HEALTH POLICY & ANALYTICS DIVISION
Health Evidence Review Commission
Kate Brown, Governor

Oregon Health Authority

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February 1, 2021

The Honorable Peter Courtney
Senate President
Oregon State Senate
900 Court St. NE, S-201
Salem, OR 97301

The Honorable Tina Kotek
Speaker of the House
Oregon House of Representatives
900 Court St NE, Rm 269
Salem, OR 97301

Dear Senator Courtney and Representative Kotek:

The Health Evidence Review Commission (the Commission) of the Oregon Health Authority's Health Policy & Analytics Division respectfully reports to you, in accordance with ORS 414.690(7), several interim modifications that have been made to the Prioritized List of Health Services (the List) appearing in the Commission's May 2019 Report to the Governor and 80th Oregon Legislative Assembly. Therefore, in accordance with ORS 414.690(8), the Health Evidence Review Commission is writing to report these interim modifications.

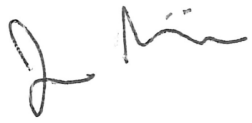
These changes represent technical changes to the List and other changes made due to the release of new billing codes, some of which are related to COVID-19. The remaining changes consist of new HCPCS (procedure) codes, which were released too late to place on the January 1, 2021 Prioritized List. The coding changes are listed in detail in Attachments A and B.

In addition to these changes, the Commission has made changes to practice guidelines and coding specifications associated with these coding changes, and to clarify the intent to cover any new COVID-19 vaccine administration codes that may released prior to the next interim modification. Attachment C contains these revised practice guidelines. Attachment D contains errata to previous lists.

The changes described in this letter are being forwarded to the Health Systems Division which, in consultation with the OHA Actuarial Services Unit, will determine if these changes will involve a significant financial impact under the Medicaid Demonstration. If the changes are found to be within the current funding level of the List, HSD will determine the effective date for these changes, which will be no earlier than February 1, 2021 pending approval by the Centers for Medicare and Medicaid Services. In the event any of these technical changes are determined to impact the funding level of the List as defined by HSD's legislatively authorized budget, we will send a separate notice to you prior to requesting direction from the Joint Ways & Means Committee.

The Health Evidence Review Commission thanks you for the opportunity to continue to serve the citizens of Oregon.

Respectfully submitted,



Jason Gingerich
Director, Health Evidence Review Commission

cc: Health Evidence Review Commission
Patrick Allen, Director, Oregon Health Authority
Dawn Jagger, Chief of Staff, Oregon Health Authority
Lori Coyner, Medicaid Director, Oregon Health Authority
Margie Stanton, Director, Health Systems Division, Oregon Health Authority
Jeremy Vandehey, Director, Health Policy & Analytics Division, Oregon Health Authority
Trilby de Jung, Deputy Director, Health Policy & Analytics Division, Oregon Health Authority
Dana Hargunani, Chief Medical Officer, Oregon Health Authority

ATTACHMENT A

Coding Changes to Condition-Treatment Pairs for the February 1, 2021 Prioritized List of Health Services

Line: 3
Condition: PREVENTION SERVICES WITH EVIDENCE OF EFFECTIVENESS
Treatment: MEDICAL THERAPY

Add:	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
Add:	0022A	second dose
Add:	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
Add:	Z20.822	Contact with and (suspected) exposure to COVID-19

Line: 4
Condition: SUBSTANCE USE DISORDER
Treatment: MEDICAL/PSYCHOTHERAPY

Add:	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)

Line: 73
Condition: DERMATOMYOSITIS, POLYMYOSITIS
Treatment: MEDICAL THERAPY

Add:	M35.89	Other specified systemic involvement of connective tissue

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Line: 95
Condition: DIABETIC AND OTHER RETINOPATHY
Treatment: MEDICAL, SURGICAL, AND LASER TREATMENT

Add:	C9770	Vitrectomy, mechanical, pars plana approach, with subretinal injection of pharmacologic/biologic agent

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Line: 139
Condition: GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
Treatment: MEDICAL, SURGICAL AND LASER TREATMENT

