Oregon Health Authority

Quality and Health Outcomes Committee
AGENDA

Everyone is welcome to the meetings. For questions about accessibility or to request an accommodation, please call 971-304-6236 or write OHA.qualityquestions@dhsoha.state.or.us.

Requests should be made at least 48 hours prior to the event. Documents can be provided upon request in an alternate format for individuals with disabilities or in a language other than English for people with limited English skills. To request a document in another format or language, please call 971-304-6236 or write OHA.qualityquestions@dhsoha.state.or.us

MEETING INFORMATION

Meeting Date/Time: June 13, 2022 / 10 a.m. – 3 p.m.
Location: Zoom
Call in information: 1-669-254-5252 / **Meeting ID**: 160 948 0484 / **Passcode**: 114502
Registration required: **Zoom registration**
On meeting day, after registered, click the join link: **Zoom join link**
All meeting materials are posted on the QHOC website

TIME	TOPIC	OWNER	MATERIALS (page #)
Clinical Director Work Group 10:00 a.m. – 11:00 a.m.			
10:00 a.m.	Welcome & Announcements	Jeanne Savage Lisa Bui	TC TA handout (1-7)
10:05 a.m.	OUD / SUD telehealth	Lisa Bui	
10:15 a.m.	OUD / SUD bupo prescribing	John McIlveen	
10:30 a.m.	HERC update	Ariel Smits	
10:50 a.m.	**BREAK**		
Learning Collaborative 11:00 a.m. – 12:30 p.m.			
11:00 a.m.	Childhood Immunizations		
12:30 p.m.	**LUNCH**		
Quality and Performance Improvement Session 1:00 p.m. – 3:00 p.m.			
1:00 p.m.	QPI introductions / Announcements	Laura Matola Lisa Bui	
1:15 p.m.	SUD statewide PIP design discussion	Lisa Bui	
2:15 p.m.	National DPP technical assistance	Lisa Bui	
2:45 p.m.	Items from the floor	All	
3:00 p.m.	**ADJOURN**		

SPEAKER CONTACT SHEET
QHOC – June 13, 2022

AGENDA TOPIC	SPEAKER	CONTACT INFO
OUD / SUD telehealth	Lisa Bui Dawn Mautner	LISA.T.BUI@dhsoha.state.or.us Dawn.Mautner@dhsoha.state.or.us
OUD / SUD bupo	John McIlveen	JOHN.W.MCILVEEN@dhsoha.state.or.us
HERC Update	Ariel Smits, MD, MPH	ariel.smits@dhsoha.state.or.us
Learning Collaborative Childhood Immunizations	Lisa Bui Sara Kleinschmit Andy Parker Steve Robison Susan Wickstrom Elke Geiger (PacificSource) Dr. Jay Rosenbloom	LISA.T.BUI@dhsoha.state.or.us SARA.KLEINSCHMIT@dhsoha.state.or.us ANDREW.R.PARKER@dhsoha.state.or.us Steve.G.ROBISON@dhsoha.state.or.us Susan.D.WICKSTROM@dhsoha.state.or.us Elke.Geiger@pacificsource.com JRosenbloom@ch-alliance.org
QHOC Chairs		
Medical	Jeanne Savage	Jeanne.Savage@trilliumchp.com
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Behavioral Health	Jeremy Koehler	koehlerj@healthshareoregon.org
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Behavioral Health	TBD	
Oral Health	Kaz Rafia	kaz.rafia@dhsoha.state.or.us
Quality	Lisa Bui	LISA.T.BUI@dhsoha.state.or.us

QHOC Website:
https://www.oregon.gov/oha/HPA/DSI/Pages/Quality-Health-Outcomes-Committee.aspx

Questions:
OHA.qualityquestions@state.or.us or call Lisa Bui at 971-673-3397

OHA Transformation Center Technical Assistance for CCOs

TA index

Metrics TA

Diabetes (HbA1c poor control and oral evaluations for adults with diabetes)

Motivational interviewing trainings for diabetes management (no-cost CME)

Oregon Medicaid providers are invited to no-cost virtual trainings (with CME) on motivational interviewing for diabetes management. The trainings will focus on improving providers' confidence and skills in conversations about sensitive behavior change topics required for diabetes management. Dana Sturtevant, MS, RD, will lead these trainings. Three types of trainings are available, with multiple opportunities to attend each between June 2022 and February 2023:

- Motivational interviewing for diabetes management: Level 1
- Motivational interviewing for diabetes management: Level 2
- Using motivational interviewing in diabetes management groups

See full details, including prerequisites, draft agendas, schedules and registration links:
https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Motivational-Interviewing-for-Diabetes-Management.aspx

Contact: Laura Kreger (Laura.E.Kreger@dhsoha.state.or.us)

Social-emotional health

System-level social-emotional health metric virtual learning collaborative

The Transformation Center is working with Artemis Consulting to facilitate a virtual learning collaborative to support the CCO system-level social-emotional health metric. The learning collaborative had its initial meeting on May 25 and will meet monthly through June 2023.

CCO participants are completing a survey to identify the best date/time for the monthly series — stay tuned for registration information for the next session and future session topics. Artemis will be working with CCO participants to craft each agenda according to CCOs needs and the metric requirements.

- For an **overview of the metric,** watch a presentation given at the March Metric TAG here: https://www.youtube.com/watch?v=d2DJeA_-160, and see the slides here: https://www.oregon.gov/oha/HPA/ANALYTICS/MetricsTAGMeetingDocuments/TAG_slides_March2022_final.pdf (slides 16–28)
- **Audience:** CCO staff working on the social-emotional health metric.
- **Contact:** Rachel Burdon (Rachel.E.Burdon@dhsoha.state.or.us)

System-level social-emotional health metric asset map template

The social-emotional health measure asset map template is a tool that CCOs may use to complete the asset map of existing social-emotional services and resources requirement of the measure.

- Webinar recording – How to use the asset map template
- Webinar recording – Behavioral health services for children, infant to five years

Tobacco cessation

Tobacco cessation counseling training for providers; free and online (with CME); On demand, 45 minutes

What: This short online course will improve your care team's ability to help patients quit tobacco. The course focuses on brief tobacco intervention and motivational interviewing techniques.

Who: All members of the care team committed to supporting their patients to quit tobacco.

When: The course is self-paced and takes approximately 45 minutes. The course can be started, paused and resumed later as needed.

CMEs: This training has been reviewed and is accepted for up to 1.0 prescribed credit from the American Academy of Family Physicians (AAFP). For other licensing boards that may not pre-approve continuing education credits (for example, the Board of Licensed Professional Counselors and Therapists), please submit the certificate of participation to your accrediting body.

Access the training: https://learn.optum.com/redeem/or

Non-metrics TA

Care coordination

Virtual learning collaborative: Care coordination and intensive care coordination (CC/ICC)

The Oregon Health Authority Transformation Center is hosting a monthly virtual learning collaborative to support CCOs and other organizations that provide care coordination services to Oregon Health Plan (OHP) members. The year-long learning collaborative will provide support toward understanding and meeting CCO 2.0 care coordination requirements and facilitate sharing of CC/ICC best practices.

Audience: This event series is for staff of CCOs, Kepro, and other organizations who are involved in planning or delivering CC/ICC to OHP members.

Participants will hear from subject matter experts and peers on key topics such as:

- CCO contract requirements and OARs related to CC/ICC
- Best practices for:
    - Interdisciplinary care team (ICT) meetings
    - Sharing assessments and care plans
    - CC/ICC staffing models
- CC/ICC reporting requirements/template

- Face-to-face requirements in rural/urban areas
- Prioritized populations
- Using data to support CC/ICC activities and workflows
- In lieu of services (ILOS) and care coordination

When: This virtual collaborative will be held on the 3rd Thursday each month in 2022, noon–2 p.m.

To sign up, please contact Alissa Robbins (Alissa.Robbins@dhsoha.state.or.us)

Community health assessment and community health improvement plans

Virtual Community Health Assessment (CHA) & Community Health Improvement Plan (CHP) Learning Collaborative

The OHA Transformation Center is hosting a new virtual CHA and CHP learning collaborative, focusing on the operations side of developing a collaborative CHA and CHP. This learning collaborative is being facilitated by the Providence Center for Outcomes Research and Education (CORE).

