS 322 STROKE 349 NEUROLOGICAL DYSFUNCTION IN COMMUNICATION CAUSED BY CHRONIC CONDITIONS 381 DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE LEVEL OF INDEPENDENCE IN SELF-DIRECTED CARE CAUSED BY CHRONIC CONDITIONS THAT CAUSE NEUROLOGICAL DYSFUNCTION 659 INTRACRANIAL CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY
I67.89	Other cerebrovascular disease		75 NEUROLOGICAL DYSFUNCTION IN BREATHING, EATING, SWALLOWING, BOWEL, OR BLADDER CONTROL CAUSED BY CHRONIC CONDITIONS 297 NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS 322 STROKE 349 NEUROLOGICAL DYSFUNCTION IN COMMUNICATION CAUSED BY CHRONIC CONDITIONS 381 DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE LEVEL OF INDEPENDENCE IN SELF-DIRECTED CARE CAUSED BY CHRONIC CONDITIONS THAT CAUSE NEUROLOGICAL DYSFUNCTION 659 INTRACRANIAL CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY
I74.01	Saddle embolus of abdominal aorta		257 ARTERIAL EMBOLISM/THROMBOSIS: ABDOMINAL AORTA, THORACIC AORTA
I74.09	Other arterial embolism and thrombosis of abdominal aorta		257 ARTERIAL EMBOLISM/THROMBOSIS: ABDOMINAL AORTA, THORACIC AORTA
J09.x1	Influenza due to identified novel influenza A virus with pneumonia		403 INFLUENZA

J09.x2	Influenza due to identified novel influenza A virus with other respiratory manifestations		403 INFLUENZA
J09.x3	Influenza due to identified novel influenza A virus with gastrointestinal manifestations		403 INFLUENZA
J09.x9	Influenza due to identified novel influenza A virus with other manifestations		403 INFLUENZA
J15.211	Pneumonia due to Methicillin susceptible Staphylococcus aureus		208 PNEUMOCOCCAL PNEUMONIA, OTHER BACTERIAL PNEUMONIA, BRONCHOPNEUMONIA
J15.212	Pneumonia due to Methicillin resistant Staphylococcus aureus		208 PNEUMOCOCCAL PNEUMONIA, OTHER BACTERIAL PNEUMONIA, BRONCHOPNEUMONIA
J70.5	Respiratory conditions due to smoke inhalation		237 ADULT RESPIRATORY DISTRESS SYNDROME; ACUTE RESPIRATORY FAILURE; RESPIRATORY CONDITIONS DUE TO PHYSICAL AND CHEMICAL AGENTS
J84.01	Alveolar proteinosis		223 PULMONARY FIBROSIS
J84.02	Pulmonary alveolar microlithiasis		223 PULMONARY FIBROSIS
J84.03	Idiopathic pulmonary hemosiderosis		223 PULMONARY FIBROSIS
J84.09	Other alveolar and parieto-alveolar conditions		223 PULMONARY FIBROSIS
J84.10	Pulmonary fibrosis, unspecified		223 PULMONARY FIBROSIS
J84.111	Idiopathic interstitial pneumonia, not otherwise specified	J84.1 put on 244 with ICD10 review	223 PULMONARY FIBROSIS 244 CONDITIONS REQUIRING HEART-LUNG AND LUNG TRANSPLANTATION
J84.112	Idiopathic pulmonary fibrosis		223 PULMONARY FIBROSIS 244 CONDITIONS REQUIRING HEART-LUNG AND LUNG TRANSPLANTATION
J84.113	Idiopathic non-specific interstitial pneumonitis		223 PULMONARY FIBROSIS 244 CONDITIONS REQUIRING HEART-LUNG AND LUNG TRANSPLANTATION
J84.114	Acute interstitial pneumonitis		223 PULMONARY FIBROSIS 244 CONDITIONS REQUIRING HEART-LUNG AND LUNG TRANSPLANTATION
J84.115	Respiratory bronchiolitis interstitial lung disease		223 PULMONARY FIBROSIS 244 CONDITIONS REQUIRING HEART-LUNG AND LUNG TRANSPLANTATION
J84.116	Cryptogenic organizing pneumonia		223 PULMONARY FIBROSIS 244 CONDITIONS REQUIRING HEART-LUNG AND LUNG TRANSPLANTATION
J84.117	Desquamative interstitial pneumonia		223 PULMONARY FIBROSIS 244 CONDITIONS REQUIRING HEART-LUNG AND LUNG TRANSPLANTATION
J84.17	Other interstitial pulmonary diseases with fibrosis in diseases classified elsewhere		223 PULMONARY FIBROSIS 244 CONDITIONS REQUIRING HEART-LUNG AND LUNG TRANSPLANTATION

J84.81	Lymphangioleiomyomatosis	J84.8 put on 244 with ICD10 review	223 PULMONARY FIBROSIS 244 CONDITIONS REQUIRING HEART-LUNG AND LUNG TRANSPLANTATION
J84.82	Adult pulmonary Langerhans cell histiocytosis		223 PULMONARY FIBROSIS 244 CONDITIONS REQUIRING HEART-LUNG AND LUNG TRANSPLANTATION
J84.83	Surfactant mutations of the lung		223 PULMONARY FIBROSIS 244 CONDITIONS REQUIRING HEART-LUNG AND LUNG TRANSPLANTATION
J84.841	Neuroendocrine cell hyperplasia of infancy		223 PULMONARY FIBROSIS 244 CONDITIONS REQUIRING HEART-LUNG AND LUNG TRANSPLANTATION
J84.842	Pulmonary interstitial glycogenosis		223 PULMONARY FIBROSIS 244 CONDITIONS REQUIRING HEART-LUNG AND LUNG TRANSPLANTATION
J84.843	Alveolar capillary dysplasia with vein misalignment		223 PULMONARY FIBROSIS 244 CONDITIONS REQUIRING HEART-LUNG AND LUNG TRANSPLANTATION
J84.848	Other interstitial lung diseases of childhood		223 PULMONARY FIBROSIS 244 CONDITIONS REQUIRING HEART-LUNG AND LUNG TRANSPLANTATION
J84.89	Other specified interstitial pulmonary diseases		223 PULMONARY FIBROSIS 244 CONDITIONS REQUIRING HEART-LUNG AND LUNG TRANSPLANTATION
J93.11	Primary spontaneous pneumothorax		147 PNEUMOTHORAX AND PLEURAL EFFUSION TUBE THORACOSTOMY
J93.12	Secondary spontaneous pneumothorax		147 PNEUMOTHORAX AND PLEURAL EFFUSION TUBE THORACOSTOMY
J93.81	Chronic pneumothorax		147 PNEUMOTHORAX AND PLEURAL EFFUSION TUBE THORACOSTOMY
J93.82	Other air leak		147 PNEUMOTHORAX AND PLEURAL EFFUSION TUBE THORACOSTOMY
J93.83	Other pneumothorax		147 PNEUMOTHORAX AND PLEURAL EFFUSION TUBE THORACOSTOMY
J95.811	Postprocedural pneumothorax		147 PNEUMOTHORAX AND PLEURAL EFFUSION TUBE THORACOSTOMY
J95.812	Postprocedural air leak		147 PNEUMOTHORAX AND PLEURAL EFFUSION TUBE THORACOSTOMY
J95.821	Acute postprocedural respiratory failure		237 ADULT RESPIRATORY DISTRESS SYNDROME; ACUTE RESPIRATORY FAILURE; RESPIRATORY CONDITIONS DUE TO PHYSICAL AND CHEMICAL AGENTS
J95.822	Acute and chronic postprocedural respiratory failure		237 ADULT RESPIRATORY DISTRESS SYNDROME; ACUTE RESPIRATORY FAILURE; RESPIRATORY CONDITIONS DUE TO PHYSICAL AND CHEMICAL AGENTS

K31.84	Gastroparesis		535 DISORDERS OF FUNCTION OF STOMACH AND OTHER FUNCTIONAL DIGESTIVE DISORDERS
K43.0	Incisional hernia with obstruction, without gangrene		172 COMPLICATED HERNIAS; UNCOMPLICATED INGUINAL HERNIA IN CHILDREN AGE 18 AND UNDER; PERSISTENT HYDROCELE
K43.1	Incisional hernia with gangrene		172 COMPLICATED HERNIAS; UNCOMPLICATED INGUINAL HERNIA IN CHILDREN AGE 18 AND UNDER; PERSISTENT HYDROCELE
K43.2	Incisional hernia without obstruction or gangrene		530 UNCOMPLICATED HERNIA AND VENTRAL HERNIA (OTHER THAN INGUINAL HERNIA IN CHILDREN AGE 18 AND UNDER OR DIAPHRAGMATIC HERNIA)
K43.3	Parastomal hernia with obstruction, without gangrene		172 COMPLICATED HERNIAS; UNCOMPLICATED INGUINAL HERNIA IN CHILDREN AGE 18 AND UNDER; PERSISTENT HYDROCELE
K43.4	Parastomal hernia with gangrene		172 COMPLICATED HERNIAS; UNCOMPLICATED INGUINAL HERNIA IN CHILDREN AGE 18 AND UNDER; PERSISTENT HYDROCELE
K43.5	Parastomal hernia without obstruction or gangrene		530 UNCOMPLICATED HERNIA AND VENTRAL HERNIA (OTHER THAN INGUINAL HERNIA IN CHILDREN AGE 18 AND UNDER OR DIAPHRAGMATIC HERNIA)
K43.6	Other and unspecified ventral hernia with obstruction, without gangrene		172 COMPLICATED HERNIAS; UNCOMPLICATED INGUINAL HERNIA IN CHILDREN AGE 18 AND UNDER; PERSISTENT HYDROCELE
K43.7	Other and unspecified ventral hernia with gangrene		172 COMPLICATED HERNIAS; UNCOMPLICATED INGUINAL HERNIA IN CHILDREN AGE 18 AND UNDER; PERSISTENT HYDROCELE
K43.9	Ventral hernia without obstruction or gangrene		530 UNCOMPLICATED HERNIA AND VENTRAL HERNIA (OTHER THAN INGUINAL HERNIA IN CHILDREN AGE 18 AND UNDER OR DIAPHRAGMATIC HERNIA)
K64.0	First degree hemorrhoids		629 UNCOMPLICATED HEMORRHOIDS
K64.1	Second degree hemorrhoids		629 UNCOMPLICATED HEMORRHOIDS
K64.2	Third degree hemorrhoids		629 UNCOMPLICATED HEMORRHOIDS
K64.3	Fourth degree hemorrhoids		480 THROMBOSED AND COMPLICATED HEMORRHOIDS
K64.4	Residual hemorrhoidal skin tags		667 GENITOURINARY CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECE
K64.5	Perianal venous thrombosis	thrombosed hemorrhoid	480 THROMBOSED AND COMPLICATED HEMORRHOIDS
K64.8	Other hemorrhoids		629 UNCOMPLICATED HEMORRHOIDS

