Value-based Benefits Subcommittee Recommendations Summary
For Presentation to:
Health Evidence Review Commission on August 11, 2016

For specific coding recommendations and guideline wording, please see the text of the 8/11/2016 VbBS minutes.

RECOMMENDED CODE MOVEMENT (effective 10/1/16 unless otherwise noted)

- Make various straightforward coding changes.
- Place the 2017 ICD-10-CM codes on various lines on the Prioritized List or on alternate lists.
- Add treatment codes and a new guideline to the covered laryngeal stenosis line to allow treatment of vocal cord dysfunction in children with dysphonia or dysphagia.
- Add placement code for implantable cardiac loop recorders to the diagnostic list with a new diagnostic guideline note.
- Add treatment codes for electronic tumor treatment fields to a covered cancer line with a new guideline limiting use to initial treatment of glioblastoma that meets certain criteria.

RECOMMENDED GUIDELINE CHANGES (effective 10/1/16 unless otherwise noted)

- Edit the preventive services guideline to remove dates for documents and add in links to the underlying government documents.
- Edit the hyperbaric oxygen guideline to correct two ICD-10-CM codes.
- Delete the diagnostic guideline regarding TB testing.
- Add a new guideline specifying coverage of acute mediastinitis, but not chronic mediastinitis.
- Add a new guideline requiring that the underlying diagnosis be covered to allow for an encounter for desensitization for allergens.
- Edit the acupuncture guideline to clarify that coverage the number of visits is per year or per pregnancy.
- Edit the back conditions medical guideline and opioid guideline to clarify the intent of coverage.

VALUE-BASED BENEFITS SUBCOMMITTEE
Clackamas Community College
Wilsonville Training Center, Rooms 111-112
Wilsonville, Oregon
August 11, 2016
8:00 AM – 1:00 PM

Members Present: Kevin Olson, MD, Chair; David Pollack, MD; Susan Williams, MD; Mark Gibson; Holly Jo Hodges, MD; Vern Saboe, DC; Gary Allen, DMD.

Members Absent: Irene Croswell, RPh.

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

Also Attending: Kim Wentz, MD, MPH, Jessie Little (Oregon Health Authority); Adam Obley, MD, MPH (Center for Evidence Based Policy); Henry Milzcuk, MD (OHSU Pediatric ENT); Alejandro Perez, MD (Providence); Justin Kelly and Alison Yoxall (Novocure); Duncan Neilson, MD and Charles Bentz, MD (Legacy Health); Megan Patton; Jamie Hewlett and Michael Straight (Osiris); Scott Kitchel, MD (Neurospine Institute); Grant Hamilton (SI-Bone); Andy Kranenburg, MD (via phone).

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

  The meeting was called to order at 8:05 am and roll was called. Minutes from the May 19, 2016 VbBS meeting were reviewed and approved.

  Smits reviewed the errata document. Hodges raised concerns about the movement of torticollis (ICD-10-CM M43.6) to an uncovered line. There was discussion that this code is for acquired torticollis. Staff will review the placement of congenital torticollis (ICD-10-CM Q68.0) and bring recommendations for coverage to the next VbBS meeting.

  Livingston reviewed the HERC staff's intent to delay formation of a workgroup to examine the opioid for back conditions guideline until after the Oregon Opioid Prescribing Guidelines Task Force's work is complete and further information is available after there has been a period of implementation of HERC's new guideline. She requested feedback on the type of data subcommittee members would like to see to inform decision-making for evaluating changes to this guideline. The members felt that the results of the statewide task force would be sufficient.

  Smits said all coverage changes approved at this meeting that would result in significant cost increases will not take effect until January 1, 2017.

Smits reviewed the new meeting form that includes a consent agenda section without discussion, unless a member has questions or concerns, and a straightforward list of topics with minimal discussion. Feedback about this change was encouraged.

- **Topic: Consent Agenda**

Discussion:

1) CPT 35261: Coffman said lines 82 and 135 appear to have overlapping neck blood vessel injury diagnoses and repair treatment codes. He requested that staff review lines 82 INJURY TO MAJOR BLOOD VESSELS OF EXTREMITIES AND NECK and 135 CRUSH INJURIES OTHER THAN DIGITS; COMPARTMENT SYNDROME; INJURIES TO BLOOD VESSEL(S) OF THE NECK to see if the neck vessel treatment portions of these lines can be combined.

2) 31603 and 31605: Hodges requested clarification that adding emergency tracheostomy CPT codes to the Ancillary File will allow coverage for all indications. Staff feels that if an emergency tracheostomy is performed for a diagnosis which is below the funding line, then the immediate diagnosis need for this procedure (airway obstruction) would still be a covered indication.

Recommended Actions:

1) Remove 54235 (Injection of corpora cavernosa with pharmacologic agent(s) (eg, papaverine, phentolamine)) from lines 332, FUNCTIONAL AND MECHANICAL DISORDERS OF THE GENITOURINARY SYSTEM INCLUDING BLADDER OUTLET OBSTRUCTION, 418 BALANOPOSTHITIS AND OTHER DISORDERS OF PENIS and 438 HYPOSPADIAS AND EPISPADIAS
2) Add 54235 (Injection of corpora cavernosa with pharmacologic agent(s) (eg, papaverine, phentolamine)) to line 526 SEXUAL DYSFUNCTION
3) Add 92250 (Fundus photography with interpretation and report) to lines 8 TYPE 1 DIABETES MELLITUS and 30 TYPE 2 DIABETES MELLITUS
4) Add all inpatient CPT codes to line 122 NUTRITIONAL DEFICIENCIES
5) Add O89.4 (Spinal and epidural anesthesia-induced headache during the puerperium) to line 428 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
6) Add 42900 (Suture pharynx for wound or injury) and 42950 (Pharyngoplasty (plastic or reconstructive operation on pharynx)) to line 292 CANCER OF ORAL CAVITY, PHARYNX, NOSE AND LARYNX
7) Remove 31603 and 31605 (Tracheostomy, emergency procedure) from all lines on the Prioritized List
    a. Advise HSC to add 31603 and 31605 to the Ancillary File
8) Add 35261 (Repair blood vessel with graft other than vein; neck) to line 82 INJURY TO MAJOR BLOOD VESSELS OF EXTREMITIES AND NECK
9) Remove 35261 (Repair blood vessel with graft other than vein; neck) from line 135 CRUSH INJURIES OTHER THAN DIGITS; COMPARTMENT SYNDROME; INJURIES TO BLOOD VESSEL(S) OF THE NECK
10) Add M21.6X (Other acquired deformities of foot) to line 545 DEFORMITIES OF FOOT

11) Remove M21.6X (Other acquired deformities of foot) from line 530 DEFORMITIES OF UPPER BODY AND ALL LIMBS
12) Add Q71.0-Q71.3 (Congenital complete absence of all or part of upper limb), Q72.0-72.3 (Congenital complete absence of all or part of lower limb), and Q73.0 (Congenital absence of unspecified limb(s)) to line 382 DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE LEVEL OF INDEPENDENCE IN SELF- DIRECTED CARE CAUSED BY CHRONIC CONDITIONS THAT CAUSE NEUROLOGICAL DYSFUNCTION
13) Remove Q71.0-Q71.3 (Congenital complete absence of all or part of upper limb), Q72.0-72.3 (Congenital complete absence of all or part of lower limb), and Q73.0 (Congenital absence of unspecified limb(s)) from line 364 DEFORMITY/CLOSED DISLOCATION OF MAJOR JOINT AND RECURRENT JOINT DISLOCATIONS
14) Guideline note 3 was modified as shown in Appendix A

MOTION: To approve the coding and guideline note changes as presented in the consent agenda. CARRIES 7-0.

- **Topic: Straightforward Items**

Discussion: There was no discussion about any of the straightforward agenda items.

Note: HERC discussed the coverage of hyperbaric oxygen therapy for radiation cystitis and radiation proctitis. HERC voted to include radiation cystitis (ICD-10-CM N30.4) and radiation proctitis (ICD-10-CM K62.7) on line 337 CONDITIONS REQUIRING HYPERBARIC OXYGEN THERAPY. See the HERC minutes for details and final decision.

Recommended Actions:
1) Add G0396 and G0397 (Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and brief intervention) to line 4 SUBSTANCE USE DISORDER
2) Add H0004 (Behavioral health counseling and therapy, per 15 minutes) to line 197 AUTISM SPECTRUM DISORDERS
3) Add H0006 (Alcohol and/or drug services; case management) to line 66 SUBSTANCE-INDUCED MOOD, ANXIETY, DELUSIONAL AND OBSESSIVE-COMPULSIVE DISORDERS
4) Add H0032 (Mental health service plan development by non-physician) to lines 4 SUBSTANCE USE DISORDER, 66 SUBSTANCE-INDUCED MOOD, ANXIETY, DELUSIONAL AND OBSESSIVE-COMPULSIVE DISORDERS, 69 SUBSTANCE-INDUCED DELIRIUM; SUBSTANCE INTOXICATION AND WITHDRAWAL, and 614 ABUSE OF NONADDICTIVE SUBSTANCES
5) Remove G96.8 (Other specified disorders of the central nervous system) and G98.8 (Other disorders of the nervous system) from lines 75, 297, 350, 382 (dysfunction lines)
    a. Advise HSD to place G96.8 and G98.8 in the Undefined File