Add:	C9770	Vitrectomy, mechanical, pars plana approach, with subretinal injection of pharmacologic/biologic agent

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Line: 247
Condition: RETAINED INTRAOCULAR FOREIGN BODY, MAGNETIC AND NONMAGNETIC
Treatment: FOREIGN BODY REMOVAL

Add:	C9770	Vitrectomy, mechanical, pars plana approach, with subretinal injection of pharmacologic/biologic agent

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Line: 279
Condition: RETINAL DETACHMENT AND OTHER RETINAL DISORDERS
Treatment: RETINAL REPAIR, VITRECTOMY

Add:	C9770	Vitrectomy, mechanical, pars plana approach, with subretinal injection of pharmacologic/biologic agent

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Line: 285
Condition: COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
Treatment: MEDICAL AND SURGICAL TREATMENT

Add:	C9770	Vitrectomy, mechanical, pars plana approach, with subretinal injection of pharmacologic/biologic agent

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Line: 299
Condition: VITREOUS DISORDERS
Treatment: VITRECTOMY

Add:	C9770	Vitrectomy, mechanical, pars plana approach, with subretinal injection of pharmacologic/biologic agent

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Line: 318
Condition: PURULENT ENDOPHTHALMITIS
Treatment: VITRECTOMY

Add:	C9770	Vitrectomy, mechanical, pars plana approach, with subretinal injection of pharmacologic/biologic agent

ATTACHMENT A

Coding Changes to Condition-Treatment Pairs for the February 1, 2021 Prioritized List of Health Services

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Line: 348
Condition: MILD/MODERATE BIRTH TRAUMA FOR BABY
Treatment: MEDICAL THERAPY

Add:	C9770	Vitrectomy, mechanical, pars plana approach, with subretinal injection of pharmacologic/biologic agent

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Line: 360
Condition: CHORIORETINAL INFLAMMATION
Treatment: MEDICAL, SURGICAL, AND LASER TREATMENT

Add:	C9770	Vitrectomy, mechanical, pars plana approach, with subretinal injection of pharmacologic/biologic agent

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Line: 383
Condition: CENTRAL SEROUS CHORIORETINOPATHY
Treatment: MEDICAL AND SURGICAL TREATMENT

Add:	C9770	Vitrectomy, mechanical, pars plana approach, with subretinal injection of pharmacologic/biologic agent

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Line: 399
Condition: INFLUENZA, COVID-19 AND OTHER RESPIRATORY VIRAL ILLNESS
Treatment: MEDICAL THERAPY

Add:	J12.82	Pneumonia due to coronavirus disease 2019
Add:	M35.81	Multisystem inflammatory syndrome (MIS)
Add:	M0239	Intravenous infusion, bamlanivimab-xxxx, includes infusion and post administration monitoring
Add:	M0243	Intravenous infusion, casirivimab and imdevimab includes infusion and post administration monitoring

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Line: 424
Condition: COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
Treatment: MEDICAL AND SURGICAL TREATMENT

Add:	C9770	Vitrectomy, mechanical, pars plana approach, with subretinal injection of pharmacologic/biologic agent

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Line: 478
Condition: CLOSED DISLOCATIONS/FRACTURES OF NON-CERVICAL VERTEBRAL COLUMN WITHOUT NEUROLOGIC INJURY OR STRUCTURAL INSTABILITY
Treatment: MEDICAL AND SURGICAL TREATMENT

Add:	C1062	Intravertebral body fracture augmentation with implant (e.g., metal, polymer)

ATTACHMENT B

Coding Changes to Condition-Treatment Pairs Affecting Numerous Lines for the February 1, 2021 Prioritized List of Health Services

Add code 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 biologi) to the following lines:
1,2,5,7-17,21,22,24-33,35-48,50-52,55-65,67-86,88-108,110-112,115-118,120-138,140-148,150,151,153-155,157-165,167-186,188-191,193-195,197-201,203-217,219,221-236,239-260,262,264,265,268-274,276-294,296-311,313-318,323-330,332-342,345,347-350,352-355,357-359,362,363,365,367-372,374-378,380-383,385,387,389,390,392,393,395,404-410,412,413,415-418,421-425,430-434,436-438,441,442,444,446-450,454,455,458-467,469-474,477-480,482-484,486-491,493-496,498-501,503-506,508-513,515-518,522,523,525-528,531-533,535,536,538-561,563-573,575,576,578-581,584-589,592-597,600,602-610,613-617,623-626,629,630,632-643