K64.9	Unspecified hemorrhoids		629 UNCOMPLICATED HEMORRHOIDS
K76.81	Hepatopulmonary syndrome		312 CIRRHOSIS OF LIVER OR BILIARY TRACT; BUDD-CHIARI SYNDROME; HEPATIC VEIN THROMBOSIS; INTRAHEPATIC VASCULAR MALFORMATIONS; CAROLI'S DISEASE
K76.89	Other specified diseases of liver	liver cyst, focal nodular hyperplasia of liver, hepatoptosis ICD 9 573.8 to lines 319, 360 and 365 May 2013, on 219	298 ANOMALIES OF GALLBLADDER, BILE DUCTS, AND LIVER 338 ALCOHOLIC FATTY LIVER OR ALCOHOLIC HEPATITIS, CIRRHOSIS OF LIVER 342 ACUTE NECROSIS OF LIVER
K91.86	Retained cholelithiasis following cholecystectomy	ICD9 997.41 is on line 308	290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
K95.01	Infection due to gastric band procedure		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
K95.09	Other complications of gastric band procedure		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT 427 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
K95.81	Infection due to other bariatric procedure		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT 427 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
K95.89	Other complications of other bariatric procedure		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT 427 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
L72.11	Pilar cyst		632 SEBACEOUS CYST
L72.12	Trichodermal cyst		632 SEBACEOUS CYST
L72.3	Sebaceous cyst		632 SEBACEOUS CYST
M21.051	Valgus deformity, not elsewhere classified, right hip	Similar to M21.252	381 DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE LEVEL OF INDEPENDENCE IN SELF-DIRECTED CARE CAUSED BY CHRONIC CONDITIONS THAT CAUSE NEUROLOGICAL DYSFUNCTION 534 DEFORMITIES OF UPPER BODY AND ALL LIMBS 391 DEFORMITY/CLOSED DISLOCATION OF MINOR JOINT AND RECURRENT JOINT DISLOCATIONS

M21.052	Valgus deformity, not elsewhere classified, left hip		381 DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE LEVEL OF INDEPENDENCE IN SELF-DIRECTED CARE CAUSED BY CHRONIC CONDITIONS THAT CAUSE NEUROLOGICAL DYSFUNCTION 534 DEFORMITIES OF UPPER BODY AND ALL LIMBS 391 DEFORMITY/CLOSED DISLOCATION OF MINOR JOINT AND RECURRENT JOINT DISLOCATIONS
M21.059	Valgus deformity, not elsewhere classified, unspecified hip		381 DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE LEVEL OF INDEPENDENCE IN SELF-DIRECTED CARE CAUSED BY CHRONIC CONDITIONS THAT CAUSE NEUROLOGICAL DYSFUNCTION 534 DEFORMITIES OF UPPER BODY AND ALL LIMBS 391 DEFORMITY/CLOSED DISLOCATION OF MINOR JOINT AND RECURRENT JOINT DISLOCATIONS
M21.151	Varus deformity, not elsewhere classified, right hip		381 DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE LEVEL OF INDEPENDENCE IN SELF-DIRECTED CARE CAUSED BY CHRONIC CONDITIONS THAT CAUSE NEUROLOGICAL DYSFUNCTION 534 DEFORMITIES OF UPPER BODY AND ALL LIMBS 391 DEFORMITY/CLOSED DISLOCATION OF MINOR JOINT AND RECURRENT JOINT DISLOCATIONS
M21.152	Varus deformity, not elsewhere classified, left hip		381 DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE LEVEL OF INDEPENDENCE IN SELF-DIRECTED CARE CAUSED BY CHRONIC CONDITIONS THAT CAUSE NEUROLOGICAL DYSFUNCTION 534 DEFORMITIES OF UPPER BODY AND ALL LIMBS 391 DEFORMITY/CLOSED DISLOCATION OF MINOR JOINT AND RECURRENT JOINT DISLOCATIONS
M21.159	Varus deformity, not elsewhere classified, unspecified		381 DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE LEVEL OF INDEPENDENCE IN SELF-DIRECTED CARE CAUSED BY CHRONIC CONDITIONS THAT CAUSE NEUROLOGICAL DYSFUNCTION 534 DEFORMITIES OF UPPER BODY AND ALL LIMBS 391 DEFORMITY/CLOSED DISLOCATION OF MINOR JOINT AND RECURRENT JOINT DISLOCATIONS

M75.100	Unspecified rotator cuff tear or rupture of unspecified shoulder, not specified as traumatic		422 DISORDERS OF SHOULDER, INCLUDING SPRAINS/STRAINS GRADE 3 THROUGH 6
M75.101	Unspecified rotator cuff tear or rupture of right shoulder, not specified as traumatic		422 DISORDERS OF SHOULDER, INCLUDING SPRAINS/STRAINS GRADE 3 THROUGH 6
M75.102	Unspecified rotator cuff tear or rupture of left shoulder, not specified as traumatic		422 DISORDERS OF SHOULDER, INCLUDING SPRAINS/STRAINS GRADE 3 THROUGH 6
M75.110	Incomplete rotator cuff tear or rupture of unspecified shoulder, not specified as traumatic		422 DISORDERS OF SHOULDER, INCLUDING SPRAINS/STRAINS GRADE 3 THROUGH 6
M75.111	Incomplete rotator cuff tear or rupture of right shoulder, not specified as traumatic		422 DISORDERS OF SHOULDER, INCLUDING SPRAINS/STRAINS GRADE 3 THROUGH 6
M75.112	Incomplete rotator cuff tear or rupture of left shoulder, not specified as traumatic		422 DISORDERS OF SHOULDER, INCLUDING SPRAINS/STRAINS GRADE 3 THROUGH 6
M75.120	Complete rotator cuff tear or rupture of unspecified shoulder, not specified as traumatic		422 DISORDERS OF SHOULDER, INCLUDING SPRAINS/STRAINS GRADE 3 THROUGH 6
M75.121	Complete rotator cuff tear or rupture of right shoulder, not specified as traumatic		422 DISORDERS OF SHOULDER, INCLUDING SPRAINS/STRAINS GRADE 3 THROUGH 6
M75.122	Complete rotator cuff tear or rupture of left shoulder, not specified as traumatic		422 DISORDERS OF SHOULDER, INCLUDING SPRAINS/STRAINS GRADE 3 THROUGH 6
N36.5	Urethral false passage		331 FUNCTIONAL AND MECHANICAL DISORDERS OF THE GENITOURINARY SYSTEM INCLUDING BLADDER OUTLET OBSTRUCTION
N40.2	Nodular prostate without lower urinary tract symptoms		576 UNSPECIFIED URINARY OBSTRUCTION AND BENIGN PROSTATIC HYPERPLASIA WITHOUT OBSTRUCTION
N40.3	Nodular prostate with lower urinary tract symptoms		576 UNSPECIFIED URINARY OBSTRUCTION AND BENIGN PROSTATIC HYPERPLASIA WITHOUT OBSTRUCTION
N41.0	Acute prostatitis		278 UROLOGIC INFECTIONS
N41.1	Chronic prostatitis		521 CHRONIC PROSTATITIS, OTHER DISORDERS OF PROSTATE
N42.83	Cyst of prostate		521 CHRONIC PROSTATITIS, OTHER DISORDERS OF PROSTATE
N48.82	Acquired torsion of penis		667 GENITOURINARY CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY
N48.83	Acquired buried penis		667 GENITOURINARY CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY
N50.3	Cyst of epididymis	like 608.1 spermatocele	331 FUNCTIONAL AND MECHANICAL DISORDERS OF THE GENITOURINARY SYSTEM INCLUDING BLADDER OUTLET OBSTRUCTION

O02.81	Inappropriate change in quantitative human chorionic gonadotropin (hCG) in early pregnancy		1 PREGNANCY 67 SPONTANEOUS ABORTION; MISSED ABORTION
O02.89	Other abnormal products of conception		1 PREGNANCY 39 TERMINATION OF PREGNANCY 67 SPONTANEOUS ABORTION; MISSED ABORTION
O36.80x0	Pregnancy with inconclusive fetal viability, not applicable or unspecified		1 PREGNANCY 39 TERMINATION OF PREGNANCY 67 SPONTANEOUS ABORTION; MISSED ABORTION
O36.80x1	Pregnancy with inconclusive fetal viability, fetus 1		1 PREGNANCY 39 TERMINATION OF PREGNANCY 67 SPONTANEOUS ABORTION; MISSED ABORTION
O36.80x2	Pregnancy with inconclusive fetal viability, fetus 2		1 PREGNANCY 39 TERMINATION OF PREGNANCY 67 SPONTANEOUS ABORTION; MISSED ABORTION
O36.80x3	Pregnancy with inconclusive fetal viability, fetus 3		1 PREGNANCY 39 TERMINATION OF PREGNANCY 67 SPONTANEOUS ABORTION; MISSED ABORTION
O36.80x4	Pregnancy with inconclusive fetal viability, fetus 4		1 PREGNANCY 39 TERMINATION OF PREGNANCY 67 SPONTANEOUS ABORTION; MISSED ABORTION
O36.80x5	Pregnancy with inconclusive fetal viability, fetus 5		1 PREGNANCY 39 TERMINATION OF PREGNANCY 67 SPONTANEOUS ABORTION; MISSED ABORTION
O36.80x9	Pregnancy with inconclusive fetal viability, other fetus		1 PREGNANCY 39 TERMINATION OF PREGNANCY 67 SPONTANEOUS ABORTION; MISSED ABORTION
O75.82	Onset (spontaneous) of labor after 37 completed weeks of gestation but before 39 completed weeks gestation, with delivery by (planned) cesarean section		1 PREGNANCY

