Quality and Health Outcomes Committee
Agenda
April 13, 2015

DHS Building Room 137A-D, Salem, OR
Toll free dial-in: **888-278-0296** Participant Code: **310477**

Medical Director Workgroup			
Time	**Topic**	**Owner**	**Related Documents**
9:00 – 9:05 a.m.	**Welcome** - **Consent Agenda** - **March QHOC meeting notes**	Tracy Muday, Chair	March QHOC minutes
9:05 – 9:15 a.m.	**MAP Updates**	Chris Barber, Chris Norman	
9:15 – 9:30 a.m.	**Legislative Update**	Brian Nieubuurt	
9:30 – 9:40 a.m.	**Metrics Update**	Sarah Bartelmann	April metrics update
9:40 – 10:05 a.m.	**HERC Update**	Ariel Smits	HERC minutes VbBS minutes Back pain handout IVC filter TURP alternatives
10:05 – 10:20 a.m.	**QPI Updates**	Chris Barber	
10:20 – 10:30 a.m.	**BREAK**		
Joint Session: Medical Directors and QPI Workgroup			
10:30 – 3:00 p.m.	**CCO Learning Collaborative: Leading Change**	Ed O'Neil, PhD	Leading Change Leadership Lab Book
12:30 – 1:00 p.m.	**Lunch Break**		

Division of Medical Assistance Programs
Quality & Health Outcomes Committee
Meeting Notes
March 9, 2015 9:00 a.m. –2:30 p.m.
Human Services Bldg. 500 Summer St. NE, Salem, Oregon
Room 137 A-D

In Attendance:

Anne Alftine (JCC), Susan Arbor (OHA/MAP), Joell Archibald (OHA), Lori Ashbaugh (WVCH), Bruce Austin (Capitol Dental), Joseph Badolato (FamilyCare), Chris Barber (OHA/MAP), Sarah Bartlemann (OHA), Bill Bouska (OHA), Stuart Bradley (WVCH), Lisa Bui, Jim Calvert (CHA), Emileigh Canales (FamilyCare), Barbara Carey (Health Share), Jody Carson (Acumentra), Christine Castle (YCCO), Thomas Cogswell (OHA), Laurence Colman (GOBHI), Coleen Connoly (Trillium), Peg Crowley (WOAH), Eric Davis (Pain Commission), Trevor Douglass (OHA/MAP), David Engen (IHN/CCO), David Fischer (OHA), Rosa Frank (OHA/MAP), Jim Gaudino (OHSU), Walter Hardin (THA), Rosanne Harksen (OHA/MAP), Jenna Harms (Yamhill CCO), Hank Hickman (OHA/MAP), Holly Jo Hodges (WVP/WVCH), Matthew Hough (Jackson Care Connect), Angela Kimball (OHA), Deborah Larkins (DHS), Lynnea Lindsey-Pengelly (Trillium), Alison Little (PacificSource), Cat Livingston (HERC), Stephen Loudermilk, Deborah Loy (Capitol Dental), Kathryn Lueken (WVCH), Laura Matola (AllCare), Laura McKeane (AllCare), Keri Mintun (OHA), Tracy Muday (WOAH), Chris Norman (OHA/MAP), Paolo Paz (THA), Jordan Raweins (EOCCO), Rose Rice (UHA), Dean Robinson (Peace Health), Ryan Rushy (Kaiser), Wally Shaffer (OHA/MAP), Belle Shepherd (OHA),Nancy Siegel (Acumentra), Maria Snegirev (OHA/MAP), Debbie Standridge (UHA), Anna Stiefvater (PHD), Dayna Steringer WOAH & Advantage Dental), Ron Stock (OHA), Tidia Tan (FamilyCare), Jed Tancher (AllCare), Denise Taray (OHA), Jaclyn Testalli (CareOregon), Corinne Thayer (ODS), Melanie Tong (Wash. Co.), Jennifer Valentine (OHA/MAP), Mark Whitaker (Providence),

By phone: Ellen Altman (IHN-CCO), Tim Baxter, Darlene Cosby, Emilee Coulter-Thompson (OHA), Lyle Jackson (Mid-Rogue), Todd Jacobsen (GOBHI), Jennifer Johnstun (Primary Health), Cyndi Kallstrom (OHA), Kathleen Klemann (Family Care), Andrew Luther (OHMS), Melinda West (Access Dental), Dina Sites (GOBI), Rebecca Ross (UHA), Karri Benjamin (FamilyCare)

	Medical Directors Segment Chair: Tracy Muday	**9:00-11:00**
TOPIC ITEMS – UPDATES	**PRESENTATIONS / DISCUSSIONS**	**Action Items, Materials, & Resources**
Introductions & Announcements	▪ Consent Agenda	**Materials:** ▪ Agenda ▪ Meeting Notes from March QHOC meeting ▪ OHA/PHD Updates
MAP Updates	Wally Shaffer: ▪ Applications are being taken for Dr. Shaffer's replacement. Chris Barber: ▪ With changes in the staffing levels in QI, MAP will be working closely with the plans to manage deliverables Chris Norman: ▪ Discussed redeterminations and closures that did not happen.	

DME Rule Changes- Trevor Douglass	Discussed DME rule changes 410-122-0080 (19 & 20)	**Materials:** ▪ 410-122-0080
CoIIN Network- Anna Stiefvater, Cate Wilcox, and Chris Barber	CoIIN (Collaborative Improvement & Innovation Network) purpose is to reduce infant mortality. Targeted concerns are birth/death rates by race/ethnicity, and smoking cessation.	**Materials:** ▪ Collaborative Improvement & Innovation Network (CoIIN) to Reduce Infant Mortality
Complaints & Grievances- Chris Barber	Complaints/Grievances data is collected on the following five domains: ▪ Access ▪ Billing ▪ Clinical care ▪ Consumer rights ▪ Interaction ▪ Quality Statewide data is measured quarterly and per 1000 members.	**Materials:** ▪ Rates for all CCOs ▪ Hearings Outcomes Completed Quarter 4, 2014
Metrics Update- Sarah Bartlemann	▪ Data collection of hospital early elective delivery rates began March 6th and must be in by April 17, 2015; ▪ Cut-off date for claims submission (for metrics) is April 3, 2015;	**Materials:** ▪ Metrics Update for QHOC

	▪ Year Two Technology Plans- All CCOs have successfully submitted. Last date for approval is March 31, 2015; ▪ Year Two data submissions are due no later than April 1, 2015. ▪ Discussed the revised 2014 Quality Pool Estimates.	▪ OHA Revised 2014 Quality Pool Estimates by CCO
HERC Update- Cat Livingston	▪ Current OHP back pain coverage; ▪ Coverage Guidance's- Biomarker tests of cancerous tissue, Advanced imaging for staging of prostate cancer; ▪ EbGS Minutes 2/5/15 ▪ HTAS Minutes 2/23/15	**Materials:** ▪ Current OHP back pain coverage ▪ Coverage Guidance's- Biomarker tests of cancerous tissue, Advanced imaging for staging of prostate cancer ▪ EbGS Minutes 2/5/15 ▪ HTAS Minutes 2/23/15
	CCO Learning Collaborative	**11:00-12:30**
	Opiates and Pain Management	**Materials:** ▪ Evidence-based Strategies to Reduce Opiate Use for Chronic Pain
	QI Segment	**1:00- 3:00**

Announcements, Updates: MAP, DCO, EQRO	**Announcements: Chris Barber** ▪ March OHA/PHD update was on Meningococcal Immunizations; ▪ Interviews were conducted in the last few weeks to fill one of the Quality Improvement positions for OHA/MAP. **DCO Updates: Dayna Steringer** ▪ DCOs were asked for their final edits for the dental brochure by 3/12 and hope to finalize brochure at the March meeting; ▪ Dr. Bruce Austin is the new Dental Director for OHA and has requested for some time on the March DCO agenda. **EQRO Updates: Jody Carson** ▪ This year's Quality Assessment Performance Improvement reviews have started; ▪ Next, phone follow-ups on ISCA reviews will be conducted.	
PIP Work Session- Development of New Statewide PIP- Current PIP Review	▪ PIP work session was conducted to come up with at least 3 options/topics for the Statewide PIP. Once, the 3 options get identified, Chris and Lisa will work together with the state teams on how to move forward with the new integrated Statewide PIP for 2015-2017. Below are all the topics that came out of the work session: **Preconception Health-** ▪ Aligns with dental incentive, tobacco incentive, and COIIN-PH.	

Obesity-

- Nutrition services and chronic disease management.

Tobacco Cessation-

- Big topic- will have a metric;
- Fold into maternity care and other metrics;
- Social determinant of health.

Pediatric Population Rx Management (MH & PH)-

- Yes to data accessibility;
- Psychotropic rx/MH evaluation metric possibility.

Trauma Informed Care-

- Process based tool.

Maternal Medical Home-

- Preconception health had more interest;
- Comprehensive, and pre & post screening;
- Dental;
- SBIRT (7 Ps).

OPOID-

- Back pain HERC line change, MH/PH Integration;
- Opiod-Benzo use;
- 120 mg morphine equalivent;
- Data accessibility and population based.

DHS Incentive Metric-

- Population size too small, lack of scalability, coordination metric, and high priority population.

	MH/PCP Integration- ▪ Broad topic-need to narrow and how to take beyond our existing PHP (SPMI/DM). Depression Screening Dental Maternal Care Health Literacy SBIRT Chronic Disease Management: Diabetes Out of the 14 great topics/ideas 9 were selected (above in **bold**). The workgroup was asked to prioritize and rank all 9 categories using the tool (that came out of the PIP training) and submit to Chris. Chris and Lisa will work together on collating the info and will get back to group with the PIP results.	**Action Item:** • Chris and Lisa will be working with the group back and forth on the PIP selection. **Hand-out (Tool):** • July 2015-June 2017 Statewide PIP Prioritization Matrix; • This tool was sent out electronically to group prior to the meeting.

Next meeting:

Date: April 13, 2015

Time: 9:00 a.m. – 3:00 p.m.

Place: Human Services Building

500 Summer St NE, Room 137 A-D

Salem, OR

Metrics Updates for QHOC

April 13, 2015

2014 Metrics Timeline

OHA has provided a timeline for finalizing the 2014 CCO incentive metrics and distributing the quality pool. Upcoming dates are listed on page 2 below and the full timeline is available online at http://www.oregon.gov/oha/analytics/CCOData/2014%20Metrics%20Timeline.pdf.

2015 Specification Sheets

OHA has posted the 2015 measure specification sheets for the remaining state performance measures: http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx

Tobacco Prevalence using EHRs survey

OHA would like to learn more about EHR functionality and how tobacco use status is collected and reported. As a follow up to the March 26th Metrics TAG meeting, OHA is requesting CCOs explore a series of questions about EHRs at the CCO level or with various practices. This is not a required survey or new reporting requirement for CCOs; however, this information will provide additional context for developing a tobacco prevalence measure. The survey is available online at: https://www.surveymonkey.com/s/TobaccoEHR

Metrics Deeper Dive

In their March 2015 meeting, the Metrics & Scoring Committee expressed interest in learning more about what was "under the hood" driving CCO performance on the incentive metrics. The Committee is interested in additional context, or case studies, from CCOs and practices to help determine where improvements in performance are due to improved coding practices, random variation, or specific interventions put in place by the CCO or practice. Innovator Agents will be following up with CCOs to ask for additional information related to emergency department utilization and developmental screening in advance of the Committee's May 15th meeting.

Year Two Data Submissions

The CCOs' Year Two Data Submissions were due to OHA on April 1st; all 16 CCOs successfully submitted data. Each submission will undergo a two-step review process in order to determine that all requirements have been met and OHA will work with CCOs if modifications are needed. Submissions must be approved by May 31st in order to qualify for the associated incentive payment.

Medicaid Behavioral Risk Factor Surveillance Survey

OHA is releasing CCO-level and state-level results from the 2014 Medicaid Behavioral Risk Factor Surveillance Survey (MBRFSS) in April. OHA will be hosting a webinar on MBRFSS on Wednesday, April 15th at 1 pm. Register online at: https://attendee.gotowebinar.com/register/6502365897190437889

Questions

Please contact us at Metrics.Questions@state.or.us

2014 Metrics Timeline

Date	Item	For More Information
April 30, 2015	Chart review submission due to OHA • Colorectal cancer screening • Prenatal care • Postpartum care	Chart Review Guidance Document http://www.oregon.gov/oha/analytics/CCOData/2014%20Chart%20Review%20Guidance%20Document.pdf
April 30, 2015	OHA will provide CCOs with dashboard reflecting full-year 2014 metric results for CCOs to validate 2014 data. *Note this dashboard will not include the following CCO incentive measures: CAHPS access to care and satisfaction with care; colorectal cancer screening, prenatal care, and the three clinical quality measures (depression screening, hypertension, and HbA1c control)*	
May – June TBD	OHA will provide CCOs with 2014 baseline data for the new 2015 measures including dental sealants, effective contraceptive use, and SBIRT for adolescents.	
May 31, 2015	Cut off for approval of the three clinical quality measures. OHA will send notifications to CCOs via email.	
May 31, 2015	All CCO questions related to validation of 2014 data must be submitted to OHA.	
June 19 – 24, 2015	OHA will send CCOs their final 2014 measure results along with 2014 quality pool payment amounts, including challenge pool distribution. *Results will be included for the following CCO incentive measures: CAHPS access to care and satisfaction with care; colorectal cancer screening; and prenatal care rate.*	
June 23, 2015	OHA will release June dashboard to CCOs, including the rolling 12-month period of Feb 2014 – Jan 2015.	*This dashboard will be the first to reflect the 2015 specifications.*
June 30, 2015	CCOs will receive their 2014 quality pool payments no later than this date.	

Minutes

HEALTH EVIDENCE REVIEW COMMISSION
Clackamas Community College
Wilsonville Training Center, Rooms 111-112
Wilsonville, Oregon
March 12, 2015

Members Present: Susan Williams, MD, Chair Pro Tempore; Beth Westbrook, PsyD; Wiley Chan, MD; Vern Saboe, DC; Mark Gibson; Leda Garside, RN, MBA; Gerald Ahmann, MD, PhD; Holly Jo Hodges, MD; Chris Labhart.

Members Absent: Som Saha, MD, MPH, Chair; James Tyack, DMD; Irene Croswell, RPh.

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

Also Attending: Marty Carty, Perserverance Strategies; Jane Stephen & Karen Campbell, Allergan; Susan Bamberger & Mary Hlday, Oregon Physical Therapy Association; Robyn Liu, MD & Valerie King, MD, Center for Evidence-based Policy; Nora Stern, Providence.

Call to Order

Susan Williams, MD, Chair Pro Tempore of the Health Evidence Review Commission (HERC), called the meeting to order. Role was called.

Minutes Approval

MOTION: To approve the minutes of the 1/8/2015 meeting as presented. CARRIES 9-0.

Director's Report
Meeting materials, pages 44-46

Coffman shared recruitment for the DO vacancy is on hold until review by the new Governor. We are expecting an appointment in the next month.

The subcommittee restructuring approved at the last meeting is in transition. In addition to the new members who were seated in January, Saha will join HTAS, as chair, in June. To create a more even balance in subcommittees between physician and non-physicians, Coffman proposed to move:

- Dr. George Waldman from HTAS to EbGS
- Leda Garside, RN, from EbGS to HTAS

MOTION: To approve the proposed subcommittee member restructuring. CARRIES: 8-0. (Garside absent).

Coffman announced Dr. Wally Shaffer's retirement. Dr. Shaffer had been serving as lead clinical staff to HTAS.

Dr. Livingston noted a change to the coverage guidance evidence presentation process. VbBS will now hear the full evidence presentation, as the subcommittee's primary function is to review evidence related to Prioritized List changes. HERC members will still hear evidence, but in a less formal way, though the materials will be available in the meeting packet. This new process should theoretically bring more informed recommendations to HERC.

Jason Gingerich presented proposed changes to the Commission's public comment webpage; there is no content or process change, just a different way to present the information.

Value-based Benefits Subcommittee (VbBS) Report on Prioritized List Changes
Meeting materials, pages 47-99

Drs. Kevin Olson, Ariel Smits and Cat Livingston reported the VbBS met earlier in the day, March 12, 2015. Each helped to summarize a number of topics discussed.

Recommended code movement (effective 10/1/2015):
- Add straightforward coding changes and corrections
- Delete two dental procedure codes for sealant repair and cleaning of removable appliances and place on the *Services Not Recommended for Coverage Table*
- Add the procedure code for inferior vena cava (IVC) filters to three lines with deep vein thrombosis (DVT) and pulmonary embolism (PE) codes
- Add various procedures for treatment of lower urinary tract symptoms resulting from benign prostatic hypertrophy (BPH) to the covered BPH line, and delete several treatment codes, bringing the Prioritized List into agreement with the coverage guidance on treatments for BPH.

Recommended guideline changes (effective 10/1/15):
- Add a new guideline indicating that unilateral hearing loss treatment is only covered for children through age 20 and outlining what treatments are available for various levels of unilateral hearing loss
- Modify the guideline regarding bone anchored hearing aids (BAHAs) to reflect that BAHAs are only covered for children up to age 20 with normal hearing in the contralateral ear with or without hearing aids
- Add a new guideline allowing up to 8 weeks of proton pump inhibitor (PPI) treatment for gastroesophageal reflux (GERD). Failure of medication is a step in diagnostic evaluation for Barrett's esophagus.
- Add a new ancillary guideline which specifies that inferior vena cava (IVC) filters are covered for trauma patients requiring prolonged hospitalization when medically appropriate
- Add a new guideline regarding coverage of treatments for benign prostatic hypertrophy (BPH)
- Modify the guideline regarding intraocular steroid injections to include coverage criteria for use in diabetic macular edema

Recommended Biennial Review Changes (Effective 1/1/16):

- Merge and modify the cochlear implant guidelines to
  - allow hearing loss of 70dB or greater as the threshold to consider implantation for both children and adults
  - change the benefit received from hearing aids from “little or no” to “limited”
  - define what limited benefit means
- Merge the two cochlear implant lines and accept scoring that indicates placement into the funded region of the Prioritized List
- Add a new line for bone and joint conditions as high risk for complications and accept scoring that indicates placement into the funded region of the Prioritized List, with a guideline specifying when these conditions are eligible for treatment.
  - Accept rescoring the existing unfunded benign bone and joint conditions line to an appropriate lower priority position

MOTION: To accept the VbBS recommendations on Prioritized List changes not related to coverage guidances, as stated. See the VbBS minutes of 3/12/15 for a full description. Carries: 9-0.

Smits mentioned two ICD-10 codes were omitted from her earlier presentation and asked the Commission to considerer adding ICD-10-CM codes KO9.0 and KO9.1 to the lower bone and joint condition line.

MOTION: To accept recommendation as stated. CARRIES: 9-0.