- **Timing:** Six virtual learning collaborative sessions from March 2022–June 2023
- **Audience:** CCOs, local public health authorities, hospitals, CHA/CHP backbone entities, or other organization staff partnering to develop the CHA/CHP (Nine Federally Recognized Tribes of Oregon, community-based organizations).
- **Schedule:**
    - **Resourcing (funding and staffing)** – March 29
        - **Recording:** https://www.youtube.com/watch?v=8aUMiDkBhaM
        - **Slides:** https://www.oregon.gov/oha/HPA/dsi-tc/Documents/3-29-22%20CHA-CHP%20LC%20slides-final.pdf
    - **Governance** – May 17
        - **Recording:** https://www.youtube.com/watch?v=ISzf7PRAbLk
        - **Slides:** https://www.oregon.gov/oha/HPA/dsi-tc/Documents/OHA%20TA%20CHA-CHP%20Governance%20Slide%20Deck_FINAL.pdf
    - **Timelines/cycles** – September 13, 11 a.m. –12:30 p.m. Register here: https://www.zoomgov.com/meeting/register/vJItf-igrzsoHmDjZrK0vNeeO70VVZJtd7I
    - **Community engagement** – November 2, 10-11:30 a.m. Register here: https://www.zoomgov.com/meeting/register/vJIsdOyvqD4rGU7qWlZUMX3p85mdMZj2_9w
    - **Tribal engagement** – February 2023
    - **Sustainability & dissemination** – April 2023
- **Sign up** to receive future communications about this learning collaborative: https://www.surveymonkey.com/r/5KNMT37
- **If you require any accommodations** to fully participate in these sessions, or have any other questions about this learning collaborative, please contact Thomas.Cogswell@dhsoha.state.or.us.

Community advisory councils (CACs)

2022 CAC demographic report guidance and template

Report guidance and a template are now available for the 2022 CAC Demographic Report deliverable: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/2022%20CAC%20Demographic%20Report%20Template-final.docx

- This report is due June 30 to CCO.MCODeliverableReports@dhsoha.state.or.us.
- Contact: Tom Cogswell (Thomas.Cogswell@dhsoha.state.or.us)

CAC member learning series: The social determinants of health and equity

The Oregon Health Authority Transformation Center recently concluded a learning series for CAC members focused on the social determinants of health and equity.

- Click here to access session materials and recordings.
- Haga clic aquí para ver un folleto de la serie de aprendizaje en español.

Consumer CAC members are eligible for a $10 electronic gift card for each recording they watch in the learning series through 6/15/22. Electronic gift cards are available from Albertsons, Safeway and CVS.

Questions? Contact Tom Cogswell (Thomas.Cogswell@dhsoha.state.or.us)

COVID-19 supports

COVID-19 feedback learning series

Join Oregon Health Authority's COVID-19 Feedback Team to learn how we are using direct feedback from people in Oregon to support the COVID-19 Response and Recovery. We will also be sharing strategies and tips on how to build "feedback culture" within your organization. See flier for additional information: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/CFT%20Webinar%20Series%20Flyer.pdf

- Session 1: Planning and Development (recording: https://www.youtube.com/watch?v=0QQWIMCr6To)
- Session 2: Implementation and Innovation (recording: https://www.youtube.com/watch?v=E6qm7wxDQrY)
- Session 3: Partnerships and Collaboration: (recording coming soon)

Contact: COVID.19@dhsoha.state.or.us or 503-945-5488
Audience: CCOs, local public health authorities, hospitals, providers, community-based organizations, OHA and ODHS staff

For individuals with disabilities or individuals who speak limited English we can provide free help. Some examples are sign language and spoken language interpreters, real-time captioning, braille, large print, audio, and written materials in other languages. If you need help with these services or other related services please contact Colin Sanders, 503-602-2220 (voice/text), colin.s.sanders@dhsoha.state.or.us at least 48 hours before the meeting. All relay service calls are accepted. To best ensure our ability to provide a modification, please contact us if you are considering attending the meeting and require a modification. The earlier you make a request the more likely we can meet the need.

Health-related services

Addressing Oregon's Housing Crisis through HRS, SHARE, ILOS: CCO Efforts and Opportunities

What: Annual convening for CCOs on OHA spending initiatives
Date: Tuesday, September 20, 2022 – Friday, September 23, 2022
Time: 9 a.m.–1:15 p.m. each day
Where: Virtual meeting via Zoom

- **Register in advance (required)**: **https://us02web.zoom.us/meeting/register/tZAld--urjMrHdUKgIqt9v-swZ4Mvk-ZKIhp**

Who should attend: CCOs interested in sharing and learning from others about how Health-Related Services (HRS), Supporting Health for All through REinvestment (SHARE) and In Lieu of Services (ILOS) can support their work to address housing as a social determinant of health and equity. CCOs are strongly encouraged to invite their community partners involved in this work.
Presentation proposals due June 22 (see below).

By attending this conference, **participants can expect to**

- Increase their awareness of statewide, regional and local housing efforts, as well as opportunities to learn from national partners
- Learn about innovative approaches and identify partnership opportunities for SHARE, HRS and ILOS broadly

- Discuss current barriers and best practices to developing and sustaining housing
- Identify approaches to centering equity and lifting community voice in HRS, SHARE and ILOS strategies
- Identify ways to take action by utilizing HRS, SHARE and ILOS community benefit initiatives
- Connect with other CCOs in the state

Interested in presenting? This virtual convening will serve as an opportunity for CCOs to learn from and align with each other to address Oregon's housing crisis. Each day will include a mix of panels, interactive sessions and presentations from CCOs, CBOs, OHA and national organizations. **CCOs are invited to submit presentation proposals across key topics. Presentations in partnership with CBOs are highly encouraged.**

Please submit a presentation proposal here by June 22, 2022.

Please select one of the following topics for your presentation:
Addressing houselessness

- Strategies to identify and understand causes of houselessness and/or barriers to housing in your community [15 min presentation, 10 min discussion]
- Examples of CCOs addressing houselessness [30 min presentation, 20 min Q&A]
    - Centering equity in addressing houselessness
    - Mental/behavioral health interventions to address houselessness implemented through SHARE, HRS

Developing affordable, accessible housing

- Successful partnership characteristics and strategies to developing housing and services [Seeking two, 15 min CCO/CBO joint presentations, 20 min Q&A/discussion]
- Addressing housing inequities in a specific population [60 min panel with other CCO presenters, including Q&A/discussion]

Growing impact, maintaining commitment

- Current work in developing and growing a housing strategy [20 min presentation, 20 min discussion]

Background: This convening is sponsored by the Oregon Health Authority (OHA) Transformation Center in partnership with Oregon Rural Practice-based Research Network (ORPRN) in an effort to support Coordinated Care Organizations (CCOs) in implementing Supporting Health for All through REinvestment (SHARE), Health-Related Services (HRS) and In Lieu Of Services (ILOS).

Accessibility: Everyone has a right to know about and use OHA programs and services. Some examples of the services and accommodations OHA can provide: sign language and spoken language interpreters, written materials in other languages, braille, large print, audio and other formats. If you need help or have questions, please contact Anne King (kinga@ohsu.edu) or Nancy Goff (nancy055@gmail.com) at least 72 hours before the meeting.

For more information, contact: Anne King (kinga@ohsu.edu), Nancy Goff (nancy055@gmail.com) or the Transformation Center (Transformation.Center@dhsoha.state.or.us).

SHARE, HRS and ILOS comparison document

This new comparison of CCO spending programs provides an overview of health-related services, in lieu of services and the SHARE Initiative (Supporting Health for All through Reinvestment). The document includes examples of activities that could fall into each category. View the comparison here: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/HRS-SHARE-ILOS-Comparison.pdf

CCO learning collaborative: SHARE and HRS community benefit

OHA is hosting a monthly CCO learning collaborative focused on SHARE (Supporting Health for All through Reinvestment) and health-related services (HRS) community benefit, which will take place on the 4th Monday of each month through June 2022. These meetings will be facilitated by technical assistance consultants, and will be an informal way for CCO staff to share ideas around program strategy and implementation. The list of monthly topics is forthcoming and will be created based on ideas from conversations with CCOs.

Who: All CCO staff working on SHARE or HRS are welcome to attend.

When: Next meeting June 27, 11 a.m.–12:30 p.m.

Register here: https://us02web.zoom.us/meeting/register/tZwvcuigrT8tE9ylvWs79L86TfxilqibPkQ3

Contact: Nancy Goff (nancy055@gmail.com)

HRS office hours

CCO staff are invited to participate in general HRS office hours and staff may join the calls at any point during the scheduled times.

- **When**: Every three months through 2022
  - Next: July 12, 11–11:30 a.m.
  - Full schedule at https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Health-Related-Services.aspx
- **Join on your computer or mobile app** (no registration required)
  - Or call in (audio only): +1 971-277-2343
  - Phone conference ID: 895 910 664#

SHARE (supporting health for all through reinvestment)

Webinar – Partnering to provide supportive housing services: An introduction for CCOs to permanent supportive housing and beyond

Please join us for a webinar to learn about opportunities for CCOs to partner with the housing sector to provide supportive services. Permanent supportive housing (PSH) is a proven model for transitioning people out of homelessness, and several PSH projects are underway across Oregon. In addition to PSH, there are other opportunities for CCOs to partner with local housing agencies, service providers and developers to bring case management and supportive services to people experiencing homelessness. Presenters from Oregon Housing and Community Services (OHCS) will provide an overview of the PSH model, details about PSH projects underway across Oregon, and ideas for other ways that CCOs can partner to provide supportive services.