6) Change the treatment description of line 206 CHRONIC ORGANIC MENTAL DISORDERS INCLUDING DEMENTIAS to CONSULTATION/MEDICATION MANAGEMENT/ ~~LIMITED~~ BEHAVIORAL ~~MODIFICATION~~ SUPPORT
7) Add 99354-99355 (Prolonged evaluation and management or psychotherapy service(s) in the office or other outpatient setting) to all mental health lines
8) Add 99356-99357 (Prolonged service in the inpatient or observation setting) to all mental health lines with inpatient CPT codes
9) GN106 was modified as shown in Appendix A
10) Diagnostic Guideline D2 was deleted
11) Remove S02.2XXA (Fracture of nasal bones, initial encounter for closed fracture) from line 233 FRACTURE OF FACE BONES; INJURY TO OPTIC AND OTHER CRANIAL NERVES
12) Add S02.2XXD (Fracture of nasal bones, subsequent encounter for fracture with routine healing) and S02.2XXG (Fracture of nasal bones, subsequent encounter for fracture with delayed healing) to line 578 DEVIATED NASAL SEPTUM, ACQUIRED DEFORMITY OF NOSE, OTHER DISEASES OF UPPER RESPIRATORY TRACT
13) Add L59.8 (Other specified disorders of the skin and subcutaneous tissue related to radiation) to line 337 CONDITIONS REQUIRING HYPERBARIC OXYGEN THERAPY
14) Delete M27.8 (Other specified diseases of jaws) from line 337 CONDITIONS REQUIRING HYPERBARIC OXYGEN THERAPY
15) Add M27.2 (Inflammatory conditions of jaws), which includes osteoradionecrosis of the jaw, to line 337 CONDITIONS REQUIRING HYPERBARIC OXYGEN THERAPY
16) Modify GN107 as shown in Appendix A
17) Remove ICD-10-CM H93.1 (Tinnitus) from line 450 HEARING LOSS - OVER AGE OF FIVE and add to line 658 SENSORY ORGAN CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY

MOTION: To approve the coding and guideline note changes as presented in the straightforward items section. CARRIES 7-0.

- **Topic: 2017 ICD-10-CM Code Placement**

Discussion: There was minimal discussion about 2017 ICD-10-CM-CM code placements or related Prioritized List changes.

E08.3521-E08.3549 (Diabetes mellitus due to underlying condition with…retinal detachment) were also added to line 284 RETINAL DETACHMENT AND OTHER RETINAL DISORDERS.

NOTE: codes M84.750S - O33.7XX0 had incorrect placements shown in the meeting materials. Corrected line placements were published as an errata.

Recommended Actions:
1) See Appendix C for the placements of 2017 ICD-10-CM codes

2) Change the line title of line 317 to GENDER DYSPHORIA/TRANSEXUALISM
3) Add E08.3521-E08.3549 to line 284 RETINAL DETACHMENT AND OTHER RETINAL DISORDERS
4) Remove I77.71 (Dissection of carotid artery) and I77.74 (Dissection of vertebral artery) from line 290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT and add to line 420 TRANSIENT CEREBRAL ISCHEMIA; OCCLUSION/STENOSIS OF PRECEREBRAL ARTERIES WITHOUT OCCLUSION
5) Remove I67.0 (Dissection of cerebral arteries, nonruptured) from line 290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT and add to line 322 STROKE
6) Remove I77.72 (Dissection of iliac artery) and I77.73 (Dissection of renal artery) from line 290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT and add to line 289 DISSECTING OR RUPTURED AORTIC ANEURYSM
7) Add CPT 39000 and 39010 (Mediastinotomy with exploration, drainage, removal of foreign body, or biopsy) to lines 51 DEEP ABSCESSES, INCLUDING APPENDICITIS AND PERIORBITAL ABSCESS and 290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
8) Add a new guideline note for mediastinitis to lines 290 and 661 as shown in Appendix D
9) Add a new guideline regarding administration of allergy desensitization as shown in Appendix D

MOTION: To approve the coding placements, coding changes and guideline note adoptions as presented. CARRIES 7-0

- **Topic: Laryngeal reinnervation in children**

Discussion: Smits reviewed the evidence and the staff recommendations for laryngeal reinnervation for vocal cord paralysis.

Dr. Henry Milczuk from OHSU Pediatric ENT testified that children don't have very good options for treatment. Literature combines kids and adults. Medialization is an effective treatment for adults, but not for kids due to growth issues. Another issue with the literature on this topic is that it examines aspiration pneumonia when dysphagia is the usual issue in children. Kids with dysphagia from vocal cord dysfunction need feeding tubes or g-tubes. Providers can do injections/fillers into vocal cords, but these are temporary procedures generally. Laryngeal reinnervation was developed to help kids with dysphasia. Ratings in trials that based results on parent's impression of how the child deals with clear liquids—generally saw improvement on parental rating scales. No studies did barium swallows or other gold standard measurements. Dr. MIlzcuk argued that dysphagia should be an indication for children, and aspiration needs to be covered but generally for adults. Treating dysphagia in children can be inferred to improve aspiration. Dysphonia can be absence of voice as well as hoarseness. The weakness of voice can make kids fall behind in school and social settings; it's a quality of life issue. Dysphonia is a disability which qualifies for

individual educational plans in the school setting. He is here to advocate for use of this in kids as they have fewer treatment options.

Olson asked about spontaneous recovery. Milczuk testified that approximately one-third of kids with this condition will have spontaneous recovery of vocal cord function. Due to this fact, providers generally wait 6-12 months before any interventions.

When queried about the frequency of this condition, Dr. Milczuk said he sees about one case per month.

Hodges suggested that we could put dysphonia/vocal cord dysfunction on a complications line as it results from surgery or other interventions. Milczuk replied that some cases are due to cancer or other non-procedural causes.

Wentz said that she has seen several cases of vocal cord dysfunction during review as HSD. This condition is very different in adults vs kids. She noted that there is a gap in the literature in which aspiration is not studied in children. She said she feels that treatment of dysphonia is important for speech development.

Smits said that previous HSC discussion regarding dysphonia was on spasmotic dysphonia, which is a completely different medical condition that happens in adults. Based on that review the current HERC policy is to not cover dysphonia. Dysphonia in children due to vocal cord dysfunction has not been previously reviewed.

There was discussion about whether there should be a level of dysphonia in children which should qualify for services. There was discussion about whether a new line for dysphonia in children should be created. It was decided that the condition and treatment should be added to an existing line as a biennial change would take a long time to implement and this condition is rare and treatments are not likely to be abused.

Recommended Actions:

1) Modify GN141 as shown in Appendix A
2) Add CPT 92507 (Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual), 92508 (group, 2 or more individuals), 92524 (Behavioral and qualitative analysis of voice and resonance) to line 70 LARYNGEAL STENOSIS OR PARALYSIS WITH AIRWAY COMPLICATIONS and line 521 PARALYSIS OF VOCAL CORDS OR LARYNX
3) Remove CPT 31590 (Laryngeal reinnervation by neuromuscular pedicle) from line 210 SUPERFICIAL ABSCESSES AND CELLULITIS
4) Add CPT 31590 (Laryngeal reinnervation by neuromuscular pedicle) to line 70 LARYNGEAL STENOSIS OR PARALYSIS WITH AIRWAY COMPLICATIONS and line 521 PARALYSIS OF VOCAL CORDS OR LARYNX
5) Add CPT 31513 (Laryngoscopy, indirect; with vocal cord injection) to line 521 PARALYSIS OF VOCAL CORDS OR LARYNX

6) Add CPT 31570-31571 (Laryngoscopy, direct, with injection into vocal cord(s), therapeutic) to line 70 LARYNGEAL STENOSIS OR PARALYSIS WITH AIRWAY COMPLICATIONS and line 521 PARALYSIS OF VOCAL CORDS OR LARYNX
7) Rename line 367 DYSTONIA (UNCONTROLLABLE); LARYNGEAL SPASM ~~AND STENOSIS~~
8) Remove ICD-10-CM J38.6 (Stenosis of larynx) from line 367 DYSTONIA (UNCONTROLLABLE); LARYNGEAL SPASM ~~AND STENOSIS~~
9) Remove CPT 31528-31529 (Laryngoscopy direct, with or without tracheoscopy; with dilation) and 31582 (Laryngoplasty; for laryngeal stenosis, with graft or core mold, including tracheotomy) from line 367 DYSTONIA (UNCONTROLLABLE); LARYNGEAL SPASM ~~AND STENOSIS~~
10) Add ICD-10-CM J38.6 (Stenosis of larynx) to line 521 PARALYSIS OF VOCAL CORDS OR LARYNX
11) Remove CPT 31528 (Laryngoscopy direct, with or without tracheoscopy; with dilation) from line 133 GRANULOMATOSIS WITH POLYANGIITIS

MOTION: To approve the line title, coding and guideline note changes as amended. CARRIES 7-0.

- **Topic: Acupuncture guideline clarification**

Discussion: There was no discussion about this topic.

Recommended Actions:
1) GN 92 was modified as shown in Appendix A

MOTION: To recommend the guideline note changes as presented. CARRIES 7-0.

- **Topic: Opioids for back conditions guideline**

Discussion: There was no discussion about this topic.

Recommended Actions:
1) Guideline note 56 was modified as shown in Appendix A
2) Guideline note 60 was modified as shown in Appendix A

MOTION: To approve the guideline note changes as presented. CARRIES 7-0.

- **Topic: Tobacco cessation and elective surgery**

Discussion:

Livingston presented the issue summary. Olson discussed concern around the fact that the evidence shows that offering intensive counselling and NRT is associated with benefit, even when abstinence is not universally achieved. However, the standard of care in the surgical community is around abstinence.

Gibson raised concern about limiting the guideline to specific types of surgeries which have more evidence of harm rather than expanding the guideline to all elective surgeries. Additionally, with regard to the exception for people with mental illness, abstinence does not seem insurmountable. For example, the state hospital does not allow smoking, demonstrating the feasibility of cessation among the mentally ill.