Recommendations of the Back Pain Line Reorganization Task Force

Meeting materials, page 100-169

Under the current line structure, patients with a radiculopathy (nerve pain, pain radiating from the spine) may receive various treatments including medication, surgery (if needed), chiropractic care, acupuncture, and physical and occupational therapy. Patients without symptoms of radiculopathy theoretically receive no care without applying the comorbidity rule, though in reality, they would receive primary care office visits and medication, including opioids.

Oregon has seen a dramatic increase in the number of opioid overdose deaths and hospitalizations over the past few years. High-level meetings have been convened around the state to determine a root cause; one cause addressed was the Oregon Health Plan not providing treatment for back pain. Recent studies on opioid use show insufficient evidence for long term benefit and significant evidence of dose-dependent risk of harms.

Jason Gingerich gave an overview of certain statistics about OHP patients who have had treatment for back pain. The data sample was taken from the All Payer All Claims (APAC) database for calendar year 2013. The data has certain exclusions and does not account for every scenario, including patients moving on and off OHP and the differences in benefits between OHP Standard and OHP Plus at that time.

- Of 47,000 patients who had a primary diagnosis of back pain, there were:
  - 9,500 emergency department visits
  - 1,500 surgeries performed

- Costs break down for patients who did not have surgery:
    - Prescription costs: $4.3M were spent on opioids, for all patients, not just those reporting back pain (at least a portion of this was related to surgeries). This amount does not include patients with a cancer diagnosis.
    - $11.2 M Other, including emergency department, imaging, nursing, home health
    - Office visits: ~$5.7M
    - Less than $100K for chiropractic, acupuncture, OMT combined
    - ~$300K for PT/OT

Smits reported that the Back Pain Lines Reorganization Task Force, which includes representation from many fields (physicians, chiropractor, physiatrist, mental health professionals, etc), met a couple more times since she last reported in January. They propose a new emphasis on conservative care which focuses on timely treatment with a bio-psycho-social approach, encouraging patient activation and functional improvements:

- Those in a *low risk* category would receive office visits, up to 4 physical therapy (PT), occupational therapy (OT), osteopathic manipulation (OMT), chiropractic, or acupuncture treatments and certain over-the-counter medication and muscle relaxers.
- Those in the *high risk* category receive office visits, cognitive behavior therapy, up to 30 PT/OT/OMT/chiropractic/acupuncture treatments, certain over-the-counter medication and muscle relaxers, limited opioids, steroid injections and, if available, yoga, interdisciplinary rehab, supervised exercise and massage.
- Surgery would only be available for certain high risk conditions with good evidence that surgery helps more than conservative therapy
    - No coverage for non-urgent conditions
    - Scoliosis surgery limited to adolescents only

Proposal, to be effective January 1, 2016:

- Four back pain lines (see Appendix A), including:
    - One medical line prioritized approximately on Line 405
        - Combines conditions on current lines 374,412,545,588 as well as several diagnoses currently in the MAP Diagnostic Workup File (sciatica, lumbago, etc.). Procedures on this line include primary care and specialty office visits, emergency department (ED) visits, skilled nursing facility (SNF) care, patient education, medications, OMT/CMT, acupuncture, PT/OT, and cognitive behavioral therapy
    - Three surgical lines, all including office visits, medications, ED visits, inpatient and ICU care and SNF care
        - Prioritized approximately on Line 350: diagnoses with urgent/emergent surgical indications with good evidence that surgery is an effective treatment
        - Prioritized approximately on Line 364: scoliosis surgery for adolescents
        - Prioritized approximately on Line 535: diagnoses without good evidence of effective surgical treatment, or with evidence that surgery is equally effective to non-surgical care but with greater expense and/or risk
- Four new guidelines (see Appendix B):
    - Non-Interventional Treatments for Conditions of the Back and Spine – Outlines bio-psycho-social approach, encouraging patient activation and functional improvements.
        - **Discussion:**

            Westbrook asked if the task force considered group therapy.

        - Smits assured her the CPT code is included on the line, but was not specifically called out in the guideline language
    - Chan asked if we should recommend a specific evaluation tool.
        - The task force encouraged use of STarT Back but others can be used
        - Livingston shared information about an ARC study, pointing to inconsistencies in tools with no best tool recommendation
        - Smits said staff will work with the Transformation Center to disseminate a toolbox
  - Opioid Prescribing for Conditions of the Back and Spine – Restricts opioid prescribing to acute cases where conservative drugs have failed or are contraindicated and no more than 90 days for chronic cases
    - **Discussion**
      - Chan asked for examples of tools to evaluation function.
        - Hodges shared there are several available and did not think it appropriate to name one in the guideline
          - Hodges will send a list of tools to HERC staff
        - Taray added the tool selection depends on the population served
  - Surgical Interventions for Conditions of the Back and Spine Other Than Scoliosis – Outlines when surgery is appropriate
  - Scoliosis – Surgery only available for children and adolescents with spinal curvature greater than 45 degrees
- Revisions to existing guidelines (see Appendix C)
  - Diagnostic Guideline D4, Advanced Imaging for Low Back Pain
  - Guideline Note 92, Acupuncture
  - Percutaneous Interventions
    - Lumbar epidural steroid injections – available for radicular pain, 1-2 injections only
    - Cervical epidural steroid injections and facet joint radiofrequency neurotomy – not available
- Delete now obsolete guideline notes (see Appendix D)
- Relevant coding changes (see Appendix E)

Gibson called attention to the evidence summary (meeting materials, pages 121-125) which breaks down interventions and their efficacy, provided a crosswalk from research to reached conclusions. He observed the task force had a broad cross-section of professionals who work on back pain issues and even though this proposal is a departure from the way back pain has been handled in the past, this recommendation came with a very high degree of consensus.

MOTION: To adopt the VbBS proposal as presented (see Appendices A-E for details). CARRIES: 9-0.

Coverage Guidance: Alternatives to Transurethral Resection of the Prostate (TURP)
Meeting materials, page 171 | Handout, pages 10-27

Wally Shaffer, MD, presented a summary of the evidence. Dr. Eugene Fuchs (not present), of OHSU, was the appointed ad-hoc expert on this topic.

Lower Urinary Tract Syndrome happens when an enlarged prostate causes urinary retention symptoms. The treatment involves destroying prostate tissue, or lifting it out of the way. Transurethral Resection of the Prostate (TURP) is the established treatment, but requires hospitalization and has risk of transurethral resection (TUR) syndrome, a serious complication.

Evidence Summary:

- TURP has significantly better symptomatic outcomes (symptoms, flow rate, QoL) than most of the alternative procedures
  - at the expense of a higher rate of transfusions, and in some cases, other adverse outcomes
- TURP alternatives where symptomatic outcomes are similar or better, resulting in strong recommendation of coverage:
  - Bipolar resection of the prostate (Bipolar TURP)
  - Photoselective Vaporization of the Prostate (PVP, also know as "Greenlight")
  - Laser Enucleation of Prostate, including Holmium (HoLEP)
  - TUIP (Transurethral Incision of the Prostate)
- TURP alternatives where outcomes are not as good as alternatives but risks are less or other considerations resulted in weaker recommendation:
  - Transurethral Needle Ablation of Prostate (TUNA)
  - Transurethral Microwave Thermotherapy (TUMT)
- TURP alternatives where outcomes/risks are similar but quality of evidence not as good, resulting in weaker recommendation:
  - Thulium vaporization/laser resection
- TURP alternatives where outcomes are better in short-term but not long-term, resulting in weaker recommendation:
  - Bipolar TUVP (Transurethral Electrovaporization of Prostate) or "Button procedure"
- TURP alternatives where evidence is insufficient to recommend coverage:
  - Botulinum toxin
  - HIFU (High Intensity Focused Ultrasound)
  - TEAP (Transurethral Ethanol Ablation of the Prostate)
  - Prostatic urethral lifts
- TURP alternatives where evidence is insufficient to recommend coverage:
  - Laser coagulation
  - Prostatic artery embolization

MOTION: To approve the proposed coverage guidance for Alternatives to Transurethral Resection of the Prostate (TURP) as presented. Carries 9-0.

MOTION: To approve the proposed coding changes and new guideline, Treatments for Benign Prostate Enlargement with Lower Urinary Tract Symptoms, for the Prioritized List as proposed. Carries 9-0.

Approved Coverage Guidance:

HERC Coverage Guidance

For men with lower urinary tract symptoms (LUTS) due to benign prostate enlargement, coverage of surgical procedures is recommended only if symptoms are severe, and if drug treatment and conservative management options have been unsuccessful or are not appropriate. (*strong recommendation*)

The following are coverage recommendations regarding surgical alternatives to transurethral resection of the prostate (TURP):

Recommended for coverage (*strong recommendation*):

- Bipolar TURP
- Photoselective vaporization of the prostate (PVP)
- Laser enucleation; HoLEP (Holmium Laser Enucleation of Prostate)
- TUIP (Transurethral Incision of the Prostate)

Recommended for coverage (weak recommendation):

- TUNA (Transurethral Needle Ablation of Prostate)
- TUMT (Transurethral Microwave Thermotherapy)
- Bipolar TUVP (Transurethral Electrovaporization of Prostate) (Button procedure)
- Thulium laser vaporization/resection of the prostate

Not recommended for coverage (*weak recommendation*):

- Botulinum toxin
- HIFU (High Intensity Focused Ultrasound)
- TEAP (Transurethral Ethanol Ablation of the Prostate)
- Prostatic urethral lifts

Not recommended for coverage (*strong recommendation*):

- Laser coagulation (for example, VLAP/ILC)
- Prostatic artery embolization

Changes Approved to the Prioritized List of Health Services:

Coding changes to the Prioritized List:

1) *Prostatic urethral lifts:* Remove 52441 (Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant), 52442 (each additional implant), C9739 and C9740 (Cystourethroscopy, with insertion of transprostatic implant) from line 331 FUNCTIONAL AND MECHANICAL DISORDERS OF THE GENITOURINARY SYSTEM INCLUDING BLADDER OUTLET OBSTRUCTION and add to the Services Recommended for Non-Coverage Table
2) *Laser coagulation:* Remove 52647 (Laser coagulation of prostate, including control of postoperative bleeding, complete) from line 331 FUNCTIONAL AND MECHANICAL DISORDERS OF THE GENITOURINARY SYSTEM INCLUDING BLADDER OUTLET OBSTRUCTION and add to the Services Recommended for Non-Coverage Table

3) *Transurethral incision of prostate (TUIP):* Add 52450 to lines 331 and 576
    - Advise MAP to remove 52450 from the Ancillary File
4) *Transurethral microwave thermoplasty (TUMT)* Add 53850 to line 331
    - Advise MAP to remove 53850 from the Non-Covered File
5) *Transurethral needle ablation of the prostate (TUNA)* 53852 (Transurethral destruction of prostate tissue; by radiofrequency thermotherapy) to line 331
    - Advise MAP to remove 53852 from the Non-Covered File

New guideline note:

GUIDELINE NOTE XXX, TREATMENTS FOR BENIGN PROSTATE ENLARGEMENT WITH LOWER URINARY TRACT SYMPTOMS

Line 331

For men with lower urinary tract symptoms (LUTS) due to benign prostate enlargement, coverage of surgical procedures is recommended only if symptoms are severe, and if drug treatment and conservative management options have been unsuccessful or are not appropriate.

The following interventions for benign prostate enlargement are not included on line 331 due to lack of evidence of effectiveness:

- Botulinum toxin
- HIFU (High Intensity Focused Ultrasound)
- TEAP (Transurethral Ethanol Ablation of the Prostate)
- Prostatic urethral lifts
- Laser coagulation. For example, visual laser ablation of prostate (VLAP)/Interstitial Laser Coagulation (ILC)
- Prostatic artery embolization

Coverage Guidance Topic: Inferior Vena Cava (IVC) Filters for Prevention of Pulmonary Emboli

Meeting materials, page 236
Handout, pages 1-9

Cat Livingston provided clinical background on the topic. She said filters are recommended for proximal deep venous thrombosis (DVT) and/or pulmonary embolism (PE) and when anticoagulation too dangerous. Filters are placed in vena cava, mechanically trap emboli before reaching heart and lungs. Filters may be permanent or retrievable. IVC filters are standard of care so lack of clinical equipoise makes study difficult.

Livingston gave a high level summary of the evidence:

IVC filter for proximal (DVT) with anticoagulation

- Insufficient evidence on efficacy of IVC filters to prevent PE or impact mortality
- Evidence that long-term use of IVC filters increase risk of DVT (low strength of evidence (SOE))

Hospitalized patients with trauma

- IVC filter associated with lower incidence of PE in general and a lower incidence of fatal PE in particular compared with no filter (low SOE)
- No statistically significant impact on overall mortality (insufficient SOE)

Cat Livingston reviewed each element in the GRADE table with the committee including the EbGS recommendations (see Meeting materials page 229).

Chan wondered if "retrieval of removable IVC filters" should be listed in a separate row on the GRADE table. Members felt that kind of re-working should happen in the research phase, rather than the meeting. Dr. Valerie King, OHSU, mentioned some patients might be too ill to undergo a procedure to remove a filter within an appropriate window, and a decision is made to leave the filter in place. Discussion centered on adding a footnote about IVC filter removal, settling instead on the following statement in the box language:

> Retrieval of removable IVC filters is recommended for coverage if the benefits of removal outweigh harms (weak recommendation)

MOTION: To approve the proposed coverage guidance for Inferior Vena Cava Filters for Prevention of Pulmonary Emboli as amended. Carries 9-0.

MOTION: To approve the proposed IVC Filters For Active PE/DVT Guideline, IVC Filters for Trauma Ancillary guideline and coding changes for the Prioritized List as proposed. Carries 9-0.

Approved Coverage Guidance:

HERC COVERAGE GUIDANCE

Inferior vena cava (IVC) filters are recommended for coverage in:

- Patients with active deep vein thrombosis/pulmonary embolism (DVT/PE) for which anticoagulation is contraindicated *(strong recommendation)*
- Some hospitalized patients with trauma* *(weak recommendation)*

Retrieval of removable IVC filters is recommended for coverage if the benefits of removal outweigh harms *(weak recommendation)*

IVC filters are not recommended for coverage for patients with DVT who are candidates for anticoagulation *(strong recommendation)*

*Examples of trauma for which IVC filters may be indicated include patients with severe trauma and prolonged hospitalization.

Changes approved to the Prioritized List of Health Services:

Coding changes to the Prioritized List:

1) Add CPT 37191-37193 (Insertion, repositioning and removal of IVC filter) to lines 1 PREGNANCY, 217 ACUTE PULMONARY HEART DISEASE AND PULMONARY EMBOLI, and 285 BUDD-CHIARI SYNDROME AND OTHER VENOUS EMBOLISM AND THROMBOSIS
2) Adopt a new guideline of IVC filters for PE/DVT (deep vein thrombosis) as shown below
3) Adopt a new ancillary guideline for IVC filters for trauma/prolonged hospitalization as shown below

- There are multiple lines with conditions the may represent severe trauma and require prolonged hospitalization. IVC filter CPT codes would not be practical on all of these lines.

New guideline notes:

GUIDELINE NOTE XXX, IVC FILTERS FOR ACTIVE PE/DVT

Lines 1, 83, 217, 285, 290

Inferior vena cava (IVC) filter placement (CPT 37191) is included on these lines for patients with active deep vein thrombosis/pulmonary embolism (DVT/PE) for which anticoagulation is contraindicated. IVC filter placement is not included on these lines for patients with DVT who are candidates for anticoagulation.

Retrieval of removable IVC filters (CPT 37193) is included on these lines when the benefits of removal outweigh the harms.

ANCILLARY GUIDELINE AXX, IVC FILTERS FOR TRAUMA

It is the intent of the Commission that inferior vena cava (IVC) filter placement (CPT 37191) and subsequent repositioning and removal (CPT 37192, 37193) are covered when medically indicated for hospitalized patients with severe trauma resulting in prolonged hospitalization.

Review of Topics Nominated for Coverage Guidance Development
Meeting materials, page 262

Gingerich stated that in January HERC solicited topic nominations through an open survey. Six topics were nominated through public solicitation; three were suggested by members. Staff evaluated and scored the nominations using their established criteria. Livingston reviewed the details of each topic.

- Nitrous oxide use for labor pain management (Score: 30)
- Smoking cessation interventions in pregnancy and postpartum care (Score: 26)
- Telepsychiatry and telecounseling (Score: 26)
- Transitional care interventions to prevent readmissions for people with heart failure (Score: 30)
- Treatments for acquired nontraumatic cognitive impairment/dementia (Score: 30)
    - Members expressed interest in this topic, partially because the medications are expensive and not particularly useful. The "Meaningful Coverage Guidance" score was changed from 1 to 2 , which doubled the original score of 15.
- Bariatric surgery for obesity with comorbidities other than type 2 diabetes (Score: 45)
- Hypofractionated whole breast irradiation (Score: 28)
- Nitric oxide for the diagnosis and management of asthma (Score:33)
- Skin substitutes for diabetic foot ulcers or venous leg ulcers (Score: 20)
- Myriad MyRisk™ hereditary cancer test (Score: 0)
- Removal of torus mandibularis for patients needing lower dentures or partials (Score: 0)

MOTION: To add the nine new topics with a score of 20 or higher to the list of potential future new coverage guidance topics. Carries: 9-0.

Retreat Follow-up
Meeting materials, pages 274-278

Gingerich discussed recent staff work to implement the process improvements identified at the October 2014 retreat. Many areas identified were implemented (a full list is available on pages 277-78), such as:

- Topic nomination survey
- Engaging experts and stakeholder groups early in the process
- Remove two-month delay between VbBS and HERC reviews
- Subcommittee restructuring
- A plan to handle subcommittee disagreements

Work still to come includes:

- Finalize the searchable Prioritized List, addressing:
  - Questions between the roles of coverage guidances, List, MAP rules for CCOs
  - Services recommended for non-coverage
  - Optimizing web presence
- Orientation materials/training
- Improving expert input process by learning from other groups conducting HTAs
- Patient decision tools
- Changes to the coverage guidance development framework (algorithm)

Coffman asked for feedback on the changes to the coverage guidance process resulting in VbBS hearing a topic in the morning, then HERC hearing it the same afternoon. Gibson offered the change is helpful for him, as a person who sits on both groups, keeping him immersed in the process through both discussions, with less possibility of forgetting what was discussed two months ago.

Chan introduced two coverage guidance development framework (algorithm) proposals, one more simple in concept, though both leading to the same outcome (meeting materials pages 275-76). One begins with the question of strength of evidence and is more complicated. The other begins with the question of net benefit.

Gibson remarked he favors the framework that begins with a question of evidence quality but questioned grouping low and very low evidence together, as they are not the same thing. There were suggestions to add a branch for very low evidence, leading directly to an uncertain conclusion.

King expressed concern in the algorithm that begins with a question of net benefit, cautioning that a process which appears to put a higher emphasis on justifying cost might inspire more political/ethical discussion than we might wish.