- **When:** June 2
- **Recording:** Available soon on the SHARE webpage
- **Presenters:** Dana Schultz, Permanent Supportive Housing (PSH) Program Manager at OHCS; and Amy Cole, State Development Resources Manager at OHCS
- **Background:** This webinar series is sponsored by the Oregon Health Authority in partnership with Oregon Rural Practice-based Research Network to support CCOs in implementing Supporting Health for All through REinvestment (SHARE), health-related services (HRS) and in lieu of services (ILOS).
- **Contact**: Nancy Goff (nancy055@gmail.com)

Webinar – Collaborating to address housing and homelessness: An overview for CCOs from one Oregon region's experience

This recorded webinar (April 13, 2022) includes innovative ways for CCOs to collaborate within their region to address housing and homelessness. Kenny LaPoint, executive director of Mid-Columbia Community Action Council (MCCAC) provides an overview of Oregon's state and local housing systems and share ideas about specific housing supports and services that CCOs can partner locally on, and potentially use Medicaid spending flexibilities to support (SHARE, HRS and ILOS).

- Slides: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/Health-and-Housing-Integration.pdf
- Recording: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/Health-and-Housing-Integration.pdf

SHARE office hours

OHA staff will hold office hours to answer CCO questions about SHARE Initiative deliverables. CCO staff may join at any point during the scheduled times:

- June 15, 9:30–10 a.m.

Join meeting (same link for all)
Or call in: +1 971-277-2343
Phone conference ID: 878 492 774#

Contact: Laura Kreger (Laura.E.Kreger@dhsoha.state.or.us)

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Contact: Nancy Goff (nancy055@gmail.com)

Transformation Center technical assistance updates

For updates, sign up for the Transformation Center's events, resources and learning opportunities distribution list.

MINUTES

HEALTH EVIDENCE REVIEW COMMISSION
Online Meeting
May 19, 2022

Members Present: Kevin Olson, MD, Chair; Holly Jo Hodges, MD, MBA, Vice-Chair; Devan Kansagara, MD; Lynnea Lindsey, PhD; Leslie Sutton; Adriane Irwin, PharmD, Kathryn Schabel, MD; Max Kaiser, DO; Cris Pinzon, MPH, BSN, BS, RN; Stacy Geisler, DDS, PhD; Ben Hoffman, MD; Mike Collins (departed prior to the votes on PANDAS and PANS).

Members Absent: Deborah Espesete, LAc, MAcOM, MPH.

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

Also Attending: Bethany Godlewski, Shauna Durbin, Val King, MD, (OHSU Center for Evidence-based Policy); Andrea Stroud; Antoinette Awuakye; Ben Botkin (The Lund Report); Bob Cuyler; Cathy Daraee; Christian Moller-Andersen; Christin Gallo; Christina Cronin-Vejar; Cynthia Witcraft; Dan Twibell (PACE Foundation); David Zimmerman; Dr. Rogalsky; Elisa Bledsoe; Erin Thompson, MD; Gabriella True (ASPIRE); Greg Showell; Ivan Vejar; Jaymey Sweeney; Jen; Joe Perekupka; Kimberly; Kym McCornack Laura McKeane; Leia Hughey, Ph.D; Leif Bruce; Marija Micic; Mary Clogston; Maureen McGee; Mike Cusnir MD; Mike Daines, MD; Miya; Monica Frederick; Nate Myszka; Paul Lewis, MD; Rachael Wiggins Emory; Renee Doan; Sarah Lemley; Stephanie; Tyler Miguel-Harrison; Val Halpin; Wendy Nawara.

Call to Order

Kevin Olson, Chair of the Health Evidence Review Commission (HERC), called the meeting to order; roll was called. A quorum of members was present at the meeting.

Each member and staff person introduced themselves.

Minutes Approval

MOTION: To approve the minutes of the 3/10/2022 meeting as presented. CARRIES 12-0.

Director's Report

Staff changes
Gingerich said Daphne Peck has a new role, as Program and Outreach Coordinator. She will continue to support the Commission and take on the additional role. He then said Dr. Amy Cantor, a new Medical Director recently started. Cantor introduced herself.

EPSDT waiver discussions
No update to report; hopefully by the August meeting there will be more to discuss.

Equity project update/outreach plan
Gingerich discussed Peck's work with plain language and community outreach plans. He said this is a part of a larger equity initiative, which will include the discussions referenced at the last meeting regarding making decisions when there is insufficient evidence. As a part of this, Peck will be polling for dates for a potential day-long retreat, in winter or spring of 2023.

Naturopath applications status update
Gingerich said there are four applicants thus far and the recruitment is open until May 31, 2022.

Value-based Benefits Subcommittee (VbBS) Report on Prioritized List Changes
Meeting materials pages 36-90

Ariel Smits reported the VbBS met earlier in the day, 5/19/2022. She summarized the subcommittee's recommendations.

RECOMMENDED CODE MOVEMENT (changes to the 10/1/2022 Prioritized List unless otherwise noted)

- Add the procedure codes for visual field testing to the list of covered diagnostic tests
- Add the code for temporary urethral stents to a non-funded line
- Add the code for fecal lactoferrin quantitative testing to the list of covered diagnostic tests
- Add the codes for placements of gastric neurostimulators to a funded line with a new guideline
- Add the procedure codes for coronary CT angiography to the list of covered diagnostic tests
- Delete the procedure code for rhinophyma shaving from a currently-funded line and add to an unfunded line
- Add the procedure code for shoulder arthroplasty with subacromial spacers to an unfunded line
- Add the diagnosis codes for benign carcinoid tumors to several funded lines
- Make various straightforward guideline and coding changes

RECOMMENDED GUIDELINE CHANGES (changes to the 10/1/2022 Prioritized List unless otherwise noted)

- Edit the adenoidectomy guideline to allow adenoidectomy with the placement of the first set of tympanostomy tubes in certain situations
- Edit the guideline regarding bone anchored hearing aids (BAHAs) so that bilateral BAHAs are included on the relevant lines. Specify that maintenance and replacement of BAHAs in adulthood is also included
- Delete the guideline restricting the use of MRIs in multiple sclerosis
- Add the guideline for erythropoietin to a line with non-end stage chronic renal disease and add a requirement that the patient have sufficient iron stores in order to receive this treatment
- Edit the new orthodontia guideline to remove separate mention of qualifying criteria which are already encompassed in another tool, and add a requirement for a dental visit to ensure good oral health before beginning orthodontia treatment

Testimony:

Equine Therapy
Leia Hughey, PhD, who testified at VbBS earlier in the day, said she had her concerns addressed at that meeting and had nothing further to add.

Freespira:
Monica Frederick, an employee of Freespira. Ms. Frederick clarified that Freespira is not a smartphone app but is an FDA cleared class to medical device that is supported by health coaching and data analytics. Also, it treats panic disorders and post-traumatic stress disorder (PTSD), rather than substance use disorder. She said that as of April 1, CMS established a HCPCS code for this application.

Robert Cuyler, PhD, an employee of Freespira and a clinical psychologist. Dr. Cuyler gave a very brief walkthrough of the intervention and the components.

Joe Perekupka, CEO of Freespira highlighted a 35% overall reduction of medical costs within the Medicaid marketplace with this device.

Olson said the MED Project is currently doing a review of these types of services and we will wait for that report before we take up a review.

Y90 liver directed therapy:
Mike Cusnir MD, of Mount Sinai in Miami, testified about treatment for metastatic colon cancer and liver disease.

MOTION: To accept the VbBS recommendations on *Prioritized List changes* not related to coverage guidances, as stated. See the VbBS minutes of 5/19/2022 for a full description. Carries: 12-0.

Coverage Guidance Topic: Bariatric procedures scope statement
Meeting materials, page 91

Testimony

Derek Rogalsky MD said he is an Oregon Southern coast bariatric surgeon whose patients are mainly on the Oregon Health Plan. He said he thought it would be useful to look at the long-term comparative studies and not just randomized control trials (RTCs).

Dr. Valerie King from OHSU's Center for Evidence-based Policy, HERC's contractor, said the work they do for HERC usually uses RTCs unless there is a compelling reason to look at other comparative studies. Discussion centered around what would be helpful to look for in the literature.

MOTION: To approve the proposed scope statement as presented. Carries 12-0.

Coverage Guidance Topic: PANDAS/PANS
Meeting materials, pages 96-224

Gingerich read the appointed experts' biographies. Godlewski and Smits presented an overview of the evidence, the GRADE Table and the proposed coverage guidance from EbGS.

Testimony

Sarah Lemley, Executive Director of Northwest PANDAS/PANS Network offered testimony. She said there are 20 years of published data about the efficacy of IVIG. She then read through a list of names of persons and organizations endorsing coverage.