P07.24	Extreme immaturity of newborn, gestational age 25 completed weeks		17 VERY LOW BIRTH WEIGHT (UNDER 1500 GRAMS) 23 LOW BIRTH WEIGHT (1500-2500 GRAMS) 75 NEUROLOGICAL DYSFUNCTION IN BREATHING, EATING, SWALLOWING, BOWEL, OR BLADDER CONTROL CAUSED BY CHRONIC CONDITIONS 297 NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS 349 NEUROLOGICAL DYSFUNCTION IN COMMUNICATION CAUSED BY CHRONIC CONDITIONS 381 DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE LEVEL OF INDEPENDENCE IN SELF-DIRECTED CARE CAUSED BY CHRONIC CONDITIONS THAT CAUSE NEUROLOGICAL DYSFUNCTION
P07.25	Extreme immaturity of newborn, gestational age 26 completed weeks		17 VERY LOW BIRTH WEIGHT (UNDER 1500 GRAMS) 23 LOW BIRTH WEIGHT (1500-2500 GRAMS) 75 NEUROLOGICAL DYSFUNCTION IN BREATHING, EATING, SWALLOWING, BOWEL, OR BLADDER CONTROL CAUSED BY CHRONIC CONDITIONS 297 NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS 349 NEUROLOGICAL DYSFUNCTION IN COMMUNICATION CAUSED BY CHRONIC CONDITIONS 381 DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE LEVEL OF INDEPENDENCE IN SELF-DIRECTED CARE CAUSED BY CHRONIC CONDITIONS THAT CAUSE NEUROLOGICAL DYSFUNCTION

P07.26	Extreme immaturity of newborn, gestational age 27 completed weeks		17 VERY LOW BIRTH WEIGHT (UNDER 1500 GRAMS) 23 LOW BIRTH WEIGHT (1500-2500 GRAMS) 75 NEUROLOGICAL DYSFUNCTION IN BREATHING, EATING, SWALLOWING, BOWEL, OR BLADDER CONTROL CAUSED BY CHRONIC CONDITIONS 297 NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS 349 NEUROLOGICAL DYSFUNCTION IN COMMUNICATION CAUSED BY CHRONIC CONDITIONS 381 DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE LEVEL OF INDEPENDENCE IN SELF-DIRECTED CARE CAUSED BY CHRONIC CONDITIONS THAT CAUSE NEUROLOGICAL DYSFUNCTION
P07.33	Preterm newborn, gestational age 30 completed weeks		17 VERY LOW BIRTH WEIGHT (UNDER 1500 GRAMS) 23 LOW BIRTH WEIGHT (1500-2500 GRAMS) 75 NEUROLOGICAL DYSFUNCTION IN BREATHING, EATING, SWALLOWING, BOWEL, OR BLADDER CONTROL CAUSED BY CHRONIC CONDITIONS 297 NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS 349 NEUROLOGICAL DYSFUNCTION IN COMMUNICATION CAUSED BY CHRONIC CONDITIONS 381 DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE LEVEL OF INDEPENDENCE IN SELF-DIRECTED CARE CAUSED BY CHRONIC CONDITIONS THAT CAUSE NEUROLOGICAL DYSFUNCTION

P07.34	Preterm newborn, gestational age 31 completed weeks		17 VERY LOW BIRTH WEIGHT (UNDER 1500 GRAMS) 23 LOW BIRTH WEIGHT (1500-2500 GRAMS) 75 NEUROLOGICAL DYSFUNCTION IN BREATHING, EATING, SWALLOWING, BOWEL, OR BLADDER CONTROL CAUSED BY CHRONIC CONDITIONS 297 NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS 349 NEUROLOGICAL DYSFUNCTION IN COMMUNICATION CAUSED BY CHRONIC CONDITIONS 381 DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE LEVEL OF INDEPENDENCE IN SELF-DIRECTED CARE CAUSED BY CHRONIC CONDITIONS THAT CAUSE NEUROLOGICAL DYSFUNCTION
P07.35	Preterm newborn, gestational age 32 completed weeks		17 VERY LOW BIRTH WEIGHT (UNDER 1500 GRAMS) 23 LOW BIRTH WEIGHT (1500-2500 GRAMS) 75 NEUROLOGICAL DYSFUNCTION IN BREATHING, EATING, SWALLOWING, BOWEL, OR BLADDER CONTROL CAUSED BY CHRONIC CONDITIONS 297 NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS 349 NEUROLOGICAL DYSFUNCTION IN COMMUNICATION CAUSED BY CHRONIC CONDITIONS 381 DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE LEVEL OF INDEPENDENCE IN SELF-DIRECTED CARE CAUSED BY CHRONIC CONDITIONS THAT CAUSE NEUROLOGICAL DYSFUNCTION

P07.36	Preterm newborn, gestational age 33 completed weeks		17 VERY LOW BIRTH WEIGHT (UNDER 1500 GRAMS) 23 LOW BIRTH WEIGHT (1500-2500 GRAMS) 75 NEUROLOGICAL DYSFUNCTION IN BREATHING, EATING, SWALLOWING, BOWEL, OR BLADDER CONTROL CAUSED BY CHRONIC CONDITIONS 297 NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS 349 NEUROLOGICAL DYSFUNCTION IN COMMUNICATION CAUSED BY CHRONIC CONDITIONS 381 DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE LEVEL OF INDEPENDENCE IN SELF-DIRECTED CARE CAUSED BY CHRONIC CONDITIONS THAT CAUSE NEUROLOGICAL DYSFUNCTION
P07.37	Preterm newborn, gestational age 34 completed weeks		17 VERY LOW BIRTH WEIGHT (UNDER 1500 GRAMS) 23 LOW BIRTH WEIGHT (1500-2500 GRAMS) 75 NEUROLOGICAL DYSFUNCTION IN BREATHING, EATING, SWALLOWING, BOWEL, OR BLADDER CONTROL CAUSED BY CHRONIC CONDITIONS 297 NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS 349 NEUROLOGICAL DYSFUNCTION IN COMMUNICATION CAUSED BY CHRONIC CONDITIONS 381 DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE LEVEL OF INDEPENDENCE IN SELF-DIRECTED CARE CAUSED BY CHRONIC CONDITIONS THAT CAUSE NEUROLOGICAL DYSFUNCTION

P07.38	Preterm newborn, gestational age 35 completed weeks		17 VERY LOW BIRTH WEIGHT (UNDER 1500 GRAMS) 23 LOW BIRTH WEIGHT (1500-2500 GRAMS) 75 NEUROLOGICAL DYSFUNCTION IN BREATHING, EATING, SWALLOWING, BOWEL, OR BLADDER CONTROL CAUSED BY CHRONIC CONDITIONS 297 NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS 349 NEUROLOGICAL DYSFUNCTION IN COMMUNICATION CAUSED BY CHRONIC CONDITIONS 381 DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE LEVEL OF INDEPENDENCE IN SELF-DIRECTED CARE CAUSED BY CHRONIC CONDITIONS THAT CAUSE NEUROLOGICAL DYSFUNCTION
P07.39	Preterm newborn, gestational age 36 completed weeks		17 VERY LOW BIRTH WEIGHT (UNDER 1500 GRAMS) 23 LOW BIRTH WEIGHT (1500-2500 GRAMS) 75 NEUROLOGICAL DYSFUNCTION IN BREATHING, EATING, SWALLOWING, BOWEL, OR BLADDER CONTROL CAUSED BY CHRONIC CONDITIONS 297 NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS 349 NEUROLOGICAL DYSFUNCTION IN COMMUNICATION CAUSED BY CHRONIC CONDITIONS 381 DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE LEVEL OF INDEPENDENCE IN SELF-DIRECTED CARE CAUSED BY CHRONIC CONDITIONS THAT CAUSE NEUROLOGICAL DYSFUNCTION
Q25.71	Coarctation of pulmonary artery		109 TETRALOGY OF FALLOT (TOF); CONGENITAL VENOUS ABNORMALITIES
Q25.72	Congenital pulmonary arteriovenous malformation		109 TETRALOGY OF FALLOT (TOF); CONGENITAL VENOUS ABNORMALITIES
Q25.79	Other congenital malformations of pulmonary artery		109 TETRALOGY OF FALLOT (TOF); CONGENITAL VENOUS ABNORMALITIES

Q55.63	Congenital torsion of penis		438 HYPOSPADIAS AND EPISPADIAS 667 GENITOURINARY CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY
Q55.64	Hidden penis	ICD9 equivalent just on 438	438 HYPOSPADIAS AND EPISPADIAS
Q65.81	Congenital coxa valga		315 CONGENITAL DISLOCATION OF HIP; COXA VARA AND VALGA
Q65.82	Congenital coxa vara		315 CONGENITAL DISLOCATION OF HIP; COXA VARA AND VALGA
Q65.89	Other specified congenital deformities of hip		315 CONGENITAL DISLOCATION OF HIP; COXA VARA AND VALGA
Q66.50	Congenital pes planus, unspecified foot		548 DEFORMITIES OF FOOT
Q66.51	Congenital pes planus, right foot		548 DEFORMITIES OF FOOT
Q66.52	Congenital pes planus, left foot		548 DEFORMITIES OF FOOT
Q66.80	Congenital vertical talus deformity, unspecified foot		548 DEFORMITIES OF FOOT
Q66.81	Congenital vertical talus deformity, right foot		548 DEFORMITIES OF FOOT
Q66.82	Congenital vertical talus deformity, left foot		548 DEFORMITIES OF FOOT
Q66.89	Other specified congenital deformities of feet		548 DEFORMITIES OF FOOT
R40.241	Glasgow coma scale score 13-15		DIAGNOSTIC WORKUP FILE
R40.242	Glasgow coma scale score 9-12		DIAGNOSTIC WORKUP FILE
R40.243	Glasgow coma scale score 3-8		DIAGNOSTIC WORKUP FILE
R40.244	Other coma, without documented Glasgow coma scale score, or with partial score reported		DIAGNOSTIC WORKUP FILE
R48.3	Visual agnosia		DIAGNOSTIC WORKUP FILE
R76.11	Nonspecific reaction to tuberculin skin test without active tuberculosis		DIAGNOSTIC WORKUP FILE
R76.12	Nonspecific reaction to cell mediated immunity measurement of gamma interferon antigen response without active tuberculosis		DIAGNOSTIC WORKUP FILE
R91.1	Solitary pulmonary nodule		DIAGNOSTIC WORKUP FILE
R91.8	Other nonspecific abnormal finding of lung field		DIAGNOSTIC WORKUP FILE
S32.82xA	Multiple fractures of pelvis without disruption of pelvic ring, initial encounter for closed fracture		187 FRACTURE OF PELVIS, OPEN AND CLOSE
S32.82xB	Multiple fractures of pelvis without disruption of pelvic ring, initial encounter for open fracture		187 FRACTURE OF PELVIS, OPEN AND CLOSE
S32.82xD	Multiple fractures of pelvis without disruption of pelvic ring, subsequent encounter for fracture with routine healing		187 FRACTURE OF PELVIS, OPEN AND CLOSE
S32.82xG	Multiple fractures of pelvis without disruption of pelvic ring, subsequent encounter for fracture with delayed healing		187 FRACTURE OF PELVIS, OPEN AND CLOSE
S32.82xK	Multiple fractures of pelvis without disruption of pelvic ring, subsequent encounter for fracture with nonunion		187 FRACTURE OF PELVIS, OPEN AND CLOSE
S32.82xS	Multiple fractures of pelvis without disruption of pelvic ring, sequela		187 FRACTURE OF PELVIS, OPEN AND CLOSE

