Value-based Benefits Subcommittee Recommendations Summary
For Presentation to:
Health Evidence Review Commission on January 21, 2021

For specific coding recommendations and guideline wording, please see the text of the 1/21/2021 VbBS minutes.

RECOMMENDED CODE MOVEMENT (changes to the 10/1/2021 Prioritized List unless otherwise noted)

- Add the 2021 HCPCS codes to various lines and recommend them for placement on various other files. Update the telemedicine guideline to accommodate the new codes. *These changes are effective 2/1/2021*
- Create a new line for uterine polyps and score it above the funding line. *This change is effective January 1, 2022*
- Add procedure and diagnosis codes related to COVID-19 to various lines and lists. Rename the line containing COVID-19 diagnoses to clarify that COVID-19 is included in that line. *These changes are effective 2/1/2021*
- Add biofeedback codes to the funded migraine line and the unfunded tension headache line and remove them from several lines related to urinary incontinence and pelvic floor disorders. Add the procedure codes for biofeedback to treat behavioral health diagnoses to an unfunded line.
- Delete two procedures from the funded prostate cancer line
- Delete codes for stereotactic surgery on the central nervous system from a series of funded and unfunded lines without central nervous system cancer diagnoses
- Make various straightforward code changes

ITEMS CONSIDERED BUT NO RECOMMENDATIONS FOR CHANGES MADE

- Movement of panniculectomy to a funded portion of the List was considered but not adopted.
- No change was made to non-coverage of total artificial hearts

RECOMMENDED GUIDELINE CHANGES (changes to the 10/1/2021 Prioritized List unless otherwise noted)

- Add a new guideline regarding panniculectomy to an unfunded line
- Edit the preventive services guideline to indicate that COVID-19 vaccines are included on the preventive services line even if their procedure codes do not yet appear on that line if the vaccines are FDA approved and ACIP recommended. *This change is effective 2/1/2021*
- Edit the palliative care statement of intent to include biofeedback for the treatment of cancer pain
- Edit the acupuncture guideline to include the substance use disorder line.
- Edit the artificial disk replacement guideline to clarify that the combined procedure of artificial disk replacement and fusion is not covered.
- Edit the spinal cord stimulator guideline to indicate when the replacement of these devices was covered.
- Make several straightforward guideline note changes

VALUE-BASED BENEFITS SUBCOMMITTEE
Clackamas Community College
Wilsonville Training Center, Rooms 111-112
Wilsonville, Oregon
January 21, 2021
8:00 AM – 1:00 PM

Members Present: Kevin Olson, MD, Chair; Holly Jo Hodges, MD, MBA, Vice-chair; Gary Allen, DMD; Kathryn Schabel, MD; Brian Duty, MD; Mike Collins; Adriane Irwin, PharmD; Regina Dehen, ND, LAc.

Members Absent:

Staff Present: Ariel Smits, MD, MPH; Jason Gingerich; Liz Walker, PhD, MPH; Daphne Peck.

Also Attending: Cris Pinzon; Jennifer Lewis; Lisa Gardner; Michelle Digan; Michelle Erskine; Cristina Pinzon; Gary Whitehouse; Tracy Futch, Quest Diagnostics; Dan Cushing; Laurie H; Jen Gore; Devki Nagar from Myriad[Holly Walpole; Bethany Godlewski and Valerie King, MD MPH, (Center for Evidence-based Policy); Taryn Couture; Talyor; Adria Decker; Peggy Flanigan; Mike Flanigan; Nate Myzka; Peggy Tighe; Taylor Kane; Melanie Ewald, Rick Frees; Ashley Svenson; Jeanne Laws; Rashelle Kukuk; Renee Doan, RN; Patti Maloney; Jhenna Arce; Timothy Barr (Note: Names were captured from the Teams application screen as they were displayed during the meeting.)

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

  The meeting was called to order at 8:00 am and roll was called. A quorum of members was present at the meeting. Minutes from the November 12, 2020 VbBS meeting were reviewed and approved.

  Cris Pinzon was introduced. She has been appointed by the Governor to the HERC and is awaiting Senate confirmation and is expected to join VBBS at its March 2021 meeting.

  Gingerich gave a brief update of the legislative session and reminded members to not use their HERC affiliation if giving testimony to the legislature in a personal capacity. Gingerich also requested nominations for a new statewide psilocybin board.

  Smits reviewed the items discuss with leadership and noted that staff intended to suggest to the HERC at their meeting later the same day that a Prioritized List be published on February 1, 2021 to contain just the 2021 HCPCS code placements, COVID-related code changes, and related guideline changes from today's meetings.

- **Topic: Straightforward/Consent Agenda**

  Discussion: There was no discussion about the consent agenda items.

  Recommended Actions:
  1) Add CPT 99366-99368 (Medical team conference with interdisciplinary team of health care professionals) to any line with E&M codes that currently does not have one or more of these codes
  2) Add HCPCS S2115 (Osteotomy, periacetabular, with internal fixation) to line 309 CONGENITAL DISLOCATION OF HIP; COXA VARA AND VALGA
  3) Add CPT 17110 (Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions) to line 387 ANOGENITAL VIRAL WARTS
  4) Add 25107 (Arthrotomy, distal radioulnar joint including repair of triangular cartilage, complex) and 29846 (Arthroscopy, wrist, surgical; excision and/or repair of triangular fibrocartilage and/or joint debridement) to line 376 DISRUPTIONS OF THE LIGAMENTS AND TENDONS OF THE ARMS AND LEGS, EXCLUDING THE KNEE, RESULTING IN SIGNIFICANT INJURY/IMPAIRMENT
  5) Add 29847 (Arthroscopy, wrist, surgical; internal fixation for fracture or instability), 25320 (Capsulorrhaphy or reconstruction, wrist, open (eg, capsulodesis, ligament repair, tendon transfer or graft) (includes synovectomy, capsulotomy and open reduction) for carpal instability), and 25332 (Arthroplasty, wrist, with or without interposition, with or without external or internal fixation) to line 376 DISRUPTIONS OF THE LIGAMENTS AND TENDONS OF THE ARMS AND LEGS, EXCLUDING THE KNEE, RESULTING IN SIGNIFICANT INJURY/IMPAIRMENT
  6) Remove CPT 82610 (Cystatin C) from line 662 CONDITIONS FOR WHICH CERTAIN INTERVENTIONS ARE UNPROVEN, HAVE NO CLINICALLY IMPORTANT BENEFIT OR HAVE HARMS THAT OUTWEIGH BENEFITS/GN173
     a. Modify GN173 as shown in Appendix A
     b. Advise HSD to add CPT 82610 to the Diagnostic Procedures File

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

- **Topic: 2021 HCPCS Codes**

  Discussion: There was minimal discussion regarding the suggested placement of the 2021 HCPCS Codes.

  Recommended Actions *(These changes will be effective February 1, 2021)*:
  1) See code placement recommendations in Appendix B
  2) Modify GN173 as shown in Appendix A
  3) Modify Ancillary Guideline A5 as shown as shown in Appendix A

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

- **Topic: Biennial review—uterine polyps**

Discussion: Smits reviewed the summary document. Gingerich reviewed the scoring methodology. There was limited discussion.