Pollack discussed that the language regarding exceptions from abstinence misses other categories of people for whom it may be difficult to quit, such as those with cognitive impairment. He proposed alternative language around assessing the appropriateness of smoking cessation for a particular individual with mental illness or cognitive impairment.

The invited expert on a later topic, Dr. Chuck Bentz, provided additional clinical input. Bentz shared that there is solid evidence about there being the highest benefit in people with mental illness, and that this population has a shorter life expectancy by 20 years that is partially attributable to high rates of cigarette smoking. To exempt this population would be to exclude them from a strong health benefit. He also suggested there is good data that people with psychiatric illness can quit.

Olson mentioned that there is an exceptions process that can be utilized in unusual circumstances.

A consensus was not reached, although there was a final proposal to remove the exception for severe and persistent mental illness.

Bentz provided additional information about the major benefit of tobacco cessation prior to surgery is when there is a vascular bed at risk. A large amount of risk management around surgery is related to complications from smoking.

Podiatric surgeries were recommended to be included. Smits will discuss further with the podiatrists as part of a larger upcoming review. Allen discussed the impact of smoking on dental procedures with any type of flap placement.

There was general agreement that reproductive, cancer-related, and diagnostic procedures ought to be excluded from the cessation requirement.

Dr. Bentz provided additional input on the various ways of testing for tobacco cessation, including when NRT is acceptable. He discussed that Mayo leads the country in this and is using anabasine.

Gibson proposed making the guideline about all elective procedures. Others concurred.

The issue of marijuana was raised, and the group decided not to address it in the guideline.

Recommended Actions:
1) Staff to revise propose guideline and bring back to a future meeting

- **Topic: Hand/finger injuries and malformations**

Discussion: Smits requested feedback on when hand and finger deformities and injuries should be in the funded area of the Prioritized List. Williams noted that problems that result in affected hand function should be covered. There was discussion about higher prioritization for the dominant hand vs the non-dominant hand. The subcommittee also felt that self-limiting conditions should be on unfunded lines; disabling conditions should be on a higher line. There was a question raised about whether thumb function should be given higher priority. In general, the subcommittee felt that this topic should only be addressed in the future if it did not take up undue staff time and attention.

Recommended Actions:
1) Staff to examine prioritization of hand/finger conditions as staff time and effort allow

- **Topic: Implantable cardiac loop recorders**

Discussion: Smits reviewed the staff summary. Wentz asked whether there was evidence that using implantable cardiac loop recorders (ICLRs) for transient loss of consciousness (TLoC) resulted in patient outcome changes. Smits replied that the evidence was around intermediate outcomes (e.g. arrhythmias identified) rather than patient oriented outcomes such as a mortality benefit. There was also a question about how much intervention (medications, implantable defibrillators, etc.) could help when the cardiac event, by definition, would be very rare (<1 per month). Smits replied that many of the arrhythmias being detected (ventricular fibrillation, bradycardia, etc.) could result in sudden death and therefore intervention would likely be helpful. Hodges noted that a guideline would be helpful for the medical directors of the CCOs. Without a guideline, the medical directors need to review each case.

There was discussion about the level of evidence supporting the use of ICLRs. Williams noted that diagnostic tests frequently have lower levels of evidence than therapeutic treatments. There was a general concern about the lack of evidence showing improved outcomes such as mortality. After discussion, it was felt that if ICLRs could result in diagnoses being made whose treatment could prevent catastrophic outcomes such as sudden cardiac death, then coverage for the limited indication of TLoC should be approved.

There was later testimony from Dr. Alejandro Perez regarding the use of ICLRs for evaluation of cryptogenic stroke. He noted that the WARSS study of crypogenic stroke found that anticoagulation given, regardless of a patient having known atrial fibrillation, did not improve outcomes. Guidelines say that if you cannot prove that a stroke was due to atrial fibrillation, then the patient should be treated with aspirin and not anticoagulation. Therefore it is important to figure out if crypogenic stroke is caused by atrial fibrillation. He also described the Crystal study, an RCT showing 48 hr monitoring only found a small percent with atrial fibrillation, and that this percent increased with 6 month monitoring. Finding out cause of stroke can lead to change in therapy and possibly prevent major stroke. There was no change in the subcommittee recommendation based on this testimony.

Recommended Actions:

1) Advise HSD to add CPT 33282 (Implantation of patient-activated cardiac event recorder) to the Diagnostic Procedures File and remove from the Services Recommended for Non-Coverage Table
2) Advise HSD to add HCPCS C1764 (Event recorder, cardiac (implantable)) to the Diagnostic Procedures File and remove from the Ancillary File
3) Adopt a new guideline note regarding implantable cardiac event monitors as shown in Appendix D

MOTION: To approve the coding changes and adopt the guideline note as presented CARRIES 7-0.

- **Topic: Electronic tumor treatment fields(ETTF) for initial treatment of glioblastoma**

Discussion: Smits noted that the staff summary and recommendations had been updated from that found in the meeting packet due to the newly published NCCN guideline on treatment of CNS malignancies. She reviewed the updated summary and recommendations.

Gibson noted that the overall treatment effect was statistically significant, but wondered whether the overall 5 month survival increase justified the cost. Smits noted that ASCO's website listed the cost as approximately $20,000/month. There was discussion about how this compared to standard radiation and chemotherapy. Olson noted that this malignancy has such a grim prognosis that the 5 month survival increase was approximately a 25% increase over standard therapy, which had been about the threshold for coverage in the old guideline regarding coverage of cancer near the end of life.

There was discussion about the single study on which the NCCN guideline is based. Study was stopped early due to the data safety monitoring board ruling. Gibson noted that stopping a trial early can lead to lack of identification of complications and may lead to erroneous outcomes. Obley noted that the major concern with stopping a study early is that

it guarantees a positive trial. If the study had been continued longer, it is possible that this early improvement would not follow through over time.

Justin Kelly, senior director of health policy for Novocure, testified. The trial for ETTF for initial treatment of glioblastoma was stopped early due to such compelling improvement. He referred to his more detailed testimony at the May VbBS meeting.

The VbBS decision was to cover ETTF for initial treatment of glioblastoma. VbBS felt that a specific clause should be added to the proposed guideline that specified that ETTF was not covered for treatment of recurrent glioblastoma, as the evidence for that treatment is still poor and NCCN was divided on coverage for that indication.

NOTE: later discussion at the August, 2016 HERC meeting discussed that it was discriminatory to disabled persons to include performance measure requirements such as the KPS or ECOG score over a certain level. There was concern that this provision might be in conflict with the ADA. HERC struck that portion of the proposed guideline (represented as red strike through wording in Appendix D).

Recommended Actions:

1) Add HCPCS codes A4555 and E0766 to Line 299 CANCER OF BRAIN AND NERVOUS SYSTEM and advise HSD to remove these codes from the ancillary procedures file.
2) Adopt a new guideline for electronic tumor treatment fields as shown in Appendix D

MOTION: To recommend the code and guideline note as amended. CARRIES 7-0.

- **Topic: Sacroiliac joint fusion**

Discussion: Smits reviewed the evidence summary and staff recommendation to not cover sacroiliac joint fusion. Pollack asked about long term outcomes, and Smits replied that there was one study of 2 years duration that showed improvement through those 2 years. Andy Kranenburg, MD, an orthopedist from Medford, testified via phone. He noted that he has conflicts of interest including being on the teaching panel for the manufacturer. He noted that there was a study from 2014 (Rudolf) that had a 4 year prospective follow up showing continuing improvement in symptoms, as well as a 5 year retrospective study that also showed continuing improvement.

Scott Kitchel MD, an orthopedist from Eugene at the Neurospine Institute, testified. He noted conflicts of interest including being on teaching faculty for SI Bone and a primary investigator for the SI Bone RCT at the Eugene site. Dr. Kitchel noted 40 peer reviewed articles on this technique showing evidence of improvement. Medicare is now covering it, as well as some private insurers. In his trial, he operated on about 20 patents and noted good outcomes. All large RCTs are industry sponsored. Compared to conservative

treatment, SI joint fusion is more cost effective, results in less opioid use, has a shorter time for symptom resolution, improved quality of life, and improved disability.

Saboe raised a question about the indications for surgery in the large RCT. Kitchel responded that patients needed to have pain consistent with sacroiilitis for 6 months, and have had 3 months of conservative therapy. The investigators confirmed the location of pain by 2 injections separated by 2 weeks which required an improvement in pain by 50%. Physical exam needed to be confirm SI joint pain.

Saboe asked what the comparator of conservative therapy was in these trials. Kitchel responded that this therapy consisted of injections, manual therapy (chiropractic or PT), bracing, and an exercise program. Saboe felt that it was important to note that the actual protocol for the PT or chiropractic therapy was not included in the study.

Saboe raised concerns that SI joint fusion can lead to bad outcomes. His anecdotal experience is that SI joints improved over time with any therapy. He has the concern that fusing one SI joint will lead to dysfunction in the other SI joint, leading to fusion and then dysfunction in the lumbar spine. Olson asked Kitchel whether the trials showed increasing rates of contralateral SI joint dysfunction or lumbar spine issues. Kitchel responded that these outcomes were looked at in the trials and were not seen at 2 years. He acknowledged that there is no data on whether this would happen at later times.

Kranenburg requested that the deliberations be evidence-based rather than based on anecdote. He shared the subcomittee's concern with industry sponsorship, but did not find other flaws in the study design and thought that the trials under discussion were rigorously designed.

There was discussion about adding SI joint fusion to the lower (uncovered) surgical back line. There was further discussion that such a placement would not allow patients options who fail conservative therapy.

Saboe continued to express his concerns with the possible complications of this type of surgery.