Add code 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) to the following lines:
1,2,5,7-17,21,22,24-33,35-48,50-52,55-65,67-86,88-108,110-112,115-118,120-138,140-148,150,151,153-155,157-165,167-186,188-191,193-195,197-201,203-217,219,221-236,239-260,262,264,265,268-274,276-294,296-311,313-318,323-330,332-342,345,347-350,352-355,357-359,362,363,365,367-372,374-378,380-383,385,387,389,390,392,393,395,404-410,412,413,415-418,421-425,430-434,436-438,441,442,444,446-450,454,455,458-467,469-474,477-480,482-484,486-491,493-496,498-501,503-506,508-513,515-518,522,523,525-528,531-533,535,536,538-561,563-573,575,576,578-581,584-589,592-597,600,602-610,613-617,623-626,629,630,632-643

Add code 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) to the following lines:
1,2,5,7-17,21,22,24-33,35-48,50-52,55-65,67-86,88-108,110-112,115-118,120-138,140-148,150,151,153-155,157-165,167-186,188-191,193-195,197-201,203-217,219,221-236,239-260,262,264,265,268-274,276-294,296-311,313-318,323-330,332-342,345,347-350,352-355,357-359,362,363,365,367-372,374-378,380-383,385,387,389,390,392,393,395,404-410,412,413,415-418,421-425,430-434,436-438,441,442,444,446-450,454,455,458-467,469-474,477-480,482-484,486-491,493-496,498-501,503-506,508-513,515-518,522,523,525-528,531-533,535,536,538-561,563-573,575,576,578-581,584-589,592-597,600,602-610,613-617,623-626,629,630,632-643

Remove code G2061 (Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes) from the following lines:
1-53,55-217,219-342,345-383,385-410,412-442,444-452,454-456,458-467,469-491,493-501,503-506,508-536,538-590,592-600,602-617,620-644,647-661

Remove code G2062 (Qualified nonphysician healthcare professional online assessment service, for an established patient, for up to seven days, cumulative time during the 7 days; 11-20 minutes) from the following lines:
1-53,55-217,219-342,345-383,385-410,412-442,444-452,454-456,458-467,469-491,493-501,503-506,508-536,538-590,592-600,602-617,620-644,647-661

Remove code G2063 (Qualified nonphysician qualified healthcare professional assessment service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes) from the following lines:
1-53,55-217,219-342,345-383,385-410,412-442,444-452,454-456,458-467,469-491,493-501,503-506,508-536,538-590,592-600,602-617,620-644,647-661

Add code 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') to the following lines:
1,2,5-17,19-22,24-33,35-48,50-52,55-65,67-112,115-118,120-148,150,151,153-155,157-191,193-217,219,221-236,238-262,264-266,268-294,296-311,313-318,323-330,332-342,345,347-350,352-359,362-365,367-372,374-383,385,387-393,395,403-410,412-418,421-425,428-434,436-438,440-442,444-450,454-456,458-467,469-474,476-480,482-484,486-491,493-496,498-501,503-506,508-513,515-518,522,523,525-528,531-536,538-573,575,576,578-581,584-590,592-597,600,602-610,612-617,623-626,629,630,632-643

Add code 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) to the following lines:
1,2,5-17,19-22,24-33,35-48,50-52,55-65,67-112,115-118,120-148,150,151,153-155,157-191,193-217,219,221-236,238-262,264-266,268-294,296-311,313-318,323-330,332-342,345,347-350,352-359,362-365,367-372,374-383,385,387-393,395,403-410,412-418,421-425,428-434,436-438,440-442,444-450,454-456,458-467,469-474,476-480,482-484,486-491,493-496,498-501,503-506,508-513,515-518,522,523,525-528,531-536,538-573,575,576,578-581,584-590,592-597,600,602-610,612-617,623-626,629,630,632-643