Recommended Actions:
These changes are effective January 1, 2022

1) Create a new line for uterine polyps as shown below and with line scoring as shown below
2) Rename line 404 UTERINE LEIOMYOMA ~~AND POLYPS~~
3) Remove ICD=10 N84.1 (Polyp of corpus uteri), N84.8 (Polyp of other parts of female genital tract) and N84.9 (Polyp of female genital tract, unspecified) from line 404
4) Add CPT 58558 (Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C) to all lines with D&C and advise HSD to remove CPT 58558 from the Diagnostic Procedure File
    a. 25 ABNORMAL PAP SMEARS; DYSPLASIA OF CERVIX AND CERVICAL CARCINOMA IN SITU, CERVICAL CONDYLOMA
    b. 37 ECTOPIC PREGNANCY; HYDATIDIFORM MOLE; CHORIOCARCINOMA
    c. 208 CANCER OF UTERUS
    d. 353 STRUCTURAL CAUSES OF AMENORRHEA
    e. 404 UTERINE LEIOMYOMA ~~AND POLYPS~~
    f. 422 MENSTRUAL BLEEDING DISORDERS
    g. 438 FOREIGN BODY IN UTERUS, VULVA AND VAGINA

Line:	**XXX**
Condition:	UTERINE POLYPS
Treatment:	MEDICAL AND SURGICAL TREATMENT
ICD-10:	N84.1 (Polyp of corpus uteri), N84.8 (Polyp of other parts of female genital tract) and N84.9 (Polyp of female genital tract, unspecified)
CPT:	58120 (Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)), 58558 (Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C); ,98966-98972,99051,99060,99070,99078,99184,99201-99239,99281-99285,99291-99404,99408-99449,99451,99452,99468-99472,99475-99480,99487-99491, 99495-99498,99605-99607 (office visits, etc.)
HCPCS:	G0068,G0071,G0248-G0250,G0396,G0397,G0406-G0408,G0425-G0427,G0463-G0467, G0490,G0508-G0511,G2011,G2012,G2058-G2065 (FQHC visits, etc.)

Prioritization of UTERINE POLYPS Treatment: MEDICAL AND SURGICAL TREATMENT
(Current scores for line 404 shown in parentheses)

Category: 7 (7)
Healthy life years: 3 (3)
Suffering: 2 (2)
Population effects: 0 (0)
Vulnerable population: 0 (1)
Tertiary prevention: 2 (2)
Effectiveness: 5 (5)
Need for treatment: 0.5 (0.5)
Net cost: 3 (3)
Score: 350 (400)

Line placement: 422 (404)

MOTION: To approve the line creation and scoring, line name change, and code changes as presented. CARRIES 8-0.

- **Topic: Biennial review—Inguinal hernias**

Discussion: Smits reviewed the summary document. There was discussion about adding some type of objective measurement of pain in the proposed guideline changes. Several members said that pain is a very subjective experience to base coverage decisions on. There was discussion about requiring that a patient fail conservative measures such as truss wearing; however, the group felt that trussing was not evidence-based and no other conservative measures are used.

The group agreed that the natural history of inguinal and femoral hernias are different in women and appear in the funded region of the List..

The group also discussed adding some type of standardized tool for evaluation of pain and functional issues due to hernias. Such a tool would create more similar implementation across CCOs. Schabel argued that asymptomatic patients don't generally seek surgery, so the need for measuring symptoms might not be required. However, Hodges noted that many patients are told by their provider to get a hernia repaired even if asymptomatic.

The general consensus was that the general direction laid out by staff was the preferred direction, but more specificity is needed around the criteria regarding pain and function. Staff will look into standardized instrument(s) to measure pain and functional issues from the hernia and seek general surgeon input on the proposed guideline. Staff will modify the proposed guideline and bring back for further discussion at the March 2021 meeting.

- **Topic: Biennial review—Panniculectomy**

Discussion: Smits reviewed the summary document. Schabel noted that patients refused bariatric surgery because they are aware that there is no treatment of the excess skin after surgery, which is an unintended effect of lack of coverage. She also noted that the current discussion is about excess skin on the abdomen, but patients frequently also need removal of excess skin on other parts of the body. Olson expressed concerns over the harms of panniculectomy.

The general consensus was to keep panniculectomy below the funding line but to add the staff proposed guideline to standardize the exceptions process across CCOs.

Recommended Actions:
This change is effective 10/1/2021

1) A new guideline was added to 625 SEBORRHEIC KERATOSIS, DYSCHROMIA, AND VASCULAR DISORDERS, SCAR CONDITIONS, AND FIBROSIS OF SKIN as shown in Appendix C

MOTION: To recommend the adopt the guideline note as presented. CARRIES 8-0.

- **Topic: COVID related codes**

Discussion: Smits reviewed the summary document. A member expressed concern that the line containing COVID diagnoses and treatment did not contain COVID in the line title. The subcommittee changed the line title to better reflect that COVID-19 is included on that line. There was some discussion about whether COVID-19 should be separated from influenza and made into a higher priority line; however, this discussion was tabled until a later date. The ICD-10-CM code for viral pneumonia due to COVID-19 was placed on line 399 rather than on the viral pneumonia line as proposed by staff to keep all COVID-19 related diagnoses together.

Smits reviewed the handout that was sent to members the day prior to the meeting, which included several last-minute COVID-19 related code additions. There was no discussion about these items.

Recommended Actions:

These changes are effective 2/1/2021

1) Rename line 399 INFLUENZA, COVID-19 AND OTHER NOVEL RESPIRATORY ~~VIRUSES~~ VIRAL ILLNESS
2) Advise HSD to place CPT 87428 (Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative; severe acute respiratory syndrome coronavirus (eg, SARS-CoV, SARS-CoV-2 [COVID-19]) and influenza virus types A and B) and HCPCS C9803 (Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19])) to the DIAGNOSTIC PROCEDURES file
3) Advice HSD to place ICD10 Z11.52 (Encounter for screening for COVID-19) on the DIAGNOSTIC WORKUP FILE
4) Add CPT 91302 (Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, 5x1010 viral particles/0.5mL dosage, for intramuscular use), 0021A (Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, 5x1010 viral particles/0.5mL dosage; first dose) and 0022A (second dose) and ICD-10 Z20.822 (Contact with and (suspected) exposure to COVID-19) to line 3 PREVENTION SERVICES WITH EVIDENCE OF EFFECTIVENESS
5) Advise HSD to place ICD-10 Z86.16 (Personal history of COVID-19) on the INFORMATIONAL DIAGNOSES file
6) Add ICD-10 J12.82 (Pneumonia due to coronavirus disease 2019) to line 399 INFLUENZA, COVID-19 AND OTHER NOVEL RESPIRATORY ~~VIRUSES~~ VIRAL ILLNESS
7) Add M35.89 (Other specified systemic involvement of connective tissue) to line 73 DERMATOMYOSITIS, POLYMYOSITIS
8) Add ICD-10 M35.81 (Multisystem inflammatory syndrome (MIS)) to line 399 INFLUENZA, COVID-19 AND OTHER NOVEL RESPIRATORY ~~VIRUSES~~ VIRAL ILLNESS
9) Modify GN106 as shown as shown in Appendix A

MOTION: To recommend the code, guideline, and line title changes as amended. CARRIES 7-0.
(Absent: Dehen)

- **Topic: Expanded carrier screening (ECS)**

Discussion: Smits reviewed the summary document.