Coffman shared a discussion about this topic he had with HERC Chair Som Saha. Saha expressed a desire to see the algorithm used as a tool that informs the process as opposed to an actual appendix in the coverage guidance document, as it currently is.

The group agreed this was a good introduction to the topic but more discussion is needed than the remaining meeting time would allow.

Public Comment

There was no public comment at this time.

Adjournment

Meeting adjourned at 4:45 pm. Next meeting will be from 1:30-4:30 pm on Thursday, May 7, 2015 at Clackamas Community College Wilsonville Training Center, Rooms 111-112, Wilsonville, Oregon.

Appendix A
New Lines

Line:	MMM
Condition:	CONDITIONS OF THE BACK AND SPINE
Treatment:	RISK ASSESSMENT, PHYSICAL MODALITIES, COGNITIVE BEHAVIORAL THERAPY, MEDICAL THERAPY
ICD-9:	336.0,344.60-344.61,349.2,720.2,720.81,721.0-721.9,722.0-722.9,723.0,723.1, 723.4,723.6-723.9, 724.0-724.9,731.0,732.0,737.0-737.2,737.40-737.42,737.8-737.9,738.4-738.5,739.0-739.9,742.59, 754.2,756.10-756.19,839.20-839.21,847.0-847.9,V57.1,V57.2x,V57.81-V57.89
ICD-10:	F45.42 (Pain disorder with related psychological factors),G83.4,G95.0,M24.08,M25.78,M40.x,M42.0x, M43.00-M43.28,M43-M43.9,M45.0-M45.8,M46.1,M46.40-M46.49,M46.81-M46.89,M46.91-M46.99, M47.011-M47.16,M47.20-M47.28,M47.811-M47.9,M48.00-M48.27,M48.30-M48.38,M48.9,M49.80-M49.89,M50.00-M50.93,M51.04-M51.9,M53.2x1-M53.2x8, M53.3,M53.80-M53.9,M54.0,M54.11-M54.6,M54.81-M54.9,M62.830,M96.1,M96.2-M96.5,M99.00-M99.09,M99.12-M99.13,M99.20-M99.79,M99.83-M99.84,Q06.0-Q06.3,Q06.8-Q06.9,Q67.5,Q76.0-Q76.4,Z47.82,S13.0xxA-S13.0xxD,S13.4xxA-S13.4xxD,S13.8xxA-S13.8xxD,S13.9xxA-S13.9xxD,S16.1xxA-S16.1xxD, S23.0xxA-S23.0xxD, S23.100A-S23.100D,S23.101A-S23.101D,S23.110A-S23.110D,S23.111A-S23.111D,S23.120A-S23.120D,S23.121A-S23.121D,S23.122A-S23.122D,S23.123A-S23.123D, S23.130A-S23.130D,S23.131A-S23.131D,S23.132A-S23.132D,S23.133A-S23.133D,S23.140A-S23.140D,S23.141A-S23.141D,S23.142A-S23.142D,S23.143A-S23.143D,S23.150A-S23.150D, S23.151A-S23.151D,S23.152A-S23.152D,S23.153A-S23.153D,S23.160A-S23.160D,S23.161A-S23.161D,S23.162A-S23.162D,S23.163A-S23.163D,S23.170A-S23.170D,S23.171A-S23.171D, S23.3xxA-S23.3xxD,S23.8xxA- S23.8xxD,S23.9xxA-S23.9xxD,S33.0xxA-S33.0xxD, S33.100A-S33.100D,S33.101A-S33.101D,S33.110A-S33.110D,S33.111A-S33.111D,S33.120A-S33.120D, S33.121A-S33.121D,S33.130A-S33.130D,S33.131A-S33.131D,S33.140A-S33.140D,S33.141A-S33.141D,S33.5xxA-S33.5xxD,S33.9xxA-S33.9xxD,S34.3xxA-S34.3xxD, S39.092A-S39.092D, S39.82xA-S39.82xD,S39.92xA-S39.92xD
CPT:	62311,64483,64484,90785,90832-90838,90853 (mental health visits, counseling),96150-4 (health and behavior assessment codes),97001-97004,97022,97110-97124,97140, 97150, 97530, 97535 (PT/OT evaluation and treatment),97810-97814 (acupuncture),98925-98929, 98940-98942 (OMT/CMT),98966-98968,98969,99051,99060,99070,99078,99201-99215 (outpatient medical visits),99281-99285 (ER),99304-99337 (SNF care),99340-99359, 99366-99404 (risk factor reduction intervention),99408,99409,99411,99412,99441-99449, 99487-99490,99605-99607
HPCPS:	G0157-G0160 (PT/OT),G0396-G0397 (SBRT),G0425-G0427 (telehealth),G0463,G0466, G0467,G0469,G0470 (FQHC)

Line:	S1
Condition:	CONDITIONS OF THE BACK AND SPINE WITH URGENT SURGICAL INDICATIONS
Treatment:	SURGICAL THERAPY
ICD-9:	344.60-344.61 (cauda equina),721.1,721.41-721.42,721.91 (spondylosis with myelopathy), 722.7x (intervertebral disc disorder with myelopathy),723.0 (spinal stenosis),724.0x (spinal stenosis),738.4,756.11-756.12 (spondylolisthesis),V57.1,V57.2x,V57.81-V57.89
ICD-10:	G83.4 (cauda equina),M43.1x (spondylolisthesis),M47.0x,M47.1x (spondylosis with myelopathy),M48.0x (spinal stenosis),M50.0x,M51.0x (intervertebral disc disorder with myelopathy),M53.2x (spinal instabilities),Q76.2 (spondylolisthesis),Z47.82 (aftercare after scoliosis surgery)
CPT:	20660-20665, 20930-20938,21720,21725,22206-22226,22532-22855,29000-29046,29710-29720, 62287, 62355-62370,63001-63091,63170,63180-63200,63270-63273,63295-63610,63650,63655, 63685, 97001-97004, 97022, 97110-97124, 97140,97150,97530,97535 (PT/OT evaluation and treatment),96150-4 (health and behavior assessment codes), 98966-98968,98969,99051,99060,99070,99078,99201-99215 (outpatient medical visits), 99217-99239 (hospital),99281-99285 (ER),99304-99337 (SNF care),99401-99404 (risk factor reduction intervention),99408,99409,99411,99412,99441-99444,99446-99449 (critical care),99605-99607
HPCPS:	G0157-G0160 (PT/OT),G0396-G0397 (SBRT),G0406-G0408 (inpatient consultation), G0425-G0427 (telehealth),G0463,G0466,G0467 (FQHC),S2350-S2351 (discectomy with decompression of spinal cord)

Line:	S2
Condition:	CONDITIONS OF THE BACK AND SPINE
Treatment:	SURGICAL THERAPY

Appendix A
New Lines

ICD-9: 336.0, 349.2,720.81,721.0,721.2,721.3,721.5-721.8,721.90,722.0,722.10-722.2,722.4-722.6,722.8-722.93, 723.0, 723.1,723.4-723.9, 724.0x,731.0,732.0,737.0-737.2,737.40-737.42,737.8-737.9,738.4-738.5,742.59,754.2,756.10-756.12,839.20-839.21,V57.1,V57.2x,V57.81-V57.89

ICD-10: G95.0, M40.xx,M42.xx,M43.0x,M43.1x,M43.2x,M43.5x,M43.8x,M45.x,M46.0x-M46.9x,M47.2x,M47.8x,M47.9,M48.0x (spinal stenosis),M48.1,M48.3,M48.8,M48.9, M49.8x,M50.1x-M50.9x,M51.1x-M51.9,M53..8x,M53.9,M54.1x,M96.1-M96.5,M99.2x-M99.8x,Q67.5,Q76.0-Q76.3, Q76.4x,S13.0x,S23.0x,S23.1x,S33.0x,S33.1x,S34.3x

CPT: 20660-20665, 20930-20938,21720,21725,22206-22226,22532-22865,27035,29000-29046,29710-29720,62287,62355-62370,63001-63091,63170,63180-63200, 63270-63273,63295-63610,63650, 63655,63685,96150-96154 (health and behavior assessment codes),97001-97004, 97022, 97110-97124,97140,97150,97530,97535 (PT/OT evaluation and treatment), 98966-98968,98969,99051,99060,99070,99078,99201-99215 (outpatient medical visits), 99217-99239 (hospital),99281-99285 (ER),99304-99337 (SNF care),99401-99404 (risk factor reduction intervention),99408,99409,99411,99412,99441-99444,99446-99449 (critical care),99605-99607

HPCPS: G0157-G0160 (PT/OT),G0396-G0397 (SBRT),G0406-G0408 (inpatient consultation), G0425-G0427 (telehealth),G0463,G0466,G0467 (FQHC),S2350-S2351 (discectomy with decompression of spinal cord)

Line: S3
Condition: SCOLIOSIS
Treatment: MEDICAL AND SURGICAL THERAPY

ICD-9: 737.3x, 737.43, V57.1,V57.2x,V57.81-V57.89

ICD-10: M41.xx

CPT: 20660-20665,20930-20938,21720,21725,22206-22226,22532-22865,29000-29046,29710-29720, 62287,62355-62370,63001-63091,63170,63180-63200,63210,63295-63610,63650,63655, 63685,96127,96150-96154 (health and behavior assessment codes),97001-97004, 97022,97110-97124,97140,97150,97530,97535 (PT/OT evaluation and treatment), 97760,97762,98966-98968,98969,99051,99060,99070,99078,99201-99215 (outpatient medical visits),99217-99239 (hospital),99281-99285 (ER),99304-99337 (SNF care),99401-99404 (risk factor reduction intervention),99408,99409,99411,99412,99441-99444,99446-99449 (critical care),99605-99607

HPCPS: G0157-G0160 (PT/OT),G0396-G0397 (SBRT),G0406-G0408 (inpatient consultation), G0425-G0427 (telehealth),G0463,G0466,G0467 (FQHC)

<u>Scoring—Line MMM medical treatments</u>
Category: 7
HL: 4
Suffering: 3
Population effects: 0
Vulnerable population: 0
Tertiary prevention: 2
Effectiveness: 3
Need for service: 0.8
Net cost: 2
Score: 432
Approximate line placement: 405

<u>Scoring—Line S2 surgical</u>
Category: 7
HL: 4
Suffering: 3
Population effects: 0
Vulnerable population: 0
Tertiary prevention: 0
Effectiveness: 1
Need for service: 0.8
Net cost: 2
Score: 112
Approximate line placement: 535

<u>Scoring—Line S1 urgent surgical</u>
Category: 7
HL: 5
Suffering: 4
Population effects: 0
Vulnerable population: 0
Tertiary prevention: 4
Effectiveness: 3
Need for service: 1
Net cost: 2
Score: 780
Approximate line placement: 350

<u>Scoring—Line S3 scoliosis</u>
Category: 7
HL: 5
Suffering: 3
Population effects: 0
Vulnerable population: 0
Tertiary prevention: 3
Effectiveness: 3
Need for service: 1
Net cost: 2
Score: 660
Approximate line placement: 364

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

Line MMM

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

For patients who are determined to be low risk on the assessment tool, the following services are included on this line:

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

For patients who are determined to be high risk on the validated assessment tool, the following treatments are included on this line:

- Office evaluation, consultation and education
- Cognitive behavioral therapy. The necessity for cognitive behavioral therapy should be re-evaluated every 90 days and coverage will only be continued if there is documented evidence of decreasing depression or anxiety symptomatology, improved ability to work/function, increased self-efficacy, or other clinically significant, objective improvement.
- Prescription and over the counter medications, opioid medications subject to the limitations on coverage of opioids in Guideline Note YYY OPIOID PRESCRIBING FOR CONDITIONS OF THE BACK AND SPINE. See evidence table.
- The following evidence-based therapies, when available, are encouraged: yoga, massage, supervised exercise therapy, intensive interdisciplinary rehabilitation
- A total of 30 visits per year of any combination of the following evidence-based therapies when available and medically appropriate. These therapies are only covered if provided by a provider licensed to provide the therapy and when there is documentation of measurable clinically significant progress toward the therapy plan of care goals and objectives using evidence based objective tools (e.g. Oswestry, Neck Disability Index, SF-MPQ, and MSPQ).
    1) Rehabilitative therapy (physical and/or occupational therapy), if provided according to GUIDELINE NOTE 6, REHABILITATIVE SERVICES. Rehabilitation services provided under this guideline also count towards visit totals in Guideline Note 6
    2) Chiropractic or osteopathic manipulation
    3) Acupuncture

These coverage recommendations are derived from the State of Oregon Evidence-based Guideline on the Evaluation and Management of Low Back Pain available here: http://www.oregon.gov/oha/herc/Pages/blog-low-back-non-pharmacologic-intervention.aspx

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

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

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

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

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

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

GUIDELINE NOTE YYY, OPIOID PRESCRIBING FOR CONDITIONS OF THE BACK AND SPINE

Lines MMM, S1, S2, S3

The following restrictions on opioid treatment apply to all diagnoses included on these lines.

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

1) During the first 6 weeks after the acute injury, flare or surgery, opioid treatment is included on these lines ONLY
    a. When each prescription is limited to 7 days of treatment, AND
    b. For short acting opioids only, AND
    c. When one or more alternative first line pharmacologic therapies such as NSAIDs, acetaminophen, and muscle relaxers have been tried and found not effective or are contraindicated, AND
    d. When prescribed with a plan to keep active (home or prescribed exercise regime) and with consideration of additional therapies such as spinal manipulation, physical therapy, yoga, or acupuncture, AND

   e. There is documented lack of current or prior opioid misuse or abuse.
2) Treatment with opioids after 6 weeks, up to 90 days, requires the following
   a. Documented evidence of improvement of function of at least thirty percent as compared to baseline based on a validated tools.
   b. Must be prescribed in conjunction with therapies such as spinal manipulation, physical therapy, yoga, or acupuncture.
   c. Verification that the patient is not high risk for opioid misuse or abuse. Such verification may involve
      i. Documented verification from the state's prescription monitoring program database that the controlled substance history is consistent with the prescribing record
      ii. Use of a validated screening instrument to verify the absence of a current substance use disorder (excluding nicotine) or a history of prior opioid misuse or abuse
      iii. Administration of a baseline urine drug test to verify the absence of illicit drugs and non-prescribed opioids.
   d. Each prescription must be limited to 7 days of treatment and for short acting opioids only
3) Further opioid treatment after 90 days may be considered ONLY when there is a significant change in status, such as a clinically significant verifiable new injury or surgery. In such cases, use of opioids is limited to a maximum of an additional 7 days. In exceptional cases, use up to 28 days may be covered, subject to the criteria in #2 above.

For patients with chronic pain from diagnoses on these lines currently treated with long term opioid therapy, opioids must be tapered off, with a taper of about 10% per week recommended. By the end of 2016, all patients currently treated with long term opioid therapy must be tapered off of long term opioids for diagnoses on these lines. If a patient has developed dependence and/or addiction related to their opioids, treatment is available on line 4 SUBSTANCE USE DISORDER.

GUIDELINE NOTE ZZZ, SURGICAL INTERVENTIONS FOR CONDITIONS OF THE BACK AND SPINE OTHER THAN SCOLIOSIS

Lines S1, S2

Surgical consultation/consideration for surgical intervention are included on these lines only for patients with neurological complications, defined as showing objective evidence of one or more of the following:

A) Markedly abnormal reflexes
B) Segmental muscle weakness
C) Segmental sensory loss
D) EMG or NCV evidence of nerve root impingement
E) Cauda equina syndrome
F) Neurogenic bowel or bladder
G) Long tract abnormalities

Spondylolithesis (ICD-9 738.4, 756.11-756.12 / ICD-10 M43.1x, Q76.2) is included on line S1 only when it results in spinal stenosis with signs and symptoms of neurogenic claudication. Otherwise, these diagnoses are included on line S2.

Surgical correction of spinal stenosis (ICD-9 721.1, 723.0, 724.0x / ICD-10 M48.0x) is only included on lines S1 for patients with:

1) MRI evidence of moderate to severe central or foraminal spinal stenosis AND
2) A history of neurogenic claudication, or objective evidence of neurologic impairment consistent with MRI findings.

Only decompression surgery is covered for spinal stenosis; spinal fusion procedures are not covered for this diagnosis. Otherwise, these diagnoses are included on line S2.

For conditions on line S2, surgical interventions may only be considered after the patient has completed at least 6 months of conservative treatment, provided according to Guideline Note XXX NON-INTERVENTIONAL TREATMENTS FOR CONDITIONS OF THE BACK AND SPINE.

The following interventions are not included on these lines due to lack of evidence of effectiveness for the treatment of conditions on these lines, including cervical, thoracic, lumbar, and sacral conditions:

- facet joint corticosteroid injection
- prolotherapy
- intradiscal corticosteroid injection
- local injections
- botulinum toxin injection
- intradiscal electrothermal therapy
- therapeutic medial branch block
- radiofrequency denervation
- sacroiliac joint steroid injection
- coblation nucleoplasty
- percutaneous intradiscal radiofrequency thermocoagulation
- radiofrequency denervation

GUIDELINE NOTE AAA, SCOLIOSIS

Line S3

Non-surgical treatments of scoliosis (ICD-9 737.3x,737.43/ICD-10 M41.xx) are included on line CCC when

1) the scoliosis is considered clinically significant, defined as curvature greater than or equal to 25 degrees or
2) there is curvature with a documented rapid progression.

Surgical treatments of scoliosis are included on line S3

1) only for children and adolescents (age 20 and younger) with
2) a spinal curvature of greater than 45 degrees

.

Appendix C
Revised Guidelines

DIAGNOSTIC GUIDELINE D4, ADVANCED IMAGING FOR LOW BACK PAIN

In patients with non-specific low back pain and no "red flag" conditions [see Table D4], imaging is not a covered service; otherwise work up is covered as shown in the table. Electromyelography (CPT 96002-4) is not covered for non-specific low back pain.