Gibson asked how the trials defined a clinically significant reduction in pain. Kitchel responded that the studies used a reduction of at least 2 in the pain score.

After further discussion, no consensus was reached. The motion to table this topic to a future meeting passed, and staff was directed to work with experts and examine the literature again.

Recommended Actions:

1) Tabled to a future meeting

- **Topic: Coverage Guidance—Tobacco cessation in pregnancy**

  Discussion: Obley presented the evidence review of Tobacco Cessation During Pregnancy. Livingston reviewed the Coverage Guidance and Multisector Interventions box language and proposed modifications to the Prioritized List.

  Pollack raised the concern about the use of the term "pregnant women" given that there could be transgender persons who are pregnant and do not consider themselves women and recommended that this be changed throughout the document to "during pregnancy."

  Williams expressed disappointment in the limited impact of interventions on cessation. Neilson discussed that with repeated quit attempts, there is incremental improvement. Neilson also discussed the importance of being able to use NRT in hospitalized pregnant women since hospitals are smoke free.

  Recommended Action:

  1) Replace "pregnant women" throughout the Coverage Guidance document with "during pregnancy"

  MOTION: To approve the recommended changes to the Prioritized List based on the draft Tobacco Cessation During Pregnancy Coverage Guidance scheduled for review by HERC at their 8/11/2016 meeting. CARRIES 7-0.

- **Topic: Coverage Guidance—Skin substitutes**

  Discussion: This topic was not reviewed by VbBS due to time constraints. Public testimony was heard during the public comment section of the meeting and is included below:

  Michael Sinclair, Osiris, testified about inclusion of his product, Grafix, for wounds. Grafix tissue is approved for any part of the body. A new study published last week showed that a large percent of complex wounds closed with this skin substitute and avoided amputation. Complex wounds cannot be addressed by the three products currently recommended for coverage in the coverage guidance. His product can be used for complex wounds and exposed bone and/or tendon. NICE recommends Grafix with a high rating. Only their trial used a third party to verify wound closure and to do data analysis. Grafix is available in multiple sizes, so will cost less as you can get larger sizes. It closes more wounds, closes faster than other products, and saves money due to larger sizes and reduced amputation rates. Patients in this trial were excluded from most trials.

  Alejandro Perez, MD, testified on skin substitutes. He noted inconsistencies in the VbBS materials. The Lavery study is labeled as poor in one section and fair in another. He endorses Epifix and Grafix as options as useful for venous ulcers, and notes that the majority of wounds are venous ulcers. Oasis and Apligraf are currently the only options.

Products based on pork or male foreskin can be problematic for Muslim or orthodox Jewish patients. He made other comments on coverage guidance confidence entries.

Jeff Hughes, director of reimbursement from LifeSciences, testified. He reviewed studies for his product (Omnigraft). He stated that outcomes should include percent of wounds closed and quality of life. Only their study looked at quality of life as an outcome. His product also has decreased infection rates, reduced time to healing, and reduces rates of osteomyelitis.

Recommended Actions:
1) This topic was tabled until the October, 2016 VbBS meeting

- **Topic: 2018 Biennial review**

Discussion: The two biennial review topics (Deleting line 392 and repair of inguinal and ventral hernias) were tabled to a future meeting due to time constraints.

Recommended Action:
1) Tabled to a future meeting

- **Public Comment:**

No additional public comment was received

- **Issues for next meeting:**
  - Rehabilitative services guideline
  - Tobacco cessation and elective surgery
  - Podiatry issues
    - Ankle arthritis
    - Hallus rigidus
    - Posterior tibialis tendinopathy/flatfoot
  - Spinal fusion coverage for back conditions
  - Z series ICD-10-CM code placements
  - Music therapy
  - Biennial review issues:
    - Repair of inguinal and ventral hernias
    - Deletion of line 392
    - Merging of lines 82 and 135
  - Coverage guidances on skin substitutes, liver fibrosis, and LARC
  - 2017 CDT codes
  - Congenital torticollis

- Hyperbaric oxygen therapy for sudden sensorineural hearing loss
- Wigs for treatment-related hair loss

➢ **Next meeting:**

October 6, 2016 at Clackamas Community College, Wilsonville Training Center, Wilsonville Oregon, Rooms 111-112.

➢ **Adjournment:**

The meeting adjourned at 1:10 PM.

Appendix A
Revised Guideline Notes

GUIDELINE NOTE 3, PROPHYLACTIC TREATMENT FOR PREVENTION OF BREAST CANCER IN HIGH RISK WOMEN

Line 195

Bilateral prophylactic breast removal and/or oophorectomy are included on Line 195 for women without a personal history of invasive breast cancer who meet the criteria in the NCCN Clinical Practice Guidelines in Oncology. Breast Cancer Risk Reduction. V1.2016 (2/23/16) ~~V.1.2014 (1/20/14)~~. www.nccn.org. Prior to surgery, women without a personal history of breast cancer must have a genetics consultation as defined in section A2 of the DIAGNOSTIC GUIDELINE D1, NON-PRENATAL GENETIC TESTING GUIDELINE.

Contralateral prophylactic mastectomy is included on Line 195 for women with a personal history of breast cancer.

GUIDELINE NOTE 56, NON-INTERVENTIONAL TREATMENTS FOR CONDITIONS OF THE BACK AND SPINE

Lines 366,407

Patients seeking care for back pain should be assessed for potentially serious conditions ("red flag" symptoms requiring immediate diagnostic testing), as defined in Diagnostic Guideline D4. Patients lacking red flag symptoms should be assessed using a validated assessment tool (e.g. STarT Back Assessment Tool) in order to determine their risk level for poor functional prognosis based on psychosocial indicators.
For patients who are determined to be low risk on the assessment tool, the following services are included on these lines:

- Office evaluation and education,
- Up to 4 total visits, consisting of the following treatments: OMT/CMT, acupuncture, and PT/OT. Massage, if available, may be considered.
- First line medications: NSAIDs, acetaminophen, and/or muscle relaxers. Opioids may be considered as a second line treatment, subject to the limitations on coverage of opioids in Guideline Note 60 OPIOID PRESCRIBING FOR CONDITIONS OF THE BACK AND SPINE. See evidence table.

For patients who are determined to be medium- or high risk on the validated assessment tool, as well as patients undergoing opioid tapers as in Guideline Note 60 OPIOIDS FOR CONDITIONS OF THE BACK AND SPINE, the following treatments are included on these lines:

- Office evaluation, consultation and education
- Cognitive behavioral therapy. The necessity for cognitive behavioral therapy should be re-evaluated every 90 days and coverage will only be continued if there is documented evidence of decreasing depression or anxiety symptomatology, improved ability to

work/function, increased self-efficacy, or other clinically significant, objective improvement.

- Prescription and over-the-counter medications; opioid medications subject to the limitations on coverage of opioids in Guideline Note 60 OPIOID PRESCRIBING FOR CONDITIONS OF THE BACK AND SPINE. See evidence table.
- The following evidence-based therapies, when available, are encouraged: yoga, massage, supervised exercise therapy, intensive interdisciplinary rehabilitation. HCPCS S9451 is only included on line 407 for the provision of yoga or supervised exercise therapy.
- A total of 30 visits per year of any combination of the following evidence-based therapies when available and medically appropriate. These therapies are only included on these lines if provided by a provider licensed to provide the therapy and when there is documentation of measurable clinically significant progress toward the therapy plan of care goals and objectives using evidence based objective tools (e.g. Oswestry, Neck Disability Index, SF-MPQ, PEG and MSPQ).
    1) Rehabilitative therapy (physical and/or occupational therapy), if provided according to Guideline Note 6 REHABILITATIVE THERAPIES. Rehabilitation services provided under this guideline also count towards visit totals in Guideline Note 6
    2) Chiropractic or osteopathic manipulation
    3) Acupuncture

Mechanical traction (CPT 97012) is not included on these lines, due to evidence of lack of effectiveness for treatment of back and neck conditions. Transcutaneous electrical nerve stimulation (TENS; CPT 64550, 97014 and 97032) is not included on the Prioritized List for any condition due to lack of evidence of effectiveness.

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

Appendix A
Revised Guideline Notes

Evidence Table of Effective Treatments for the Management of Low Back Pain

Intervention Category*	Intervention	Acute < 4 Weeks	Subacute & Chronic > 4 Weeks
Self-care	Advice to remain active	●	●
	Books, handout	●	●
	Application of superficial heat	●	
Nonpharmacologic therapy	Spinal manipulation	●	●
	Exercise therapy		●
	Massage		●
	Acupuncture		●
	Yoga		●
	Cognitive-behavioral therapy		●
	Progressive relaxation		●
Pharmacologic therapy (Carefully consider risks/harms)	Acetaminophen	●	●
	NSAIDs	●(▲)	●(▲)
	Skeletal muscle relaxants	●	
	Antidepressants (TCA)		●
	*Benzodiazepines***	●(▲)	●(▲)
	*Tramadol, opioids***	●(▲)	●(▲)
Interdisciplinary therapy	Intensive interdisciplinary rehabilitation		●

- ● Interventions supported by grade B evidence (at least fair-quality evidence of moderate benefit, or small benefit but no significant harms, costs, or burdens). No intervention was supported by grade "A" evidence (good-quality evidence of substantial benefit).