T80.211A	Bloodstream infection due to central venous catheter, initial encounter		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
T80.211D	Bloodstream infection due to central venous catheter, subsequent encounter		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
T80.211S	Bloodstream infection due to central venous catheter, sequela		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
T80.212A	Local infection due to central venous catheter, initial encounter		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
T80.212D	Local infection due to central venous catheter, subsequent encounter		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
T80.212S	Local infection due to central venous catheter, sequela		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
T80.218A	Other infection due to central venous catheter, initial encounter		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
T80.218D	Other infection due to central venous catheter, subsequent encounter		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
T80.218S	Other infection due to central venous catheter, sequela		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
T80.219A	Unspecified infection due to central venous catheter, initial encounter		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
T80.219D	Unspecified infection due to central venous catheter, subsequent encounter		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
T80.219S	Unspecified infection due to central venous catheter, sequela		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
T80.22xA	Acute infection following transfusion, infusion, or injection of blood and blood products, initial encounter		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
T80.22xD	Acute infection following transfusion, infusion, or injection of blood and blood products, subsequent encounter		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
T80.22xS	Acute infection following transfusion, infusion, or injection of blood and blood products, sequela		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
T80.51xA	Anaphylactic reaction due to administration of blood and blood products, initial encounter		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
T80.51xD	Anaphylactic reaction due to administration of blood and blood products, subsequent encounter		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
T80.51xS	Anaphylactic reaction due to administration of blood and blood products, sequela		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
T80.52xA	Anaphylactic reaction due to vaccination, initial encounter		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
T80.52xD	Anaphylactic reaction due to vaccination, subsequent encounter		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT

T80.52xS	Anaphylactic reaction due to vaccination, sequela		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
T80.59xA	Anaphylactic reaction due to other serum, initial encounter		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
T80.59xD	Anaphylactic reaction due to other serum, subsequent encounter		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
T80.59xS	Anaphylactic reaction due to other serum, sequela		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
T80.61xA	Other serum reaction due to administration of blood and blood products, initial encounter		427 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
T80.61xD	Other serum reaction due to administration of blood and blood products, subsequent encounter		427 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
T80.61xS	Other serum reaction due to administration of blood and blood products, sequela		427 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
T80.62xA	Other serum reaction due to vaccination, initial encounter		427 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
T80.62xD	Other serum reaction due to vaccination, subsequent encounter		427 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
T80.62xS	Other serum reaction due to vaccination, sequela		427 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
T80.69xA	Other serum reaction due to other serum, initial encounter		427 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
T80.69xD	Other serum reaction due to other serum, subsequent encounter		427 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
T80.69xS	Other serum reaction due to other serum, sequela		427 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
T81.10xA	Postprocedural shock unspecified, initial encounter	R57.9 on 235	225 DISORDERS OF FLUID, ELECTROLYTE, AND ACID-BASE BALANCE
T81.10xD	Postprocedural shock unspecified, subsequent encounter		225 DISORDERS OF FLUID, ELECTROLYTE, AND ACID-BASE BALANCE
T81.10xS	Postprocedural shock unspecified, sequela	Sequela	EXCLUDED FILE
T81.11xA	Postprocedural cardiogenic shock, initial encounter	R57.0 on 76	73 ACUTE AND SUBACUTE ISCHEMIC HEART DISEASE, MYOCARDIAL INFARCTION

T81.11xD	Postprocedural cardiogenic shock, subsequent encounter		73 ACUTE AND SUBACUTE ISCHEMIC HEART DISEASE, MYOCARDIAL INFARCTION
T81.11xS	Postprocedural cardiogenic shock, sequela		EXCLUDED FILE
T81.12xA	Postprocedural septic shock, initial encounter		186 SEPTICEMIA
T81.12xD	Postprocedural septic shock, subsequent encounter		186 SEPTICEMIA
T81.12xS	Postprocedural septic shock, sequela		EXCLUDED FILE
T81.19xA	Other postprocedural shock, initial encounter	R57.8 on 235	225 DISORDERS OF FLUID, ELECTROLYTE, AND ACID-BASE BALANCE
T81.19xD	Other postprocedural shock, subsequent encounter		225 DISORDERS OF FLUID, ELECTROLYTE, AND ACID-BASE BALANCE
T81.19xS	Other postprocedural shock, sequela		EXCLUDED FILE
T83.711A	Erosion of implanted vaginal mesh and other prosthetic materials to surrounding organ or tissue, initial encounter		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT 427 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
T83.711D	Erosion of implanted vaginal mesh and other prosthetic materials to surrounding organ or tissue, subsequent encounter		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT 427 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
T83.711S	Erosion of implanted vaginal mesh and other prosthetic materials to surrounding organ or tissue, sequela		EXCLUDED FILE
T83.718A	Erosion of other implanted mesh and other prosthetic materials to surrounding organ or tissue, initial encounter		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT 427 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
T83.718D	Erosion of other implanted mesh and other prosthetic materials to surrounding organ or tissue, subsequent encounter		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT 427 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
T83.718S	Erosion of other implanted mesh and other prosthetic materials to surrounding organ or tissue, sequela		EXCLUDED FILE
T83.721A	Exposure of implanted vaginal mesh and other prosthetic materials into vagina, initial encounter		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT 427 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
T83.721D	Exposure of implanted vaginal mesh and other prosthetic materials into vagina, subsequent encounter		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT 427 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT

T83.721S	Exposure of implanted vaginal mesh and other prosthetic materials into vagina, sequela		EXCLUDED FILE
T83.728A	Exposure of other implanted mesh and other prosthetic materials to surrounding organ or tissue, initial encounter		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT 427 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
T83.728D	Exposure of other implanted mesh and other prosthetic materials to surrounding organ or tissue, subsequent encounter		290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT 427 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
T83.728S	Exposure of other implanted mesh and other prosthetic materials to surrounding organ or tissue, sequela		EXCLUDED FILE
T86.5	Complications of stem cell transplant	38243 HPC transplant (stem cell)	103 ACUTE LEUKEMIA, MYELODYSPLASTIC SYNDROME 105 HEREDITARY IMMUNE DEFICIENCIES 125 HODGKIN'S DISEASE 170 NON-HODGKIN'S LYMPHOMAS 198 MULTIPLE MYELOMA 231 TESTICULAR CANCER 314 OSTEOPETROSIS
T87.81	Dehiscence of amputation stump		427 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
T87.89	Other complications of amputation stump		427 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
Y63.6	Underdosing and nonadministration of necessary drug, medicament or biological substance		ANCILLARY CODES
Y92.000	Kitchen of unspecified non-institutional (private) residence as the place of occurrence of the external cause		EXCLUDED FILE
Y92.001	Dining room of unspecified non-institutional (private) residence as the place of occurrence of the external cause		EXCLUDED FILE
Y92.002	Bathroom of unspecified non-institutional private) residence single-family (private) house as the place of occurrence of the external cause		EXCLUDED FILE
Y92.003	Bedroom of unspecified non-institutional (private) residence as the place of occurrence of the external cause		EXCLUDED FILE
Y92.007	Garden or yard of unspecified non-institutional (private) residence as the place of occurrence of the external cause		EXCLUDED FILE
Y92.008	Other place in unspecified non-institutional (private) residence as the place of occurrence of the external cause		EXCLUDED FILE

Y92.009	Unspecified place in unspecified non-institutional (private) residence as the place of occurrence of the external cause		EXCLUDED FILE
Z16.10	Resistance to unspecified beta lactam antibiotics		EXCLUDED FILE
Z16.11	Resistance to penicillins		EXCLUDED FILE
Z16.12	Extended spectrum beta lactamase (ESBL) resistance		EXCLUDED FILE
Z16.19	Resistance to other specified beta lactam antibiotics		EXCLUDED FILE
Z16.20	Resistance to unspecified antibiotic		EXCLUDED FILE
Z16.21	Resistance to vancomycin		EXCLUDED FILE
Z16.22	Resistance to vancomycin related antibiotics		EXCLUDED FILE
Z16.23	Resistance to quinolones and fluoroquinolones		EXCLUDED FILE
Z16.24	Resistance to multiple antibiotics		EXCLUDED FILE
Z16.29	Resistance to other single specified antibiotic		EXCLUDED FILE
Z16.30	Resistance to unspecified antimicrobial drugs		EXCLUDED FILE
Z16.31	Resistance to antiparasitic drug(s)		EXCLUDED FILE
Z16.32	Resistance to antifungal drug(s)		EXCLUDED FILE
Z16.33	Resistance to antiviral drug(s)		EXCLUDED FILE
Z16.341	Resistance to single antimycobacterial drug		EXCLUDED FILE
Z16.342	Resistance to multiple antimycobacterial drugs		EXCLUDED FILE
Z16.35	Resistance to multiple antimicrobial drugs		EXCLUDED FILE
Z16.39	Resistance to other specified antimicrobial drug		EXCLUDED FILE
Z22.321	Carrier or suspected carrier of Methicillin susceptible Staphylococcus aureus		630 PREVENTION SERVICES WITH LIMITED OR NO EVIDENCE OF EFFECTIVENESS
Z22.322	Carrier or suspected carrier of Methicillin resistant Staphylococcus aureus		630 PREVENTION SERVICES WITH LIMITED OR NO EVIDENCE OF EFFECTIVENESS
Z3A.00	Weeks of gestation of pregnancy not specified		1 PREGNANCY 39 TERMINATION OF PREGNANCY
Z3A.01	Less than 8 weeks gestation of pregnancy		1 PREGNANCY 39 TERMINATION OF PREGNANCY
Z3A.08	8 weeks gestation of pregnancy		1 PREGNANCY 39 TERMINATION OF PREGNANCY
Z3A.09	9 weeks gestation of pregnancy		1 PREGNANCY 39 TERMINATION OF PREGNANCY
Z3A.10	10 weeks gestation of pregnancy		1 PREGNANCY 39 TERMINATION OF PREGNANCY
Z3A.11	11 weeks gestation of pregnancy		1 PREGNANCY 39 TERMINATION OF PREGNANCY
Z3A.12	12 weeks gestation of pregnancy		1 PREGNANCY 39 TERMINATION OF PREGNANCY