Public testimony:

Taylor Kane: Kane introduced herself as a carrier of a rare X-linked genetic disorder. She was diagnosed as a carrier at the age of 3 when her father was diagnosed with the disease as an adult. Any children she has will have a 50/50 chance of inheriting her affected X chromosome. Ms. Kane affirmed that knowing her status has helped her make decisions about family planning. Carriers of genetic conditions have long faced obstacles in getting genetic testing to make decisions. Women face barriers to informed and knowledge about getting testing for genetic disease. Ms. Kane founded an organization in 2017 for women to get access to genetic screening. Knowing your genetic status prior to having children allows knowledgeable decisions about reproduction and Ms. Kane stated that she believes all women should have access to ECS regardless of their income level or source of health insurance. The emotional toll and financial toll of having a child with a genetic condition are high. Ms. Kane spoke about the disparities of women of color getting tested for genetic conditions.

Adria Decker: Ms. Decker identified herself as a geneticist and lawyer who is employed by the state but stated she is testifying as a family member of a person with an X-linked genetic disease that was identified through ECS. Her sister is a genetic carrier. Ms. Decker's nephew has a severe genetic illness, diagnosed at 18 months with a post-natal genetic screen. Ms. Decker waited eight months to see a geneticist; her private insurance covered her genetic testing and determined she is not a carrier. Had her sister been able to obtain ECS as a routine part of family planning, Ms. Decker stated her family would not have spent the first 18 months of her nephew's life trying to figure out what was wrong. Ms. Decker stated that information is power and that we must trust women to make decisions for their reproductive health. Making expanded carrier screening would not mandate it but would give women another tool in their toolbox.

Peggy Flanigan: Ms. Flanigan described how 34 years ago, during her first pregnancy, she and her husband were worried--Ms. Flanigan's two nephews had developmental delays and they wondered if that was a coincidence. Ms. Flanigan had a daughter without any developmental delays. After Ms. Flanigan's sister had a third son with developmental delays, the family learned that the three boys had fragile X. Upon greater testing, it was determined that Ms. Flanigan and all her sisters were carriers. The couple received genetic counseling and they now keep up with the literature to continue to monitor their family's health. Ms. Flanigan said their awareness of this family condition led to their decision to not have any more children. All patients need timely and accurate information to be able to care for themselves and their families.

Mike Flanigan: Mr. Flanigan continued Ms. Flanigan's testimony. Mr. Flanigan said they appreciate that Fragile X is now a covered prenatal screening test and said that the earlier a family can be aware of a condition, the better people are able to manage symptoms. He

compared ECS to cholesterol testing or other bloodwork, saying ECS is similarly a preventive test that people should be able to use to make health decisions. As genetics is changing rapidly, expanded carrier screening can keep up with changing tests. Providers would only offer tests they feel comfortable with. They strongly recommend expanded carrier screening.

Devki Nagar: Ms. Nagar is an employee of Myriad Genetics, a genetic counselor, and representative of the Coalition for Access to Prenatal Screening (CAPS). She said that the core goal of prenatal care is identification of higher risk pregnancies, and current ethnicity-based screening creates bias. Providers have ability to screen for multiple conditions in one test. ACOG has two committee opinions (#690 and #691) that address carrier screening. Expanded carrier screening is an acceptable approach per ACOG, if conditions included in the screen meet certain criteria. A Blue Cross and Blue Shield Technology Evaluation Center (BCBS TEC) assessment found that expanded carrier screening improved health outcomes [*Editor's note: This is a proprietary document*]. Coverage of ECS would not require providers to order them. Moving to pan-ethnic screening would make more equitable coverage for OHP patients. Nagar requested that the Commission cover the conditions in listed in ACOG committee opinions #690 and #691.

Michelle Erskine: Ms. Erskine is the mother of three, including a son with a rare X-linked condition. She discovered that several of her brothers also had this condition, but it was not diagnosed due to the fact that there was no knowledge of the condition when they were born. Ms. Erskine said that sometimes carriers express only mild symptoms of conditions. She said it is important that of women of all backgrounds have access to expanded carrier screening. Improvements in genetic testing have made this type of testing more affordable and more education of patients is available than in the past. Ms. Erskine was in favor of expanded carrier screening.

VBBS discussion:
There was discussion about the challenging nature of this topic due to the heterogeneous information generated by this testing, heterogeneous provider opinions, and heterogeneous patient populations who may or may not want testing. There was also a question of whether expanded carrier screening would address equity issues in prenatal testing. Olson noted that the HERC's Genetics Advisory Panel has twice recommended coverage of ECS.

Members expressed concern about not having the infrastructure in Oregon to counsel patients regarding their results if we broadly screen women. There was concern that general maternity care providers were not asking for this coverage.

There was agreement with the staff recommendation to strike out the requirement to be of Ashkenazi Jewish heritage to receive testing for conditions related to Ashkenazi Jewish ancestry.

There was discussion that the large gene panels in ECS give results that providers do not know what to do with, which causes patient anxiety. However, a member mentioned that providers do not need to order ECS if they are not comfortable with counseling regarding the findings. Adding coverage simply provides the opportunity for use. If providers order different types of screening based on comfort level, that equity would actually be reduced, not improved.

It was noted that if a patient or family has a known genetic disorder or a concerning family history for a possible genetic disorder, that genetic testing is covered.

The final decision was to continue non-coverage of ECS and remove requirement for Ashkenazi Jewish heritage prior to certain screening in the prenatal genetic testing guideline. Staff will consult with GAP regarding removing family history requirements for fragile X testing and the requirement for coming from a high-risk population prior to Tay-Sacks screening. Similar changes might need to be considered in the non-prenatal genetic testing guideline.

Recommended Actions:

1) Modify GN173 as shown in Appendix A
2) Modify Diagnostic Guideline D17 as shown in Appendix A

MOTION: To recommend the guideline note changes as presented. CARRIES 5-0. *(Abstained: Allen, Dehen, Collins)*

- **Topic: Biofeedback**

Discussion: Smits reviewed the summary document. Duty expressed support for the urinary incontinence-related changes. Hodges supported all the staff recommendations.

Recommended Actions:

1) Add CPT 90875 and 90876 (Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy) and 90901 (Biofeedback training by any modality) to line 662/GN173 as shown in Appendix A
2) Add the following biofeedback CPT codes to lines 410 MIGRAINE HEADACHES and 540 TENSION HEADACHES
    a. CPT 90875 Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); 30 minutes
    b. CPT 90876 Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); 45 minutes
    c. CPT 90901 Biofeedback training by any modality
3) Modify Statement of Intent 1 as shown in Appendix A
4) Remove CPT 90912 (Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; initial 15 minutes of one-on-one physician or other qualified health care professional contact with the patient) and CPT (90913 Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; each additional 15 minutes) from line 455 URINARY INCONTINENCE
5) Modify GN 47 and GN 192 as shown in Appendix A
6) Modify GN 50 as shown in Appendix A

7) Place CPT 90912 and 90913 on line 662/GN173 as shown in Appendix A

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

- **Topic: Acupuncture for substance use disorders (SUD)**

Discussion: Smits reviewed the summary document. Dehen noted that it is difficult to study acupuncture for SUD as SUD is a very broad field encompassing nicotine to opioids. Dehen agreed that acupuncture helps the anxiety that occurs during treatment for SUD, and helps patients access the other behaviors that can lead to sobriety. However, she would like to see a drill down on what types of substance and types of patients who would benefit. Gingerich noted that mental health parity makes it difficult to put in limits for SUD benefits. Collins noted that his clinic for SUD offers acupuncture. His clinic has found this to be helpful with pain management to address the pain that a patient has as an alternative to medication.