Table D4. Low Back Pain - Potentially Serious Conditions ("Red Flags") and Recommendations for Initial Diagnostic Work-up

Possible cause	Key features on history or physical examination	Imaging*	Additional studies*
Cancer	• History of cancer with new onset of LBP	MRI	ESR
	• Unexplained weight loss • Failure to improve after 1 month • Age >50 years • Symptoms such as painless neurologic deficit, night pain or pain increased in supine position	Lumbosacral plain radiography	
	• Multiple risk factors for cancer present	Plain radiography or MRI	
Spinal column infection	• Fever • Intravenous drug use • Recent infection	MRI	ESR and/or CRP
Cauda equina syndrome	• Urinary retention • Motor deficits at multiple levels • Fecal incontinence • Saddle anesthesia	MRI	None
Vertebral compression fracture	• History of osteoporosis • Use of corticosteroids • Older age	Lumbosacral plain radiography	None
Ankylosing spondylitis	• Morning stiffness • Improvement with exercise • Alternating buttock pain • Awakening due to back pain during the second part of the night • Younger age	Anterior-posterior pelvis plain radiography	ESR and/or CRP, HLA-B27
Nerve compression/ disorders (e.g. herniated disc with radiculopathy)	• Back pain with leg pain in an L4, L5, or S1 nerve root distribution present < 1 month • Positive straight-leg-raise test or crossed straight-leg-raise test	None	None
	• Radiculopathic** signs present >1 month • Severe/progressive neurologic deficits (such as foot drop), progressive motor weakness	MRI***	Consider EMG/NCV
Spinal stenosis	• Radiating leg pain • Older age • Pain usually relieved with sitting (Pseudoclaudication a weak	None	None

Possible cause	Key features on history or physical examination	Imaging*	Additional studies*
	predictor)		
	• Spinal stenosis symptoms present >1 month	MRI**	Consider EMG/NCV

* Level of evidence for diagnostic evaluation is variable
** Radiculopathic signs are defined for the purposes of this guideline as the objective evidence of ~~as in Guideline Note 37 with~~ any of the following:

A. Markedly abnormal reflexes
B. Segmental muscle weakness
C. Segmental sensory loss
D. EMG or NCV evidence of nerve root impingement
E. Cauda equina syndrome,
F. Neurogenic bowel or bladder
G. Long tract abnormalities

*** Only if patient is a potential candidate for surgery or epidural steroid injection

Red Flag: Red flags are findings from the history and physical examination that may be associated with a higher risk of serious disorders. CRP = C-reactive protein; EMG = electromyography; ESR = erythrocyte sedimentation rate; MRI = magnetic resonance imaging; NCV = nerve conduction velocity.

Extracted and modified from Chou R, Qaseem A, Snow V, et al: Diagnosis and Treatment of Low Back Pain: A Joint Clinical Practice Guideline from the American College of Physicians and the American Pain Society. Ann Intern Med. 2007; 147:478-491.

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

GUIDELINE NOTE 92, ACUPUNCTURE

Lines 1,207,~~374,~~414,468,~~545~~,546,MMM

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

Line 1 PREGNANCY

Hyperemesis gravidarum

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

Acupuncture pairs with hyperemesis gravidarum when a diagnosis is made by the maternity care provider and referred for acupuncture treatment for up to 2 sessions of acupressure/acupuncture.

Breech presentation

ICD-10-CM code: O32.1xx0, O32.8xx0

Acupuncture (and moxibustion) is paired with breech presentation when a referral with a diagnosis of breech presentation is made by the maternity care provider, the patient is between 33 and 38 weeks gestation, for up to 2 visits.

Back and pelvic pain of pregnancy

ICD-10-CM code: O33.0

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

Line 207 DEPRESSION AND OTHER MOOD DISORDERS, MILD OR MODERATE

Acupuncture is paired with the treatment of post-stroke depression only. Treatments may be billed to a maximum of 30 minutes face-to-face time and limited to 15 total sessions, with documentation of meaningful improvement.

~~Line 374 DISORDERS OF SPINE WITH NEUROLOGIC IMPAIRMENT~~

~~Acupuncture is included on Line 374 YYY only for pairing with disorders of the spine with myelopathy and/or radiculopathy represented by the diagnosis codes G83.4, M47.1x, M47.2x, M50.0x, M50.1x, M51.1x, M54.1x, with referral, for up to 12 sessions.~~

Line MMM-CONDITIONS OF THE BACK AND SPINE

Acupuncture is included this line with visit limitations as in Guideline Note XXX.

Line 414 MIGRAINE HEADACHES

Acupuncture pairs on Line 414 for ICD-10-CM code G43.9 Migraine, when referred, for up to 12 sessions.

Line 468 OSTEOARTHRITIS AND ALLIED DISORDERS

Acupuncture pairs on Line 468 for osteoarthritis of the knee only, when referred, for up to 12 sessions.

~~Line 545 ACUTE AND CHRONIC DISORDERS OF SPINE WITHOUT NEUROLOGIC IMPAIRMENT~~

~~Acupuncture pairs on Line 545 with the low back diagnoses G83.4, M47.1x, M47.2x, M50.0x, M50.1x, M51.1x, M54.1x, when referred, for up to 12 sessions. Acupuncture pairs with chronic (>90 days) neck pain diagnoses (), when referred, for up to 12 sessions~~.

Line 546 TENSION HEADACHES

Acupuncture is included on Line 546 for treatment of tension headaches G44.2x, when referred, for up to 12 sessions

GUIDELINE NOTE 105, EPIDURAL STEROID INJECTIONS~~, OTHER PERCUTANEOUS INTERVENTIONS~~ FOR ~~LOW~~ BACK PAIN

Lines ~~75, 159, 297,~~ MMM

Epidural lumbar steroid injections (CPT 62311, 64483, 64484) are included on this line for patients with persistent radiculopathy due to herniated disc, where radiculopathy is ~~as~~ defined ~~in Guideline Note 37~~ as showing objective evidence of one or more of the following:

A) Markedly abnormal reflexes
B) Segmental muscle weakness
C) Segmental sensory loss
D) EMG or NCV evidence of nerve root impingement
~~E) Cauda equina syndrome~~
~~F) Neurogenic bowel or bladder~~
~~G) Long tract abnormalities~~

One epidural steroid injection is included on these lines; a second epidural steroid injection may be provided after 3-6 months only if objective evidence of 3 months of sustained pain relief was provided by the first injection. It is recommended that shared decision-making regarding epidural steroid injection include a specific discussion about inconsistent evidence showing moderate short-term benefits, and lack of long-term benefits. Epidural lumbar steroid injections are not included on these lines for spinal stenosis or for patients with low back pain without radiculopathy.

~~The following interventions are not covered for low back pain, with or without radiculopathy:~~

- ~~facet joint corticosteroid injection~~
- ~~prolotherapy~~
- ~~intradiscal corticosteroid injection~~
- ~~local injections~~
- ~~botulinum toxin injection~~
- ~~intradiscal electrothermal therapy~~
- ~~therapeutic medial branch block~~
- ~~radiofrequency denervation~~
- ~~sacroiliac joint steroid injection~~
- ~~coblation nucleoplasty~~
- ~~percutaneous intradiscal radiofrequency thermocoagulation~~
- ~~radiofrequency denervation~~

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

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Appendix D
Deleted Guidelines

Deleted Guideline Notes:

- GUIDELINE NOTE 37, DISORDERS OF SPINE WITH NEUROLOGIC IMPAIRMENT
- GUIDELINE NOTE 41, SPINAL DEFORMITY, CLINICALLY SIGNIFICANT
- GUIDELINE NOTE 56, ACUTE AND CHRONIC DISORDERS OF SPINE WITHOUT NEUROLOGIC IMPAIRMENT
- GUIDELINE NOTE 60, SPINAL DEFORMITY, NOT CLINICALLY SIGNIFICANT
- GUIDELINE NOTE 94, EVALUATION AND MANAGEMENT OF LOW BACK PAIN

Appendix E
Coding Changes

Related coding changes required:

1) Advise MAP to remove ICD-9 724.3 (Sciatica), ICD-10 M41.40 (Neuromuscular scoliosis, site unspecified), M41.50 (Other secondary scoliosis, site unspecified), M54.3-M54.4 (Sciatica) from the Diagnostic Workup File
2) Advise MAP to remove 22830 (Exploration of spinal fusion) from the Diagnostic File
3) Advise MAP to remove 63210 (Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic) from the Ancillary File
4) Remove ICD-9 754.1/ICD-10 Q68.0 (Congenital musculoskeletal deformities of sternocleidomastoid muscle) from line 545 ACUTE AND CHRONIC DISORDERS OF SPINE WITHOUT NEUROLOGIC IMPAIRMENT and ICD-9 756.3/ICD-10 Q76.6-Q76.9 (Other anomalies of ribs and sternum) and ICD-10 Q68.0 (Congenital musculoskeletal deformities of sternocleidomastoid muscle) from lines 412 SPINAL DEFORMITY, CLINICALLY SIGNIFICANT and 588 SPINAL DEFORMITY, NOT CLINICALLY SIGNIFICANT and place on line 534 DEFORMITIES OF UPPER BODY AND ALL LIMBS
5) HERC did not approve coverage of facet joint injections for the cervical or lumbar spine.
    a. Keep 64490-64492 (Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (flouro or CT), cervical) and 64633 and 64634 (Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single or additional facet joints) on the Non-Covered File
    b. Lumbar facet joint injection currently is on the Non-Covered File

Value-based Benefits Subcommittee Recommendations Summary
For Presentation to:
Health Evidence Review Commission on March12, 2015

For specific coding recommendations and guideline wording, please see the text of the 3-12-2015 VbBS minutes.

RECOMMENDED CODE MOVEMENT (effective 10/1/15)

- Various straightforward coding changes
- Two dental procedure codes for sealant repair and cleaning of removable appliances were removed from the Prioritized List and placed on the Services Recommended for non-Coverage Table
- The procedure code for IVC filters was added to three lines with lower extremity or lung blood clot diagnostic codes
- Various procedures for treatment of lower urinary tract symptoms resulting from benign prostatic hypertrophy (BPH) were added to the funded BPH line, and several treatments were removed.

RECOMMENDED GUIDELINE CHANGES (effective 10/1/15)

- The cochlear implant guidelines were merged and modified to allow hearing loss of 70dB or greater as the threshold to consider implantation for both children and adults and to change the benefit received from hearing aids from “little or no” to “limited” and define what limited benefit means
- A new guideline was adopted indicating that unilateral hearing loss treatment is only included on funded lines for children through age 20 and outlines what treatments are available for various levels of unilateral hearing loss
- The guideline regarding bone anchored hearing aids (BAHAs) was modified to reflect that BAHAs are only included on funded lines for children up to age 20 with normal hearing in the contralateral ear with or without hearing aids
- A new guideline was adopted allowing up to 8 weeks of proton pump inhibitor (PPI) treatment for gastroesophageal reflux (GERD)
- A new guideline was adopted which specifies that IVC filters are included on covered lines only when a patient has an active peripheral or lung clot and is not a candidate for anti-coagulation medication
- A new ancillary guideline was adopted which specifies that IVC filters are covered for trauma patients requiring prolonged hospitalization when medically appropriate
- A new guideline was adopted regarding coverage of treatments for BPH
- The guideline regarding intraocular steroid injections was modified to include coverage criteria for use in diabetic macular edema

BIENNIAL REVIEW CHANGES (effective 1/1/16)

- The two cochlear implant lines were merged and re-scored, resulting in continued placement in the funded region of the Prioritized List

- A new line for bone and joint conditions at high risk for complications was created along with a guideline specifying when these conditions were eligible for treatment. Scoring of the new line placed it in the funded region, while the existing unfunded benign bone and joint conditions line was rescored to a lower priority position on the List.
- The four current back conditions lines were restructured into four new lines. The new medical treatment line will contain all back pain diagnoses and will include a variety of medical therapies, including lumbar epidural steroid injections. A new guideline was adopted for this medical line. Scoring of the new medical line placed it in the funded region. A new surgical line for urgent surgical conditions was also scored and prioritized in the funded region, with a new guideline. Scoring for a new surgical line for non-urgent surgical conditions placed it in the unfunded region, with the new surgical guideline applying to this line as well. The fourth line is a scoliosis line, whose scoring placed it in the funded region, which has a guideline limiting surgical therapies to children through age 20. A new guideline was adopted which restrict opioid therapy for the treatment of pain associated with back conditions, allowing limited use for 90 days after an acute injury or exacerbation of chronic pain, but not allowing opioid therapy after 90 days. Patients on chronic opioid therapy for back conditions will need to be tapered off. Five current guidelines for back conditions were deleted as they have been incorporated into the new guidelines. The acupuncture guideline was modified to refer to the new back condition medical guideline. The epidural steroid injection guideline was modified to specify what symptoms are required to qualify for the injection and limiting the injections to once, with a second if the first injection provided substantial pain relief for 3 months. The back pain diagnostic guideline was modified to remove the reference to a deleted guideline.

VALUE-BASED BENEFITS SUBCOMMITTEE
Clackamas Community College
Wilsonville Training Center, Rooms 111-112
Wilsonville, Oregon
March 12, 2015
8:30 AM – 1:00 PM

Members Present: Kevin Olson, MD, Chair; David Pollack, MD; Susan Williams, MD; Mark Gibson; Holly Jo Hodges, MD; Laura Ocker, LAc.

Members Absent: James Tyack, DMD; Irene Croswell, RPh.

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

Also Attending: Wally Shaffer, MD and Bruce Austin, DMD, OHA; Valerie King MD, MPH, OHSU Center for Evidence Based Policy; Mary Hlady PT, Oregon PT Association; Nora Stern PT, Providence; Gary Allen, DMD, Advantage Dental; Laura McKeane, AllCare; Frank Warren, MD, The Oregon Clinic; Jane Stephen and Karen Campbell, Allergan; Eric Davis. PK Melethil, and Donald Leary, MS, DC, JD, Health and Wellness; Fiona Clement, USCF; Kevin Wilson, ND.

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

  The meeting was called to order at 8:55 am and roll was called. Minutes from the January, 2015 VbBS meeting were reviewed and approved. Due to the delay in starting the meeting, staff report was not given.

- **Topic: Straightforward/Consent Agenda**

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

  Recommended Actions:
  1) Remove 45378 (Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed) from line 526 FOREIGN BODY IN GASTROINTESTINAL TRACT WITHOUT RISK OF PERFORATION OR OBSTRUCTION
     i. Affirm with MAP that 45378 is on the Diagnostic File
  2) Remove ICD-10 Q77.2 (Cervical rib) from lines 412 SPINAL DEFORMITY, CLINICALLY SIGNIFICANT and 588 SPINAL DEFORMITY, NOT CLINICALLY SIGNIFICANT
     a. Add Q77.2 to line 668 MUSCULOSKELETAL CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENT

3) Affirm 15777 (Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk)) placement on the Services Recommended for Non-Coverage List.
4) Remove 26045 (Fasciotomy, palmar (eg, Dupuytren's contracture); open, partial) from line 362 DEFORMITY/CLOSED DISLOCATION OF MAJOR JOINT AND RECURRENT JOINT DISLOCATIONS
    a. Add 26045 to line 420 PERIPHERAL NERVE ENTRAPMENT; PALMAR FASCIAL FIBROMATOSIS
5) Add 307.50 (Eating disorder, unspecified) to line 385 BULIMIA NERVOSA and remove from line 153 FEEDING AND EATING DISORDERS OF INFANCY OR CHILDHOOD
6) Change the name of line 385 to BULIMIA NERVOSA AND UNSPECIFIED EATING DISORDERS
7) Revise GUIDELINE NOTE 92, ACUPUNCTURE as shown in Appendix A

MOTION: To approve the recommendations stated in the consent agenda. CARRIES 5-0.

- **Topic: 2015 CDT code issues**

Discussion: There was no discussion of this topic.

Recommended Actions:
1) Remove D1353 (SEALANT REPAIR-PER TOOTH) from line 57 PREVENTIVE DENTAL SERVICES
2) Advise DMAP to remove D9219 (evaluation for deep sedation or general anesthesia) from the Exempt File
3) Remove D9931 (Cleaning and inspection of a removable appliance) from line 457 DENTAL CONDITIONS (EG. MISSING TEETH, PROSTHESIS FAILURE) and place on the Services Recommended for Non-Coverage Table

MOTION: To recommend the code changes as presented. CARRIES 5-0.

- **Topic: Cochlear implant guideline/cochlear implant line merge**

Discussion: Smits reviewed the summary document from the meeting packet. Dr. Frank Warren, ENT, from Portland, answered questions from the subcommittee to clarify the summary material. There was no substantial discussion.

Recommended Actions: (Note: the line merge is effective January 1, 2016)

1) Merge lines 283 SENSORINEURAL HEARING LOSS - AGE 5 OR UNDER and 423 SENSORINEURAL HEARING LOSS - OVER AGE OF FIVE into the new line shown below with the line scoring shown below
2) Modify GN31 as shown in Appendix A
3) Delete current GN49

Line:	**XXX**
Condition:	SENSORINEURAL HEARING LOSS (See Guideline Note 31)
Treatment:	COCHLEAR IMPLANT
ICD-9:	389.11-389.12,389.14,389.16,389.18
ICD-10:	H90.3,H90.41-H90.5,Z01.12,Z45.320-Z45.328
CPT:	64505-64530,69930,92562-92565,92571-92577,92590,92591, 92601-92604, 92626-92633,96127-96145,98966-98969,99051,99060,99070,99078,99201-99215, 99281-99285,99341-99355,99358-99378,99381-99404,99408-99412,99429-99449,99487-99498,99605-99607
HCPCS:	G0396,G0397,G0463,G0466,G0467

Scoring—Line XXX
Category: 7
HL: 5 (child weighted)
Suffering: 3 (from 283)
Population effects: 1 (average)
Vulnerable population: 0
Tertiary prevention: 3 (average)
Effectiveness: 4 (evidence/child weighted)
Need for service: 1
Net cost: 2
Score: 960
Approximate line placement: 330

MOTION: To recommend the line merging, line scoring, and guideline note changes as presented. CARRIES 5-0.

- **Topic: Unilateral hearing loss/BAHA guideline clarification**

Discussion: Smits reviewed the summary document from the meeting packet. There was discussion about the benefits of treatment of unilateral hearing loss in adults—whether this was a disability that should be treated. Smits reviewed that the literature does not support that there is sufficient evidence for coverage in adults, unlike children. Pollack asked if there was a subpopulation of adults who would benefit more from coverage; Smits responded that adults with sudden hearing loss may benefit more than adults with gradual hearing loss, but there were issues with defining sudden loss, and the benefits would still focus only on quality of life.

There were specific suggestions made regarding the wording of the proposed new guideline—modifying the reference to the cochlear implant guideline to reflect the deletion of one of the two cochlear implant guidelines approved in the preceding section of the meeting. Suggestions were made regarding the wording of GN103 regarding BAHAs. The reference to "SoftBand BAHA" was changed to a generic reference to headband mounted BAHA devices. The requirement for normal hearing in the contralateral ear was noted to be "with or without a hearing aid."

Recommended Actions:

1) Adopt a new guideline regarding treatment of unilateral hearing loss as shown in Appendix B
2) Modify GN103 for BAHAs as shown in Appendix A

MOTION: To recommend the guideline note changes as amended. CARRIES 5-0.

- **Topic: Ventral hernia guideline**

Discussion: This topic was tabled until the May, 2015 VBBS meeting.

- **Topic: Prenatal genetic testing guideline**

Discussion: This topic was tabled until the May, 2015 VBBS meeting.

- **Topic: GERD esophagitis/PPI therapy**

Discussion: Livingston reviewed the summary document in the meeting materials. There was minimal discussion.

Recommended Actions:

1) Add a new guideline regarding proton pump inhibitor therapy as shown in Appendix B
2) Modify the treatment description on line 384: "Treatment: Short-term medical therapy, Surgical treatment"

MOTION: To recommend the guideline note and line treatment description changes as presented. CARRIES 5-0.