ATTACHMENT B

Coding Changes to Condition-Treatment Pairs Affecting Numerous Lines for the February 1, 2021 Prioritized List of Health Services

Add code 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) to the following lines:
1,2,4-17,19-22,24-33,35-48,50-52,55-65,67-112,115-118,120-148,150,151,153-155,157-191,193-217,219,221-236,238-262,264-266,268-294,296-311,313-318,323-330,332-342,345,347-350,352-359,362-365,367-372,374-383,385,387-393,395,403-410,412-418,421-425,428-434,436-438,440-442,444-450,454-456,458-467,469-474,476-480,482-484,486-491,493-496,498-501,503-506,508-513,515-518,522,523,525-528,531-536,538-573,575,576,578-581,584-590,592-597,600,602-610,612-617,623-626,629-643

Add code 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 t) to the following lines:
1,2,4-17,19-22,24-33,35-48,50-52,55-65,67-112,115-118,120-148,150,151,153-155,157-191,193-217,219,221-236,238-262,264-266,268-294,296-311,313-318,323-330,332-342,345,347-350,352-359,362-365,367-372,374-383,385,387-393,395,403-410,412-418,421-425,428-434,436-438,440-442,444-450,454-456,458-467,469-474,476-480,482-484,486-491,493-496,498-501,503-506,508-513,515-518,522,523,525-528,531-536,538-573,575,576,578-581,584-590,592-597,600,602-610,612-617,623-626,629-643

Add code 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 servi) to the following lines:
1,2,4-17,19-22,24-33,35-48,50-52,55-65,67-112,115-118,120-148,150,151,153-155,157-191,193-217,219,221-236,238-262,264-266,268-294,296-311,313-318,323-330,332-342,345,347-350,352-359,362-365,367-372,374-383,385,387-393,395,403-410,412-418,421-425,428-434,436-438,440-442,444-450,454-456,458-467,469-474,476-480,482-484,486-491,493-496,498-501,503-506,508-513,515-518,522,523,525-528,531-536,538-573,575,576,578-581,584-590,592-597,600,602-610,612-617,623-626,629-643

ATTACHMENT C

Guideline Note Changes
For the February 1, 2021 Prioritized List of Health Services

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).
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.

ATTACHMENT C

Guideline Note Changes
For the February 1, 2021 Prioritized List of Health Services

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-G2252) 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)

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.

Limited information provided by one clinician to another that does not constitute collaboration (e.g., interpretation of an electroencephalogram, report on an x-ray or scan, or reporting the results of a diagnostic test) is not considered a consultation.

GUIDELINE NOTE 106, PREVENTIVE SERVICES

Lines 3,622

Included on Line 3 are the following preventive services:

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.

ATTACHMENT C

Guideline Note Changes
For the February 1, 2021 Prioritized List of Health Services

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 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:

[Additions shown below; there were no deletions]

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

ATTACHMENT D

October 1, 2020 and January 1, 2021 Prioritized List
Change Log

1) On 12/31/20, the following change was made to the January 1, 2021 Prioritized List:

Remove obsolete procedure codes C9745, G0297 and G2058 from all lines of the list.

2) On 12/21/20, the following change was made to the October 1, 2020 Prioritized List:

Diagnostic guideline D27 SARS-COV-2 (COVID-19) TESTING was amended to reflect changes made at the November 2020 meeting. It now reads as follows:

DIAGNOSTIC GUIDELINE D27, SARS-COV-2 (COVID-19) TESTING

Testing for SARS-CoV-2 (COVID-19) virus RNA or viral antigen is a covered diagnostic service.

Antibody testing for SARS-CoV-2 (COVID-19; CPT 86413, 86328 or 86769) is covered as diagnostic only when such testing meets the following criteria:

A) Testing is done using tests that have FDA Emergency Use Authorization (EUA) or FDA approval; AND
B) Testing is used as part of the diagnostic work up of multisystem inflammatory syndrome in children (MIS-C) or multisystem inflammatory syndrome in adults (MIS-A) for hospitalized persons.