There was a friendly amendment to add the line 4 to the list of lines referenced by the acupuncture guideline.

Recommended Actions:
1) Modify GN92 as shown in Appendix A
2) Add GN92 to line 4 SUBSTANCE USE DISORDER

MOTION: To recommend the guideline note changes as modified. CARRIES 8-0.

- **Topic: Localized treatments for prostate cancer**

Discussion: Smits reviewed the summary document. Duty agreed with the staff recommendations and felt that these were very appropriate recommendations supported by NCCN.

Recommended Actions:
1) Remove CPT 52649 (Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)) from line 329 CANCER OF PROSTATE GLAND
2) Remove CPT 96570 and 96571 (Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s)) from line 329 CANCER OF PROSTATE GLAND
3) Add CPT 55875 (Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy) to line 662/GN173 as shown in Appendix A

MOTION: To recommend the code and guideline note changes as presented. CARRIES 7-0. *(Absent: Allen)*

- **Topic: Hybrid artificial disc replacement with fusion**

  Discussion: Smits reviewed the summary document. There was no discussion.

  Recommended Actions:
  1) Modify GN 101 as shown in Appendix A

  MOTION: To recommend the guideline note changes as presented. CARRIES 7-0. *(Absent: Allen)*

- **Topic: Clarification of coverage of replacement of spinal cord stimulators**

  Discussion: Smits reviewed the summary document. There was a question about why "under warranty" was included. Hodges replied that if the device is under warranty, then the replacement was covered by the manufacturer.

  It was noted that three of the CPT codes for revision of spinal cord stimulators needed to be removed from the complications lines and added to the back surgery lines to allow the guideline to apply to those procedures. The subcommittee requested that staff make this modification to the staff recommendations.

  Recommended Actions:
  1) Remove CPT 63663 (Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed), 63664 (Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed) and 63688 (Revision or removal of implanted spinal neurostimulator pulse generator or receiver) from lines 285 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT and 424 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT and add to lines 292 NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS, 346 CONDITIONS OF THE BACK AND SPINE WITH URGENT SURGICAL INDICATIONS, and 529 CONDITIONS OF THE BACK AND SPINE WITHOUT URGENT SURGICAL INDICATIONS.
  2) Revise GN 178 as shown in Appendix B

  MOTION: To recommend the code and guideline note changes as amended. CARRIES 7-0. *(Absent: Allen)*

- **Topic: Stereotactic body radiation therapy and stereotactic radiosurgery**

  Discussion: Smits reviewed the summary document. There was no discussion.

  Recommended Actions:
  1) Remove CPT 77432 (Stereotactic radiation treatment management of cranial lesion(s)) from all lines not involving cranial lesions

a. 71 NEUROLOGICAL DYSFUNCTION IN BREATHING, EATING, SWALLOWING, BOWEL, OR BLADDER CONTROL CAUSED BY CHRONIC CONDITIONS; ATTENTION TO OSTOMIES
b. 157 CANCER OF COLON, RECTUM, SMALL INTESTINE AND ANUS
c. 199 CANCER OF SOFT TISSUE
d. 214 CANCER OF KIDNEY AND OTHER URINARY ORGANS
e. 215 CANCER OF STOMACH
f. 229 MALIGNANT MELANOMA OF SKIN
g. 259 CANCER OF ENDOCRINE SYSTEM, EXCLUDING THYROID; CARCINOID SYNDROME
h. 262 CANCER OF LUNG, BRONCHUS, PLEURA, TRACHEA, MEDIASTINUM AND OTHER RESPIRATORY ORGANS
i. 276 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA
j. 287 CANCER OF ORAL CAVITY, PHARYNX, NOSE AND LARYNX
k. 315 CANCER OF LIVER
l. 316 CANCER OF PANCREAS
m. 317 STROKE
n. 372 BENIGN NEOPLASM OF RESPIRATORY AND INTRATHORACIC ORGANS
o. 434 CANCER OF GALLBLADDER AND OTHER BILIARY
p. 592 SECONDARY AND ILL-DEFINED MALIGNANT NEOPLASMS

MOTION: To recommend the code changes as presented. CARRIES 7-0. *(Absent: Allen)*

- **Topic: Artificial hearts**

Discussion: Smits reviewed the summary document. There was no discussion.

Recommended Actions:
1) Modify GN173 as shown in Appendix A

MOTION: To recommend the guideline note changes as presented. CARRIES 7-0. *(Absent: Allen)*

- **Topic: Computer assisted bronchoscopy**

Discussion: Smits reviewed the summary document. There was no discussion.

Recommended Actions:
1) Modify GN173 as shown in Appendix A

MOTION: To recommend the guideline note changes as presented. CARRIES 7-0. *(Absent: Allen)*

- **Public Comment:**

No additional public comment was received.

- **Issues for next meeting:**
  - Oncotype Dx for prostate cancer
  - Inguinal/femoral hernia repair

- **Next meeting:**

  March 11, 2021 virtual meeting.

- **Adjournment:**

  The meeting adjourned at 12:45 PM.

Appendix A
Revised Guideline Notes

STATEMENT OF INTENT 1: PALLIATIVE CARE

It is the intent of the Commission that palliative care services are covered for patients with a life-threatening or serious progressive illness to alleviate symptoms and improve quality of life.

Palliative care services should include culturally appropriate discussions and medical decision making aligned with patient's personal goals of therapy, assessment of symptom burden, assistance with advance care planning, care coordination, emotional, psychosocial and spiritual support for patients and their families. Palliative care services may be provided concurrently with life prolonging/curative treatments.

Some examples of services associated with an encounter for palliative care (ICD-10 Z51.5) that should be available to patients without regard to Prioritized List line placement:

A) Inpatient palliative care consultations
   1) Hospital Care E&M (CPT 99218-99233)
B) Outpatient palliative care consultations provided in either the office or home setting
   1) E&M Services (CPT 99201-99215)
   2) Transitional Care Management Services (CPT 99495-6)
   3) Advance Care Planning (CPT 99497-8)
   4) Chronic Care Management (CPT 99487-99490)
C) Psychological support and grief counseling (CPT 99201-99215)
D) Medical equipment and supplies for the management of symptomatic complications or support activities of daily living
E) Medications or acupuncture to reduce pain and symptom burden
F) Surgical procedures or therapeutic interventions (for example, palliative radiation therapy) to relieve pain or symptom burden
G) Biofeedback (CPT 90875, 90876, 90901) for treatment of cancer pain

Other services associated with palliative care includes:

A) Social Work
B) Clinical Chaplain/ Spiritual Care
C) Care Coordination

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 PATIENT-CENTERED CARE OF ADVANCED CANCER.

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ANCILLARY GUIDELINE A5, TELEHEALTH, TELECONSULTATIONS AND ONLINE/TELEPHONIC SERVICES
Telehealth services include a variety of health services provided by synchronous or asynchronous electronic communications, including secure electronic health portal, audio, or audio and video as well as remote monitoring devices.