- **Topic: Biennial review—benign bone and joint conditions**

Discussion: Smits reviewed the summary document in the meeting materials. Williams supported the changes, noting that many of the conditions on the proposed new, covered line are locally destructive and need treatment.

Recommended Actions: (effective January 1, 2016)

1) Create a new line for benign bone and joint conditions at high risk of complication with the line and scoring as shown below
2) Modify GN137 as shown in Appendix A
    a. Note: "line 533" will need to be changed to new line number
3) Rescore line 533 as shown below
4) Miscellaneous coding changes
    a. Add 214.8 (Lipoma of other specified sites), 228.00 (Hemangioma of unspecified site), 727.02 (Giant cell tumor of tendon sheath), and 727.89 (Other disorders of synovium, tendon, and bursa) to line 533 BENIGN NEOPLASM OF BONE AND ARTICULAR CARTILAGE
    b. Add D17.79 (Benign lipomatous neoplasm of other sites), D18.09 (Hemangioma of other sites), D48.1 (Neoplasm of uncertain behavior of connective and other soft tissue), and M67.8x (Other disorders of synovium, tendon, and bursa), K09.0 (Developmental odontogenic cysts) and K09.1 (Developmental (nonodontogenic) cysts of oral region) to line 533 BENIGN NEOPLASM OF BONE AND ARTICULAR CARTILAGE
        i. Note: K09.0, K09.1 were added to line 533 at HERC as they were not shown in the VBBS summary materials correctly
    c. Remove M67.8x (Other disorders of synovium, tendon, and bursa) from line 51 DEEP ABSCESSES, INCLUDING APPENDICITIS AND PERIORBITAL ABSCESS
    d. Remove D16.00-D16.8 (Benign neoplasms of bone) from line 358 CLOSED FRACTURE OF EXTREMITIES (EXCEPT MINOR TOES)
    e. Remove K09.0 (Developmental odontogenic cysts) and K09.1 (Developmental (nonodontogenic) cysts of oral region) from line 466 BRANCHIAL CLEFT CYST; THYROGLOSSAL DUCT CYST; CYST OF PHARYNX OR NASOPHARYNX and add to line 533

Line:	XXX
Condition:	BENIGN conditions OF BONE AND Joints at high risk for complications (See Guideline Notes 6,7,11,64,65,100,137)
Treatment:	MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY
ICD-9:	213.0-213.9, 214.8, 228.00, 526.0-526.2, 719.2x, 727.02, 727.89, 733.2x

ICD-10: D16.00-16.9, D17.79, D18.09, D48.1, K09.0, K09.1, M12.2xx, M27.1, M27.40, M27.41, M67.8x, M85.40-M85.69

CPT: 11400-11446,12051,12052,13131,17106-17111,20150,20550,20551,20600-20611,20615, 20900,20930-20938,20955-20973,21011-21014,21025-21032,21040,21046-21049,21181, 21552-21556,21600,21930-21936,22532-22819,22851,23071-23076,23101,23140-23156, 23200,24071-24079,24105-24126,24420,24498,25000,25071,25073,25110-25136,25170-25240,25295-25301,25320,25335,25337,25390-25393,25441-25447,25450-25492,25810-25830,26100-26116,26200-26215,26250-26262,26449,27025,27043-27049,27054,27059, 27065-27078,27187,27327,27328,27337,27339,27355-27358,27365,27465-27468,27495, 27630-27638,27645-27647,27656,27745,28039-28045,28100-28108,28122,28124,28171-28175,28820,28825,32553,36680,49411,63081-63103,64774,64792,77014,77261-77295, 77300-77307,77331-77338,77385-77387,77401-77427,77469,77470,79005-79445,96127, 96405,96406,96420-96440,96450,96542-96571,97001-97004,97012,97022,97110-97124, 97140-97530,97535,97542,97760-97762,98966-98969,99051,99060,99070,99078,99184, 99201-99239,99281-99285,99291-99404,99408-99412,99429-99449,99468-99480,99487-99498,99605-99607

HCPCS: G0157-G0161,G0396,G0397,G0406-G0408,G0425-G0427,G0463,G0466,G0467,G6001-G6017

Scoring—Line XXX (comparison scores are from line 533)
Category: 7 (7)
HL: 3 (2)
Suffering: 2 (1)
Population effects: 0 (0)
Vulnerable population: 0 (0)
Tertiary prevention: 1 (0)
Effectiveness: 4 (4)
Need for service: 0.9 (0.5)
Net cost: 3 (3)
Score: 432 (120)
Approximate line placement: 405

Rescoring—Line 533
Category: 7 (7)
HL: 1 (2)
Suffering: 1 (1)
Population effects: 0 (0)
Vulnerable population: 0 (0)
Tertiary prevention: 0 (0)
Effectiveness: 4 (4)
Need for service: 0.2 (0.5)
Net cost: 3 (3)
Score: 32
Approximate line placement: 577

MOTION: To recommend the new line creation, new and existing line scoring, code and guideline note changes as presented for 2016 biennial list. CARRIES 5-0.

- **Topic: Biennial review—Back condition line reorganization**

  Discussion: Smits reviewed the summary document in the meeting materials. Smits and Gingerich presented a PowerPoint outlining the proposed changes, and giving approximate OHP numbers of patients with back diagnoses and approximate costs in 2013 for various treatments for back conditions.

  There was no discussion regarding the proposed new lines or line scoring. The medical guideline (GN XXX) was modified to specify that both prescription and non-prescription medications are available for patients who score as high risk on validated assessment tools. There was no discussion regarding the opioid prescribing guideline. The surgical guideline (GN ZZZ) was modified to specify that it did not apply to the scoliosis line, and to specify that the non-included procedures were not covered for any area of the spine (cervical, thoracic, lumbar, or sacral). The scoliosis guideline (GN AAA) was modified to allow surgery for patients age 20 and younger (instead of 21) to align with other guidelines covering children. The modifications to diagnostic guideline D4 were modified slightly to clarify that the radiculopathic findings need to be objectively demonstrated. One miscellaneous coding recommendation, regarding CPT 63210, was not accepted, and was decided to be a part of the percutaneous intervention discussion.

  The percutaneous interventions for cervical spine pain as well as lumbar epidural steroid injections were discussed in some detail. Due to the weak level of evidence, the subcommittee did not want to add coverage for cervical epidural steroid injections or for cervical radiofrequency neurotomy. These procedures will be added to the Services Recommended for Non-Coverage Table. The subcommittee desired maintaining the current coverage for lumbar epidural steroid injections, placing that procedure on the upper medical back conditions line, with the guideline restricting it to 1 injection with a second injection if the first gave 3 months of sustained pain relief. The definition for radiculopathy in this guideline will be readdressed at the May, 2015 VBBS meeting, as the subcommittee was not completely satisfied with the current wording. Additionally, the subcommittee asked to have further discussion regarding the requirement of PT or other active therapy for patients undergoing lumbar epidural steroid injections.

  Recommended Actions: (effective January 1, 2016)

  1) Adopt the four new back conditions lines and line scoring as shown below
  2) Delete current back condition lines 374, 412, 545, and 588
  3) Adopt the new medical guideline for back conditions, new surgical guideline for back conditions, new guideline for scoliosis, and new guideline for opioid prescribing as shown in Appendix B
  4) Adopt the modified DIAGNOSTIC GUIDELINE D4, ADVANCED IMAGING FOR LOW BACK PAIN and GUIDELINE NOTE 92, ACUPUNCTURE as shown in Appendix A

5) Delete guideline notes 37, 41, 56, 60, and 94 (see Appendix C)
6) Advise MAP to remove ICD-9 724.3 (Sciatica), ICD-10 M41.40 (Neuromuscular scoliosis, site unspecified), M41.50 (Other secondary scoliosis, site unspecified), M54.3-M54.4 (Sciatica) from the Diagnostic File
7) Advise DMAP to remove 22830 (Exploration of spinal fusion) from the Diagnostic File
8) Remove ICD-9 754.1/ICD-10 Q68.0 (Congenital musculoskeletal deformities of sternocleidomastoid muscle) from line 545 ACUTE AND CHRONIC DISORDERS OF SPINE WITHOUT NEUROLOGIC IMPAIRMENT and ICD-9 756.3/ICD-10 Q76.6-Q76.9 (Other anomalies of ribs and sternum) and ICD-10 Q68.0 (Congenital musculoskeletal deformities of sternocleidomastoid muscle) from lines 412 SPINAL DEFORMITY, CLINICALLY SIGNIFICANT and 588 SPINAL DEFORMITY, NOT CLINICALLY SIGNIFICANT and place on line 534 DEFORMITIES OF UPPER BODY AND ALL LIMBS
9) Keep 64490-64492 (Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (flouro or CT), cervical) and 64633 and 64634 (Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single or additional facet joints) on the Services Recommended for Non-Coverage Table
10) Place 63210 ((Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic)) on the Services Recommended for Non-Coverage Table
    a. Advice MAP to remove from the Ancillary File

Line:	MMM
Condition:	CONDITIONS OF THE BACK AND SPINE
Treatment:	RISK ASSESSMENT, PHYSICAL MODALITIES, COGNITIVE BEHAVIORAL THERAPY, MEDICAL THERAPY
ICD-9:	336.0,344.60-344.61,349.2,720.2,720.81,721.0-721.9,722.0-722.9,723.0,723.1, 723.4,723.6-723.9,724.0-724.9,731.0,732.0,737.0-737.2,737.40-737.42,737.8-737.9,738.4-738.5,739.0-739.9,742.59,754.2,756.10-756.19,839.20-839.21,847.0-847.9,V57.1,V57.2x, V57.81-V57.89
ICD-10:	F45.42 (Pain disorder with related psychological factors), G83.4,G95.0,M24.08,M25.78, M40.x,M42.0x,M43.00-M43.28,M43-M43.9,M45.0-M45.8,M46.1,M46.40-M46.49,M46.81-M46.89,M46.91-M46.99,M47.011-M47.16,M47.20-M47.28,M47.811-M47.9,M48.00-M48.27,M48.30-M48.38,M48.9,M49.80-M49.89,M50.00-M50.93,M51.04-M51.9,M53.2x1-M53.2x8, M53.3,M53.80-M53.9,M54.0,M54.11-M54.6,M54.81-M54.9,M62.830,M96.1, M96.2-M96.5,M99.00-M99.09,M99.12-M99.13,M99.20-M99.79,M99.83-M99.84,Q06.0-Q06.3,Q06.8-Q06.9, Q67.5,Q76.0-Q76.4,Z47.82,S13.0xxA-S13.0xxD, S13.4xxA-S13.4xxD,S13.8xxA-S13.8xxD,S13.9xxA-S13.9xxD,S16.1xxA-S16.1xxD,S23.0xxA-S23.0xxD, S23.100A-S23.100D,S23.101A-S23.101D,S23.110A-S23.110D,S23.111A-S23.111D,S23.120A-S23.120D,S23.121A-S23.121D,S23.122A-S23.122D,S23.123A-S23.123D,S23.130A-S23.130D,S23.131A-S23.131D,S23.132A-S23.132D,S23.133A-S23.133D,S23.140A-S23.140D,S23.141A-S23.141D,S23.142A-S23.142D,S23.143A-S23.143D,S23.150A-S23.150D,S23.151A-S23.151D,S23.152A-S23.152D,S23.153A-S23.153D,S23.160A-S23.160D,S23.161A-S23.161D,S23.162A-S23.162D,S23.163A-S23.163D,S23.170A-S23.170D,S23.171A-S23.171D,S23.3xxA-S23.3xxD,S23.8xxA-

S23.8xxD,S23.9xxA-S23.9xxD,S33.0xxA-S33.0xxD, S33.100A-S33.100D,S33.101A-S33.101D,S33.110A-S33.110D,S33.111A-S33.111D,S33.120A-S33.120D,S33.121A-S33.121D,S33.130A-S33.130D,S33.131A-S33.131D,S33.140A-S33.140D,S33.141A-S33.141D,S33.5xxA-S33.5xxD,S33.9xxA-S33.9xxD,S34.3xxA-S34.3xxD, S39.092A-S39.092D,S39.82xA-S39.82xD,S39.92xA-S39.92xD

CPT: 62311, 64483, 64484, 90785,90832-90838,90853 (mental health visits, counseling), 96150-4 (health and behavior assessment codes), 97001-97004, 97022, 97110-97124, 97140, 97150, 97530, 97535 (PT/OT evaluation and treatment), 97810-97814 (acupuncture), 98925-98929, 98940-98942 (OMT/CMT), 98966-98968, 98969, 99051, 99060, 99070,99078,99201-99215 (outpatient medical visits), 99281-99285 (ER), 99304-99337 (SNF care), 99340-99359, 99366-99404 (risk factor reduction intervention), 99408, 99409, 99411, 99412, 99441-99449, 99487-99490, 99605-99607

HPCPS: G0157-G0160 (PT/OT), G0396-G0397 (SBRT), G0425-G0427 (telehealth), G0463, G0466, G0467, G0469, G0470 (FQHC)

Line: S1

Condition: CONDITIONS OF THE BACK AND SPINE WITH URGENT SURGICAL INDICATIONS

Treatment: SURGICAL THERAPY

ICD-9: 344.60-344.61 (cauda equina), 721.1, 721.41-721.42,721.91 (spondylosis with myelopathy); 722.7x (intervertebral disc disorder with myelopathy), 723.0 (spinal stenosis), 724.0x (spinal stenosis), 738.4, 756.11-756.12 (spondylolisthesis), V57.1,V57.2x,V57.81-V57.89

ICD-10: G83.4 (cauda equina), M43.1x (spondylolisthesis), M47.0x, M47.1x (spondylosis with myelopathy), M48.0x (spinal stenosis), M50.0x, M51.0x (intervertebral disc disorder with myelopathy), M53.2x (spinal instabilities), Q76.2 (spondylolisthesis), Z47.82 (aftercare after scoliosis surgery)

CPT: 20660-20665, 20930-20938,21720,21725,22206-22226,22532-22855,29000-29046,29710-29720,62287, 62355-62370, 63001-63091,63170,63180-63200, 63270-63273,63295-63610,63650,63655,63685, 97001-97004, 97022, 97110-97124, 97140, 97150, 97530, 97535 (PT/OT evaluation and treatment), 96150-4 (health and behavior assessment codes), 98966-98968, 98969, 99051, 99060, 99070,99078,99201-99215 (outpatient medical visits), 99217-99239 (hospital), 99281-99285 (ER), 99304-99337 (SNF care), 99401-99404 (risk factor reduction intervention), 99408, 99409, 99411, 99412, 99441-99444, 99446-99449 (critical care), 99605-99607

HPCPS: G0157-G0160 (PT/OT), G0396-G0397 (SBRT), G0406-G0408 (inpatient consultation), G0425-G0427 (telehealth), G0463, G0466, G0467 (FQHC), S2350-S2351 (discectomy with decompression of spinal cord)

Line: S2

Condition: CONDITIONS OF THE BACK AND SPINE

Treatment: SURGICAL THERAPY

ICD-9: 336.0, 349.2,720.81,721.0, 721.2,721.3,721.5-721.8,721.90,722.0,722.10-722.2,722.4-722.6,722.8-722.93, 723.0, 723.1,723.4-723.9, 724.0x,731.0,732.0,737.0-737.2,737.40-737.42,737.8-737.9,738.4-738.5,742.59,754.2,756.10-756.12,839.20-839.21,V57.1,V57.2x, V57.81-V57.89

ICD-10: G95.0, M40.xx,M42.xx,M43.0x, M43.1x, M43.2x, M43.5x, M43.8x, M45.x, M46.0x-M46.9x,M47.2x,M47.8x,M47.9,M48.0x (spinal stenosis), M48.1, M48.3, M48.8, M48.9, M49.8x,M50.1x-M50.9x, M51.1x-M51.9,M53..8x,M53.9,M54.1x,M96.1-M96.5,M99.2x-M99.8x,Q67.5,Q76.0-Q76.3,Q76.4x,S13.0x,S23.0x, S23.1x, S33.0x, S33.1x,S34.3x

CPT: 20660-20665, 20930-20938,21720,21725,22206-22226,22532-22865,27035,29000-29046, 29710-29720,62287,62355-62370,63001-63091,63170,63180-63200, 63270-63273,63295-63610,63650,63655,63685,96150-96154 (health and behavior assessment codes), 97001-97004, 97022, 97110-97124, 97140, 97150, 97530, 97535 (PT/OT evaluation and treatment), 98966-98968, 98969, 99051, 99060, 99070,99078,99201-99215 (outpatient medical visits), 99217-99239 (hospital), 99281-99285 (ER), 99304-99337 (SNF care),

99401-99404 (risk factor reduction intervention), 99408, 99409, 99411, 99412, 99441-99444, 99446-99449 (critical care), 99605-99607
HPCPS: G0157-G0160 (PT/OT), G0396-G0397 (SBRT), G0406-G0408 (inpatient consultation), G0425-G0427 (telehealth), G0463, G0466, G0467 (FQHC), S2350-S2351 (discectomy with decompression of spinal cord)

Line: S3
Condition: SCOLIOSIS
Treatment: MEDICAL AND SURGICAL THERAPY
ICD-9: 737.3x, 737.43, V57.1,V57.2x,V57.81-V57.89
ICD-10: M41.xx
CPT: 20660-20665, 20930-20938,21720,21725,22206-22226,22532-22865,29000-29046,29710-29720,62287,62355-62370,63001-63091,63170,63180-63200,63210,63295-63610,63650, 63655,63685, 96127, 96150-96154 (health and behavior assessment codes), 97001-97004, 97022, 97110-97124, 97140, 97150, 97530, 97535 (PT/OT evaluation and treatment), 97760,97762, 98966-98968, 98969, 99051, 99060, 99070,99078,99201-99215 (outpatient medical visits), 99217-99239 (hospital), 99281-99285 (ER), 99304-99337 (SNF care), 99401-99404 (risk factor reduction intervention), 99408, 99409, 99411, 99412, 99441-99444, 99446-99449 (critical care), 99605-99607
HPCPS: G0157-G0160 (PT/OT), G0396-G0397 (SBRT), G0406-G0408 (inpatient consultation), G0425-G0427 (telehealth), G0463, G0466, G0467 (FQHC)

<u>Scoring—Line MMM medical treatments</u>
Category: 7
HL: 4
Suffering: 3
Population effects: 0
Vulnerable population: 0
Tertiary prevention: 2
Effectiveness: 3
Need for service: 0.8
Net cost: 2
Score: 432
Approximate line placement: 405

<u>Scoring—Line S2 surgical</u>
Category: 7
HL: 4
Suffering: 3
Population effects: 0
Vulnerable population: 0
Tertiary prevention: 0
Effectiveness: 1
Need for service: 0.8
Net cost: 2
Score: 112
Approximate line placement: 535

<u>Scoring—Line S1 urgent surgical</u>
Category: 7
HL: 5
Suffering: 4
Population effects: 0
Vulnerable population: 0
Tertiary prevention: 4
Effectiveness: 3
Need for service: 1
Net cost: 2
Score: 780
Approximate line placement: 350

<u>Scoring—Line S3 scoliosis</u>
Category: 7
HL: 5
Suffering: 3
Population effects: 0
Vulnerable population: 0
Tertiary prevention: 3
Effectiveness: 3
Need for service: 1
Net cost: 2
Score: 660
Approximate line placement: 364

MOTION: To recommend the new back condition lines with line scoring, deletion of current back condition lines, and guideline deletions as

presented for 2016 biennial list. To recommend the new guidelines (medical, surgical, opioid prescribing, and scoliosis), changes to existing guidelines, and miscellaneous code changes as modified for 2016 biennial list. CARRIES 5-0.