▲ *Carries greater risk of harms than other agents in table.*

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

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

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

GUIDELINE NOTE 60, OPIOIDS ~~PRESCRIBING~~ FOR CONDITIONS OF THE BACK AND SPINE

Lines 351,366,407,532

Opioid medications are only included on these lines under the following criteria:
~~The following restrictions on opioid treatment apply to all diagnoses included on these lines.~~

For acute injury, acute flare of chronic pain, or after surgery:

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1) During the first 6 weeks ~~after the acute injury, flare or surgery~~, opioid treatment is included on these lines ONLY:
   a) When each prescription is limited to 7 days of treatment, AND
   b) For short acting opioids only, AND
   c) When one or more alternative first line pharmacologic therapies such as NSAIDs, acetaminophen, and muscle relaxers have been tried and found not effective or are contraindicated, AND
   d) When prescribed with a plan to keep active (home or prescribed exercise regime) and with consideration of additional therapies such as spinal manipulation, physical therapy, yoga, or acupuncture, AND
   e) There is documented ~~lack of~~ ~~current or prior~~ verification that the patient is not high risk for opioid misuse or abuse.
2) Treatment with opioids after 6 weeks, up to 90 days after the initial injury/flare/surgery, ~~requires the following~~ is included on these lines ONLY:
   a) With ~~D~~documented evidence of improvement of function of at least thirty percent as compared to baseline based on a validated tools.
   b) ~~Must be~~ When prescribed in conjunction with therapies such as spinal manipulation, physical therapy, yoga, or acupuncture.
   c) With ~~V~~verification that the patient is not high risk for opioid misuse or abuse. Such verification may involve:
      i) Documented verification from the state's prescription monitoring program database that the controlled substance history is consistent with the prescribing record
      ii) Use of a validated screening instrument to verify the absence of a current substance use disorder (excluding nicotine) or a history of prior opioid misuse or abuse
      iii) Administration of a baseline urine drug test to verify the absence of illicit drugs and non-prescribed opioids.
   d) Each prescription must be limited to 7 days of treatment and for short acting opioids only
3) Chronic opioid treatment (>90 days) after the initial injury/flare/surgery is not included on these lines except for the taper process described below. ~~Further opioid treatment after 90 days may be considered is included on these lines ONLY when there is a significant change in status, such as a clinically significant verifiable new injury or surgery. In such cases, use of opioids is limited to a maximum of an additional 7 days. In exceptional cases, use up to 28 days may be included on these lines, subject to the criteria in #2 above.~~

Transitional coverage for patients on long-term opioid therapy as of July 1, 2016
~~For patients with chronic pain from diagnoses on these lines currently treated with long term opioid therapy, opioids must be tapered off using~~ For patients on covered chronic opioid therapy as of July 1, 2016, opioid medication is included on these lines only from July 1, 2016 to December 31, 2016. During the period from January 1, 2017 to December 31, 2017, continued coverage of opioid medications requires an individual treatment plan developed by January 1,

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2017 which includes a taper with ~~a quit date~~ an end to opioid therapy no later than January 1, 2018. Taper plans must include nonpharmacological treatment strategies for managing the patient's pain based on Guideline Note 56 NON-INTERVENTIONAL TREATMENTS FOR CONDITIONS OF THE BACK AND SPINE. If a patient has developed dependence and/or addiction related to their opioids, treatment is available on Line 4 SUBSTANCE USE DISORDER.

GUIDELINE NOTE 92, ACUPUNCTURE

Lines 1,208,366,407,415,467,543

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

Line 1 PREGNANCY

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

Hyperemesis gravidarum

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

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

Breech presentation

ICD-10-CM: O32.1

Acupuncture (and moxibustion) is paired with breech presentation when a referral with a diagnosis of breech presentation is made by the maternity care provider, the patient is between 33 and 38 weeks gestation, for up to 6 visits per pregnancy.

Back and pelvic pain of pregnancy

ICD-10-CM: O99.89

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

Line 208 DEPRESSION AND OTHER MOOD DISORDERS, MILD OR MODERATE

Acupuncture is paired with the treatment of post-stroke depression only. Treatments may be billed to a maximum of 30 minutes face-to-face time and limited to 12 total sessions per year, with documentation of meaningful improvement.

Line 366 SCOLIOSIS

Acupuncture is included on Line 366 with visit limitations as in Guideline Note 56 NON-INTERVENTIONAL TREATMENTS FOR CONDITIONS OF THE BACK AND SPINE.

Line 407 CONDITIONS OF THE BACK AND SPINE

Acupuncture is included on Line 407 with visit limitations as in Guideline Note 56 NON-INTERVENTIONAL TREATMENTS FOR CONDITIONS OF THE BACK AND SPINE.

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Line 415 MIGRAINE HEADACHES

Acupuncture pairs on Line 415 for migraine (ICD-10-CM G43.0, G43.1, G43.5, G43.7, G43.8, G43.9), for up to 12 sessions per year.

Line 467 OSTEOARTHRITIS AND ALLIED DISORDERS

Acupuncture pairs on Line 467 for osteoarthritis of the knee only (ICD-10-CM M17), for up to 12 sessions per year.

*Line 543 TENSION HEADACHES

Acupuncture is included on Line 543 for treatment of tension headaches (ICD-10-CM G44.2), for up to 12 sessions per year.

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

*Below the current funding line.

GUIDELINE NOTE 106, PREVENTIVE SERVICES

Line 3

Included on this line are the following preventive services as required by federal law:

1. US Preventive Services Task Force (USPSTF) "A" and "B" Recommendations ~~(May 2012):~~ http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/
2. American Academy of Pediatrics (AAP) Bright Futures Guidelines ~~(published 2008):~~ http://brightfutures.aap.org. Periodicity schedule available at http://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf.
3. **Health Resources and Services Administration (HRSA) Women's Preventive Services - Required Health Plan Coverage Guidelines: ~~(approved with Affordable Care Act on March 23, 2010)~~** http://www.hrsa.gov/womensguidelines/
4. Immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP): http://www.cdc.gov/vaccines/schedules/hcp/index.html

GUIDELINE NOTE 107, HYPERBARIC OXYGEN

Line 337

Hyperbaric oxygen therapy is included on this line, subject to the following limitations:

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1. Codes appearing on this line from ICD-10-CM E08-E13 are included only when they are diabetic wound ulcers of the lower extremities which are Wagner grade 3 or higher (that is, involving bone or gangrenous) and show no measurable signs of healing after 30 days of adequate standard wound therapies including arterial assessment. Courses of treatment for wounds or ulcers are limited to 30 days after the initial treatment; additional 30 day treatment courses are only covered for patients with incomplete wound/infection resolution AND measurable signs of healing
2. ICD-10-CM ~~M27.8~~M27.2 is included on this line for osteoradionecrosis of the jaw only
3. ICD-10-CM O08.0 and M60.0 are included on this line only if the infection is a necrotizing soft-tissue infection
4. ICD-10-CM S07, S17, S38, S47.1, S47.2, S47.9, S57, S67, S77, S87, S97, T79.A are included on this line only for posttraumatic crush injury of Gustilo type III B and C
5. ICD-10-CM T66.XXXA-T66.XXXD and L59.8 are included on this line only for osteoradionecrosis and soft tissue radiation injury
6. ICD-10-CM T86.82, T82.898, T82.9, T83.89, T83.9, T84.89, T84.9, T85.89, T85.9 are included on this line only for compromised myocutaneous flaps

GUIDELINE NOTE 141, LARYNGEAL STENOSIS OR PARALYSIS ~~WITH AIRWAY COMPLICATIONS~~; DYSPHONIA

Lines 70, 521

Laryngeal and vocal cord paralysis (ICD-10 J38.01 and J38.02) are ~~is~~ covered on ~~this~~ line 70 if associated with recurrent aspiration pneumonia (unilateral or bilateral) or airway obstruction (bilateral). Vocal cord paralysis is included on line 70 for children aged 18 and under with dysphonia or dysphagia persisting for at least 12 months. Treatment of ~~H~~hoarseness and dysphonia in adults ~~is~~ are included only on Line 521. Laryngeal stenosis (ICD-10 J38.6) is included on ~~this~~ line 70 only if it causes airway obstruction; otherwise it is included on line 521.

Appendix B

Deleted Guideline Notes

~~DIAGNOSTIC GUIDELINE D2, TUBERCULOSIS TESTING GUIDELINE~~

~~Quanti-FERON TB Gold (QFT-G), a blood test for detecting infection with *Mycobacterium tuberculosis*, may be used in the following circumstances:~~

- ~~A) Instead of Tuberculin Skin Test (TST) for investigation of contacts to confirmed cases of active tuberculosis (TB) disease.~~
- ~~B) Instead of TST for screening for latent TB in persons with definitive history or BCG or who have immigrated from countries with high prevalence (>10%) of latent TB where BCG is commonly given.~~
- ~~C) As a supplementary test to TST in foreign-born persons with a positive TST, history of BCG vaccination against tuberculosis, and no clinical evidence of current TB disease.~~
- ~~D) As a supplementary test in persons with a positive TST who are members of otherwise low-risk populations (e.g., U.S.-born persons and others who have immigrated to the U.S. > 5 years previously or more recently from low TB prevalence countries; absence of immunosuppressive conditions such as HIV infection, renal failure, diabetes mellitus or alcoholism; homelessness; known exposure to someone with active TB), and no clinical evidence of current TB disease.~~
- ~~E) In populations that need rapid (within 24 hours) diagnosis in order to guide appropriate public health interventions such as isolation for infectious tuberculosis or contact evaluation.~~
- ~~F) In a high-risk patient (e.g. homelessness, immune suppression or deficiency, recent immigrant) who the treating clinician believes is unlikely to return on time for the TST reading.~~