Criteria for coverage

The clinical value of the telehealth service delivered must reasonably approximate the clinical value of the equivalent services delivered in-person.

Coverage of telehealth services requires the same level of documentation, medical necessity, and coverage determinations as in-person visits. Specifically, covered telehealth services must meet all of the following criteria.

A) Documentation must include all of the following:
   1) use model SOAP charting, or as described in program's OAR;
   2) include patient history, provider assessment, treatment plan and follow-up instructions;
   3) support the assessment and plan;
   4) retain encounter in the patient's medical record and be retrievable.
B) Include medical decision making or service delivery (e.g. behavioral health intervention/psychotherapy, other forms of therapy).
C) Include permanent storage (online or hard copy) of the encounter.
D) Meet applicable HIPAA standards for privacy and security, except for regulations for which federal authorities are exercising enforcement discretion. (Certain requirements for encryption will not be enforced by federal authorities (or required by OHP) during the COVID-19 emergency.) This means services such as Facetime, Skype or Google Hangouts can be used for service delivery. See https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html for details.) HIPAA compliant platforms should be used whenever possible.
E) Include patient-clinician agreement of informed consent, discussed with and agreed to by the patient and documented in the medical record.

Examples of reimbursable telephone or online services include but are not limited to:

A) Extended counseling when person-to-person contact would involve an unwise delay or exposure to infectious disease.
B) Treatment of relapses that require significant investment of provider time and judgment.
C) Counseling and education for patients with complex chronic conditions.

Examples of non-reimbursable telehealth services include but are not limited to:

A) Prescription renewal.
B) Scheduling a test.
C) Reporting normal test results.
D) Requesting a referral.
E) Services which are part of care plan oversight or anticoagulation management (CPT codes 99339-99340, 99374-99380 or 99363-99364).

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F) Services which relate to or take place within the postoperative period of a procedure provided by the physician are not separately covered. (Such a service is considered part of the procedure and is not be billed separately.)

Telehealth services billed using in-person codes

Telehealth services described in this section are synchronous services, generally provided with both audio and video capability and billed with the same procedure codes that would be billed for in-person services, with mode of delivery indicated by the use of specific modifiers and/or place of service codes specified by the plan. Telephone visits are an acceptable replacement for the equivalent service provided by synchronous audio and video, if synchronous audio and video capabilities are not available or feasible.

The patient may be in the community or in a health care setting. The provider may be in any location in which appropriate privacy can be ensured. If language services are provided, the interpreter may be in any location in which appropriate privacy can be ensured.

Codes eligible for telehealth delivery billed in this manner include 90785, 90791, 90792, 90832-90834, 90836, 90837-90840, 90846, 90847, 90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961, 90963, 90964-90970, 96116, 96156-96171, 96160, 96161, 97802-97804, 99201-99205, 99211-99215, 99231-99233, 99307-99310, 99354-99357, 99406-99407, 99495-99498, G0108-G0109, G0270, G0296, G0396, G0397, G0406-G0408, G0420, G0421, G0425-G0427, G0438-G0439, G0442-G0447, G0459, G0506, G0508, G0509, G0513, G0514, G2086-G2088. Additional codes are covered when otherwise appropriate according to this guideline note and other applicable coverage criteria.

The originating site code Q3014 is covered only when the patient is present in an appropriate health care setting and receiving services from a provider in another location.

Telehealth services are covered for inpatient, outpatient and emergency services for new or established patients.

Clinician to Patient Services billed using specified codes indicating telephone or online service delivery

Telephonic and online services, including services related to diagnostic workup (CPT 98966-98968, 99441-99443, 99421-99423, 98970-98972, ~~G2010,~~ G2012, G2061-G2063, G2251-G2253) are covered for services for new and established patients.

Covered telephone and online services billed using these codes do not include either of the following:

A) Services related to a service performed and billed by the physician or qualified health professional within the previous seven days, regardless of whether it is the result of patient-initiated or physician-requested follow-up.
B) Services which result in the patient being seen within 24 hours or the next available appointment.

Clinician-to-Clinician Consultations (telephonic, online or using electronic health record)

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Coverage of interprofessional consultations delivered online, through electronic health records or by telephone is included as follows:

Consulting Providers (CPT 99451, 99446-99449)

A) For new or established patients.
B) Consult must be requested by another provider.
C) Can be for a new or an exacerbated condition.
D) Cannot be reported more than 1 time per 7 days for the same patient.
E) Must report cumulative time spent, even if time occurs over multiple days.
F) Cannot be reported if a transfer of care or request for face-to-face visit occurs as a result of the consultation within the following 14 days.
G) Cannot be reported if the patient was seen by the consultant within the past 14 days.
H) The request and reason for consultation is documented in the patient's medical record.
I) Requires a minimum of 5 minutes of medical consultation, discussion and/or review.

Requesting Providers (CPT 99452)

A) Consult must be reported by requesting provider. (not for the transfer of a patient or request for face-to-face consult)
B) Reported only when the patient is not on-site with the requesting provider at the time of consultation.
C) Cannot be reported more than 1 time per 14 days per patient.
D) Requires a minimum of 16 minutes. Includes time for referral prep and/or communicating with the consultant.
E) Can be reported with prolonged services, non-direct.

DIAGNOSTIC GUIDELINE D17, PRENATAL GENETIC TESTING

The following types of prenatal genetic testing and genetic counseling are covered for pregnant women:

A) Genetic counseling (CPT 96040, HPCPS S0265) for high-risk women who have family history of inheritable disorder or carrier state, ultrasound abnormality, previous pregnancy with aneuploidy, or elevated risk of neural tube defect.
B) Genetic counseling (CPT 96040, HPCPS S0265) prior to consideration of chorionic villus sampling (CVS), amniocentesis, microarray testing, Fragile X, and spinal muscular atrophy screening
C) Validated questionnaire to assess genetic risk in all pregnant women
D) Screening high-risk ethnic groups for hemoglobinopathies (CPT 83020, 83021)
E) Screening for aneuploidy with any of six screening strategies [first trimester (nuchal translucency, beta-HCG and PAPP-A), integrated, serum integrated, stepwise sequential, contingency, and cell free fetal DNA testing] (CPT 76813, 76814, 81508, -81510, 81511, 81420, 81507, 81512, 82105, 82677,84163)
F) Ultrasound for structural anomalies between 18 and 20 weeks gestation (CPT 76811, 76812)
G) CVS or amniocentesis (CPT 59000, 59015, 76945,76946, 82106, 88235, 88261-88264, 88267, 88269, 88280, 88283, 88285, 88289,88291) for a positive aneuploidy screen, maternal age >34, fetal structural anomalies, family history of inheritable chromosomal disorder or elevated risk of neural tube defect.