- **Topic: Coverage Guidance—IVC filters**

Discussion: Livingston reviewed the evidence and EGBS coverage guidance recommendations regarding IVC filters. Smits reviewed the proposed changes to the Prioritized List based on this draft coverage guidance. There was some discussion about different standards of care for use of IVC filters for use in trauma patients in different health systems in the state; however, it was determined that these filters should be available for use in trauma patients for those systems that chose to use them.

Recommended Actions:

1) Add CPT 37191-37193 to lines 1 PREGNANCY, 217 ACUTE PULMONARY HEART DISEASE AND PULMONARY EMBOLI, 285 BUDD-CHIARI SYNDROME, AND OTHER VENOUS EMBOLISM AND THROMBOSIS
2) Adopt a new guideline for IVC filters for PE/DVT as shown in Appendix B
    a. Note: a minor modification replacing the line numbers with "these lines" in the second paragraph was done by HERC at their March 12, 2015 meeting. The guideline shown is as approved by VbBS.
3) Adopt a new ancillary guideline for IVC filters for trauma/prolonged hospitalization as shown in Appendix B

MOTION: To approve the recommended changes to the Prioritized List based on the draft inferior vena cava filters for pulmonary embolism prevention coverage guidance scheduled for review by HERC at their March 12, 2015 meeting. CARRIES 5-0.

- **Topic: Coverage Guidance—Alternatives to TURP**

Discussion: Shaffer reviewed the evidence and the HTAS coverage guidance for alternatives to TURP. Smits reviewed the proposed changes to the Prioritized List. There was some clarifying discussion.

Recommended Actions:

1) Remove 600.01 (Hypertrophy (benign) of prostate with urinary obstruction and other lower urinary tract symptoms (LUTS)), 600.11 (Nodular prostate with urinary obstruction), 600.21 (Benign localized hyperplasia of prostate with urinary obstruction and other lower urinary tract symptoms (LUTS)), and 600.91 (Hyperplasia of prostate, unspecified, with urinary obstruction and

other lower urinary symptoms (LUTS)) from line 576 UNSPECIFIED URINARY OBSTRUCTION AND BENIGN PROSTATIC HYPERPLASIA WITHOUT OBSTRUCTION

2) Remove 52441 (Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant), 52442 (each additional implant), C9739, and C9740 (Cystourethroscopy, with insertion of transprostatic implant) from line 331 FUNCTIONAL AND MECHANICAL DISORDERS OF THE GENITOURINARY SYSTEM INCLUDING BLADDER OUTLET OBSTRUCTION and add to the Services Recommended for Non-Coverage Table
3) Add 52450 (Transurethral incision of prostate) to lines 218 CANCER OF KIDNEY AND OTHER URINARY ORGANS, 274 CANCER OF BLADDER AND URETER, 331 FUNCTIONAL AND MECHANICAL DISORDERS OF THE GENITOURINARY SYSTEM INCLUDING BLADDER OUTLET OBSTRUCTION, 333 CANCER OF PROSTATE GLAND, 576 UNSPECIFIED URINARY OBSTRUCTION AND BENIGN PROSTATIC HYPERPLASIA WITHOUT OBSTRUCTION
    a. Advise MAP to remove 52450 from the Ancillary File
4) Remove 52647 (Laser coagulation of prostate, including control of postoperative bleeding, complete) from lines 331 FUNCTIONAL AND MECHANICAL DISORDERS OF THE GENITOURINARY SYSTEM INCLUDING BLADDER OUTLET OBSTRUCTION and 333 CANCER OF PROSTATE GLAND and add to the Services Recommended for Non-Coverage Table
5) Remove 52648 (Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy, and transurethral resection of prostate are included if performed) from line 333 CANCER OF PROSTATE GLAND
6) Add 53850 (Transurethral destruction of prostate tissue; by microwave thermotherapy) and 53852 (Transurethral destruction of prostate tissue; by radiofrequency thermotherapy) to line 331 FUNCTIONAL AND MECHANICAL DISORDERS OF THE GENITOURINARY SYSTEM INCLUDING BLADDER OUTLET OBSTRUCTION
    a. Advise MAP to remove 53830 and 53852 from their Non-Covered File
7) Adopt a new guideline as shown in Appendix B

MOTION: To approve the recommended changes to the Prioritized List based on the draft alternative to TURP coverage guidance scheduled for review by HERC at their March 12, 2015 meeting. CARRIES 5-0.

- **Topic: Intraocular steroids for diabetic macular edema**

Discussion: Smits reviewed the summary document in the meeting materials. Testimony was heard from Allergan, Inc. representatives, who testified in support

of the staff recommendations. The Allergan representative gave information on some comparative pricing for various ocular steroid treatments. Williams raised a concern that patients who fail anti-VEGF might not benefit from intraocular steroids. Smits and the Allergan representative pointed to a study of this population that found benefit. There was some discussion about the concern for the high cataract formation rate, with the additional cost of surgeries for these cataracts. Overall, the subcommittee felt that the evidence supported the use of steroids for diabetic macular edema.

Recommended Actions:

1) Modify GN116 as shown in Appendix A

MOTION: To approve the guideline note change as presented. CARRIES 5-0.

- **Public Comment:**

No additional public comment was received.

- **Issues for next meeting:**
  - Ventral hernia guideline
  - Prenatal genetic testing guideline revisions
  - Lumbar epidural steroid injection guideline revisions
  - Smoking cessation guideline
  - Review of inpatient and outpatient visit codes for “special” lines
  - Yttrium for liver cancer and metastases
  - Penile anomalies guideline
  - Coverage guidance on
    - Planned out-of-hospital birth
  - Developmental coordination disorder and sensory integration disorder

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- **Next meeting:**

May 7, 2015 at Clackamas Community College, Wilsonville Training Center, Wilsonville Oregon, Rooms 111-112.

- **Adjournment:**

The meeting adjourned at 1:00 PM.

Appendix A

Revised Guideline Notes

Effective October 1, 2015

GUIDELINE NOTE 31, COCHLEAR IMPLANTATION~~, AGE 5 AND UNDER~~

Line XXX

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

1) Profound sensorineural hearing loss in both ears (defined as 71 ~~91~~dB hearing loss or greater at 500, 1000 and 2000 Hz)
2) Receive ~~little or no~~ limited useful benefit from appropriately fitted hearing aids, defined as a speech discrimination score of <30% on age appropriate testing for children and as scores of 40% or less on sentence recognition test in the best-aided listening condition for adults
3) No medical contraindications
4) High motivation and appropriate expectations (both ~~child~~ patient, and family when appropriate~~, and family~~)

Bilateral cochlear implants are ~~covered~~ included on these lines. Simultaneous implantation appears to be more cost-effective than sequential implantation.

GUIDELINE NOTE 92, ACUPUNCTURE

Lines 1,207,374,414,468,545,546

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

Line 1 PREGNANCY

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

Hyperemesis gravidarum

ICD-10-CM code: O21.0, O21.1
ICD-9-CM codes: 643.00, 643.03, 643.10, 643.11, 643.13
Acupuncture pairs with hyperemesis gravidarum when a diagnosis is made by the maternity care provider and referred for acupuncture treatment for up to 2 sessions of acupressure/acupuncture.

Breech presentation

ICD-10-CM code: O32.1xx0, O32.8xx0
ICD-9-CM codes: 652.20, 652.23
Acupuncture (and moxibustion) is paired with breech presentation when a referral with a diagnosis of breech presentation is made by the maternity care provider, the patient is between 33 and 38 weeks gestation, for up to 2 visits.

Back and pelvic pain of pregnancy

ICD-10-CM code: O33.0
ICD-9 codes: 648.70, 648.73
Acupuncture is paired with back and pelvic pain of pregnancy when referred by maternity care provider/primary care provider for up to 12 sessions.

Appendix A

Line 207 DEPRESSION AND OTHER MOOD DISORDERS, MILD OR MODERATE

Acupuncture is paired with the treatment of post-stroke depression only. Treatments may be billed to a maximum of 30 minutes face-to-face time and limited to 15 total sessions, with documentation of meaningful improvement.

Line 374 DISORDERS OF SPINE WITH NEUROLOGIC IMPAIRMENT

Acupuncture is included on Line 374 only for pairing with disorders of the spine with myelopathy and/or radiculopathy represented by the diagnosis codes G83.4, M47.1x, M47.2x, M50.0x, M50.1x, M51.1x, M54.1x/ICD-9-CM ~~344.60, 722.1, 722.2, 722.7 and 724.4~~ 344.6x, 721.1, 721.41, 721.42, 721.91, 722.7x, 723.4, 724.4, with referral, for up to 12 sessions.

Line 414 MIGRAINE HEADACHES

Acupuncture pairs on Line 414 for ICD-10-CM code G43.9/ICD-9-CM 346 Migraine, when referred, for up to 12 sessions.

Line 468 OSTEOARTHRITIS AND ALLIED DISORDERS

Acupuncture pairs on Line 468 for osteoarthritis of the knee only, when referred, for up to 12 sessions.

Line 545 ACUTE AND CHRONIC DISORDERS OF SPINE WITHOUT NEUROLOGIC IMPAIRMENT

Acupuncture pairs on Line 545 with the low back diagnoses (ICD-10-CM codes G83.4, M47.1x, M47.2x, M50.0x, M50.1x, M51.1x, M54.1x/ICD-9-CM ~~344.60, 722.1, 722.2, 722.7 and 724.4~~ 344.6x, 721.1, 721.41, 721.42, 721.91, 722.7x, 723.4, 724.4, when referred, for up to 12 sessions. Acupuncture pairs with chronic (>90 days) neck pain diagnoses (ICD-10-CM M53.82, M54.2, S13.4XXX, S13.8XXX/ICD-9-CM 723.1, 723.8, 723.9, 847.0), when referred, for up to 12 sessions.

Line 546 TENSION HEADACHES

Acupuncture is included on Line 546 for treatment of tension headaches (ICD-10-CM G44.2x/ICD-9-CM 307.81), when referred, for up to 12 sessions.

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

GUIDELINE NOTE 103, BONE ANCHORED HEARING AIDS

Lines 317,450

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

1) The patient is ~~age 5 years or older~~ aged 5-20 years for implanted bone anchored hearing aids; headband mounted BAHA devices may be used for children under age 5
2) Treatment is for unilateral severe to profound hearing loss (defined as 71 dB hearing loss or greater at 500, 1000 and 2000 Hz) when the contralateral ear has normal hearing with or without a hearing aid
3) 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.
4) Implantation is unilateral.

Use of BAHA for treatment of tinnitus is not included on these lines.

Appendix A

GUIDELINE NOTE 116, INTRAOCULAR STEROID TREATMENTS ~~IMPLANTS FOR CHRONIC NON-INFECTIOUS UVEITIS~~

Line 100,363

Intraocular steroid ~~implants~~ treatments (CPT 67027, 67028) are ~~only~~ included on Line 363 for pairing with uveitis (ICD-9-CM codes 360.12, 363.0x, 363.1x, 363.2x, /ICD-10-CM codes H30.0xx, H30.1xx, H30.89x, H30.9xx, H44.11x)~~, and only~~ when the following conditions are met uveitis is chronic, non-infectious, and there has been appropriate trial and failure, or intolerance of therapy, with local and systemic corticosteroids and/or immunosuppressive agents.

Intraocular steroid treatments (CPT 67027, 67028) are included on line 100 for treating chronic diabetic macular edema (ICD-9 362.07/ ICD-10 E11.311) only when there has been insufficient response to anti-VEGF therapies, and only when FDA approved treatments are utilized.

Effective January 1, 2016

DIAGNOSTIC GUIDELINE D4, ADVANCED IMAGING FOR LOW BACK PAIN

In patients with non-specific low back pain and no "red flag" conditions [see Table D4], imaging is not a covered service; otherwise work up is covered as shown in the table. Electromyelography (CPT 96002-4) is not covered for non-specific low back pain.

Table D4
Low Back Pain - Potentially Serious Conditions ("Red Flags") and Recommendations for Initial Diagnostic Work-up

Possible cause	Key features on history or physical examination	Imaging*	Additional studies*
Cancer	• History of cancer with new onset of LBP	MRI	ESR
	• Unexplained weight loss • Failure to improve after 1 month • Age >50 years • Symptoms such as painless neurologic deficit, night pain or pain increased in supine position	Lumbosacral plain radiography	
	• Multiple risk factors for cancer present	Plain radiography or MRI	
Spinal column infection	• Fever • Intravenous drug use • Recent infection	MRI	ESR and/or CRP
Cauda equina syndrome	• Urinary retention • Motor deficits at multiple levels • Fecal incontinence • Saddle anesthesia	MRI	None
Vertebral compression fracture	• History of osteoporosis • Use of corticosteroids • Older age	Lumbosacral plain radiography	None
Ankylosing	• Morning stiffness	Anterior-	ESR and/or

Appendix A

Possible cause	Key features on history or physical examination	Imaging*	Additional studies*
spondylitis	• Improvement with exercise • Alternating buttock pain • Awakening due to back pain during the second part of the night • Younger age	posterior pelvis plain radiography	CRP, HLA-B27
Nerve compression/ disorders (e.g. herniated disc with radiculopathy)	• Back pain with leg pain in an L4, L5, or S1 nerve root distribution present < 1 month • Positive straight-leg-raise test or crossed straight-leg-raise test	None	None
	• Radiculopathic** signs present >1 month • Severe/progressive neurologic deficits (such as foot drop), progressive motor weakness	MRI***	Consider EMG/NCV
Spinal stenosis	• Radiating leg pain • Older age • Pain usually relieved with sitting (Pseudoclaudication a weak predictor)	None	None
	• Spinal stenosis symptoms present >1 month	MRI**	Consider EMG/NCV

*** Level of evidence for diagnostic evaluation is variable**

**** Radiculopathic signs are defined for the purposes of this guideline as the objective evidence of ~~as in Guideline Note 37 with~~ any of the following:**

- **A. Markedly abnormal reflexes**
- **B. Segmental muscle weakness**
- **C. Segmental sensory loss**
- **D. EMG or NCV evidence of nerve root impingement**
- **E. Cauda equina syndrome,**
- **F. Neurogenic bowel or bladder**
- **G. Long tract abnormalities**

***** Only if patient is a potential candidate for surgery or epidural steroid injection**

Red Flag: Red flags are findings from the history and physical examination that may be associated with a higher risk of serious disorders. CRP = C-reactive protein; EMG = electromyography; ESR = erythrocyte sedimentation rate; MRI = magnetic resonance imaging; NCV = nerve conduction velocity.

Extracted and modified from Chou R, Qaseem A, Snow V, et al: Diagnosis and Treatment of Low Back Pain: A Joint Clinical Practice Guideline from the American College of Physicians and the American Pain Society. Ann Intern Med. 2007; 147:478-491.

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

GUIDELINE NOTE 92, ACUPUNCTURE

Lines 1,207,~~374,~~414,468,~~545~~,546,MMM

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

Line 1 PREGNANCY

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

Hyperemesis gravidarum

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

Acupuncture pairs with hyperemesis gravidarum when a diagnosis is made by the maternity care provider and referred for acupuncture treatment for up to 2 sessions of acupressure/acupuncture.

Breech presentation

ICD-10-CM code: O32.1xx0, O32.8xx0

Acupuncture (and moxibustion) is paired with breech presentation when a referral with a diagnosis of breech presentation is made by the maternity care provider, the patient is between 33 and 38 weeks gestation, for up to 2 visits.

Back and pelvic pain of pregnancy

ICD-10-CM code: O33.0

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

Line 207 DEPRESSION AND OTHER MOOD DISORDERS, MILD OR MODERATE

Acupuncture is paired with the treatment of post-stroke depression only. Treatments may be billed to a maximum of 30 minutes face-to-face time and limited to 15 total sessions, with documentation of meaningful improvement.

~~Line 374 DISORDERS OF SPINE WITH NEUROLOGIC IMPAIRMENT~~

~~Acupuncture is included on Line 374 YYY only for pairing with disorders of the spine with myelopathy and/or radiculopathy represented by the diagnosis codes G83.4, M47.1x, M47.2x, M50.0x, M50.1x, M51.1x, M54.1x, with referral, for up to 12 sessions.~~

Line MMM CONDITIONS OF THE BACK AND SPINE

Acupuncture is included this line with visit limitations as in Guideline Note XXX.

Line 414 MIGRAINE HEADACHES

Acupuncture pairs on Line 414 for ICD-10-CM code G43.9 Migraine, when referred, for up to 12 sessions.

Line 468 OSTEOARTHRITIS AND ALLIED DISORDERS

Acupuncture pairs on Line 468 for osteoarthritis of the knee only, when referred, for up to 12 sessions.

~~Line 545 ACUTE AND CHRONIC DISORDERS OF SPINE WITHOUT NEUROLOGIC IMPAIRMENT~~

~~Acupuncture pairs on Line 545 with the low back diagnoses G83.4, M47.1x, M47.2x, M50.0x, M50.1x, M51.1x, M54.1x, when referred, for up to 12 sessions. Acupuncture pairs with chronic (>90 days) neck pain diagnoses (), when referred, for up to 12 sessions~~.

Line 546 TENSION HEADACHES

Acupuncture is included on Line 546 for treatment of tension headaches G44.2x, when referred, for up to 12 sessions.

GUIDELINE NOTE 105, EPIDURAL STEROID INJECTIONS~~, OTHER PERCUTANEOUS INTERVENTIONS~~ FOR ~~LOW~~ BACK PAIN

Lines ~~75, 159, 297,~~ MMM

Epidural lumbar steroid injections (CPT 62311, 64483, 64484) are included on this line for patients with persistent radiculopathy due to herniated disc, where radiculopathy is ~~as~~ defined ~~in Guideline Note 37~~ as showing objective evidence of one or more of the following:

A) Markedly abnormal reflexes

B) Segmental muscle weakness
C) Segmental sensory loss
D) EMG or NCV evidence of nerve root impingement
~~E) Cauda equina syndrome~~
~~F) Neurogenic bowel or bladder~~
~~G) Long tract abnormalities~~

One epidural steroid injection is included on these lines; a second epidural steroid injection may be provided after 3-6 months only if objective evidence of 3 months of sustained pain relief was provided by the first injection. It is recommended that shared decision-making regarding epidural steroid injection include a specific discussion about inconsistent evidence showing moderate short-term benefits, and lack of long-term benefits. Epidural lumbar steroid injections are not included on these lines for spinal stenosis or for patients with low back pain without radiculopathy.