Z3A.13	13 weeks gestation of pregnancy		1 PREGNANCY 39 TERMINATION OF PREGNANCY
Z3A.14	14 weeks gestation of pregnancy		1 PREGNANCY 39 TERMINATION OF PREGNANCY
Z3A.15	15 weeks gestation of pregnancy		1 PREGNANCY 39 TERMINATION OF PREGNANCY
Z3A.16	16 weeks gestation of pregnancy		1 PREGNANCY 39 TERMINATION OF PREGNANCY
Z3A.17	17 weeks gestation of pregnancy		1 PREGNANCY 39 TERMINATION OF PREGNANCY
Z3A.18	18 weeks gestation of pregnancy		1 PREGNANCY 39 TERMINATION OF PREGNANCY
Z3A.19	19 weeks gestation of pregnancy		1 PREGNANCY 39 TERMINATION OF PREGNANCY
Z3A.20	20 weeks gestation of pregnancy		1 PREGNANCY 39 TERMINATION OF PREGNANCY
Z3A.21	21 weeks gestation of pregnancy		1 PREGNANCY 39 TERMINATION OF PREGNANCY
Z3A.22	22 weeks gestation of pregnancy		1 PREGNANCY 39 TERMINATION OF PREGNANCY
Z3A.23	23 weeks gestation of pregnancy		1 PREGNANCY
Z3A.24	24 weeks gestation of pregnancy		1 PREGNANCY
Z3A.25	25 weeks gestation of pregnancy		1 PREGNANCY
Z3A.26	26 weeks gestation of pregnancy		1 PREGNANCY
Z3A.27	27 weeks gestation of pregnancy		1 PREGNANCY
Z3A.28	28 weeks gestation of pregnancy		1 PREGNANCY
Z3A.29	29 weeks gestation of pregnancy		1 PREGNANCY
Z3A.30	30 weeks gestation of pregnancy		1 PREGNANCY
Z3A.31	31 weeks gestation of pregnancy		1 PREGNANCY
Z3A.32	32 weeks gestation of pregnancy		1 PREGNANCY
Z3A.33	33 weeks gestation of pregnancy		1 PREGNANCY
Z3A.34	34 weeks gestation of pregnancy		1 PREGNANCY
Z3A.35	35 weeks gestation of pregnancy		1 PREGNANCY
Z3A.36	36 weeks gestation of pregnancy		1 PREGNANCY
Z3A.37	37 weeks gestation of pregnancy		1 PREGNANCY
Z3A.38	38 weeks gestation of pregnancy		1 PREGNANCY
Z3A.39	39 weeks gestation of pregnancy		1 PREGNANCY
Z3A.40	40 weeks gestation of pregnancy		1 PREGNANCY
Z3A.41	41 weeks gestation of pregnancy		1 PREGNANCY
Z3A.42	42 weeks gestation of pregnancy		1 PREGNANCY
Z3A.49	Greater than 42 weeks gestation of pregnancy		1 PREGNANCY
Z47.31	Aftercare following explantation of shoulder joint prosthesis		422 DISORDERS OF SHOULDER, INCLUDING SPRAINS/STRAINS GRADE 3 THROUGH 6
Z47.32	Aftercare following explantation of hip joint prosthesis		85 FRACTURE OF HIP, CLOSED 315 CONGENITAL DISLOCATION OF HIP; COXA VARA AND VALGA

Z47.33	Aftercare following explantation of knee joint prosthesis	ICD9 V54.82 89,297,318,384,467	362 DEFORMITY/CLOSED DISLOCATION OF MAJOR JOINT AND RECURRENT JOINT DISLOCATIONS
Z77.012	Contact with and (suspected) exposure to uranium		DIAGNOSTIC WORKUP FILE
Z79.83	Long term (current) use of bisphosphonates		EXCLUDED FILE
Z83.511	Family history of glaucoma		EXCLUDED FILE
Z83.518	Family history of other specified eye disorder		EXCLUDED FILE
Z83.52	Family history of ear disorders		EXCLUDED FILE
Z85.54	Personal history of malignant neoplasm of ureter		EXCLUDED FILE
Z86.14	Personal history of Methicillin resistant Staphylococcus aureus infection		EXCLUDED FILE
Z86.32	Personal history of gestational diabetes		EXCLUDED FILE
Z86.711	Personal history of pulmonary embolism		EXCLUDED FILE
Z86.718	Personal history of other venous thrombosis and embolism		EXCLUDED FILE
Z87.892	Personal history of anaphylaxis		EXCLUDED FILE
Z89.511	Acquired absence of right leg below knee		ANCILLARY CODES
Z89.512	Acquired absence of left leg below knee		ANCILLARY CODES
Z89.519	Acquired absence of unspecified leg below knee		ANCILLARY CODES
Z89.521	Acquired absence of right knee		ANCILLARY CODES
Z89.522	Acquired absence of left knee		ANCILLARY CODES
Z89.529	Acquired absence of unspecified knee		ANCILLARY CODES
Z91.83	Wandering in diseases classified elsewhere		EXCLUDED FILE

ICD-10 Codes Not on Any Nondeleted lines

Question: Where should certain ICD-10 Codes not on any nondeleted lines be placed for the October 1, 2013 List?

Question source: HERC Staff

Issue: This is a cleanup item for the ICD-10 list, there are a few codes not on any non-deleted line which need placement.

Recommendations:

These codes which are recommended for deletion from their only remaining placement:

code	Description	Previous Placement	Suggested Placement
G47.10	Hypersomnia, unspecified	DWF (D)	Keep on DWF
N88.3	Incompetence of cervix uteri	1 (D)	Keep on line 1

These codes are on lines which have been deleted ("old line") and have no other placement. Proposed placement is under "new line."

Code	Description	Old Line	New Line(s)
B33.1	Ross River disease	300 ARTHROPOD-BORNE VIRAL DISEASES	271 RICKETTSIAL AND OTHER ARTHROPOD-BORNE DISEASES
B51.0	Plasmodium vivax malaria with rupture of spleen	177 RUPTURED SPLEEN	84 INJURY TO INTERNAL ORGANS
I51.4	Myocarditis, unspecified	367 IDIOPATHIC OR VIRAL MYOCARDITIS AND PERICARDITIS	86 MYOCARDITIS, PERICARDITIS, AND ENDOCARDITIS
J70.4	Drug-induced interstitial lung disorders, unspecified	256 RESPIRATORY FAILURE DUE TO PRIMARY PULMONARY HYPERTENSION, PRIMARY PULMONARY FIBROSIS,	244 CONDITIONS REQUIRING HEART-LUNG AND LUNG TRANSPLANTATION

ICD-10 Codes Not on Any Nondeleted lines

Code	Description	Old Line	New Line(s)
		LYMPHANGIOLEIOMYOMATOSIS, EISENMENGER'S DISEASE	
N72	Inflammatory disease of cervix uteri	510 CERVICITIS, ENDOCERVICITIS, HEMATOMA OF VULVA, AND NONINFLAMMATORY DISORDERS OF THE VAGINA	432 VAGINITIS AND CERVICITIS
N85.6	Intrauterine synechiae	613 OLD LACERATION OF CERVIX AND VAGINA	667 GENITOURINARY CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY
N88.1	Old laceration of cervix uteri	613 OLD LACERATION OF CERVIX AND VAGINA	638 BENIGN CERVICAL CONDITIONS
N88.3	Incompetence of cervix uteri		1 Pregnancy
N89.9	Noninflammatory disorder of vagina, unspecified	510 CERVICITIS, ENDOCERVICITIS, HEMATOMA OF VULVA, AND NONINFLAMMATORY DISORDERS OF THE VAGINA	568 BENIGN NEOPLASM AND CONDITIONS OF EXTERNAL FEMALE GENITAL ORGANS
N99.2	Postprocedural adhesions of vagina	403 IMPERFORATE HYMEN; ABNORMALITIES OF VAGINAL SEPTUM	356 STRUCTURAL CAUSES OF AMENORRHEA
P70.4	Other neonatal hypoglycemia	93 DISORDERS OF PANCREATIC ENDOCRINE SECRETION	21 SYNDROME OF "INFANT OF A DIABETIC MOTHER" AND NEONATAL HYPOGLYCEMIA
R45.2	Unhappiness	398 SOMATIZATION DISORDER; SOMATOFORM PAIN DISORDER	Exclude
R45.5	Hostility	398 SOMATIZATION DISORDER; SOMATOFORM PAIN DISORDER	Exclude
R45.6	Violent behavior	398 SOMATIZATION DISORDER; SOMATOFORM PAIN DISORDER	Exclude

CPT codes needed to support diagnoses added above

1) Need to add to line 84 INJURY TO INTERNAL ORGANS:
    a. 38100-38102, Splenectomy
    b. 38115 Repair of ruptured spleen (splenorrhaphy)
    c. 38120 Laparoscopy, surgical, splenectomy

General Surgery Follow-up issue

Question: How to adopt ICD-10 decisions regarding colostomy for fecal incontinence?

Question Source: HERC Staff

Issue: At the 8-2-12 VBBS/HERC meeting a number of changes were made to the lines pertaining to general surgery. Staff has identified a few areas requiring clarification.

R15.9 Full incontinence of feces was moved to both Line 78 and Line 551. The intention was to ensure needed supplies (e.g. diapers) were covered, but surgical treatment would pair on line 551 (colostomy only, not sphincteroplasty). However, Line 78 has surgical codes as well, meaning that pairing could occur on 78 instead of as intended on Line 551.

From meeting summary:

Line 444 INCONTINENCE OF FECES; FECAL IMPACTION

Rationale: Surgically reparable fecal incontinence is usually from old obstetric injuries. This disproportionately affects the elderly. Colostomy is very effective, particularly given wound care issues with a risk of chronic infection. If someone has complications of incontinence (sacral decubiti or chronic perineal infections, then should have diverting colostomy. Sphincertoplasty, on the other hand, should NOT be covered.

Recommendations

1) Place R15.9 Full incontinence of feces on Line 78 and on Line 551.
2) Move colostomy codes to 551.
3) Rename Line 551 Treatment: Medical and Surgical Therapy
4) Do not add sphinceteroplasty codes to 551.
    a. Rationale: That way diapers are covered, but surgery for this condition would not be covered. If someone wanted a diverting colostomy, this could be covered under the comorbidity rule.