Christina Cronin-Vejar gave testimony of her personal experience as a parent of a child with this condition. She urged the Commission to approve coverage.

Dan Twibell, PACE Foundation spoke, sharing he is the father of a PANDAS child. He said the PACE Foundation has been instrumental in helping to set up clinical trails for IVIG treatment. He urged the Commission to adopt the guidance adopted by the Value-based Benefits Subcommittee.

Discussion

Sutton said she has appreciated the conversation between the public comment and the experts during discussions on this complicated issue.

Pinzon asked about the disease occurrence. Smits said it is difficult to know as there are not rigorous standardized diagnostic criteria. Lemley offered the PANDAS network conservatively estimates that one in 200 children are affected. Daines said not all patients will require IVIG; only a very small percentage progress to that stage.

It was mentioned that certain infectious disease doctors sent in public comment asking that their specialty be removed from the list of specialties to be consultant regarding PANDAS and PANS in the coverage guidance recommendation.

MOTION: To approve the proposed coverage guidance as presented. Carries 7-3. *(Absent: Collins; Voted no: Hodges, Kaiser, Geisler)*

MOTION: To approve the proposed guideline for the Prioritized List as proposed. Carries 7-3. *(Absent: Collins; Voted no: Hodges, Kaiser, Geisler)*

Approved Coverage Guidance:

HERC Coverage Guidance

Tonsillectomy, adenoidectomy, adenotonsillectomy, plasma exchange, and prophylactic antibiotic therapy are not recommended for coverage to treat pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS) (*weak recommendation*).

Up to 3 monthly immunomodulatory courses of intravenous immunoglobulin (IVIG) therapy are recommended for coverage to treat PANDAS and PANS (*weak recommendation*) when both of the following are met:

A) A clinically appropriate trial of two or more less-intensive treatments (for example, appropriate limited course of nonsteroidal anti-inflammatory drugs (NSAIDs), corticosteroids, selective serotonin reuptake inhibitors (SSRIs), behavioral therapy, short-course antibiotic therapy) was either not effective, not tolerated, or did not result in sustained improvement in symptoms (as measured by a lack of clinically meaningful improvement on a validated instrument directed at the patient's primary symptom complex). These trials may be done concurrently, AND

B) A consultation with and recommendation from a pediatric subspecialist (for example, pediatric neurologist, pediatric psychiatrist, neurodevelopmental pediatrician, pediatric rheumatologist, pediatric allergist/immunologist) as well as the recommendation of the patient's primary care provider (for example, family physician, pediatrician, pediatric nurse practitioner, naturopath). The subspecialist consultation may be a teleconsultation. For adolescents, an adult subspecialist consult may replace a pediatric subspecialist consult.

A reevaluation at 3 months by both the primary care provider and pediatric expert is required for continued therapy of IVIG. This evaluation must include clinical testing with a validated instrument, which must be performed pretreatment and posttreatment to demonstrate clinically meaningful improvement.

Note: Other treatments (corticosteroids, SSRIs, NSAIDs, short-course antibiotics, and behavioral therapies) were included in an initial version of this report. These therapies were determined to be beyond the scope of a HERC coverage guidance, as these therapies are commonly used for many indications and are not typically subject to utilization control. Only treatments subject to coverage criteria were retained for the final version of this report.

Changes for the Prioritized List of Health Services:

1) Add ICD-10-CM D89.9 to Line 313

Add ICD-10-CM D89.9 (Disorder involving the immune mechanism, unspecified) to Line 313 DISORDERS INVOLVING THE IMMUNE SYSTEM.

2) Adopt a new guideline based on the Coverage Guidance Box Language

Guideline Note 227: PANDAS and PANS
Line 313

Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) is included on this line when coded with ICD-10-CM D89.89 (Other specified disorders involving the immune mechanism, not elsewhere classified). Pediatric Acute-Onset Neuropsychiatric Syndrome (PANS) is included on this line when coded with ICD-10-CM D89.9 (Disorder involving the immune mechanism, unspecified).

Up to 3 monthly immunomodulatory courses of intravenous immunoglobulin (IVIG) therapy are included on this line to treat PANDAS and PANS when both of the following are met:

a) A clinically appropriate trial of two or more less-intensive treatments (for example, appropriate limited course of nonsteroidal anti-inflammatory drugs (NSAIDs), corticosteroids, selective serotonin reuptake inhibitors (SSRIs), behavioral therapy, short-course antibiotic therapy) was either not effective, not tolerated, or did not result in sustained improvement in symptoms (as measured by a lack of clinically meaningful improvement on a validated instrument directed at the patient's primary symptom complex). These trials may be done concurrently, AND
b) A consultation with and recommendation from a pediatric subspecialist (for example, pediatric neurologist, pediatric psychiatrist, neurodevelopmental pediatrician, pediatric rheumatologist, pediatric allergist/immunologist) as well as the recommendation of the patient's primary care provider (for example, family physician, pediatrician, pediatric nurse practitioner, naturopath). The subspecialist consultation may be a teleconsultation. For adolescents, an adult subspecialist consult may replace a pediatric subspecialist consult.

A reevaluation at 3 months by both the primary care provider and pediatric expert is required for continued therapy of IVIG. This evaluation must include clinical testing with a validated instrument, which must be performed pretreatment and posttreatment to demonstrate clinically meaningful improvement. Long term antibiotic therapy is not included on this line for treatment of PANDAS/PANS. Therapeutic plasma exchange (CPT 36514) does not pair with PANDAS or PANS (ICD-10-CM D89.89 or D89.9).

Next Steps

Next meeting is August 11, 2022, online. Several Commissioners may be unable to attend. Peck will poll the membership to find a suitable date for an August meeting.

Public Comment

There was no additional public comment at this time.

Adjournment

Meeting adjourned at 4:15 pm. Next meeting will be from 1:30-4:30 pm in August, online.

Value-based Benefits Subcommittee Recommendations Summary
For Presentation to:
Health Evidence Review Commission on May 19, 2022

For specific coding recommendations and guideline wording, please see the text of the 5/19/2022 VbBS minutes.

RECOMMENDED CODE MOVEMENT (changes to the 10/1/2022 Prioritized List unless otherwise noted)

- Add the procedure codes for visual field testing to the list of covered diagnostic tests
- Add the code for temporary urethral stents to a non-funded line
- Add the code for fecal lactoferrin quantitative testing to the list of covered diagnostic tests
- Add the codes for placements of gastric neurostimulators to a funded line with a new guideline
- Add the procedure codes for coronary CT angiography to the list of covered diagnostic tests
- Delete the procedure code for rhinophyma shaving from a currently-funded line and add to an unfunded line
- Add the procedure code for shoulder arthroplasty with subacromial spacers to an unfunded line
- Add the diagnosis codes for benign carcinoid tumors to several funded lines
- Make various straightforward guideline and coding changes

ITEMS CONSIDERED BUT NO RECOMMENDATIONS FOR CHANGES MADE

- Coverage for spinal cord stimulation for diabetic peripheral neuropathy was considered but not added

RECOMMENDED GUIDELINE CHANGES (changes to the 10/1/2022 Prioritized List unless otherwise noted)

- Edit the adenoidectomy guideline to allow adenoidectomy with the placement of the first set of tympanostomy tubes in certain situations
- Edit the guideline regarding bone anchored hearing aids (BAHAs) so that bilateral BAHAs are included on the relevant lines. Specify that maintenance and replacement of BAHAs in adulthood is also included
- Delete the guideline restricting the use of MRIs in multiple sclerosis
- Add the guideline for erythropoietin to a line with non-end stage chronic renal disease and add a requirement that the patient have sufficient iron stores in order to receive this treatment
- Edit the new orthodontia guideline to remove separate mention of qualifying criteria which are already encompassed in another tool, and add a requirement for a dental visit to ensure good oral health before beginning orthodontia treatment *(effective January 1, 2023)*

VALUE-BASED BENEFITS SUBCOMMITTEE
Online meeting
May 19, 2022
8:00 AM – 1:00 PM

Members Present: Kevin Olson, MD, Chair; Holly Jo Hodges, MD, MBA, Vice-chair; Cris Pinzon, MPH, BSN, BS, RN; Kathryn Schabel, MD (arrived 8:45); Brian Duty, MD (arrived 8:30); Mike Collins; Adriane Irwin, PharmD; David Saenger, MD.