~~The following interventions are not covered for low back pain, with or without radiculopathy:~~
- ~~facet joint corticosteroid injection~~
- ~~prolotherapy~~
- ~~intradiscal corticosteroid injection~~
- ~~local injections~~
- ~~botulinum toxin injection~~
- ~~intradiscal electrothermal therapy~~
- ~~therapeutic medial branch block~~
- ~~radiofrequency denervation~~
- ~~sacroiliac joint steroid injection~~
- ~~coblation nucleoplasty~~
- ~~percutaneous intradiscal radiofrequency thermocoagulation~~
- ~~radiofrequency denervation~~

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

GUIDELINE NOTE 137, BENIGN BONE ~~TUMORS~~ AND JOINT CONDITIONS AT HIGH RISK FOR COMPLICATIONS

Lines XXX, ~~154,358,484,496,~~ 533

Treatment of benign conditions of joints (ICD-9/ICD-10 727.89/M67.8x synovial chondromatosis, ICD-9/ICD-10 228.00/D18.09 synovial hemangioma, ICD-9/ICD-10 214.8/D17.79 lipoma arborescens, ICD-9/ICD-10 727.02/D48.1 tenosynovial giant cell tumor, and ICD-9/ICD-10 719.2x/ M12.2xx villonodular synovitis) are included on Line XXX for those conditions only when there are significant functional problems of the joint due to size, location, or progressiveness of the disease. Treatment of all other benign joint conditions are included on Line 533.

Treatment of benign tumors of bones (ICD-9 213.0-213.9, 526.0-526.2, 733.2x/ICD-10 D16.00-D16.9, K09.0, K09.1, M27.1, M27.40, M27.49, M85.40-M85.69) are included on ~~Lines 154, 358, 484 and 496~~ Line XXX for those neoplasms associated with pathologic fractures, at high risk of fracture, or which cause function problems including impeding joint function due to size, causing nerve compression, have malignant potential or are considered precancerous. Treatment of all other benign bone tumors are included on Line 533.

Appendix B

New Guideline Notes

Effective October 1, 2015

ANCILLARY GUIDELINE A3, IVC FILTERS FOR TRAUMA

It is the intent of the Commission that inferior vena cava (IVC) filter placement (CPT 37191) and subsequent repositioning and removal (CPT 37192, 37193) are covered when medically indicated for hospitalized patients with severe trauma resulting in prolonged hospitalization.

GUIDELINE NOTE XXX, TREATMENT OF UNILATERAL HEARING LOSS

Lines 317, 450

Unilateral hearing loss treatment is Included on these lines only for children aged 20 and younger with the following conditions:

1) For mild to moderate sensorineural unilateral hearing loss (defined as 26-70 dB hearing loss at 500, 1000 and 2000 Hz), first line intervention should be a conventional hearing aid, with second line therapy being contralateral routing of signal (CROS) system
2) For severe to profound unilateral sensorinerual hearing loss (defined as 71 dB hearing loss or greater at 500, 1000 and 2000 Hz), first line therapy should be a contralateral routing of signal (CROS) system with second line therapy being a bone anchored hearing aid (BAHA). BAHA SoftBand therapy may be first line therapy for children under age 5 or patients with severe ear deformities (e.g. microstia, severe canal atresia).

Cochlear implants are not included on these lines for unilateral hearing loss per guideline note 31 COCHLEAR IMPLANTATION.

GUIDELINE NOTE XXX, PROTON PUMP INHIBITOR THERAPY FOR GASTROESOPHAGEAL REFLUX DISEASE (GERD)

Lines 384, 519

Short term treatment (up to 8 weeks) of GERD with proton pump inhibitor therapy is included on line 384. Long term treatment is included on line 519.

GUIDELINE NOTE XXX, IVC FILTERS FOR ACTIVE PE/DVT

Lines 1, 83, 217, 285, 290

Inferior vena cava (IVC) filter placement (CPT 37191) is included on lines 1, 83, 217, 285, 290 for patients with active deep vein thrombosis/pulmonary embolism (DVT/PE) for which anticoagulation is contraindicated. IVC filter placement is not included on these lines for patients with DVT who are candidates for anticoagulation.

Retrieval of removable IVC filters (CPT 37193) is included on these lines when the benefits of removal outweigh the harms.

Appendix B

GUIDELINE NOTE XXX, TREATMENTS FOR BENIGN PROSTATE ENLARGEMENT WITH LOWER URINARY TRACT SYMPTOMS

Line 331

For men with lower urinary tract symptoms (LUTS) due to benign prostate enlargement, coverage of surgical procedures is recommended only if symptoms are severe, and if drug treatment and conservative management options have been unsuccessful or are not appropriate.

The following interventions for benign prostate enlargement are not included on line 331 due to lack of evidence of effectiveness:

- Botulinum toxin
- HIFU (High Intensity Focused Ultrasound)
- TEAP (Transurethral Ethanol Ablation of the Prostate)
- Prostatic urethral lifts
- Laser coagulation (for example, VLAP/ILC)
- Prostatic artery embolization

Effective January 1, 2016

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

Line MMM

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

For patients who are determined to be low risk on the assessment tool, the following services are included on this line:

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

For patients who are determined to be high risk on the validated assessment tool, the following treatments are included on this line:

- Office evaluation, consultation and education
- Cognitive behavioral therapy. The necessity for cognitive behavioral therapy should be re-evaluated every 90 days and coverage will only be continued if there is documented evidence of decreasing depression or anxiety symptomatology, improved ability to work/function, increased self-efficacy, or other clinically significant, objective improvement.

Appendix B

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

These coverage recommendations are derived from the State of Oregon Evidence-based Guideline on the Evaluation and Management of Low Back Pain available here: http://www.oregon.gov/oha/herc/Pages/blog-low-back-non-pharmacologic-intervention.aspx

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

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

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

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

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

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

Appendix B

GUIDELINE NOTE YYY, OPIOID PRESCRIBING FOR CONDITIONS OF THE BACK AND SPINE

Lines MMM, S1, S2, S3

The following restrictions on opioid treatment apply to all diagnoses included on these lines.

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

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

For patients with chronic pain from diagnoses on these lines currently treated with long term opioid therapy, opioids must be tapered off, with a taper of about 10% per week recommended. By the end of 2016, all patients currently treated with long term opioid therapy must be tapered off of long term opioids for diagnoses on these lines. If a patient has developed dependence and/or addiction related to their opioids, treatment is available on line 4 SUBSTANCE USE DISORDER.

Appendix B

GUIDELINE NOTE ZZZ SURGICAL INTERVENTIONS FOR CONDITIONS OF THE BACK AND SPINE OTHER THAN SCOLIOSIS

Lines S1, S2

Surgical consultation/consideration for surgical intervention are included on these lines only for patients with neurological complications, defined as showing objective evidence of one or more of the following:

A) Markedly abnormal reflexes
B) Segmental muscle weakness
C) Segmental sensory loss
D) EMG or NCV evidence of nerve root impingement
E) Cauda equina syndrome
F) Neurogenic bowel or bladder
G) Long tract abnormalities

Spondylolithesis (ICD-9 738.4, 756.11-756.12 / ICD-10 M43.1x, Q76.2) is included on line S1 only when it results in spinal stenosis with signs and symptoms of neurogenic claudication. Otherwise, these diagnoses are included on line S2.

Surgical correction of spinal stenosis (ICD-9 721.1, 723.0, 724.0x / ICD-10 M48.0x) is only included on lines S1 for patients with:

1) MRI evidence of moderate to severe central or foraminal spinal stenosis AND
2) A history of neurogenic claudication, or objective evidence of neurologic impairment consistent with MRI findings.
3)

~~Otherwise, these diagnoses are included on line S2.~~ Only decompression surgery is covered for spinal stenosis; spinal fusion procedures are not covered for this diagnosis. Otherwise, these diagnoses are included on line S2.

For conditions on line S2, surgical interventions may only be considered after the patient has completed at least 6 months of conservative treatment, provided according to Guideline Note XXX NON-INTERVENTIONAL TREATMENTS FOR CONDITIONS OF THE BACK AND SPINE.

The following interventions are not ~~covered~~ included on these lines due to lack of evidence of effectiveness for the treatment of conditions on these lines, including cervical, thoracic, lumbar, and sacral conditions ~~back pain, with or without radiculopathy~~:

- facet joint corticosteroid injection
- prolotherapy
- intradiscal corticosteroid injection
- local injections
- botulinum toxin injection
- intradiscal electrothermal therapy
- therapeutic medial branch block
- radiofrequency denervation
- sacroiliac joint steroid injection
- coblation nucleoplasty
- percutaneous intradiscal radiofrequency thermocoagulation
- radiofrequency denervation

Appendix B

GUIDELINE NOTE AAA, SCOLIOSIS

Line S3

Non-surgical treatments of scoliosis (ICD-9 737.3x,737.43/ICD-10 M41.xx) are included on line CCC when

1) the scoliosis is considered clinically significant, defined as curvature greater than or equal to 25 degrees or
2) there is curvature with a documented rapid progression.

Surgical treatments of scoliosis are included on line ~~CCC~~ S3

1) only for children and adolescents (age ~~21~~ 20 and younger) with
2) a spinal curvature of greater than 45 degrees

Appendix C

Deleted Guidelines

GUIDELINE NOTE 37, DISORDERS OF SPINE WITH NEUROLOGIC IMPAIRMENT

Lines 374,545

Diagnoses are included on Line 374 when objective evidence of neurologic impairment or radiculopathy is present, as defined as:

A) Markedly abnormal reflexes
B) Segmental muscle weakness
C) Segmental sensory loss
D) EMG or NCV evidence of nerve root impingement
E) Cauda equina syndrome,
F) Neurogenic bowel or bladder
G) Long tract abnormalities

Otherwise, disorders of spine not meeting these criteria (e.g. pain alone) fall on Line 545.

GUIDELINE NOTE 41, SPINAL DEFORMITY, CLINICALLY SIGNIFICANT

Line 412

Clinically significant scoliosis is defined as curvature greater than or equal to 25 degrees or curvature with a documented rapid progression. Clinically significant spinal stenosis is defined as having MRI evidence of moderate to severe central or foraminal spinal stenosis in addition to a history of neurogenic claudication, or objective evidence of neurologic impairment consistent with MRI findings (see Guideline Note 37).

GUIDELINE NOTE 56, ACUTE AND CHRONIC DISORDERS OF SPINE WITHOUT NEUROLOGIC IMPAIRMENT

Line 545

Disorders of spine without neurologic impairment include any conditions represented on this line for which objective evidence of one or more of the criteria stated in Guideline Note 37 is not available

GUIDELINE NOTE 60, SPINAL DEFORMITY, NOT CLINICALLY SIGNIFICANT

Line 588

Scoliosis not defined as clinically significant included curvature less than 25 degrees that does not have a documented progression of at least 10 degrees

GUIDELINE NOTE 94, EVALUATION AND MANAGEMENT OF LOW BACK PAIN

Lines 374,545

Procedures for the evaluation and management of low back pain are included on these lines when provided subject to the State of Oregon Evidence-based Clinical Guidelines dated 10/2011 located at:
http://www.oregon.gov/oha/OHPR/pages/herc/evidence-based-guidelines.aspx.

CHANGES IN COVERAGE FOR BACK CONDITIONS

What are the approved changes to OHP's coverage for treatment of back conditions?

At its March 12, 2015 meeting, the Health Evidence Review Commission (HERC), approved changes to coverage for the treatments of back conditions in the Oregon Health Plan. The changes will take effect January 1, 2016.

The HERC based its decisions on new evidence, including a bio-psycho-social model designed to help people with back problems resume normal activities. This model will help people manage their pain with less reliance on medication and fewer costly surgeries.

Until now, the OHP has limited treatment to patients who have muscle weakness or other signs of nerve damage. Beginning in 2016, treatments will be available for all back conditions. Before treatment begins, providers will assess patients to determine their level of risk for chronic back pain, and whether they meet criteria for a surgical consultation. Based on the results, one or more of the following covered treatments may be appropriate:

- Acupuncture
- Chiropractic manipulation
- Cognitive behavioral therapy (a form of talk therapy)
- Medications (including short-term opiate drugs, but not long-term prescriptions)
- Office visits
- Osteopathic manipulation
- Physical and occupational therapy
- Surgery (only for a limited number of conditions where evidence shows surgery is more effective than other treatment options)

In addition, yoga, intensive rehabilitation, massage, and/or supervised exercise therapy are recommended to be included in the comprehensive treatment plans. These services, which also have evidence of effectiveness, will be provided where available as determined by each Coordinated Care Organization (CCO).

HERC based its decision on the recommendations of the Back Lines Reorganization Task Force, a special workgroup consisting of a neurosurgeon, a chiropractor, an acupuncturist, an orthopedic surgeon, a primary care physician, a physiatrist, physical therapists, specialists in mental health and addiction, a health plan medical director, pain specialists, and a national expert in the evidence on treatments for back pain. This Task Force reviewed a large body of evidence about the effectiveness of various treatments and the potential harms of certain therapies.

CHANGES IN COVERAGE FOR BACK CONDITIONS

Why did HERC undertake this process?

Back pain and other back conditions are very common for OHP members. In 2013, about 8 percent of OHP recipients saw a provider for back conditions, and over half of those individuals received narcotic medications, often for many months. OHP has spent a great deal of public money on treatments such as surgery and medications, without good evidence that they improve patient's lives. At the same time, narcotics also carry risks of dependency, misuse and overdose.

In recent years, the HERC has conducted reviews which found evidence that various therapies help back pain and other back conditions. These therapies could not, however, be added to the prioritized list because of the way back conditions were ranked. As a part of its biennial review, the HERC created a task force to find a way to reorganize the Prioritized List to reflect the new evidence. The task force created recommendations which prioritize therapies such as acupuncture, chiropractic, and physical therapy over surgery and narcotics for most back conditions, recognizing the effectiveness of these treatments in improving people's health and reducing suffering.

What is the history of OHP coverage of treatments for back conditions?

1. OHP historically has covered only the back conditions with radiating symptoms of weakness or numbness due to nerve damage, for a full range of services such as physical therapy, chiropractic, acupuncture and surgery.
2. People with back pain without nerve symptoms were limited to primary care visits and medications such as narcotics.

What was the process for HERC's decision?

1. The HERC adopted coverage guidances regarding diagnostic testing and effective treatments for low back pain and neck pain in 2013 and 2014.
2. The HERC created a Task Force to reorganize the Prioritized List lines dealing with back pain to allow coverage of evidence-based, effective therapies.
3. The Back Line Reorganization Task Force was created in the fall of 2014, and met monthly through February 2015
4. At its January, 2015, meeting, the Value-based Benefits Subcommittee (VbBS) and the HERC heard a draft proposal from the Task Force
5. At its March, 2015 meeting, VbBS and HERC heard the final proposal from the Task Force, made revisions, and approved the revised prioritization of back treatments resulting in the new coverage package

How can I participate or get updates on HERC's activities?

You can subscribe at the HERC website at www.oregon.gov/OHA/OHPR/Pages/HERC/ to receive notifications of future meetings and look at materials being discussed. You can attend the meetings, which are open to the public, and speak during time set aside for public comment.

COVERAGE GUIDANCE: INFERIOR VENA CAVA FILTERS FOR PREVENTION OF PULMONARY EMBOLI

Approved March 12, 2015

HERC COVERAGE GUIDANCE

Inferior vena cava (IVC) filters are recommended for coverage in:

- Patients with active deep vein thrombosis/pulmonary embolism (DVT/PE) for which anticoagulation is contraindicated *(strong recommendation)*
- Some hospitalized patients with trauma* *(weak recommendation)*

Retrieval of removable IVC filters is recommended for coverage if the benefits of removal outweigh harms *(weak recommendation)*

IVC filters are not recommended for coverage for patients with DVT who are candidates for anticoagulation *(strong recommendation)*

*Examples of trauma for which IVC filters may be indicated include patients with severe trauma and prolonged hospitalization.

Note: Definitions for strength of recommendation are provided in Appendix A. GRADE Element Description

RATIONALE FOR GUIDANCE DEVELOPMENT

The HERC selects topics for guideline development or technology assessment based on the following principles:

- Represents a significant burden of disease
- Represents important uncertainty with regard to efficacy or harms
- Represents important variation or controversy in clinical care
- Represents high costs, significant economic impact
- Topic is of high public interest

Coverage guidance development follows to translate the evidence review to a policy decision. Coverage guidance may be based on an evidence-based guideline developed by the Evidence-based Guideline Subcommittee or a health technology assessment developed by the Heath Technology Assessment Subcommittee. In addition, coverage guidance may utilize an existing evidence report produced by one of HERC's trusted sources, generally within the last three years.

HEALTH EVIDENCE REVIEW COMMISSION (HERC)

COVERAGE GUIDANCE: SURGICAL ALTERNATIVES TO TRANSURETHRAL RESECTION OF THE PROSTATE FOR LOWER URINARY TRACT SYMPTOMS IN MEN

Approved March 12, 2015

HERC Coverage Guidance

For men with lower urinary tract symptoms (LUTS) due to benign prostate enlargement, coverage of surgical procedures is recommended only if symptoms are severe, and if drug treatment and conservative management options have been unsuccessful or are not appropriate. (*strong recommendation*)

The following are coverage recommendations regarding surgical alternatives to transurethral resection of the prostate (TURP):

Recommended for coverage (*strong recommendation*):

- Bipolar TURP
- Photoselective vaporization of the prostate (PVP)
- Laser enucleation; HoLEP (Holmium Laser Enucleation of Prostate)
- TUIP (Transurethral Incision of the Prostate)

Recommended for coverage (weak recommendation):

- TUNA (Transurethral Needle Ablation of Prostate)
- TUMT (Transurethral Microwave Thermotherapy)
- Bipolar TUVP (Transurethral Electrovaporization of Prostate) (Button procedure)
- Thulium laser vaporization/resection of the prostate

Not recommended for coverage (*weak recommendation*):

- Botulinum toxin
- HIFU (High Intensity Focused Ultrasound)
- TEAP (Transurethral Ethanol Ablation of the Prostate)
- Prostatic urethral lifts

Not recommended for coverage (*strong recommendation*):

- Laser coagulation (for example, VLAP/ILC)
- Prostatic artery embolization

Note: Definitions for strength of recommendation are provided in Appendix B GRADE Element Description

Leading Change

Edward O'Neil, PhD, MPA, FAAN

Edward O'Neil is the owner of O'Neil & Associates, a management consulting and leadership development firm focused on change and renewal in the health care system. He is also a Senior Fellow at Stanford University's Center for Clinical Excellence Research Center and a Senior Advisor to the Blue Shield Foundation of California and the Gordon and Betty Moore Foundation.