Appendix C
New 2017 ICD-10-CM Placement

Code	Title	Placement
M84.750S	Atypical femoral fracture, unspecified, sequela	Informational
M84.751A	Incomplete atypical femoral fracture, right leg, initial encounter for fracture	360 CLOSED FRACTURE OF EXTREMITIES (EXCEPT MINOR TOES)
M84.751D	Incomplete atypical femoral fracture, right leg, subsequent encounter for fracture with routine healing	360 CLOSED FRACTURE OF EXTREMITIES (EXCEPT MINOR TOES)
M84.751G	Incomplete atypical femoral fracture, right leg, subsequent encounter for fracture with delayed healing	360 CLOSED FRACTURE OF EXTREMITIES (EXCEPT MINOR TOES)
M84.751K	Incomplete atypical femoral fracture, right leg, subsequent encounter for fracture with nonunion	447 MALUNION AND NONUNION OF FRACTURE
M84.751P	Incomplete atypical femoral fracture, right leg, subsequent encounter for fracture with malunion	447 MALUNION AND NONUNION OF FRACTURE
M84.751S	Incomplete atypical femoral fracture, right leg, sequela	Informational
M84.752A	Incomplete atypical femoral fracture, left leg, initial encounter for fracture	360 CLOSED FRACTURE OF EXTREMITIES (EXCEPT MINOR TOES)
M84.752D	Incomplete atypical femoral fracture, left leg, subsequent encounter for fracture with routine healing	360 CLOSED FRACTURE OF EXTREMITIES (EXCEPT MINOR TOES)
M84.752G	Incomplete atypical femoral fracture, left leg, subsequent encounter for fracture with delayed healing	360 CLOSED FRACTURE OF EXTREMITIES (EXCEPT MINOR TOES)
M84.752K	Incomplete atypical femoral fracture, left leg, subsequent encounter for fracture with nonunion	447 MALUNION AND NONUNION OF FRACTURE
M84.752P	Incomplete atypical femoral fracture, left leg, subsequent encounter for fracture with malunion	447 MALUNION AND NONUNION OF FRACTURE
M84.752S	Incomplete atypical femoral fracture, left leg, sequela	Informational
M84.753A	Incomplete atypical femoral fracture, unspecified leg, initial encounter for fracture	360 CLOSED FRACTURE OF EXTREMITIES (EXCEPT MINOR TOES)
M84.753D	Incomplete atypical femoral fracture, unspecified leg, subsequent encounter for fracture with routine healing	360 CLOSED FRACTURE OF EXTREMITIES (EXCEPT MINOR TOES)
M84.753G	Incomplete atypical femoral fracture, unspecified leg, subsequent encounter for fracture with delayed healing	360 CLOSED FRACTURE OF EXTREMITIES (EXCEPT MINOR TOES)
M84.753K	Incomplete atypical femoral fracture, unspecified leg, subsequent encounter for fracture with nonunion	447 MALUNION AND NONUNION OF FRACTURE
M84.753P	Incomplete atypical femoral fracture, unspecified leg, subsequent encounter for fracture with malunion	447 MALUNION AND NONUNION OF FRACTURE

M84.753S	Incomplete atypical femoral fracture, unspecified leg, sequela	Informational
M84.754A	Complete transverse atypical femoral fracture, right leg, initial encounter for fracture	360 CLOSED FRACTURE OF EXTREMITIES (EXCEPT MINOR TOES)
M84.754D	Complete transverse atypical femoral fracture, right leg, subsequent encounter for fracture with routine healing	360 CLOSED FRACTURE OF EXTREMITIES (EXCEPT MINOR TOES)
M84.754G	Complete transverse atypical femoral fracture, right leg, subsequent encounter for fracture with delayed healing	360 CLOSED FRACTURE OF EXTREMITIES (EXCEPT MINOR TOES)
M84.754K	Complete transverse atypical femoral fracture, right leg, subsequent encounter for fracture with nonunion	447 MALUNION AND NONUNION OF FRACTURE
M84.754P	Complete transverse atypical femoral fracture, right leg, subsequent encounter for fracture with malunion	447 MALUNION AND NONUNION OF FRACTURE
M84.754S	Complete transverse atypical femoral fracture, right leg, sequela	Informational
M84.755A	Complete transverse atypical femoral fracture, left leg, initial encounter for fracture	360 CLOSED FRACTURE OF EXTREMITIES (EXCEPT MINOR TOES)
M84.755D	Complete transverse atypical femoral fracture, left leg, subsequent encounter for fracture with routine healing	360 CLOSED FRACTURE OF EXTREMITIES (EXCEPT MINOR TOES)
M84.755G	Complete transverse atypical femoral fracture, left leg, subsequent encounter for fracture with delayed healing	360 CLOSED FRACTURE OF EXTREMITIES (EXCEPT MINOR TOES)
M84.755K	Complete transverse atypical femoral fracture, left leg, subsequent encounter for fracture with nonunion	447 MALUNION AND NONUNION OF FRACTURE
M84.755P	Complete transverse atypical femoral fracture, left leg, subsequent encounter for fracture with malunion	447 MALUNION AND NONUNION OF FRACTURE
M84.755S	Complete transverse atypical femoral fracture, left leg, sequela	Informational
M84.756A	Complete transverse atypical femoral fracture, unspecified leg, initial encounter for fracture	360 CLOSED FRACTURE OF EXTREMITIES (EXCEPT MINOR TOES)
M84.756D	Complete transverse atypical femoral fracture, unspecified leg, subsequent encounter for fracture with routine healing	360 CLOSED FRACTURE OF EXTREMITIES (EXCEPT MINOR TOES)
M84.756G	Complete transverse atypical femoral fracture, unspecified leg, subsequent encounter for fracture with delayed healing	360 CLOSED FRACTURE OF EXTREMITIES (EXCEPT MINOR TOES)
M84.756K	Complete transverse atypical femoral fracture, unspecified leg, subsequent encounter for fracture with nonunion	447 MALUNION AND NONUNION OF FRACTURE

M84.756P	Complete transverse atypical femoral fracture, unspecified leg, subsequent encounter for fracture with malunion	447 MALUNION AND NONUNION OF FRACTURE
M84.756S	Complete transverse atypical femoral fracture, unspecified leg, sequela	Informational
M84.757A	Complete oblique atypical femoral fracture, right leg, initial encounter for fracture	360 CLOSED FRACTURE OF EXTREMITIES (EXCEPT MINOR TOES)
M84.757D	Complete oblique atypical femoral fracture, right leg, subsequent encounter for fracture with routine healing	360 CLOSED FRACTURE OF EXTREMITIES (EXCEPT MINOR TOES)
M84.757G	Complete oblique atypical femoral fracture, right leg, subsequent encounter for fracture with delayed healing	360 CLOSED FRACTURE OF EXTREMITIES (EXCEPT MINOR TOES)
M84.757K	Complete oblique atypical femoral fracture, right leg, subsequent encounter for fracture with nonunion	447 MALUNION AND NONUNION OF FRACTURE
M84.757P	Complete oblique atypical femoral fracture, right leg, subsequent encounter for fracture with malunion	447 MALUNION AND NONUNION OF FRACTURE
M84.757S	Complete oblique atypical femoral fracture, right leg, sequela	Informational
M84.758A	Complete oblique atypical femoral fracture, left leg, initial encounter for fracture	360 CLOSED FRACTURE OF EXTREMITIES (EXCEPT MINOR TOES)
M84.758D	Complete oblique atypical femoral fracture, left leg, subsequent encounter for fracture with routine healing	360 CLOSED FRACTURE OF EXTREMITIES (EXCEPT MINOR TOES)
M84.758G	Complete oblique atypical femoral fracture, left leg, subsequent encounter for fracture with delayed healing	360 CLOSED FRACTURE OF EXTREMITIES (EXCEPT MINOR TOES)
M84.758K	Complete oblique atypical femoral fracture, left leg, subsequent encounter for fracture with nonunion	447 MALUNION AND NONUNION OF FRACTURE
M84.758P	Complete oblique atypical femoral fracture, left leg, subsequent encounter for fracture with malunion	447 MALUNION AND NONUNION OF FRACTURE
M84.758S	Complete oblique atypical femoral fracture, left leg, sequela	Informational
M84.759A	Complete oblique atypical femoral fracture, unspecified leg, initial encounter for fracture	360 CLOSED FRACTURE OF EXTREMITIES (EXCEPT MINOR TOES)
M84.759D	Complete oblique atypical femoral fracture, unspecified leg, subsequent encounter for fracture with routine healing	360 CLOSED FRACTURE OF EXTREMITIES (EXCEPT MINOR TOES)
M84.759G	Complete oblique atypical femoral fracture, unspecified leg, subsequent encounter for fracture with delayed healing	360 CLOSED FRACTURE OF EXTREMITIES (EXCEPT MINOR TOES)
M84.759K	Complete oblique atypical femoral fracture, unspecified leg, subsequent encounter for fracture with nonunion	447 MALUNION AND NONUNION OF FRACTURE

M84.759P	Complete oblique atypical femoral fracture, unspecified leg, subsequent encounter for fracture with malunion	447 MALUNION AND NONUNION OF FRACTURE
M84.759S	Complete oblique atypical femoral fracture, unspecified leg, sequela	Informational
M96.840	Postprocedural hematoma of a musculoskeletal structure following a musculoskeletal system procedure	428 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
M96.841	Postprocedural hematoma of a musculoskeletal structure following other procedure	428 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
M96.842	Postprocedural seroma of a musculoskeletal structure following a musculoskeletal system procedure	428 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
M96.843	Postprocedural seroma of a musculoskeletal structure following other procedure	428 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
M97.01XA	Periprosthetic fracture around internal prosthetic right hip joint, initial encounter	290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
M97.01XD	Periprosthetic fracture around internal prosthetic right hip joint, subsequent encounter	290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
M97.01XS	Periprosthetic fracture around internal prosthetic right hip joint, sequela	Informational
M97.02XA	Periprosthetic fracture around internal prosthetic left hip joint, initial encounter	290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
M97.02XD	Periprosthetic fracture around internal prosthetic left hip joint, subsequent encounter	290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
M97.02XS	Periprosthetic fracture around internal prosthetic left hip joint, sequela	Informational
M97.11XA	Periprosthetic fracture around internal prosthetic right knee joint, initial encounter	290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
M97.11XD	Periprosthetic fracture around internal prosthetic right knee joint, subsequent encounter	290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
M97.11XS	Periprosthetic fracture around internal prosthetic right knee joint, sequela	Informational
M97.12XA	Periprosthetic fracture around internal prosthetic left knee joint, initial encounter	290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
M97.12XD	Periprosthetic fracture around internal prosthetic left knee joint, subsequent encounter	290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT

M97.12XS	Periprosthetic fracture around internal prosthetic left knee joint, sequela	Informational
M97.21XA	Periprosthetic fracture around internal prosthetic right ankle joint, initial encounter	290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
M97.21XD	Periprosthetic fracture around internal prosthetic right ankle joint, subsequent encounter	290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
M97.21XS	Periprosthetic fracture around internal prosthetic right ankle joint, sequela	Informational
M97.22XA	Periprosthetic fracture around internal prosthetic left ankle joint, initial encounter	290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
M97.22XD	Periprosthetic fracture around internal prosthetic left ankle joint, subsequent encounter	290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
M97.22XS	Periprosthetic fracture around internal prosthetic left ankle joint, sequela	Informational
M97.31XA	Periprosthetic fracture around internal prosthetic right shoulder joint, initial encounter	290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
M97.31XD	Periprosthetic fracture around internal prosthetic right shoulder joint, subsequent encounter	290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
M97.31XS	Periprosthetic fracture around internal prosthetic right shoulder joint, sequela	Informational
M97.32XA	Periprosthetic fracture around internal prosthetic left shoulder joint, initial encounter	290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
M97.32XD	Periprosthetic fracture around internal prosthetic left shoulder joint, subsequent encounter	290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
M97.32XS	Periprosthetic fracture around internal prosthetic left shoulder joint, sequela	Informational
M97.41XA	Periprosthetic fracture around internal prosthetic right elbow joint, initial encounter	290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
M97.41XD	Periprosthetic fracture around internal prosthetic right elbow joint, subsequent encounter	290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
M97.41XS	Periprosthetic fracture around internal prosthetic right elbow joint, sequela	Informational
M97.42XA	Periprosthetic fracture around internal prosthetic left elbow joint, initial encounter	290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT

M97.42XD	Periprosthetic fracture around internal prosthetic left elbow joint, subsequent encounter	290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
M97.42XS	Periprosthetic fracture around internal prosthetic left elbow joint, sequela	Informational
M97.8XXA	Periprosthetic fracture around other internal prosthetic joint, initial encounter	290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
M97.8XXD	Periprosthetic fracture around other internal prosthetic joint, subsequent encounter	290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
M97.8XXS	Periprosthetic fracture around other internal prosthetic joint, sequela	Informational
M97.9XXA	Periprosthetic fracture around unspecified internal prosthetic joint, initial encounter	290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
M97.9XXD	Periprosthetic fracture around unspecified internal prosthetic joint, subsequent encounter	290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
M97.9XXS	Periprosthetic fracture around unspecified internal prosthetic joint, sequela	Informational
N13.0	Hydronephrosis with ureteropelvic junction obstruction	184 URETERAL STRICTURE OR OBSTRUCTION; HYDRONEPHROSIS; HYDROURETER
N39.491	Coital incontinence	459 URINARY INCONTINENCE
N39.492	Postural (urinary) incontinence	459 URINARY INCONTINENCE
N42.30	Unspecified dysplasia of prostate	518 CHRONIC PROSTATITIS, OTHER DISORDERS OF PROSTATE 662 GENITOURINARY CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY
N42.31	Prostatic intraepithelial neoplasia	518 CHRONIC PROSTATITIS, OTHER DISORDERS OF PROSTATE 662 GENITOURINARY CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY
N42.32	Atypical small acinar proliferation of prostate	518 CHRONIC PROSTATITIS, OTHER DISORDERS OF PROSTATE 662 GENITOURINARY CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY
N42.39	Other dysplasia of prostate	518 CHRONIC PROSTATITIS, OTHER DISORDERS OF PROSTATE 662 GENITOURINARY CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY
N50.811	Right testicular pain	Diagnostic Workup File
N50.812	Left testicular pain	Diagnostic Workup File

N50.819	Testicular pain, unspecified	Diagnostic Workup File
N50.82	Scrotal pain	Diagnostic Workup File
N50.89	Other specified disorders of the male genital organs	547 HYDROCELE 662 GENITOURINARY CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY
N52.35	Erectile dysfunction following radiation therapy	526 SEXUAL DYSFUNCTION
N52.36	Erectile dysfunction following interstitial seed therapy	526 SEXUAL DYSFUNCTION
N52.37	Erectile dysfunction following prostate ablative therapy	526 SEXUAL DYSFUNCTION
N61.0	Mastitis without abscess	210 SUPERFICIAL ABSCESSES AND CELLULITIS
N61.1	Abscess of the breast and nipple	210 SUPERFICIAL ABSCESSES AND CELLULITIS
N83.00	Follicular cyst of ovary, unspecified side	434 NONINFLAMMATORY DISORDERS AND BENIGN NEOPLASMS OF OVARY, FALLOPIAN TUBES AND UTERUS; OVARIAN CYSTS; GONADAL DYSGENISIS
N83.01	Follicular cyst of right ovary	434 NONINFLAMMATORY DISORDERS AND BENIGN NEOPLASMS OF OVARY, FALLOPIAN TUBES AND UTERUS; OVARIAN CYSTS; GONADAL DYSGENISIS
N83.02	Follicular cyst of left ovary	434 NONINFLAMMATORY DISORDERS AND BENIGN NEOPLASMS OF OVARY, FALLOPIAN TUBES AND UTERUS; OVARIAN CYSTS; GONADAL DYSGENISIS
N83.10	Corpus luteum cyst of ovary, unspecified side	434 NONINFLAMMATORY DISORDERS AND BENIGN NEOPLASMS OF OVARY, FALLOPIAN TUBES AND UTERUS; OVARIAN CYSTS; GONADAL DYSGENISIS
N83.11	Corpus luteum cyst of right ovary	434 NONINFLAMMATORY DISORDERS AND BENIGN NEOPLASMS OF OVARY, FALLOPIAN TUBES AND UTERUS; OVARIAN CYSTS; GONADAL DYSGENISIS
N83.12	Corpus luteum cyst of left ovary	434 NONINFLAMMATORY DISORDERS AND BENIGN NEOPLASMS OF OVARY, FALLOPIAN TUBES AND UTERUS; OVARIAN CYSTS; GONADAL DYSGENISIS
N83.201	Unspecified ovarian cyst, right side	434 NONINFLAMMATORY DISORDERS AND BENIGN NEOPLASMS OF OVARY, FALLOPIAN TUBES AND UTERUS; OVARIAN CYSTS; GONADAL DYSGENISIS
N83.202	Unspecified ovarian cyst, left side	434 NONINFLAMMATORY DISORDERS AND BENIGN NEOPLASMS OF OVARY, FALLOPIAN TUBES AND UTERUS; OVARIAN CYSTS; GONADAL DYSGENISIS

N83.209	Unspecified ovarian cyst, unspecified side	434 NONINFLAMMATORY DISORDERS AND BENIGN NEOPLASMS OF OVARY, FALLOPIAN TUBES AND UTERUS; OVARIAN CYSTS; GONADAL DYSGENISIS
N83.291	Other ovarian cyst, right side	434 NONINFLAMMATORY DISORDERS AND BENIGN NEOPLASMS OF OVARY, FALLOPIAN TUBES AND UTERUS; OVARIAN CYSTS; GONADAL DYSGENISIS
N83.292	Other ovarian cyst, left side	434 NONINFLAMMATORY DISORDERS AND BENIGN NEOPLASMS OF OVARY, FALLOPIAN TUBES AND UTERUS; OVARIAN CYSTS; GONADAL DYSGENISIS
N83.299	Other ovarian cyst, unspecified side	434 NONINFLAMMATORY DISORDERS AND BENIGN NEOPLASMS OF OVARY, FALLOPIAN TUBES AND UTERUS; OVARIAN CYSTS; GONADAL DYSGENISIS
N83.311	Acquired atrophy of right ovary	473 GONADAL DYSFUNCTION, MENOPAUSAL MANAGEMENT
N83.312	Acquired atrophy of left ovary	473 GONADAL DYSFUNCTION, MENOPAUSAL MANAGEMENT
N83.319	Acquired atrophy of ovary, unspecified side	473 GONADAL DYSFUNCTION, MENOPAUSAL MANAGEMENT
N83.321	Acquired atrophy of right fallopian tube	662 GENITOURINARY CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY
N83.322	Acquired atrophy of left fallopian tube	662 GENITOURINARY CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY
N83.329	Acquired atrophy of fallopian tube, unspecified side	662 GENITOURINARY CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY
N83.331	Acquired atrophy of right ovary and fallopian tube	473 GONADAL DYSFUNCTION, MENOPAUSAL MANAGEMENT
N83.332	Acquired atrophy of left ovary and fallopian tube	473 GONADAL DYSFUNCTION, MENOPAUSAL MANAGEMENT
N83.339	Acquired atrophy of ovary and fallopian tube, unspecified	473 GONADAL DYSFUNCTION, MENOPAUSAL MANAGEMENT
N83.40	Prolapse and hernia of ovary and fallopian tube, unspecified side	434 NONINFLAMMATORY DISORDERS AND BENIGN NEOPLASMS OF OVARY, FALLOPIAN TUBES AND UTERUS; OVARIAN CYSTS; GONADAL DYSGENISIS
N83.41	Prolapse and hernia of right ovary and fallopian tube	434 NONINFLAMMATORY DISORDERS AND BENIGN NEOPLASMS OF OVARY, FALLOPIAN TUBES AND UTERUS; OVARIAN CYSTS; GONADAL DYSGENISIS
N83.42	Prolapse and hernia of left ovary and fallopian tube	434 NONINFLAMMATORY DISORDERS AND BENIGN NEOPLASMS OF OVARY, FALLOPIAN TUBES AND UTERUS; OVARIAN CYSTS; GONADAL DYSGENISIS
N83.511	Torsion of right ovary and ovarian pedicle	65 TORSION OF OVARY