Members Absent:

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

Also Attending: Dawn Mautner, MD, Kaz Rafia DMD, and Kristty Zamora-Polanco (Oregon Health Authority); Michael Yu (OHA Ombuds); Bethany Godlewski, Shauna Durbin, and Valerie King, MD, MPH (Center for Evidence Based Policy); Alison Christy, MD, PhD; Paria Zarrinnegar, MD; Michael Daines, MD; Julie Falardeau, MD; Peggy Kelley, MD; Leia Hughey, PhD; Monica Frederick, Robert Cuyler, PhD, and Joe Perekupka (Freespira); Sarah Lemley and Kym McCornack, Northwest PANDAS/PANS Network; Cristin Cronin-Vejar; Ivan Vejar; Deborah Miller; Dan Twibell (PACE Foundation); Laura McKeane; Kimberly Goddard (Rep Prusak's office); Cynthis Witcraft, Christian Moller-Andersen; Bob Cuyler; bhoveke_gobhi

- **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 March 10, 2022 VbBS meeting were reviewed and approved.

  Gingerich introduced Amy Cantor as a new Medical Director for HERC. He also announced Daphne Peck's expanded role as Program and Outreach Coordinator for HERC, to sustain the efforts related to plain language summaries as well as other initiatives to improve public engagement and gather community input.

  Gingerich mentioned that a new law (HB 2992) will allow a per diem reimbursement to members in certain situations, and more information is forthcoming. Smits announced that the congenital foot diagnosis review has been delayed until August to allow further expert input. She also reviewed the errata document and presented the summary of the HERC staff's below the funding line diagnosis review. Members of the subcommittee as well as the public were encouraged to suggest additional topics or research related to these decisions.

- **Topic: Straightforward/Consent Agenda**

Discussion: There was no discussion about the consent agenda items other than the "items discussed with leadership with no changes recommended" [see below].

The following members gave public testimony about topics which staff reviewed and discussed with leadership, but recommended no changes:

1) Freespira: Monica Frederick, an employee of Freespira, testified that Freespira is a digital therapeutic device with FDA approval. Freespira is for the treatment of panic disorder and post-traumatic stress disorder (PTSD), not opioid use. It is not a smartphone app. She said that HCPCS A9291 was published in April 2022: "Prescription digital behavioral therapy, FDA cleared, per course of treatment", and this code would be appropriate to use with Freespira. Bob Cuyler, PhD, Clinical Psychologist and Chief Clinical Officer of Freespira testified about how the device addresses respiratory dysfunction related to panic and PTSD. The device is used at home and monitored by a health coach at the company. The typical treatment protocol is twice daily use for 28 days. He noted that there is an extensive public literature on this intervention and multiple peer-reviewed studies find clinically significant symptom reduction in >70% of patients. Other studies have found a savings of 35% in medical spending in the one year period after treatment, mainly due to reduced medical visits. He noted the device has a high response rate in Medicaid populations. Joe Perekupka, CEO of Freespira, testified about how the device can help symptoms, address social determinants of health, and help patients gain access to care.
    a. HERC staff noted that devices like Freespira are likely to be included in an upcoming MED report on digital therapeutics. If it is not included in the published MED report, staff will research this device for a future HERC meeting.
2) Equine therapy: Leia Hughey, a licensed clinical psychologist who owns an equine facility where she treats families/children with mental health issues, testified about one CCO discontinuing coverage for equine therapy, which she said is evidence-based practice. Children with better insurance can access this treatment, so it is discriminatory for OHP patients.
    a. Subcommittee members encouraged Dr. Hughey to contact OHA's Health Systems Division regarding contracting. This is not an evidence question as psychotherapy is covered whether or not it is conducted in an equine setting.

Recommended Actions:

1) Remove 11960 (Insertion of tissue expander(s) for other than breast, including subsequent expansion) and 11971 (Removal of tissue expander without insertion of implant) from all current Prioritized List lines.
    a. Advise HSD to add 11960 and 11971 to the Ancillary Procedures File
2) Advise HSD to add B4100 (Food thickener, administered orally, per ounce) to the Ancillary Procedure File
3) Remove 58559-58563 (Hysteroscopy with various surgical procedures) from line 1 PREGNANCY
4) Add 61538 and 61539 (Craniotomy with elevation of bone flap), and 61781 (Stereotactic computer-assisted (navigational) procedure; cranial, intradural) to line 174 GENERALIZED CONVULSIVE OR PARTIAL EPILEPSY WITHOUT MENTION OF IMPAIRMENT OF CONSCIOUSNESS
5) Change the name of line 572 to ~~OTHER~~ MINOR COMPLICATIONS OF A PROCEDURE
6) Delete I86.1 (Scrotal varices) from line 548 SUBLINGUAL, SCROTAL, AND PELVIC VARICES
    a. Rename line 548 SUBLINGUAL~~, SCROTAL,~~ AND PELVIC VARICES
7) Add 90759 (Hepatitis B vaccine (HepB), 3-antigen (S, Pre-S1, Pre-S2), 10 mcg dosage, 3 dose schedule) to line 3 PREVENTION SERVICES WITH EVIDENCE OF EFFECTIVENESS

a. Advise HSD to remove 90759 from the Excluded File

8) Add 47562 and 47563 (Laparoscopy, surgical; cholecystectomy) to line 641 GALLSTONES WITHOUT CHOLECYSTITIS
9) Advise HSD to place the new COVID-related ICD-10-CM codes as shown below:

ICD-10 Code	Code Description	Recommended Placement
Z28.310	Unvaccinated for COVID-19	Informational File
Z28.311	Partially vaccinated for COVID-19	Informational File
Z28.39	Other under-immunization status [non-COVID vaccines]	Informational File

10) Add the following HCPCS codes to the line/file as shown below:

HCPCS Code	Code Description	Recommended Placement
D1708	Pfizer-BioNTech Covid-19 vaccine administration – third dose	3 PREVENTION SERVICES WITH EVIDENCE OF EFFECTIVENESS or line 399 INFLUENZA, COVID-19 AND OTHER NOVEL RESPIRATORY VIRAL ILLNESS
D1709	Pfizer-BioNTech Covid-19 vaccine administration – booster dose	3
D1710	Moderna Covid-19 vaccine administration – third dose	3
D1711	Moderna Covid-19 vaccine administration – booster dose	3
D1712	Janssen Covid-19 vaccine administration - booster dose	3
D1713	Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric – first dose	3
D1714	Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric – second dose	3
M0220	Injection, tixagevimab and cilgavimab, for the pre-exposure prophylaxis only, for certain adults and pediatric individuals (12 years of age and older weighing at least 40kg) with no known sars-cov-2 exposure, who either have moderate to severely compromised immune systems or for whom vaccination with any available covid-19 vaccine is not recommended due to a history of severe adverse reaction to a covid-19 vaccine(s) and/or covid-19 vaccine component(s), includes injection and post administration monitoring	3
M0221	Injection, tixagevimab and cilgavimab, for the pre-exposure prophylaxis only, for certain adults and pediatric individuals (12 years of age and older weighing at least 40kg) with no known sars-cov-2 exposure, who either have moderate to severely compromised immune systems or for whom vaccination with any available covid-19 vaccine is not	3

HCPCS Code	Code Description	Recommended Placement
	recommended due to a history of severe adverse reaction to a covid-19 vaccine(s) and/or covid-19 vaccine component(s), includes injection and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider-based to the hospital during the covid-19 public health emergency	
Q0220	Injection, tixagevimab and cilgavimab, for the pre-exposure prophylaxis only, for certain adults and pediatric individuals (12 years of age and older weighing at least 40kg) with no known sars-cov-2 exposure, who either have moderate to severely compromised immune systems or for whom vaccination with any available covid-19 vaccine is not recommended due to a history of severe adverse reaction to a covid-19 vaccine(s) and/or covid-19 vaccine component(s), 600 mg.	ANCILLARY PROCEDURES FILE
Q0221	Injection, tixagevimab and cilgavimab, for the pre-exposure prophylaxis only, for certain adults and pediatric individuals (12 years of age and older weighing at least 40kg) with no known sars-cov-2 exposure, who either have moderate to severely compromised immune systems or for whom vaccination with any available covid-19 vaccine is not recommended due to a history of severe adverse reaction to a covid-19 vaccine(s) and/or covid-19 vaccine component(s), 300 mg.	ANCILLARY PROCEDURES FILE
Q0222	Injection, bebtelovimab, 175 mg	ANCILLARY PROCEDURES FILE
M0222	Intravenous injection, bebtelovimab, includes injection and post administration monitoring	399
M0223	Intravenous injection, bebtelovimab, includes injection and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider-based to the hospital during the covid-19 public health emergency	399
Q0239	Injection, bamlanivimab, 700 mg	ANCILLARY PROCEDURES FILE
M0239	Intravenous infusion, bamlanivimab-xxxx, includes infusion and post administration monitoring	399

11) Add the following CPT codes to line 3 PREVENTION SERVICES WITH EVIDENCE OF EFFECTIVENESS

CPT Code	Code Description	Recommended Placement
91310	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, monovalent, preservative free, 5 mcg/0.5 mL dosage, adjuvant AS03 emulsion, for intramuscular use	3 PREVENTION SERVICES WITH EVIDENCE OF EFFECTIVENESS

CPT Code	Code Description	Recommended Placement
		Pending FDA approval/EUA
0104A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, monovalent, preservative free, 5 mcg/0.5 mL dosage, adjuvant AS03 emulsion, booster dose	3 *Pending FDA approval/EUA*
0074A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV- 2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation; booster dose	3 PREVENTION SERVICES WITH EVIDENCE OF EFFECTIVENESS

MOTION: To approve the recommendations stated in the consent agenda. CARRIES 6-0. *(Absent: Duty, Schabel)*

- **Topic: Visual field testing**

Discussion: Smits presented the summary document. There was minimal discussion.