HERC Staff Recommendations

1) **Add a guideline to Line 78**

GUIDELINE NOTE XXX FECAL INCONTINENCE
Line 78, 551
ICD-10-CM code R15.9 (Full incontinence of feces) is included on Line 78 only for supportive equipment (e.g. diapers, gloves). Surgical treatment for fecal incontinence is included on Line 551 DISORDERS OF FUNCTION OF STOMACH AND OTHER FUNCTIONAL DIGESTIVE DISORDERS.

General Surgery Follow-up issue

2) **Add the following codes labeled "Yes" to Line 551** DISORDERS OF FUNCTION OF STOMACH AND OTHER FUNCTIONAL DIGESTIVE DISORDERS .

CODE	DESCRIPTION	CURRENT PRIORITIZED LIST PLACEMENT	Appropriate for pairing with fecal incontinence? YES/NO
44141	Colectomy, partial; with skin level cecostomy or colostomy	35,48,78,84,97,111,163,165, 173,191,339,503 and 1 other lines.	YES
44143	Colectomy, partial; with end colostomy and closure of distal segment (Hartmann type procedure)	35,48,78,84,97,111,163,165, 173,191,339,503 and 1 other lines.	YES
44144	Colectomy, partial; with resection, with colostomy or ileostomy and creation of mucofistula	35,48,78,84,97,111,163,165, 173,191,339,503 and 1 other lines.	YES
44146	Colectomy, partial; with coloproctostomy (low pelvic anastomosis), with colostomy	35,48,78,84,97,111,163,165, 173,191,339	NO
44160	Colectomy, partial, with removal of terminal ileum with ileocolostomy	35,48,62,78,84,97,111,163, 165,173,191	NO
44188	Laparoscopy, surgical, colostomy or skin level cecostomy	35,48,78,84,111,144,165,191	YES
44205	Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocolostomy	35,48,78,84,111,163,165, 173,191,339,503,667	NO
44206	Laparoscopy, surgical; colectomy, partial, with end colostomy and closure of distal segment (Hartmann type procedure)	35,48,78,84,111,163,165, 173,191,339,503,667	YES
44208	Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis) with colostomy	35,48,78,84,111,163,165, 173,191,339,503,667	NO
44320	Colostomy or skin level cecostomy;	35,48,62,78,88,97,111,144, 165,191,245,353	YES
44322	Colostomy or skin level cecostomy; with multiple biopsies (eg, for congenital megacolon) (separate procedure)	111,165	NO
44340	Revision of colostomy; simple (release of superficial scar) (separate procedure)	97,111,165,308,448	YES
44345	Revision of colostomy; complicated (reconstruction in-depth) (separate procedure)	35,97,111,165,448	YES
44346	Revision of colostomy; with repair of paracolostomy hernia (separate procedure)	97,111,165,448	YES
44604	Suture of large intestine (colorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture (single or multiple perforations); without colostomy	84,88,97,111,240,593	NO
44605	Suture of large intestine (colorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture (single or multiple perforations); with	84,88,97,111,240	NO

General Surgery Follow-up issue

CODE	DESCRIPTION	CURRENT PRIORITIZED LIST PLACEMENT	Appropriate for pairing with fecal incontinence? YES/NO
	colostomy		
45110	Proctectomy; complete, combined abdominoperineal, with colostomy	111,165	YES
45395	Laparoscopy, surgical; proctectomy, complete, combined abdominoperineal, with colostomy	111,165	YES
45563	Exploration, repair, and presacral drainage for rectal injury; with colostomy	88 INJURY TO INTERNAL ORGANS	NO
45805	Closure of rectovesical fistula; with colostomy	35 REGIONAL ENTERITIS, IDIOPATHIC PROCTOCOLITIS, ULCERATION OF INTESTINE	NO
45825	Closure of rectourethral fistula; with colostomy	35 REGIONAL ENTERITIS, IDIOPATHIC PROCTOCOLITIS, ULCERATION OF INTESTINE	NO
50810	Ureterosigmoidostomy, with creation of sigmoid bladder and establishment of abdominal or perineal colostomy, including intestine anastomosis	30 VESICOURETERAL REFLUX	NO
57307	Closure of rectovaginal fistula; abdominal approach, with concomitant colostomy	323 FISTULA INVOLVING FEMALE GENITAL TRACT	NO
88304	Level III - Surgical pathology, gross and microscopic examination Abortion, induced Abscess Aneurysm - arterial/ventricular Anus, tag Appendix, other than incidental Artery, atheromatous plaque Bartholin's gland cyst Bone fragment(s), other than pathologi	DMAP Diagnostic Procedure File	NO
99505	Home visit for stoma care and maintenance including colostomy and cystostomy	DMAP Ancillary Codes File	N/A

Prioritized List Changes Found During ICD-10 Review

1) Line 166 is mistakenly on guideline note 14 and needs to be removed as line 166 does not have bone marrow transplant as a treatment.

GUIDELINE NOTE 14, SECOND BONE MARROW TRANSPLANTS

Lines 79,103,105,125,131,~~166,~~170,198,206,231,280,314

Second bone marrow transplants are not covered except for tandem autologous transplants for multiple myeloma.

2) The nerve block guideline was added to many lines, but the CPT codes for the types of nerve blocks involved are on the DMAP Ancillary List.
    1. Recommend adding nerve block codes (CPT 64400-64455, 64505-64530) to all lines noted in Guideline Note 76
    2. Advise DMAP to remove these CPT codes from the Ancillary List

GUIDELINE NOTE 76, NERVE BLOCKS

Lines 1,4,7,10,11,14,22,26,30,31,33,35,40-43,48-56,59,61-66,69,71,73-80,84-106,108-111,113,115,116,118,122-126,129-132,136-139,141-151,153,154,158,159, 161-167, 169-173, 175-178,181,182,184,186-202,204,206-208,210,213,214,216-221,223-226, 228-231,233, 235-238,240,242,243,245,247-250,252-263,266-268,270-280,282,286-288,291-294,297-299,301,303,304,307-315, 318-326,328,330-333,335-337,339-342,344-347,349-356,359-364,366-368,371,374-376,378-385,388,389,391-395,397,400-407, 409-411,415,418,420-423,426-430,432,434,438-444,446,448-450,452-456,458-461,463-467,470, 472,473,476, 478,484-486,489- 493,495,497-499,501-507,509-511,566

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

3) The following lines were found to have chemotherapy CPT codes, but lack "Chemotherapy Treatment" in the treatment descriptions
    1. Recommendation: change the treatment description for the following lines to "MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY
        1. **124** CANCER OF EYE AND ORBIT
        2. **137** BENIGN NEOPLASM OF THE BRAIN AND SPINAL CORD
        3. **549** BENIGN NEOPLASM OF BONE AND ARTICULAR CARTILAGE INCLUDING OSTEOID OSTEOMAS; BENIGN NEOPLASM OF CONNECTIVE AND OTHER SOFT TISSUE

Prioritized List Changes Found During ICD-10 Review

4) The following lines were found to not have radiation therapy CPT codes, but contain "radiation therapy" in the treatment description
    1. Recommendation: change the treatment description of the following lines
        1. **371** OTHER AND UNSPECIFIED ANTERIOR PITUITARY HYPERFUNCTION, BENIGN NEOPLASM OF THYROID GLAND AND OTHER ENDOCRINE GLANDS to MEDICAL AND SURGICAL TREATMENT~~, WHICH INCLUDES RADIATION THERAPY~~
        2. **466** TRIGEMINAL AND OTHER NERVE DISORDERS to MEDICAL AND SURGICAL TREATMENT~~, RADIATION THERAPY~~
        3. **485** CENTRAL PTERYGIUM AFFECTING VISION to EXCISION OR TRANSPOSITION OF PTERYGIUM WITHOUT GRAFT~~, RADIATION THERAPY~~

Changes Required for ICD-10 Prioritized List (October 1, 2014 Tentative)

1) Central serous retinopathy
    a. The diagnosis name (central serious retinopathy ICD-9 362.41) is changing to Central serous chorioretinopathy (ICD-10 H35.71x)
    b. Staff recommends changing the name of line 387 to Central Serous Chorioretinopathy

Straightforward Issues—March, 2013

Code	Code Description	Line(s) Involved	Issue	Recommendation(s)
32663	Thoracoscopy, surgical; with lobectomy (single lobe)	**204** CONGENITAL CYSTIC LUNG - MILD AND MODERATE	An OHP Medical Director requested that 32663 be added to line 204, to pair with congenital cystic lung. Currently, 32663 is found only on line 677 CONGENITAL CYSTIC LUNG – SEVERE. The open equivalent, 32480 (Removal of lung, other than pneumonectomy; single lobe (lobectomy)) is located on line 204. Similar thorascopic codes are already present on line 204 (i.e. 32670 thorascopic bilobectomy).	Add 32663 to line 204
92250	Fundus photography with interpretation and report	**106** DIABETIC AND OTHER RETINOPATHY **147** OPPORTUNISTIC INFECTIONS IN IMMUNOCOMPROMISED HOSTS; CANDIDIASIS OF STOMA; PERSONS RECEIVING CONTINUOUS ANTIBIOTIC THERAPY **354** COCCIDIOIDOMYCOSIS, HISTOPLASMOSIS, BLASTOMYCOTIC INFECTION, OPPORTUNISTIC AND OTHER MYCOSES	DMAP is requesting that 92250 be added to line 354 to pair with 115.92 (Unspecified Histoplasmosis retinitis). Currently, 92250 is on more than 40 lines. The only effective treatment for histoplasmosis retinitis is photocoagulation (CPT 67210)—there is no treatment for the underlying infection.. The majority of retinitis diagnosis codes are on line 106, with a full range of treatment codes.	Add 115.92 to line 106 Remove 115.92 from lines 147 and 354