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H) Array CGH (CPT 81228, 81229) when major fetal congenital anomalies are apparent on imaging, or with normal imaging when array CGH would replace karyotyping performed with CVS or amniocentesis in (H) above.
I) FISH testing (CPT 88271, 88272, 88274, 88275, 81171, 81172) only if karyotyping is not possible due a need for rapid turnaround for reasons of reproductive decision-making (i.e. at 22w4d gestation or beyond)
J) Screening for Tay-Sachs carrier status (CPT 81255) in high-risk populations. First step is hex A, and then additional DNA analysis in individuals with ambiguous Hex A test results, suspected variant form of TSD or suspected pseudodeficiency of Hex A
K) Screening for cystic fibrosis carrier status once in a lifetime (CPT 81220-81224)
L) Screening for fragile X status (CPT 81243, 81244, 81171. 81172) in patients with a personal or family history of
    a. fragile X tremor/ataxia syndrome
    b. premature ovarian failure
    c. unexplained early onset intellectual disability
    d. fragile X intellectual disability
    e. unexplained autism through the pregnant woman's maternal line
M) Screening for spinal muscular atrophy (CPT 81329) once in a lifetime
N) Screening ~~those with Ashkenazi Jewish heritage~~ for Canavan disease (CPT 81200), familial dysautonomia (CPT 81260), and Tay-Sachs carrier status (CPT 81255). Ashkenazi Jewish carrier panel testing (CPT 81412) is covered if the panel would replace and would be of similar or lower cost than individual gene testing including CF carrier testing.
O) Expanded carrier screening only for those genetic conditions identified above

The following genetic screening tests are not covered:
A) Serum triple screen
B) Expanded carrier screening which includes results for conditions not explicitly recommended for coverage

The development of this guideline note was informed by a HERC coverage guidance. See https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Evidence-based-Reports.aspx.

GUIDELINE NOTE 47, URINARY INCONTINENCE

Line 455

Surgery for genuine stress urinary incontinence may be indicated when all of the following are documented (A-G):
A) Patient history of (1, 2, and 3):
    1) Involuntary loss of urine with exertion
    2) Identification and treatment of transient causes of urinary incontinence, if present (e.g., delirium, infection, pharmaceutical causes, psychological causes, excessive urine production, restricted mobility, and stool impaction)
    3) Involuntary loss of urine on examination during stress (provocative test with direct visualization of urine loss) and low or absent post void residual
B) Patient's voiding habits
C) Physical or laboratory examination evidence of either (1 or 2):

1) Urethral hypermobility
2) Intrinsic sphincter deficiency

D) Diagnostic workup to rule out urgency incontinence
E) Negative preoperative pregnancy test result unless patient is postmenopausal or has been previously sterilized
F) Nonmalignant cervical cytology, if cervix is present
G) Patient required to have 3 months of alternative therapy (e.g., pessaries or physical therapy, including bladder training~~,~~ and/or pelvic floor exercises ~~and/or biofeedback~~, as available). If limited coverage of physical therapy is available, patients should be taught pelvic floor exercises by their treating provider, physical therapist or trained staff, and have documented consistent practice of these techniques over the 3 month period.

GUIDELINE NOTE 50, PELVIC ORGAN PROLAPSE SURGERY

Line 466

Hysterectomy, cystocele repair, and/or other surgery for pelvic organ prolapse may be indicated when all of the following are documented (A-E):

A) Patient history of symptoms of pelvic prolapse such as:
   1) Complaints of the pelvic organs prolapsing at least to the introitus, and one or more of the following:
      b) Low back discomfort or pelvic pressure, or
      c) Difficulty in defecating, or
      d) Difficulty in voiding
B) For hysterectomy
   1) Nonmalignant cervical cytology, if cervix is present, and
   2) Assessment for absence of endometrial malignancy in the presence of abnormal bleeding
C) Physical examination is consistent with patient's symptoms of pelvic support defects indicating either symptomatic prolapse of the cervix, enterocele, cystocele, rectocele or prolapse of the vaginal vault
D) Negative preoperative pregnancy test unless patient is postmenopausal or has been previously sterilized
E) Patient required to have 3 months of alternative therapy (e.g., pessaries or physical therapy, including bladder training~~,~~ and/or pelvic floor exercises ~~and/or biofeedback~~, as available). If limited coverage of physical therapy is available, patients should be taught pelvic floor exercises by their treating provider, physical therapist or trained staff, and have documented consistent practice of these techniques over the 3 month period.

GUIDELINE NOTE 92, ACUPUNCTURE

Lines 1,4,5,92,111,112,114,125,129,133,135,157,158,191,199-202,208,210,214,215,229,234,237, 238,258,259,261,262,271,276,286,287,294,314-316,329,342,361,372,396,397,401,402,409,410,420, 434,461,463,538,540,558

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.

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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 session 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 4 SUBSTANCE USE DISORDER

Acupuncture is included on this line only when used as part of a program that offer patients a variety of evidence-based interventions including behavioral interventions, social support, and Medication Assisted Treatment (MAT), as appropriate.

Line 5 TOBACCO DEPENDENCE

Acupuncture is included on this line for a maximum of 12 sessions per quit attempt up to two quit attempts per year; additional sessions may be authorized if medically appropriate.

Lines 92, 111, 112, 114, 125, 129, 133, 135, 157, 158, 191, 199, 200, 208, 210, 214, 215, 229, 234, 237, 238, 258, 259, 261, 262, 271, 276, 286, 287, 294, 314, 315, 316, 329, 342, 372, 396, 397, 420, 434 and 558

Acupuncture is paired only with the ICD-10 code G89.3 (Neoplasm related pain (acute) (chronic)) when there is active cancer and limited to 12 total sessions per year; patients may have additional visits authorized beyond these limits if medically appropriate.

Line 201 CHRONIC ORGANIC MENTAL DISORDERS INCLUDING DEMENTIAS

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; patients may have additional visits authorized beyond these limits if medically appropriate.

Line 361 SCOLIOSIS

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

Line 402 CONDITIONS OF THE BACK AND SPINE

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

Line 410 MIGRAINE HEADACHES

Acupuncture pairs on Line 410 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 463 OSTEOARTHRITIS AND ALLIED DISORDERS

Acupuncture pairs on Line 463 for osteoarthritis of the knee only (ICD-10-CM M17), for up to 12 sessions per year.

*Line 540 TENSION HEADACHES

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Acupuncture is included on Line 540 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 https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Evidence-based-Reports.aspx

*Below the current funding line.

GUIDELINE NOTE 101, ARTIFICIAL DISC REPLACEMENT

Lines 346,529

Artificial disc replacement (CPT 22856-22865) is included on ~~these lines~~ line 346 as an alternative to fusion only when all of the following criteria are met:

Lumbar artificial disc replacement

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

Cervical artificial disc replacement

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

Otherwise, artificial disc replacement is included on line 529.

Artificial disc replacement combined with fusion in a single procedure (hybrid procedure) is not covered.

The development of this guideline note was informed by a HERC coverage guidance. See http://www.oregon.gov/oha/herc/Pages/blog-artificial-disc-replace.aspx

GUIDELINE NOTE 106, PREVENTIVE SERVICES

Lines 3,622

Included on Line 3 are the following preventive services:

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A) US Preventive Services Task Force (USPSTF) "A" and "B" Recommendations in effect and issued prior to January 1, 2020.
   1) http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/
      a) Treatment of falls prevention with exercise interventions is included on Line 292.
   2) USPSTF "D" recommendations are not included on this line or any other line of the Prioritized List.

B) American Academy of Pediatrics (AAP) Bright Futures Guidelines:
   1) http://brightfutures.aap.org. Periodicity schedule available at http://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity Schedule_FINAL.pdf.
   2) Screening for lead levels is defined as blood lead level testing and is indicated for Medicaid populations at 12 and 24 months. In addition, blood lead level screening of any child between ages 24 and 72 months with no record of a previous blood lead screening test is indicated.