Public testimony
Julie Falardeau, ophthalmologist, OHSU: Dr. Falardeau testified that visual field testing is a diagnostic tool for a variety of conditions, such as tumor progression or localizing residual field deficits. The ability to objectively quantify visual deficits is very important and she relies very heavily on this tool to answer diagnostic questions.

Recommended Actions:
1) Remove visual field testing (CPT 92081-92083, 92133) from all current lines on the Prioritized List
    a. Advise HSD to add CPT 92081-92083, 92133 to the Diagnostic Procedure File

MOTION: To recommend the code changes as presented. CARRIES 6-0.
(Absent: Duty, Schabel)

- **Topic: Adenoidectomy update**

Discussion: Smits presented the summary document. Hodges requested clarification of the wording around when symptoms were directly related to the adenoids. Dr. Kelley suggested "ear infections associated with rhinorrhea." Further subcommittee discussion also added "and/or upper respiratory infection."

Dr. Kelley also requested a review of the current guideline for tonsillectomy, specifically on the number of required strep infections needed for qualifying for surgery. HERC staff will review her materials and bring this topic in August for further discussion.

Recommended Actions:
1) Modify GN51 as shown in Appendix A

MOTION: To recommend the guideline note changes as amended. CARRIES 6-0.
(Absent: Duty, Schabel)

- **Topic: Bilateral bone anchored hearing aids**

Discussion: Smits reviewed the summary document. Dr. Kelley recommended removing the proposed guideline criteria that a "patient is clinically unsuitable for other medical or surgical treatments" as a patient might be suitable for a surgery but is getting adequate hearing with a BAHA. Dr. Kelley also noted that some children older than age 5 use the headband-mounted BAHA devices and that if these work well, then the child should not be forced to undergo surgical implantation. The guideline was modified to allow headband use after age 5.

The subcommittee discussed coverage after age 20. The intent is that persons who had a BAHA inserted or a BAHA headband used prior to age 21 to continue to have these devices maintained after that age. Two sentences which reflect that intent were added to the guideline.

Recommended Actions:
1) Modify GN103 as shown in Appendix A

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

- **Topic: Temporary urethral stents 2022**

Discussion: There was minimal discussion for this topic.

Recommended Actions:
1) Add HCPCS C9769 (Cystourethroscopy, with insertion of temporary prostatic implant/stent with fixation/anchor and incisional struts) to line 662 CONDITIONS FOR WHICH CERTAIN INTERVENTIONS ARE UNPROVEN, HAVE NO CLINICALLY IMPORTANT BENEFIT OR HAVE HARMS THAT OUTWEIGH BENEFITS
2) Modify GN173 as shown in Appendix A

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

- **Topic: Fecal lactoferrin**

Discussion: There was minimal discussion for this topic.

Recommended Actions:
1) Remove 83631 Lactoferrin, fecal; quantitative from Line 662 CONDITIONS FOR WHICH CERTAIN INTERVENTIONS ARE UNPROVEN, HAVE NO CLINICALLY IMPORTANT BENEFIT OR HAVE HARMS THAT OUTWEIGH BENEFITS

a. Advise HSD to place CPT 83631 on the Diagnostic Procedures File

2) Delete the GN173 entry for CPT 83631

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

- **Topic: Gastric neurostimulators**

Discussion: There was minimal discussion for this topic.

Recommended Actions:

1) Add the following codes to lines 8 TYPE 1 DIABETES MELLITUS, 27 TYPE 2 DIABETES MELLITUS and 529 DISORDERS OF FUNCTION OF STOMACH AND OTHER FUNCTIONAL DIGESTIVE DISORDERS
    a. CPT 43647 Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum
    b. CPT 43648 Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum
    c. CPT 43881 Implantation or replacement of gastric neurostimulator electrodes, antrum, open
    d. CPT 43882 Revision or removal of gastric neurostimulator electrodes, antrum, open
    e. HCPCS E0765 FDA approved nerve stimulator, with replaceable batteries, for treatment of nausea
2) Advise HSD to remove the above codes from the Excluded File
3) Adopt a new guideline for lines 8, 27, and 529 as shown in Appendix B

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

- **Topic: Routine monitoring MRIs in multiple sclerosis**

Discussion: There was minimal discussion for this topic. Hodges requested that the minutes reflect the intent is that MRI of both the brain and spine are covered for multiple sclerosis.

Recommended Actions:

1) Delete Diagnostic Guideline D10

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

- **Topic: Coronary CT angiography**

Discussion: There was minimal discussion for this topic.

Recommended Actions:

1) Remove CPT 75572 and 75574 (CT heart) from line 662 CONDITIONS FOR WHICH CERTAIN INTERVENTIONS ARE UNPROVEN, HAVE NO CLINICALLY IMPORTANT BENEFIT OR HAVE HARMS THAT OUTWEIGH BENEFITS
    a. Advise HSD to add CPT 75572 and 75574 to the Diagnostic Procedures File
    b. Remove the entries for CPT 75572 and 75574 from GN173
2) Advise HSD to add CPT 0501T-0504T (Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease) to the Diagnostic Procedures File

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

- **Topic: Rhinophyma shaving**

Discussion: There was minimal discussion for this topic.

Recommended Actions:

1) Remove CPT 30120 (Excision or surgical planing of skin of nose for rhinophyma) from the following lines
    a. 466 CHRONIC SINUSITIS
    b. 506 NASAL POLYPS, OTHER DISORDERS OF NASAL CAVITY AND SINUSES
    c. 525 BENIGN NEOPLASM OF NASAL CAVITIES, MIDDLE EAR AND ACCESSORY SINUSES
2) Add CPT 30120 to line 522 ROSACEA; MILD/MODERATE ACNE

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

- **Topic: Spinal cord stimulators for diabetic peripheral neuropathy**

Discussion: Smits presented the issue summary. There was concern regarding the small sample sizes in the studies presented. Olson noted that the best evidence regarding rates of adverse events was 6%, there was a signal for effectiveness of this therapy, but the lack of large sample sizes makes the effectiveness of the therapy in a larger population unknown. He noted that it was an invasive therapy. Pinzon noted that diabetics are at high risk of infection with any surgery. Hodges noted the high cost of the procedure, as well as the cost of treating complications. The decision was to make no change in the non-pairing of spinal cord stimulators with diabetic peripheral neuropathy.

- **Topic: Shoulder arthroplasty with subacromial spacers**

Discussion: There was minimal discussion for this topic

Recommended Actions:

1) Place HCPCS C9781 (Arthroscopy, shoulder, surgical; with implantation of subacromial spacer (e.g., balloon), includes debridement (e.g., limited or extensive), subacromial decompression,

acromioplasty, and biceps tenodesis when performed) on line 662/GN173 as shown in Appendix A

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

- **Topic: Erythropoietin in chronic renal disease**

Discussion: Smits reviewed the issue summary. Olson requested that wording be added to the guideline to require that there be no iron deficiency prior to erythropoietin therapy.

Recommended Actions:
1) Modify GN7 as shown in Appendix A

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

- **Topic: Orthodontia guideline update**

Discussion: There was minimal discussion for this topic.

Recommended Actions:
1) Modify Guideline Note 196 as shown in Appendix A

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

- **Topic: Benign gastrointestinal carcinoid tumors**

Discussion: There was minimal discussion for this topic.

Recommended Actions:
1) Add the ICD-10-CM D3A.0 family (benign GI carcinoid tumors) to line 157 CANCER OF COLON, RECTUM, SMALL INTESTINE AND ANUS and remove from line 638 BENIGN NEOPLASMS OF DIGESTIVE SYSTEM
2) Add ICD-10CM D3A.093 (Benign carcinoid tumor of the kidney) to line 214 CANCER OF KIDNEY AND OTHER URINARY ORGANS and remove from line 638 BENIGN NEOPLASMS OF DIGESTIVE SYSTEM

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

- **Topic: Coverage Guidance— PANDAS/PANS**

Discussion: The Center for Evidence Based Policy (CEBP) and HERC staff presented the evidence review on PANDAS/PANS from EbGS. Smits reviewed the recommended changes to the Prioritized List that would correspond with the EbGS recommendations.

Staff noted that the Oregon pediatric infectious disease specialists requested that they not be included in this guideline. A friendly amendment was made to remove mention of this group from the proposed Prioritized List guideline.