N83.512	Torsion of left ovary and ovarian pedicle	65 TORSION OF OVARY
N83.519	Torsion of ovary and ovarian pedicle, unspecified side	65 TORSION OF OVARY
N83.521	Torsion of right fallopian tube	65 TORSION OF OVARY
N83.522	Torsion of left fallopian tube	65 TORSION OF OVARY
N83.529	Torsion of fallopian tube, unspecified side	65 TORSION OF OVARY
N90.60	Unspecified hypertrophy of vulva	662 GENITOURINARY CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY
N90.61	Childhood asymmetric labium majus enlargement (CALME)	662 GENITOURINARY CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY
N90.69	Other specified hypertrophy of vulva	662 GENITOURINARY CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY
N93.1	Pre-pubertal vaginal bleeding	Diagnostic List
N94.10	Unspecified dyspareunia	534 CHRONIC PELVIC INFLAMMATORY DISEASE, PELVIC PAIN SYNDROME, DYSPAREUNIA
N94.11	Superficial (introital) dyspareunia	534 CHRONIC PELVIC INFLAMMATORY DISEASE, PELVIC PAIN SYNDROME, DYSPAREUNIA
N94.12	Deep dyspareunia	534 CHRONIC PELVIC INFLAMMATORY DISEASE, PELVIC PAIN SYNDROME, DYSPAREUNIA
N94.19	Other specified dyspareunia	534 CHRONIC PELVIC INFLAMMATORY DISEASE, PELVIC PAIN SYNDROME, DYSPAREUNIA
N99.115	Postprocedural fossa navicularis urethral stricture	290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
N99.523	Herniation of incontinent stoma of urinary tract	290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
N99.524	Stenosis of incontinent stoma of urinary tract	290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
N99.533	Herniation of continent stoma of urinary tract	290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
N99.534	Stenosis of continent stoma of urinary tract	290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
N99.840	Postprocedural hematoma of a genitourinary system organ or structure following a genitourinary system procedure	428 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
N99.841	Postprocedural hematoma of a genitourinary system organ or structure following other procedure	428 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT

N99.842	Postprocedural seroma of a genitourinary system organ or structure following a genitourinary system procedure	428 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
N99.843	Postprocedural seroma of a genitourinary system organ or structure following other procedure	428 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
O00.00	Abdominal pregnancy without intrauterine pregnancy	41 ECTOPIC PREGNANCY; HYDATIDIFORM MOLE; CHORIOCARCINOMA
O00.01	Abdominal pregnancy with intrauterine pregnancy	41 ECTOPIC PREGNANCY; HYDATIDIFORM MOLE; CHORIOCARCINOMA
O00.10	Tubal pregnancy without intrauterine pregnancy	41 ECTOPIC PREGNANCY; HYDATIDIFORM MOLE; CHORIOCARCINOMA
O00.11	Tubal pregnancy with intrauterine pregnancy	41 ECTOPIC PREGNANCY; HYDATIDIFORM MOLE; CHORIOCARCINOMA
O00.20	Ovarian pregnancy without intrauterine pregnancy	41 ECTOPIC PREGNANCY; HYDATIDIFORM MOLE; CHORIOCARCINOMA
O00.21	Ovarian pregnancy with intrauterine pregnancy	41 ECTOPIC PREGNANCY; HYDATIDIFORM MOLE; CHORIOCARCINOMA
O00.80	Other ectopic pregnancy without intrauterine pregnancy	41 ECTOPIC PREGNANCY; HYDATIDIFORM MOLE; CHORIOCARCINOMA
O00.81	Other ectopic pregnancy with intrauterine pregnancy	41 ECTOPIC PREGNANCY; HYDATIDIFORM MOLE; CHORIOCARCINOMA
O00.90	Unspecified ectopic pregnancy without intrauterine pregnancy	41 ECTOPIC PREGNANCY; HYDATIDIFORM MOLE; CHORIOCARCINOMA
O00.91	Unspecified ectopic pregnancy with intrauterine pregnancy	41 ECTOPIC PREGNANCY; HYDATIDIFORM MOLE; CHORIOCARCINOMA
O09.A0	Supervision of pregnancy with history of molar pregnancy, unspecified trimester	1 PREGNANCY
O09.A1	Supervision of pregnancy with history of molar pregnancy, first trimester	1 PREGNANCY
O09.A2	Supervision of pregnancy with history of molar pregnancy, second trimester	1 PREGNANCY
O09.A3	Supervision of pregnancy with history of molar pregnancy, third trimester	1 PREGNANCY
O11.4	Pre-existing hypertension with pre-eclampsia, complicating childbirth	1 PREGNANCY

O11.5	Pre-existing hypertension with pre-eclampsia, complicating the puerperium	1 PREGNANCY
O12.04	Gestational edema, complicating childbirth	1 PREGNANCY
O12.05	Gestational edema, complicating the puerperium	1 PREGNANCY
O12.14	Gestational proteinuria, complicating childbirth	1 PREGNANCY
O12.15	Gestational proteinuria, complicating the puerperium	1 PREGNANCY
O12.24	Gestational edema with proteinuria, complicating childbirth	1 PREGNANCY
O12.25	Gestational edema with proteinuria, complicating the puerperium	1 PREGNANCY
O13.4	Gestational [pregnancy-induced] hypertension without significant proteinuria, complicating childbirth	1 PREGNANCY
O13.5	Gestational [pregnancy-induced] hypertension without significant proteinuria, complicating the puerperium	1 PREGNANCY
O14.04	Mild to moderate pre-eclampsia, complicating childbirth	1 PREGNANCY
O14.05	Mild to moderate pre-eclampsia, complicating the	1 PREGNANCY
O14.14	Severe pre-eclampsia complicating childbirth	1 PREGNANCY
O14.15	Severe pre-eclampsia, complicating the puerperium	1 PREGNANCY
O14.24	HELLP syndrome, complicating childbirth	1 PREGNANCY
O14.25	HELLP syndrome, complicating the puerperium	1 PREGNANCY
O14.94	Unspecified pre-eclampsia, complicating childbirth	1 PREGNANCY
O14.95	Unspecified pre-eclampsia, complicating the puerperium	1 PREGNANCY
O16.4	Unspecified maternal hypertension, complicating childbirth	1 PREGNANCY
O16.5	Unspecified maternal hypertension, complicating the puerperium	1 PREGNANCY
O24.415	Gestational diabetes mellitus in pregnancy, controlled by oral hypoglycemic drugs	1 PREGNANCY
O24.425	Gestational diabetes mellitus in childbirth, controlled by oral hypoglycemic drugs	1 PREGNANCY
O24.435	Gestational diabetes mellitus in puerperium, controlled by oral hypoglycemic drugs	1 PREGNANCY
O33.7XX0	Maternal care for disproportion due to other fetal deformities, not applicable or unspecified	1 PREGNANCY

Appendix D
New Guideline Notes

DIAGNOSTIC GUIDELINE DX, IMPLANTABLE CARDIAC LOOP RECORDERS

Use of an implantable cardiac loop recorder (ICLR) is a covered service only when the patient meets all of the following criteria:

1) The evaluation is for recurrent transient loss of consciousness (TLoC); and
2) A comprehensive evaluation including 30 days of noninvasive ambulatory cardiac monitoring did not demonstrate a cause of the TLoC; and
3) A cardiac arrhythmia is suspected to be the cause of the TLoC; and
4) There is a likely recurrence of the TLoC within the battery longevity of the device.

ICLRs are not a covered service for evaluation of cryptogenic stroke or any other indication.

GUIDELINE NOTE XXX, MEDIASTINITIS

Lines 290, 661

ICD-10 J98.51 (Mediastinitis) is included on line 290 for acute mediastinitis and on line 661 for chronic or fibrosing mediastinitis.

GUIDELINE NOTE XXX, ENCOUNTER FOR DESENSITIZATION TO ALLERGENS

Lines 9. 107, 128, 227, 318, 535, 536, 555, 564, 571

ICD-10 Z51.6 (Encounter for desensitization to allergens) is only included on these lines when used to treat a diagnosis appearing on a line above the current funding line (i.e. lines 9, 107, 128, 227, 318).

GUIDELINE NOTE XXX, ELECTRIC TUMOR TREATMENT FIELDS FOR GLIOBLASTOMA

Line 299

Electric tumor treatment fields (codes HCPCS A4555 and E0766) are included on this line only when

1) Used for the initial treatment of supratentorial glioblastoma
2) Used in combination with temozolomide
3) ~~The patient has Karnofsky Performance Status score of 70 or higher or Eastern Cooperative Oncology Group (ECOG) performance status 0-1~~ *[strike due to HERC decision—see HERC August 2016 minutes for details]*

Electric tumor treatment fields are not included on this line for recurrent glioblastoma or any other indication.