C) Health Resources **and Services Administration (HRSA) Women's Preventive Services-Required Health Plan Coverage Guidelines a**s updated by HRSA in December 2019. Available at https://www.hrsa.gov/womens-guidelines-2019 as of September 4, 2020.

D) Immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP): http://www.cdc.gov/vaccines/schedules/hcp/index.html or approved for the Oregon Immunization Program: https://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/ImmunizationProviderResources/Documents/DMAPvactable.pdf
   1) COVID-19 vaccines are intended to be included on this line even if the specific administration code(s) do not yet appear on the line when the vaccine has both 1) FDA approval or FDA emergency use authorization (EUA) and 2) ACIP recommendation.

Colorectal cancer screening is included on Line 3 for average-risk adults aged 50 to 75, using one of the following screening programs:

A) Colonoscopy every 10 years
B) Flexible sigmoidoscopy every 5 years
C) Fecal immunochemical test (FIT) every year
D) Guaiac-based fecal occult blood test (gFOBT) every year

Colorectal cancer screening for average-risk adults aged 76 to 85 is covered only for those who

A) Are healthy enough to undergo treatment if colorectal cancer is detected, and
B) Do not have comorbid conditions that would significantly limit their life expectancy.

The development of this guideline note was informed by a HERC coverage guidance. See https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Evidence-based-Reports.aspx

GUIDELINE NOTE 178, SPINAL CORD STIMULATOR THERAPY

Lines 292,346,529

A spinal cord stimulator trial is included on Lines 292 and 346 only when a patient meets all of the following criteria:

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A) The patient has moderate to severe (>5 on the VAS pain scale) neuropathic pain and objective neurologic impairment with documented pathology related to pain complaint (i.e. abnormal MRI). Neurologic impairment is defined as objective evidence of one or more of the following:
   1) Markedly abnormal reflexes
   2) Segmental muscle weakness
   3) Segmental sensory loss
   4) EMG or NCV evidence of nerve root impingement
   5) Cauda equina syndrome
   6) Neurogenic bowel or bladder
   7) Long tract abnormalities; AND

B) The patient has failed 12 or more months of other treatment modalities (e.g. pharmacological, surgical, physical therapy, cognitive therapy, and activity lifestyle modification); AND

C) The patient has had an evaluation by a mental health provider (e.g., a face-to-face assessment with or without psychological questionnaires and/or psychological testing) which revealed no evidence of an inadequately controlled mental health problem (e.g., alcohol or drug dependence, depression, psychosis) and the patient receives written clearance from the mental health provider for device placement.

Implantation of a spinal cord stimulator is included on Lines 292 and 346 when the trial criteria above are met and the patient experienced significant pain reduction (50% or more) with a 3 to 7 day trial of percutaneous spinal stimulation.

Spinal cord stimulation (CPT 63650-63688) is not included on Line 292 when paired with ICD-10-CM category G90.5 Complex regional pain syndrome/reflex sympathetic dystrophy.

Replacement of a spinal cord stimulator is included on lines 292 and 346 only for patients who

1) meet the criteria for initial insertion above; AND
2) have experienced significant pain reduction (50% or more) with the stimulator prior to its malfunction; AND
3) and the existing stimulator is no longer under warranty and cannot be repaired.

Otherwise, spinal cord stimulation therapy is included on Line 529.

GUIDELINE NOTE 192, SACRAL NERVE STIMULATION FOR URINARY CONDITIONS

Lines 327,455

Sacral nerve stimulation is included on these lines only for urinary incontinence, non-obstructive urinary retention, and overactive bladder AND only when all of the following criteria are met:

A) The patient has had symptoms for at least 12 months and the condition has resulted in significant disability (the frequency and/or severity of symptoms are limiting the member's ability to participate in daily activities); AND

B) Documented failure or intolerance to pharmacotherapies and behavioral treatments (e.g., pelvic floor exercise, ~~biofeedback,~~ timed voids, and fluid management) and, for non-obstructive urinary retention, intermittent catheterization; AND

C) The patient must be an appropriate surgical candidate such that implantation with anesthesia can occur; AND

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D) The patient does not have stress incontinence, urinary obstruction, or specific neurologic diseases (e.g., diabetes with peripheral nerve involvement, spinal cord injury, or multiple sclerosis); AND

E) Patient must have had a successful test stimulation, defined as a 50% or greater improvement in symptoms.

GUIDELINE NOTE 173, INTERVENTIONS THAT ARE UNPROVEN, HAVE NO CLINICALLY IMPORTANT BENEFIT OR HAVE HARMS THAT OUTWEIGH BENEFITS FOR CERTAIN CONDITIONS

Line 662

The following Interventions are prioritized on Line 662 CONDITIONS FOR WHICH CERTAIN INTERVENTIONS ARE UNPROVEN, HAVE NO CLINICALLY IMPORTANT BENEFIT OR HAVE HARMS THAT OUTWEIGH BENEFITS:

Procedure Code	Intervention Description	Rationale	Last Review
C1825	Generator, neurostimulator (implantable), non-rechargeable with carotid sinus baroreceptor stimulation lead(s)	Insufficient evidence of effectiveness	January 2021
C9771	Nasal/sinus endoscopy, cryoablation nasal tissue(s) and/or nerve(s), unilateral or bilateral	Insufficient evidence of effectiveness	January 2021
C9772-C9775	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies), with intravascular lithotripsy	Insufficient evidence of effectiveness	January 2021
G2010, G2250	Remote assessment of recorded video and/or images	Clinical value not established	January 2021
31627	Computer assisted bronchoscopy	Insufficient evidence of effectiveness	~~December, 2009~~ January 2021
33927-33929	Total artificial heart	Unproven treatment	~~November, 2017~~ January 2021
55875	Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy	Insufficient evidence of effectiveness	January 2021
81443	Expanded carrier screening	Insufficient evidence of effectiveness	~~November, 2018~~ January 2021
~~82610~~	~~Cystatin~~	~~Insufficient evidence of effectiveness~~	~~October, 2020~~
90875-90876	Individual psychophysiological therapy incorporating biofeedback	Insufficient evidence of effectiveness	January 2021

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Procedure Code	Intervention Description	Rationale	Last Review
90901	training by any modality Biofeedback training by any modality		
90912-90913	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed	Insufficient evidence of effectiveness	January 2021