Public testimony

1) Sarah Lemley, Executive Director of the NW PANDAS/PANS Network and mother of a child with PANDAS: Ms. Lemley testified that there is a lack of expertise in these conditions in Oregon. She said the Commission needs to rely on the expertise of national experts. She listed Oregon and national experts who agreed with current recommendations, including psychiatrists and neurologists. Per Ms. Lemley, IVIG is approved for PANDAS by several commercial insurers. Bethany Godlewski, CEBP staff, clarified that that research reflected in the coverage guidance failed to find payer policies supporting coverage by commercial insurers.

2) Cristina Cronin-Vejar, mother of a patient with PANDAS/PANS: Ms. Cronin-Vejar testified of her daughter's symptoms, which were relieved partially by antibiotics, NSAIDs, tonsillectomy, SSRIs, and other treatments. However, she noted that her daughter has never returned to her baseline self after these therapies. Her daughter has difficultly with school. Not having access to IVIG is very distressing to her family.

3) Deborah Miller, the mother of patient with PANDAS: Ms. Miller urged adoption of proposed coverage, stating that her child needs IVIG therapy.

4) Dan Twibell, PACE foundation and father of a PANDAS child: Mr. Twibell testified that PACE is a non-profit organization dedicated to increasing awareness and treatment for PANDAS/PANS. PACE recommends that the EbGS recommendation be adopted by VbBS and HERC.

The subcommittee discussed their concerned with the lack of efficacy for these invasive and possibly harmful treatments. The experts were asked what percentage of PANDAS/PANS patients require IVIG. Daines replied that 10-15% of patients receive IVIG in his specialty clinic and that less-invasive treatments are always tried first. Olson asked how the effectiveness of IVIG or other therapies are determined. Daines replied that his center uses neuropsychiatric testing, but he has many specialists in his clinic. OCD-related scores can be used. Olson asked what the timeframe is for when clinicians see a response to IVIG treatment. Daines replied that response is generally seen in the first 3 months of IVIG. He only continues IVIG past 3 months if there is a significant but partial response. Pinzon asked how long children require IVIG treatment. Daines replied that most children only require a few months of treatment, but about 5% require long-term IVIG treatment. Some children need repeat IVIG for recurrent symptoms after a subsequent infection. Multidisciplinary clinics that are readily available are the ideal setting for treatment; in the absence of such a center, a skilled provider can be sufficient for IVIG decisions. Hodges asked if this therapy is available in Oregon, as OHP rules require treatment in-state when available. Drs. Zarrinnegar and Christy both indicated that their health systems provide IVIG treatment. It was also noted that IVIG can be infused in the home.

Pinzon reflected that the testimony indicated that Oregon does not have the expertise for treatment of PANDAS/PANS. Zarrinnegar noted that she learned about PANDAS treatment through individual training/education and through reaching out to specialty centers in other states.

Olson reflected on the lack of evidence but the need to balance the vulnerability of the population. Pinzon also noted that the severity of the symptoms affects the decision around coverage. There was general concern with including coverage for plasmapheresis. The subcommittee recommended removing plasmapheresis from the proposed Prioritized List guideline as well as recommend that HERC strike coverage of plasmapheresis from the blue box of the coverage guidance report and amend the plasmapheresis evidence table.

Saenger expressed concern for how the end point of treatment is determined. He also expressed concern for the very small trial as the only evidence for this decision. He noted concern that assessment of effectiveness could be biased in these trials. Olson responded that the evidence base is very small, but the population is vulnerable and there is national expert consensus regarding treatment. Godlewski noted that Daines' IVIG trial data should be available in the next year or two. The subcommittee had concerns with waiting to provide coverage for sick, vulnerable children in the interim until the data from that study is available. Olson noted that if coverage of IVIG is adopted, it can be revisited once trial data from the study is available.

Saenger noted concern with publication bias, as negative trials tend to not get published. Hodges expressed concern about paying for an experimental treatment.

The final decision was to recommend the proposed guideline with the striking of plasmapheresis as a coverage therapy.

Recommended Actions:

1) Add ICD-10-CM D89.9 (Disorder involving the immune mechanism, unspecified) to line 313
2) Add a new guideline to line 313 DISORDERS INVOLVING THE IMMUNE SYSTEM as shown in Appendix B

A motion was made to approve the amended changes to the Prioritized List based on the draft coverage guidance scheduled for review by HERC at its May 19, 2022 meeting. **Motion approved 6-2** *(Opposed: Hodges, Saenger).*

- **Public Comment:**

  No additional public comment was received.

- **Issues for next meeting:**
  Review of the tonsillectomy guideline

- **Next meeting:**

  August 11, 2022, virtual meeting.

- **Adjournment:**

  The meeting adjourned at 12:30 PM.

Appendix A

Revised Guideline Notes

~~**DIAGNOSTIC GUIDELINE D10, MRI IN MULTIPLE SCLEROSIS**~~

~~MRI is a diagnostic test for multiple sclerosis and should not be used for routine monitoring of disease.~~

~~MRI may be considered in the following circumstances:~~

- ~~A) Suspected drug failure in the setting of clinical relapse in patients with objective changes in neurological status or documented new clinical symptoms such as urinary urgency or cognitive changes~~
- ~~B) Evaluation of a clear objective progression in clinical symptoms in patients with previously relapsing disease to rule out ongoing inflammatory disease when conversion to secondary progressive MS is suspected~~
- ~~C) Patients who require enhanced pharmacovigilance, including~~
  - ~~1) Yearly monitoring for patients treated with natalizumab who are JCV seropositive~~
  - ~~2) One MRI for patients who switch from natalizumab to other therapeutics (including fingolimod, alemtuzumab and dimethyl fumarate) one year after the switch from natalizumab~~

GUIDELINE NOTE 7, ERYTHROPOIESIS-STIMULATING AGENT (ESA) GUIDELINE

Lines 12,59,92,94,111-115,125,133,135,157,158,161,163,179,191,199,200,208,210,214,215,217, 229,234,237,238,258-262,271,276,286-288,294,295,314-316,329,339,396,397,401,419,435,559,593

- A) Indicated for anemia (Hgb < 10gm/dl or Hct < 30%) induced by cancer chemotherapy given within the previous 8 weeks or in the setting of myelodysplasia.
  - 1) Reassessment should be made after 8 weeks of treatment. If no response, treatment should be discontinued. If response is demonstrated, ESAs should be discontinued once the hemoglobin level reaches 10, unless a lower hemoglobin level is sufficient to avoid the need for red blood cell (RBC) transfusion.
- B) Indicated for anemia (Hgb < 10gm/dl or HCT < 30%) associated with HIV/AIDS.
  - 1) An endogenous erythropoietin level < 500 IU/L is required for treatment, and patient may not be receiving zidovudine (AZT) > 4200 mg/week.
  - 2) Reassessment should be made after 8 weeks. If no response, treatment should be discontinued. If response is demonstrated, the lowest ESA dose sufficient to reduce the need for RBC transfusions should be used, and the Hgb should not exceed 11gm/dl.
- C) Indicated for anemia (Hgb < 10 gm/dl or HCT <30%) associated with chronic renal disease ~~failure~~, with or without dialysis, in the absence of iron deficiency.
  - 1) Reassessment should be made after 12 weeks. If no response, treatment should be discontinued. If response is demonstrated, the lowest ESA dose sufficient to reduce the need for RBC transfusions should be used, and the Hgb should not exceed 11gm/dl. In those not on dialysis, the Hgb level should not exceed 10gm/dl.

Appendix A

GUIDELINE NOTE 51, CHRONIC OTITIS MEDIA WITH EFFUSION

Lines 311,424,446,476

Antibiotic and other medication therapy (including antihistamines, decongestants, and nasal steroids) are not indicated for children with chronic otitis media with effusion (OME) (without another appropriate diagnosis).

Patients with specific higher risk conditions (including craniofacial anomalies, Down's syndrome, and cleft palate, or documented speech and language delay) along with hearing loss and chronic otitis media with effusion are intended to be included on Line 311 or Line 446 for children up to and including age 7. Otherwise hearing loss associated with chronic otitis media with effusion (without those specific higher risk conditions) is only included on Line 476.

For coverage to be considered on Line 311, Line 446 or Line 476, there should be a 3 to 6 month watchful waiting period after diagnosis of otitis media with effusion, and if documented hearing loss is greater than or equal to 25dB in the better hearing ear, tympanostomy surgery may be indicated, given short- but not long- term improvement in hearing. Formal audiometry is indicated for children with chronic OME present for 3 months or longer. Children with language delay, learning problems, or significant hearing loss should have hearing testing upon diagnosis. Children with chronic OME who are not at risk for language delay (such as those with hearing loss <25dB in the better hearing ear) or developmental delay should be reexamined at 3- to 6-month intervals until the effusion is no longer present, significant hearing loss is identified, or structural abnormalities of the eardrum or middle ear are suspected.