Straightforward Issues—March, 2013

Code	Code Description	Line(s) Involved	Issue	Recommendation(s)
77421	Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy	**287** CANCER OF BLADDER AND URETER	DMAP is requesting that 77421 be added to line 287 to pair with 188.8 (Malignant neoplasm of other specified sites of bladder). 77421 currently pairs on multiple lines; other radiation therapy codes are on line 287.	Add 77421 to line 287
57505	Endocervical curettage (not done as part of a dilation and curettage)	**144** CANCER OF CERVIX	DMAP is requesting that 57505 be added to line 144 to pair with 180.0 (Malignant neoplasm of endocervix). 57505 is currently on line 31, DYSPLASIA OF CERVIX AND CERVICAL CARCINOMA IN SITU, CERVICAL CONDYLOMA.	Add 57505 to line 144
77301	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications	**340** CANCER OF LIVER **356** CANCER OF PROSTATE GLAND	DMAP is requesting that 77301 be added to line 356 to pair with 185 (Malignant neoplasm of prostate) and to line 340 to pair with 155.0 (Malignant neoplasm of liver, primary). 77301 is currently on more than 20 lines. Both line 340 and 356 have multiple radiation CPT codes.	Add 77301 to lines 340 and 356.
61548	Hypophysectomy or excision of pituitary tumor, transnasal or transseptal approach, nonstereotactic	**46** PANHYPOPITUITARISM, IATROGENIC AND OTHER PITUITARY DISORDERS **162** BENIGN NEOPLASM OF PITUITARY GLAND	DMAP is requesting that 61548 be paired with 253.8 (Other disorders of the pituitary & other syndromes of diencephalon-hypophyseal origin). 61548 is currently on lines 137, 162, 201, 371, 622. Line 46 is a medical line only. 253.8 is used for various benign diagnoses.	Add 253.8 to line 162

Straightforward Issues—March, 2013

Code	Code Description	Line(s) Involved	Issue	Recommendation(s)
67412	Orbitotomy without bone flap (frontal or transconjunctival approach); with removal of lesion	**124** CANCER OF EYE AND ORBIT **208** CANCER OF BONES	DMAP is requesting that 67412 be added to line 124 to pair with 238.8 (Neoplasm of uncertain behavior of other specified sites). 67412 is currently on lines 147 and 354. Similar code 67414 is on line 124. DMAP is also requesting that 67412 be added to line 208 to pair with 238.0 (Neoplasm of uncertain behavior of bone & articular cartilage).	Add 67412 to lines 124 and 208
52214	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands	**228** CANCER OF KIDNEY AND OTHER URINARY ORGANS **287** CANCER OF BLADDER AND URETER **291** UROLOGIC INFECTIONS	DMAP is requesting that 52214 be added to line 287 to pair with 188.9 (Malignant neoplasm of bladder, part unspecified) and 233.7 (Carcinoma in situ of bladder), to line 228 to pair with 236.99 (Neoplasm of uncertain behavior of other & unspecified urinary organs, Other) and to line 291 to pair with 595.81 (Cystitis cystica) and 595.82 (Irradiation cystitis. 52214 is currently on lines 96 and 351. Similar codes 52224-52240 are on lines 228 and 287. No similar codes are on line 291.	Add 52214 to lines 228 and 287 Do not add 52214 to line 291
54520 54522 54530 54535	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach Orchiectomy, partial Orchiectomy, radical, for tumor; inguinal approach Orchiectomy, radical, for tumor; with abdominal exploration	**104** UNDESCENDED TESTICLE **261** TORSION OF TESTIS **275** CANCER OF PENIS AND OTHER MALE GENITAL ORGANS	DMAP is requesting review of placement of 54530. This code is currently on lines 104, 123, 261, 356. 54535 is currently found on lines 104, 123, 261. DMAP is requesting that 54530 be added to line 275 to pair with 233.6 (Carcinoma in situ of other and unspecified male genital organs).	Remove 54530 and 54535 from lines 104 and 261. Add 54520-54535 to line 275

Straightforward Issues—March, 2013

Code	Code Description	Line(s) Involved	Issue	Recommendation(s)
		70 SUBSTANCE-INDUCED DELIRIUM	Recently, psychotherapy codes 90785, 90832-90838, and 90840 were added to Line 70. DMAP is requesting that the line treatment description be changed from MEDICAL THERAPY to MEDICAL / PSYCHOTHERAPY. This would be consistent with the treatment descriptions on lines 32 and 68.	Change treatment description for line 70 to MEDICAL / PSYCHOTHERAPY
99241-99245	Office consultation for a new or established patient		CMS no longer covers consultation codes and these codes have been removed from the DMAP fee schedule. Providers are asked to use E&M codes instead. The consultation codes are currently on >600 lines on the List.	Remove 99241-99245 from all lines on the Prioritized List Advise DMAP to place 99241-99245 on the Excluded List
41512	Tongue base suspension, permanent suture technique	**171** LEUKOPLAKIA AND CARCINOMA IN SITU OF ORAL MUCOSA, INCLUDING TONGUE	41512 was added to the Excluded List at the December, 2008 HSC meeting. However, it was mistakenly also added to line 171 and has appeared on that line since 2009.	Remove 41512 from line 171 Keep 41512 on Excluded List

Straightforward Issues—March, 2013

Code	Code Description	Line(s) Involved	Issue	Recommendation(s)
56441	Lysis of labial adhesions	**380** CONGENITAL ABSENCE OF VAGINA **658** NONINFLAMMATORY DISORDERS OF CERVIX; HYPERTROPHY OF LABIA	Dr. Chris Kirk requested that 56441 be considered for pairing with 752.49 (Other anomalies of cervix, vagina, and external female genitalia) which includes congenital labial adhesions as a subdiagnosis. Currently, 56441 is on line 587. On further review, 624.8 (Other specified noninflammatory disorders of vulva and perineum) codes for non-congenital labial adhesions. 624.8 is on line 658 and should be paired with this procedure as well.	Add 56441 to lines 380 and 658
62272	Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter)	**320** CANCER OF BRAIN AND NERVOUS SYSTEM	DMAP is requesting that 62272 be added to line 320 for use for malignant neoplasms of the CNS. 62272 is on 4 lines, including benign neoplasms of the CNS. Shunt placement is currently on line 320.	Add 62272 to line 320
45114 45116	Proctectomy, partial, with anastomosis; abdominal and transsacral approach Proctectomy, partial, with anastomosis; transsacral approach only (Kraske type)	**35** REGIONAL ENTERITIS, IDIOPATHIC PROCTOCOLITIS, ULCERATION OF INTESTINE	DMAP is requesting that 45114 be added to line 35 to pair with 555.1 Regional enteritis large intestine. 45114 is currently on lines 111 and 174. Similar CPT procedures 45112, 45113, 45119, 45123 are located on line 35. On review, 45116 is also missing from line 35.	Add 45114 and 45116 to line 35

Straightforward Issues—March, 2013

Code	Code Description	Line(s) Involved	Issue	Recommendation(s)
44130	Enteroenterostomy, anastomosis of intestine, with or without cutaneous enterostomy (separate procedure)	**163** ACUTE VASCULAR INSUFFICIENCY OF INTESTINE	DMAP is requesting that 45130 be added to line 163 to pair with 557.0 (Acute vascular insufficiency of intestine). 44130 is currently on lines 48, 78, 97, 111, 229, 341. Several enterectomy codes are on line 163.	Add 44130 to line 163
59821	Treatment of missed abortion, completed surgically; second trimester	**394** SPONTANEOUS ABORTION	DMAP is requesting that 59821 be added to line 394 to pair with 634.71 Incomplete spontaneous abortion with other specified complications. 59820 (Treatment of missed abortion, completed surgically; first trimester) is on line 394	Add 59821 to line 394
27707	Osteotomy; fibula	**467** MALUNION AND NONUNION OF FRACTURE	DMAP is requesting that 27707 be added to line 467 to pair with 733.82 Nonunion of fracture. 27707 is currently only on line 190 ACUTE OSTEOMYELITIS. Osteotomy of other bones are included on line 467.	Add 27707 to line 467

Straightforward Issues—May, 2013

Code	Code Description	Line(s) Involved	Issue	Recommendation(s)
62160	Neuroendoscopy, intracranial, for placement or replacement of ventricular catheter and attachment to shunt system or external drainage	**40** SPINA BIFIDA **308** COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT	DMAP has requested that 62160 be added to line 40 to pair with 741.00 (Spina bifida with hydrocephalus, unspecified region) and to line 308 to pair with 996.2 (Mechanical complication of nervous system device, implant, and graft). 62160 is currently on lines 22, 84, 137, 401. Various shunt procedures are currently on line 40.	Add 62160 to lines 40 and 308
61322	Craniectomy or craniotomy, decompressive, with or without duraplasty, for treatment of intracranial hypertension, without evacuation of associated intraparenchymal hematoma; without lobectomy	**101** SEVERE/MODERATE HEAD INJURY: HEMATOMA/EDEMA WITH LOSS OF CONSCIOU0SNESS, COMPOUND/DEPRESSED FRACTURES OF SKULL	DMAP has requested that 61322 be added to line 101 to pair with 801.30 Closed fracture of base of skull with other & unspecified intracranial hemorrhage, unspecified state of consciousness. 61322 is currently on lines 22, 84, 137, 201, 273, 342, 401. Multiple similar procedures on line 101	Add 61322 to line 101
35516 35616	Bypass graft, with vein; subclavian-axillary Bypass graft, with other than vein; subclavian-axillary	**293** INJURY TO BLOOD VESSELS OF THE THORACIC CAVITY	DMAP has requested that 35616 be added to line 293 to pair with 901.1 Injury to innominate & subclavian arteries. 35616 is currently on lines 307, 331, 349, 472. Similar CPT 35506 is on line 293. 35516 should be added to line 293 is 35616 is added.	Add 35516 and 35616 to line 293

Straightforward Issues—May, 2013

44143 44147	Colectomy, partial; with end colostomy and closure of distal segment (Hartmann type procedure) Colectomy, partial; abdominal and transanal approach	**84** DEEP ABSCESSES, INCLUDING APPENDICITIS AND PERIORBITAL ABSCESS; INTESTINAL PERFORATION **88** INJURY TO INTERNAL ORGANS	DMAP has requested that 44143 be added to line 88 to pair with 863.54 Injury to sigmoid colon. 44143 is currently on 13 lines. 44140 (Colectomy, partial, with anastamosis) is on line 88. On review, most of the colectomy CPT codes were not included on line 88. One code in this series was missing from line 84. 44140-44160 are the colectomy CPT codes.	Add 44147 to line 84 Add 44141-44160 to line 88
37183	Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanulization/dilatation, stent placement and all associated imaging guidance	**308** COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT	DMAP has requested that 37183 be added to line 308 to pair with 996.1 Mechanical complication of other vascular device, implant, and graft. 38183 is currently on lines 224, 230, 303, 360.	Add 37183 to line 308
61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array	**308** COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT	DMAP has requested that 61885 be added to line 308 to pair with 996.2 (Mechanical complication of nervous system device, implant, and graft). 61885 is on line 182 GENERALIZED CONVULSIVE OR PARTIAL EPILEPSY WITHOUT MENTION OF IMPAIRMENT OF CONSCIOUSNESS.	Add 61885 to line 308