HCPC	LONG DESCRIPTION	Suggested Placement
C1062	Intravertebral body fracture augmentation with implant (e.g., metal, polymer)	478 CLOSED DISLOCATIONS/FRACTURES OF NON-CERVICAL VERTEBRAL COLUMN WITHOUT NEUROLOGIC INJURY OR STRUCTURAL INSTABILITY
C1825	Generator, neurostimulator (implantable), non-rechargeable with carotid sinus baroreceptor stimulation lead(s)	662 CONDITIONS FOR WHICH CERTAIN INTERVENTIONS ARE UNPROVEN, HAVE NO CLINICALLY IMPORTANT BENEFIT OR HAVE HARMS THAT OUTWEIGH BENEFITS
C9770	Vitrectomy, mechanical, pars plana approach, with subretinal injection of pharmacologic/biologic agent	95 DIABETIC AND OTHER RETINOPATHY 139 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE 247 RETAINED INTRAOCULAR FOREIGN BODY, MAGNETIC AND NONMAGNETIC 279 RETINAL DETACHMENT AND OTHER RETINAL DISORDERS 285 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT 299 VITREOUS DISORDERS 318 PURULENT ENDOPHTHALMITIS 348 MILD/MODERATE BIRTH TRAUMA FOR BABY 360 CHORIORETINAL INFLAMMATION 383 CENTRAL SEROUS CHORIORETINOPATHY 424 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
C9771	Nasal/sinus endoscopy, cryoablation nasal tissue(s) and/or nerve(s), unilateral or bilateral	662 CONDITIONS FOR WHICH CERTAIN INTERVENTIONS ARE UNPROVEN, HAVE NO CLINICALLY IMPORTANT BENEFIT OR HAVE HARMS THAT OUTWEIGH BENEFITS
C9772	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies), with intravascular lithotripsy, includes angioplasty within the same vessel (s), when performed	662 CONDITIONS FOR WHICH CERTAIN INTERVENTIONS ARE UNPROVEN, HAVE NO CLINICALLY IMPORTANT BENEFIT OR HAVE HARMS THAT OUTWEIGH BENEFITS

HCPC	LONG DESCRIPTION	Suggested Placement
C9773	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy, and transluminal stent placement(s), includes angioplasty within the same vessel(s), when performed	662 CONDITIONS FOR WHICH CERTAIN INTERVENTIONS ARE UNPROVEN, HAVE NO CLINICALLY IMPORTANT BENEFIT OR HAVE HARMS THAT OUTWEIGH BENEFITS
C9774	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel (s), when performed	662 CONDITIONS FOR WHICH CERTAIN INTERVENTIONS ARE UNPROVEN, HAVE NO CLINICALLY IMPORTANT BENEFIT OR HAVE HARMS THAT OUTWEIGH BENEFITS
C9775	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel (s), when performed	662 CONDITIONS FOR WHICH CERTAIN INTERVENTIONS ARE UNPROVEN, HAVE NO CLINICALLY IMPORTANT BENEFIT OR HAVE HARMS THAT OUTWEIGH BENEFITS
G0088	Professional services, initial visit, for the administration of anti-infective, pain management, chelation, pulmonary hypertension, inotropic, or other intravenous infusion drug or biological (excluding chemotherapy or other highly complex drug or biological) for each infusion drug administration calendar day in the individual's home, each 15 minutes	All lines with E&M codes
G0089	Professional services, initial visit, for the administration of subcutaneous immunotherapy or other subcutaneous infusion drug or biological for each infusion drug administration calendar day in the individual's home, each 15 minutes	All lines with E&M codes
G0090	Professional services, initial visit, for the administration of intravenous chemotherapy or other highly complex infusion drug or biological for each infusion drug administration calendar day in the individual's home, each 15 minutes	All lines with E&M codes

HCPC	LONG DESCRIPTION	Suggested Placement
G2211	Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)	All lines with E&M codes
G2212	Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to cpt codes 99205, 99215 for office or other outpatient evaluation and management services) (do not report g2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416). (do not report g2212 for any time unit less than 15 minutes)	All lines with E&M codes
G2213	Initiation of medication for the treatment of opioid use disorder in the emergency department setting, including assessment, referral to ongoing care, and arranging access to supportive services (list separately in addition to code for primary procedure)	4 SUBSTANCE USE DISORDER
G2214	Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional	All lines with E&M codes

HCPC	LONG DESCRIPTION	Suggested Placement
G2250	Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment	662 CONDITIONS FOR WHICH CERTAIN INTERVENTIONS ARE UNPROVEN, HAVE NO CLINICALLY IMPORTANT BENEFIT OR HAVE HARMS THAT OUTWEIGH BENEFITS
G2251	Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5?10 minutes of clinical discussion	All lines with E&M codes
G2252	Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	All lines with E&M codes
M0239	Intravenous infusion, bamlanivimab-xxxx, includes infusion and post administration monitoring	399 INFLUENZA, NOVEL RESPIRATORY VIRUSES
M0243	Intravenous infusion, casirivimab and imdevimab includes infusion and post administration monitoring	399 INFLUENZA, NOVEL RESPIRATORY VIRUSES

HCPC	LONG DESCRIPTION	Suggested Placement
U0005	Infectious agent detection by nucleic acid (dna or rna); severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]), amplified probe technique, cdc or non-cdc, making use of high throughput technologies, completed within 2 calendar days from date of specimen collection (list separately in addition to either hcpcs code u0003 or u0004) as described by cms-2020-01-r2	Diagnostic Procedures File

Appendix C
New Guideline Notes

GUIDELINE NOTE XXX, PANNICULECTOMY
Line 625
Panniculectomy (CPT 15830) is included on this line when ALL of the following conditions are met:

1) The pannus hangs at or below the level of the symphysis pubis as evidence by photographs; AND
2) The pannus is causing persistent intertriginous dermatitis, cellulitis, or skin ulceration, which is refractory to at least three months of medical management, including topical antifungals, topical and/or systemic corticosteroids, and/or local or systemic antibiotics; AND
3) There is documented difficulty with ambulation and/or interference with the activities of daily living due to the pannus.

If the procedure is being performed following significant weight loss, in addition to meeting the criteria noted above, there should be evidence that the individual has maintained a stable weight for at least six months. If the weight loss is the result of bariatric surgery, panniculectomy should not be performed until at least 18 months after bariatric surgery and only when weight has been stable for at least the most recent six months.

Panniculectomy is not included on this line for any other indication, including but not limited to when performed primarily for ANY of the following:

1) treatment of neck or back pain; OR
2) improving appearance (i.e., cosmesis); OR
3) treating psychological symptomatology or psychosocial concerns; OR
4) when performed in conjunction with abdominal or gynecological procedures (e.g., abdominal hernia repair, hysterectomy, obesity surgery) unless criteria for panniculectomy are met separately.

GUIDELINE NOTE XXX, PANNICULECTOMY
Line 625
Panniculectomy (CPT 15830) is included on this line when ALL of the following conditions are met:

4) The pannus hangs at or below the level of the symphysis pubis as evidence by photographs; AND
5) The pannus is causing persistent intertriginous dermatitis, cellulitis, or skin ulceration, which is refractory to at least three months of medical management, including topical antifungals, topical and/or systemic corticosteroids, and/or local or systemic antibiotics; AND
6) There is documented difficulty with ambulation and/or interference with the activities of daily living due to the pannus.

If the procedure is being performed following significant weight loss, in addition to meeting the criteria noted above, there should be evidence that the individual has maintained a stable weight for at least six months. If the weight loss is the result of bariatric surgery, panniculectomy should not be performed until at least 18 months after bariatric surgery and only when weight has been stable for at least the most recent six months.

Panniculectomy is not included on this line for any other indication, including but not limited to when performed primarily for ANY of the following:

Appendix C
New Guideline Notes

5) treatment of neck or back pain; OR
6) improving appearance (i.e., cosmesis); OR
7) treating psychological symptomatology or psychosocial concerns; OR
8) when performed in conjunction with abdominal or gynecological procedures (e.g., abdominal hernia repair, hysterectomy, obesity surgery) unless criteria for panniculectomy are met separately.