Adenoidectomy is ~~not indicated at the time of first pressure equalization tube insertion. It may be indicated in children aged 4 and older who are having their second set of tubes.~~ included on these lines at the time of tympanostomy tube insertion for children under age 4 with symptoms directly related to the adenoids (for example, ear infection associated with rhinorrhea and/or upper respiratory infection) OR in children aged 4 years or older.

Removal of retained tympanostomy tubes requiring anesthesia (CPT code 69424) or as an office visit, is included on Line 424 as a complication, pairing with ICD-10-CM H74.8.

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 103, BONE ANCHORED HEARING AIDS

Lines 311,446

Bone anchored hearing aids (BAHA, CPT 69714, 69715; HCPCS L8690-L8694) are included on these lines when the following criteria are met:

A) The patient is aged 5-20 years for initial implanted bone anchored hearing aids or headband mounted BAHA devices; headband mounted BAHA devices may be used for children under age 5; AND

B) ~~Treatment is for unilateral severe to profound hearing loss when the contralateral ear has normal hearing with or without a hearing aid~~

C) ~~Traditional air amplification hearing aids and contralateral routing of signal (CROS) hearing aid systems are not indicated or have been tried and are found to be not effective~~
D) ~~Implantation is unilateral.~~
E) The patient has one of the following:
   1) Permanent bilateral conductive or mixed hearing loss (for example, congenital malformation of the middle/external ear, microtia, or ossicular disease) unable to be aided by conventional air conducting devices; OR
   2) Unilateral conductive hearing loss with ear canal stenosis or ear canal atresia that is unlikely to benefit from surgery; OR
   3) Profound unilateral sensorineural hearing loss when the contralateral ear has normal hearing with or without a hearing aid; OR
   4) Temporary bilateral conductive hearing loss in patients with cleft palate and middle ear effusions until their palate is repaired and tympanostomy tubes can be placed (for BAHA headband only).

Continuation and maintenance of these devices is included on these lines. This includes patients over the age of 20 who received these devices in childhood or adolescence.

Use of BAHA for treatment of tinnitus is not covered.

[see further wording changes made at the 5/19/22 HERC meeting]

GUIDELINE NOTE 169, ORTHODONTICS FOR CRANIOFACIAL ANOMALIES AND HANDICAPPING MALOCCLUSION

Line 256

Orthodontic treatment is included on this line for persons under the age of 21 with

1) Cleft lip and palate, cleft palate or cleft lip with alveolar process involvement, OR
2) Other craniofacial anomalies resulting in significant malocclusion expected to result in difficulty with mastication, speech, or other oral function, OR
3) ~~Deep impinging overbite when lower incisors are destroying the soft tissue of the palate, tissue laceration and/or clinical attachment must be present, OR~~
4) ~~Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present, OR~~
5) ~~Severe traumatic deviation, OR~~
6) ~~Overjet greater than 9mm with incompetent lips or mandibular protrusion (reverse overjet) greater than 3.5mm with masticatory and speech difficulties; OR~~
7) Severe malocclusions with a Handicapping Labiolingual Deviation Index California Modification score of 26 or higher; AND
8) Free and clear of active decay and periodontal disease, verified by a dental exam in past 6 months

Advanced dental imaging is included on this line only when required for surgical planning for repair of craniofacial anomalies

Appendix A

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
C9781	Arthroscopy, shoulder, surgical; with implantation of subacromial spacer (e.g., balloon)	Insufficient evidence of effectiveness	May 2022
53855 C9769	Temporary prostatic stents	Insufficient evidence of effectiveness	~~October, 2015~~ May 2022
~~75572~~	~~Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology~~	~~Insufficient evidence of effectiveness~~	~~December, 2009~~
~~75574~~	~~Computed tomography, heart~~	~~Insufficient evidence of benefit, unclear harms of radiation exposure~~	~~August, 2013 Coverage guidance~~
~~83631~~	~~Lactoferrin, fecal; quantitative~~	~~Insufficient evidence of effectiveness~~	~~January 2006~~

Appendix B

New Guideline Notes

GUIDELINE NOTE XXX GASTRIC ELECTRICAL STIMULATION

Line 8, 27,529

Gastric electrical stimulation (CPT 43657, 43648, 43881, 43882) is included on these lines only for pairing with diabetic gastroparesis (ICD-10-CM E10.43, E11.43) or idiopathic gastroparesis (ICD-10-CM K31.84) and only when ALL of the following criteria are met:

1) The patient has intractable nausea and vomiting secondary to gastroparesis of diabetic or idiopathic etiology; AND
2) The patient is refractory or intolerant of prokinetic medications and antiemetic medications; AND
3) The patient is not on opioid medications; AND
4) The patient does not have abdominal pain as the predominant symptom.

GUIDELINE NOTE XXX PANDAS AND PANS

Line 313

Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) is included on this line when coded with ICD-10-CM D89.89 (Other specified disorders involving the immune mechanism, not elsewhere classified). Pediatric Acute-Onset Neuropsychiatric Syndrome *(*PANS) is included on this line when coded with ICD-10-CM D89.9 (Disorder involving the immune mechanism, unspecified).

Up to 3 monthly immunomodulatory courses of intravenous immunoglobulin (IVIG) therapy is included on this line to treat PANDAS and PANS when both of the following are met:

a) A clinically appropriate trial of two or more less-intensive treatments (for example, appropriate limited course of nonsteroidal anti-inflammatory drugs (NSAIDs), corticosteroids, selective serotonin reuptake inhibitors (SSRIs), behavioral therapy, short-course antibiotic therapy) was either not effective, not tolerated, or did not result in sustained improvement in symptoms (as measured by a lack of clinically meaningful improvement on a validated instrument directed at the patient's primary symptom complex). These trials may be done concurrently, AND
b) A consultation with and recommendation from a pediatric subspecialist (for example, pediatric neurologist, pediatric psychiatrist, neurodevelopmental pediatrician, pediatric rheumatologist, pediatric allergist/immunologist) as well as the recommendation of the patient's primary care provider (for example, family physician, pediatrician, pediatric nurse practitioner, naturopath). The subspecialist consultation may be a teleconsultation. For adolescents, an adult subspecialist consult may replace a pediatric subspecialist consult.

A reevaluation at 3 months by both the primary care provider and pediatric expert is required for continued therapy of IVIG. This evaluation must include clinical testing with a validated instrument, which must be performed pretreatment and posttreatment to demonstrate clinically meaningful improvement.

Appendix B

Long term antibiotic therapy is not included on this line for treatment of PANDAS/PANS. Therapeutic plasma exchange (CPT 36514) does not pair with PANDAS or PANS (ICD-10-CM D89.89 or D89.9) on this line.

Statewide CCO Learning Collaborative Agenda

Quality and Health Outcomes Committee Meeting
June 13, 2022
11 a.m.–12:30 p.m.

Register here (required): https://www.zoomgov.com/meeting/register/vJItfu2grj8iHrsRSmVLIwECQ_IYL5GNlKs

Zoom meeting info

- **Link to join after registering:** https://www.zoomgov.com/j/1609480484?pwd=em50aUorQ3JWYjRBeFpEa2dudE1ydz09
- **Meeting ID:** 160 948 0484
- **Passcode:** 114502
- **One tap mobile:** +16692545252,,1609480484#,,,,*114502#

CCO incentive metric: Childhood immunization status (combo 3)

Session objective: Explore barriers and strategies for increasing routine childhood immunizations (percentage of kids who are up to date on vaccines by their second birthday).

1. **Welcome and overview** (5 minutes)
    - Lisa Bui, Quality Improvement Director, OHA Health Policy and Analytics

2. **Review of childhood immunization measure specifications and CCO performance** (5 minutes)
    - Sara Kleinschmit, Senior Policy Advisor, OHA Health Policy and Analytics
    - Andy Parker, Lead Medicaid Research Analyst, OHA Health Policy and Analytics

3. **Impact of COVID-19 pandemic on routine immunizations in Oregon** (10 minutes)
    - Steve Robison, OHA Immunization Program

4. **Promoting routine immunization catch-up: communication resources** (20 minutes)
    - Susan Wickstrom, Communications Coordinator, OHA Immunization Program

5. **CCO strategies for increasing childhood immunizations** (15 minutes)
    - Elke Geiger, CCO Director, PacificSource – Columbia Gorge

6. **Clinic strategies for increasing childhood immunizations** (15 minutes)
    - Dr. Jay Rosenbloom, Medical Director, Children's Health Alliance Medical Director; Pediatrician, Pediatric Associates of the NW

7. **Discussion** (15 minutes)
    - Susan Wickstrom, Communications Coordinator, OHA Immunization Program

8. **Wrap-up and next steps** (5 minutes)
    - Lisa Bui, Quality Improvement Director, OHA Health Policy and Analytics