Straightforward Issues—May, 2013

47562	Laparoscopy, surgical; cholecystectomy	**459** CANCER OF GALLBLADDER AND OTHER BILIARY	DMAP has requested that 47562 be added to line 459 to pair with 156.0 Malignant neoplasm of gallbladder. 47562 is currently on lines 61, 199, 332, 340. Similar code 47564 is on line 459. 47563 is also missing from line 459.	Add 47562 and 47563 to line 459
77418	Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session	**277** CANCER OF RETROPERITONEUM, PERITONEUM, OMENTUM AND MESENTERY	DMAP has requested that 77418 be added to line 277 to pair with 158.0 Malignant neoplasm of retroperitoneum. 77418 is currently on approximately 30 lines. Similar radiology codes are on line 277	Add 77418 to line 277
569.89	Other specified disorders of intestine	**503** RECTAL PROLAPSE	DMAP Hearings Division had a request for pairing 569.89 with 45540 (Proctopexy (eg, for prolapse). 569.89 is currently on line 240 RUPTURED VISCUS. 569.89 has a variety of sub-diagnoses, including "prolapse of intestine." Line 503 has a series of appropriate treatment codes for this condition.	Add 569.89 to line 503 Keep 569.89 on line 240
62223	Creation of shunt; ventriculo-peritoneal, -pleural, other terminus	**359** BENIGN CEREBRAL CYSTS	DMAP has requested that 62223 be added to line 359 to pair with 348.0 Cerebral cysts. 62223 is on lines 22,40,137,201,320,401.	Add 62223 to line 359

Straightforward Issues—May, 2013

47010	Hepatotomy; for open drainage of abscess or cyst, 1 or 2 stages	**84** DEEP ABSCESSES, INCLUDING APPENDICITIS AND PERIORBITAL ABSCESS; INTESTINAL PERFORATION	DMAP has requested that 47010 be added to line 84 to pair with 572.0 Abscess of liver. 47010 is currently only on line 111 CONGENITAL ANOMALIES OF DIGESTIVE SYSTEM AND ABDOMINAL WALL EXCLUDING NECROSIS; CHRONIC INTESTINAL PSEUDO-OBSTRUCTION. Line 111 has no appropriate diagnoses for this procedure.	Add 47010 to line 84 Remove 47010 from line 111
573.8	Other specified disorders of liver	**319** ANOMALIES OF GALLBLADDER, BILE DUCTS, AND LIVER **360** ALCOHOLIC FATTY LIVER OR ALCOHOLIC HEPATITIS, CIRRHOSIS OF LIVER **365** ACUTE NECROSIS OF LIVER	ICD-9 573.8 contains a wide variety of sub-diagnoses, including liver cyst, AV malformation of liver, hemorrhage of liver, hepatocellular dysplasia, drug-induced cholestatic hepatitis, toxic liver disease with hepatic necrosis, among many others. Currently, 573.8 is only on line 219 RUPTURE OF LIVER. Line 319 would be appropriate for liver cysts, and therefore should have 47010 on it (see above).	Add 573.8 to lines 319, 360 and 365 Add 47010 to line 319
96150-96154	Health and behavior assessment	**5** ABUSE OR DEPENDENCE OF PSYCHOACTIVE SUBSTANCE	DMAP is requesting that the health and behavior assessment codes be added to line 5.	Add 96150-96154 to line 5
66680	Repair of iris, ciliary body (as for iridodialysis)	362 RUBEOSIS IRIDIS	DMAP has requested that 66680 be added to line 362 to pair with 364.76 Iridodialysis. 66680 is currently on line 364 WOUND OF EYE GLOBE.	Add 66680 to line 362

Clarification for Guideline Note 28

Question: Is diagnosis code 296.90 applicable for adults?

Question source: Sue Larson, Polk County Mental Health

Issue: GN 28 has 2 clauses with no connector. Ms. Larson requested clarification if the clauses should be connected with an OR or and AND.

The ICD-9 code 296.90 has been felt to be inappropriate for an adult (a more specific diagnosis should be used) but in children it was thought this could be the only valid option.

Recommendation:

1) Adopt the following changes to GN 28 to clarify the HERC intent

GUIDELINE NOTE 28, MOOD DISORDERS IN CHILDREN AGE EIGHTEEN AND UNDER

Line 212

The use of 296.90, Unspecified Episodic Mood Disorder, is appropriate only ~~when the following apply: F~~for children 18 years old and under~~. I~~in ~~the presence of~~ who have ~~significant difficulty with emotional regulation that causes~~ functional impairment caused by significant difficulty with emotional regulation.

Use of 296.90 is limited to pairings with the following procedure codes:

- Assessment and Screening: 90801, 90802, H0002, H0031, H0032, T1023
- Family interventions and supports: 90846, 90847, 90849, 90887, H0038, H0045, H2021, H2022, H2027, S5151, S9125, T1005
- Individual Counseling and Therapy: 90804, 90806, 90810, 90812, H0004
- Group therapy: 90853, 90857, H2032
- Medication management: 90862
- Case Management: 90882, T1016
- Interpreter Service: T1013

Hyperbaric Oxygen Guideline

Issue: the Hyperbaric Oxygen Guideline was adopted in August, 2012 for the October, 2012 Prioritized List as part of the ICD-10 Hyperbaric Oxygen review. However, it was mistakenly not included in the October, 2012 or the April, 2013 Lists. HERC staff wish to notify committee members of the mistake and confirm that this guideline should be added to the October 1, 2013 Prioritized List. Additionally, ICD-10 codes were added that correspond with the approved ICD-9 codes for adoption with the October 2014 ICD-10 List and the guideline structure was changed to increase clarity.

Guideline as adopted August, 2012:

GUIDELINE NOTE XXX HYPERBARIC OXYGEN

Lines 358, 399

Hyperbaric oxygen is a covered service for pairing with 526.4/M27.2 for osteomyelitis of the jaw only; 526.89/M27.8 for osteoradionecrosis of the jaw only; 639.0, 670.02, and 670.04/O08.0, M60.000-M60.09 only if the infection is a necrotizing soft-tissue infection; 730.10-9/M46.20-M46.39, M86.9 only for chronic refractory osteomyelitis unresponsive to conventional medical and surgical management; 927-929/S47.9, S57.0, S57.8, S67, S77, S87, S97 only for posttraumatic crush injury of Gustilo type III B and C; 990/T66.xxxA only for osteoradionecrosis; 996.7/T82.898A, T82.9xxA, T83.89xA, T83.9xxA, T84.89xA, T84.9xxA, T85.89xA, T859xxA only for compromised myocutaneous flaps

Recommendation:

1) Approve the following modified guideline for the October, 2013 List:

GUIDELINE NOTE XXX HYPERBARIC OXYGEN

Lines 358, 399

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

- when paired with ICD-9-CM code 526.4 for osteomyelitis of the jaw only
- when paired with ICD-9-CM codes 526.89 for osteoradionecrosis of the jaw only
- when paired with ICD-9-CM codes 639.0, 670.02, and 670.04 only if the infection is a necrotizing soft-tissue infection;
- when paired with ICD-9-CM codes 730.10-730.99 only for chronic refractory osteomyelitis unresponsive to conventional medical and surgical management;
- when paired with ICD-9-CM codes 927-929 only for posttraumatic crush injury of Gustilo type III B and C;
- when paired with ICD-9-CM codes 990 only for osteoradionecrosis;
- when paired with ICD-9-CM codes 996.7 only for compromised myocutaneous flaps

Hyperbaric Oxygen Guideline

2) Approve the following modified guideline for the October, 2014 ICD-10 List:

GUIDELINE NOTE XXX HYPERBARIC OXYGEN

Lines 358, 399

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

- when paired with ICD-10-CM code M27.2 for osteomyelitis of the jaw only
- when paired with ICD-10--CM codes M27.8 for osteoradionecrosis of the jaw only
- when paired with ICD-10--CM codes O08.0, M60.000-M60.09 only if the infection is a necrotizing soft-tissue infection;
- when paired with ICD-10--CM codes M46.20-M46.39, M86.9 only for chronic refractory osteomyelitis unresponsive to conventional medical and surgical management;
- when paired with ICD-10--CM codes S47.9, S57.0, S57.8, S67, S77, S87, S97 only for posttraumatic crush injury of Gustilo type III B and C;
- when paired with ICD-10--CM codes T66.xxxA only for osteoradionecrosis;
- when paired with ICD-10--CM codes T82.898A, T82.9xxA, T83.89xA, T83.9xxA, T84.89xA, T84.9xxA, T85.89xA, T859xxA only for compromised myocutaneous flaps

Death Code Placements

Issue: There are several ICD-9 codes that include death on the Prioritized List and on other Lists. Traditionally, these codes have been on the Exempt List as the HSC/HERC intended that the final care of a patient (ER/ICU/hospital/EMS, etc.) should be covered regardless of the cause of death. However, several of these codes have been found to be in unusual places or currently not on any line/List. HERC staff has reviewed them and suggests placement as noted below.

Recommendation:

1) Adopt code placement as noted in the table below

Code	Code description	Current List/Line	Recommended List/Line
348.82	Brain death	DMAP Diagnostic Workup File	DMAP Diagnostic Workup File
656.40	Intrauterine death, affecting management of mother, unspecified as to episode of care or not applicable		1 PREGNANCY
656.41	Intrauterine death, affecting management of mother, delivered, with or without mention of antepartum condition		1 PREGNANCY
656.43	Intrauterine death, affecting management of mother, antepartum condition or complication		1 PREGNANCY
761.6	Maternal death affecting fetus or newborn		1 PREGNANCY 2 BIRTH OF INFANT
768.0	Fetal death from asphyxia or anoxia before onset of labor or at unspecified time		1 PREGNANCY
768.1	Fetal death from asphyxia or anoxia during labor	37 SEVERE BIRTH TRAUMA FOR BABY	1 PREGNANCY
798.0	Sudden infant death syndrome	DMAP Diagnostic Workup File	DMAP Diagnostic Workup File
798.1	Instantaneous death	DMAP Exempt File	DMAP Exempt File
798.2	Death occurring in less than 24 hours from onset of symptoms, not otherwise explained	DMAP Exempt File	DMAP Exempt File
798.9	Unattended death	DMAP Exempt File	DMAP Exempt File
V17.41	Family history of sudden cardiac death (SCD)	DMAP Ancillary Codes File	DMAP Diagnostic Workup File
V61.07	Family disruption due to death of family member	Excluded	DMAP Excluded File