In June of 2012 he retired from his position as professor in the Departments of Family and Community Medicine, Preventive and Restorative Dental Sciences, and Social and Behavioral Sciences (School of Nursing) at the University of California, San Francisco (UCSF). During his time at UCSF, he also served as the director of the Center for the Health Professions, a research, advocacy, and training institute that he created in 1992. The mission of the Center is to assist health care professionals, health professions schools, care delivery organizations, and public policy makers in understanding the challenges and opportunities of educating and managing a health care workforce capable of improving the health and well-being of people and their communities. His work has focused on change within the US health care system through improved policy and leadership.

In 2001 he created O'Neil & Associates with an aim to assist organizations in understanding the strategic challenges they face in a changing health care world and developing strategies and leadership competencies to succeed. His clients include foundations, academic health centers, public sector providers, policy makers, the pharmaceutical industry, and providers in health systems and professional practices.

He holds a bachelor's and a master's degree from the University of Alabama as well as a master's of public administration and a doctorate in history from Syracuse University. In addition, he holds honorary degrees from New York Medical College, the Western University of Health Sciences, and two other universities. In 2003 he was elected to an honorary fellowship in the American Academy of Nursing.

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Leadership vs. Management

What do you think the key differences are between managing and leading?

Share these with a classmate. What do you agree on? Are there differences?

Much is made by some about this distinction, but they seem to be more a matter of degree or emphasis more than two different undertakings. John Kotter in a useful article made these distinctions:

Leadership	Management
Sets directions	Creates plans and budgets
Aligns people	Organizes and staffs
Motivates people	Controls and problem solves

Leading When the World Turns Complex

One way of seeing the difference between management and leadership is reflected below:

When things are not moving much, management probably is enough, but when things are changing, more leadership will be demanded.

Models of Leadership

We all have a model of leadership that operates inside our head. Often that model fits with the challenges before us, but sometimes the model and the situation don't align and that is when mischief starts. To start this exploration of leadership lets look at some models of leadership. Let's start with yours.

Think about the best leader you have ever worked with directly. What were the key characteristics that distinguished him or her from other good leaders to make them the best? List those traits here:

Most Effective Leader

- _____
- _____
- _____
- _____
- _____
- _____

What do you notice about your group's leadership model?

Any surprises?

A General Leadership Model

For this leadership program we are going to use a simple leadership model:

Leadership = **V**ision + **T**ask + **R**elationship

In this formulation vision leadership is synonymous with purpose, knowledge of the changing environment, strategy and communication of a general nature. Task addresses the process considerations that vary from sector to sector and even organization, but there are some general task concerns such as running a meeting, providing project leadership, ensuring adequate oversight and technical communication. Relationship speaks to connections to other people, the personal insight needed to fully value these relationships and how to work effectively through and with the people that you lead. We sometimes call this emotional intelligence. Interpersonal communication is key to the dimension of leadership.

All of these elements are necessary and none are sufficient. Knowing your strengths and weaknesses in each area will help make you a more effective leader. A leadership challenge rarely comes across as "vision" problem or a "relationship" issue in an uncomplicated manner. They usually involve a host of elements from each of the big three categories. Your job as leader is to master them all and respond in the moment when the leadership issue presents itself. Synthesizing the particular skills into the demands of the moment is what leadership is truly about.

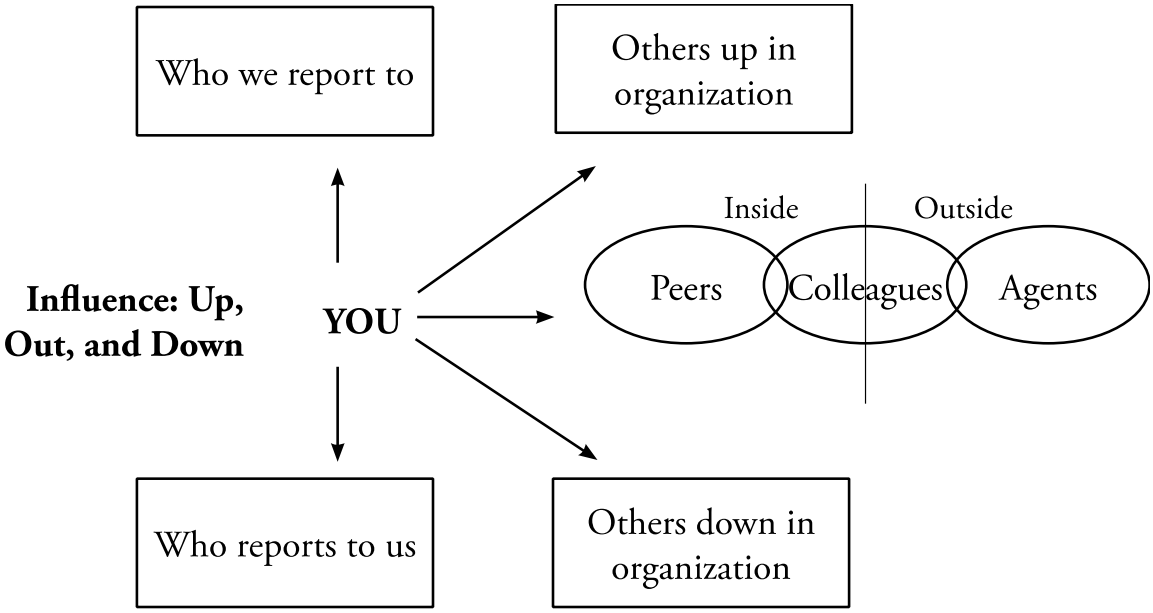
Leadership in All Directions

It is easy to think of leadership of those people that report to you. But true leadership in an organization goes in three directions: **down, out and up. Down** to those that report to us or are levels below our position in the organization and need to be actively engaged in the work we are leading. **Out** to peers or near peers within our organizations or part of the organization most of whom we do not have direct authority over and must enlist them in our leadership work when they have a host of other interests and demands competing for their time. Out also reaches even more distantly out to colleagues and collaborators that may be outside of our part of the organization or even in another organization. Here the leader must align interests, develop relationships and push a leadership agenda where little conventional authority exists. Finally, all true leaders must lead **up**. This may seem like it

should not be our job, but the reality is that the demands of leadership often mean effectively influencing the person we report to or pushing a leadership agenda up in the organization in decision making channels that exist outside the standard lines of authority.

The chart below captures the three basic directions of influence that any leader will need to manifest in order to be effective. Take a moment to think about which individuals and groups go into each domain for your leadership work.

A Model for Influence



Influence is a complex undertaking, and each of the three basic directions has its own characteristics and qualities that we will explore over the course of this program. In general, however, influencing others involves the development of trust, but it is developed in different ways as we influence in different directions. While not exclusive to any one direction, trust is enhanced **upward by demonstrating performance, support, and loyalty**. Outwardly trust is increased as **transparency, accountability, and collaboration** grow. And when working to improve the relationship and trust downward, leaders commit to **motivating, developing, and delegating** to those that they need to

influence. Again, all actions work in all directions, but they are particularly effective in the directions indicated.

Why Change is Hard

Over the past decade many authors writing on change and how to manage it effectively have assured us that the postmodern world in which we live will be marked by constant whitewater and their sage advice, "Get use to it." This may sound reasonable while reading in the comfort of a warm bed late at night. It does not, however, offer much consolation when faced with a bunch of hostile and recalcitrant coworkers in health care or education who are not really ready to "embrace the challenge" of a constantly changing world.

The ideal crew to handle constant change would embrace the task ahead, be ready to support one another through any weather, willingly reframe their work to address the mission and be capable of restraining individual desire for collective effort. Instead it is likely that your experience managing change more closely resembles this:

A challenge you must meet for the patients, students or customers you serve that will require a significant change among faculty, researchers, practitioners and staff. Though these changes are necessary adjustments, not merely made up by the "leadership suits," you have been met with reluctance, confusion, heckling, anger and finally rejection, either active or passive, to the proposed course of action.

You want to be the leader; they just do not seem to want to follow.

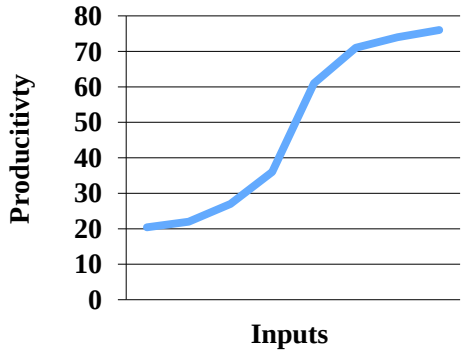
Or as David Nadler has put it, "Change is persuading massive numbers of people to stop what they have been doing and start doing something that they probably don't want to do." This leadership module is about how to manage and lead the change process.

Coherence and Paradigms

In his classic work on the structures and frameworks that shape and mold the realities of scientists, Thomas Kuhn introduced us to the enormously powerful notions of *paradigms* and how they both create understating and limit innovation. [1]Paradigms are frameworks of understanding that organize the world in a way that makes it productive and useful for those who hold the paradigm. This utility is the source of a paradigm's awesome power.

Health care workers organized into professional guilds with special skills, vocabularies, privileges and work has been the dominating paradigm for the organization of health services for centuries. The paradigm produced much of the gains that have come from health care in the past ranging from basic biomedical knowledge to its application in immunizations and surgery. Because it worked so well, it also produced economic gain and social prestige for the incumbents within the system. However, today this health care paradigm may actually be inadequate to addressing the challenges of health care which leaves a large percentage of the population without regular service, uses more and more economic resources every year, is uneven, at best, in its standards of quality, and which causes thousands of avoidable deaths annually.

Yet, because of its effectiveness in the past and because the incumbents derive so much from its maintenance, we continue to offer it resources, like some primitive cult, hoping against hope that it will return to its effectiveness of old. To break such a hold, a powerful vision is needed; one that explains the irrationality of sustaining what we do and challenges us to create a new paradigm.



Press, 111-113.

What are your paradigms?

Take a minute to reflect on the addition exercise. Did your actions reveal anything about your paradigms? Describe them here and see how they might limit your adaptation to a changing environment.

My paradigms?

- _____
- _____
- _____
- _____
- _____
- _____

How do they limit me?

- _____
- _____
- _____
- _____
- _____
- _____

When Paradigms Need to Change

Paradigms exist to help us make sense of the world around us. They exhibit themselves in myths, culture, rules, theories, tools, techniques, and technology. Their ability to explain reality and to make us effective actors in the world around us is what gives them power, because they give us power. This is why we are so attached to paradigms that are still working, or seem to be, and why they are so hard to break.

If the world around us was static and never needed to change, then we would never be aware of our paradigms as they would continue to effectively explain and order reality. However, as circumstances change then our tools and frameworks may no longer work or work as well as they once did. At first we will not see the changes, but will try to make our familiar paradigm work, maybe spending more resources to see if we can get it started again. Ultimately, the group that uses the paradigm will adapt a new more functional framework or they will lose their position or role in the larger society, economy, or organization.

The driver of such changes of course is the environment. There are many ways to categorize the changes in the environment. Four helpful "buckets" for changes are external, internal, global and local. They are not exclusive of each other, there might be a need to be cost effective that is external with significant local implications. Use the boxes below to identify some of the factors that are driving the need for change in your paradigm or reality.

Global Changes

Internal Changes

External Changes

Local Changes

Take a few minutes to compare your sense of how the environment is changing with a colleague. How do you see it in the same way? How do you see it differently?

Changing Environment

The current way is not sustainable and already a new paradigm is emerging. It is not exactly clear what the paradigm will look like and it will definitely vary in its shape, power, and speed from region to region and profession to profession, but it is changing.

The general shape and direction of the shift seems likely to move from the left to the right in the figure below.

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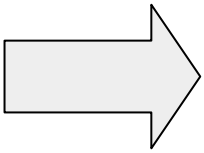
Today

- Acute treatment
- Pay for transactions
- Cost unaware
- Professional prerogative
- In-patient
- Individual profession
- Traditional practice
- Information as record
- Patient passivity



Tomorrow

- Chronic prevention and management
- Pay for value
- Price competitive
- Consumer responsive
- Ambulatory – Home and Community
- Team
- Evidence based practice
- Information as tool
- Consumer engagement and accountability

The smart question for leaders is how to adjust to this shift in paradigms, not suffer from the pain of the change. To do this will require movement from the highly independent and uniform reality of the old paradigm to the more interdependent and diverse world that is emerging. This will take partnerships and leadership to make them happen.

As a leader your success will be in large part determined by your ability to help others understand and develop in this new paradigm.

One Model for Change

Because change is a complex undertaking there are many ways to frame it for consideration. One basic change formula looks like this:

Change =
Benefits of the Status Quo < A*B*C

When:
A = Pain of maintaining the status quo
B = Vision of a different world
C= Small steps to achieve that vision

Leading Change and Influencing Others

Any time we are responsible for leading change there is both a strategic and a tactical game that is played. Most of us are not asked to address broad issues of strategic change, but many of us are responsible for leading and managing the implementation of changes that are essential for the long term health of our organizations from private practices to hospitals to large public agencies. Today in health care there is a considerable quantity of change and if you have a leadership or management role in health care today, it is likely that you are or will soon be involved in a change effort.

Maria Chang, MD

Maria is a young very promising doctor at the Anzar Medical Center. She has always been drawn to leadership rolls and has held these even before going to medical school. She enjoys putting things in order so that improvements can be made and that people can enjoy their work and be more productive. She had a great role model in the senior physician who directed her training program. Dr. Nancy Sims was the epitome of the organized physician leader, always on time and prepared, she exuded control in every situation. She always knew what to do and was not afraid of saying it directly in an effective business-like manner. Maria was in special awe of the way that Dr. Sims interacted with older male physicians. There was none of the overly deferential behavior she sometimes witnessed young female docs exhibit in the face of a dominating male presence. Dr. Sims always cut to the chase and always got her way.

Dr. Chang has some good ideas on how the in-patient service can better meet its quality performance goals that have been established by the Joint Commission. QI has been an area

of interest of hers since residency and she is excited that the Chief of her service has asked her to be on a project to develop some recommendations for actions that the hospital can take quickly to make some early progress on this important task. She was delighted that the Chief had such confidence in her abilities as he seemed to indicate that he would be depending on her leadership of the group.

She took time off-duty to compile the best evidenced based improvements that she believed would make the biggest and quickest impact an Anzar. She divided these into three areas that built on one another. These neatly fit into a package that clearly showed that they would not only save lives, but money as well. She drafted a proposal for action and even took a chance to send a final draft to her mentor Dr. Sims asking if she had time for a quick reaction. Dr. Sims wrote back within an hour giving her a few really good suggestions and the encouragement to "stick by your guns" with this outstanding proposal; closing with the comment "you make me very proud Dr. Chang."

Maria presented her recommendations to the task force that her Chief had established to advance the QI work. She expected that they would ask some questions and essentially turn the implementation of the plan over to her. She had already developed her presentation to the Chief on how she would go about the implementation. She was shocked by the reaction of the working group. Her colleagues either did not understand what QI was about or they were threatened by how good her ideas were. There were other suggestions for action that did not fit into her plan and anyone could see simply would not work. Other ideas were just wrong and the literature that she provided proved how wrong they were. She tried to show them this with the same determination that had worked for Dr. Sims, but no one seemed to pay much attention. Finally one of the other members of the group suggested that the best thing they could do would be to plan to attend an IHI meeting where improvement strategies were going to be discussed. Everyone, except Dr. Chang, agreed with this recommendation and they agreed to advance this idea to the Chief and voted to adjourn.

Maria was crestfallen. The next day she scheduled time with the Chief and laid out her plans to him. She also indicated that others in the group did not seem to be up to the task or were not taking it seriously. She also suggested that the Chief plan to attend the next session and use his authority to get the group back on track. She also indicated that she would be happy to accept a formal leadership role for the group if the Chief wanted to go in that direction.

The next day Dr. Chang got an email from the chief thanking her for her work on the Task Force and re-assigning her to an inventory control problem. She sat at the nurse's station in a stunned state. Nelson Tudor one of the promising young charge nurses on the service who Maria had hoped to enlist in the QI work asked if she was OK. She didn't hear at first and when he repeated the question she shook her head from side to side and said, "I suppose so for working in a place that is a hundred years out of date."

What things did Maria do correctly in this change process?

Where did she make missteps?

What might have been done differently by any of the actors to have a different outcome?

What steps could be taken to rekindle the effort?

What would you do differently?

Influencing Lessons from Maria

What lessons from Maria's experience do you want to remember when you do your change work?

When Leading Change, I Will

- _____
- _____
- _____
- _____
- _____
- _____

Six Essential Influencing Elements

Most efforts to lead or manage change involve the process of how we can influence others, usually without much formal authority. This influence will need to be aimed in three different directions from where we sit as leaders: down, out and up. Each of these involves a different framework and understanding, but effective influence without authority begins with understanding the following six elements.

Self-awareness – Having insight into your skills and weaknesses as an influencer and the ability to move beyond the heroic leader role to being a collaborator. Self-insight also includes what you want from a situation and what you are willing to give to secure it.

For **Change Work** you will need to add in awareness of what you think about the change. Are you supportive of the change? Do you understand the reasons for the change? How will this change impact you and how you work? How will it impact your career? How do you feel

about change in general? Is now a time in your life, professional or personal, that you can tolerate more change?

Needs of others- Understanding the full range of needs, from strategic to interpersonal, of those that you want to influence. Knowing what they need, desire and want is essential to your being an effective influence. Often people talk of "stakeholder analysis" in change work and this is the same thing as the needs of others.

For **Change Work** you will need to ask many of the same questions of others that you have asked of yourself. One of the big disconnects in leading change is assuming that once we come to a place where we can support change, we believe that others share that commitment. One of the best ways to enhance your ability to lead change is to truly understand how others see and will experience the change. It will also help immensely if you have a deep understand of what they value and believe they need.

Common ground – Having the ability to develop, share and gain buy-in to a broad vision about your collective work that is shared in all directions. This also includes knowledge about the mutual gain that we will share in, even if the motivation for that mutual gain varies from person to person.

For **Change Work** that is of a more tactical nature you hopefully will be working with an existing framework for carrying out the change from a strategic perspective. Your job will be to translate the change into something that can be understood and valued at the level of the people that you must influence. This does not mean "dumbing it down". It does mean understanding the strategic change with enough precision that you as a leader can translate the impact of the change to your team, unit, department, office or organization. Not all news about change is welcome news. In fact, even developments that some might see as positive will be perceived by others in a negative light.

Relationship capital – Your stock of good will that has built up over time with the various constituencies and stakeholders, in all three directions. The process of influencing either builds or draws down on our relationship capital.

Change Work will draw on your stock of relationship capital, but it is possible to lead in a way that might minimize these withdrawals and perhaps even allow you to make a deposit or two. In general the way to do this are to be clear, focused on the people changing and be willing to share what you can as openly as possible- both the good and the not so good news. Many of the leadership qualities that can add to your stock of relationship capital when things are changing are reviewed below in the "Rules for Uncertain Times".

Reciprocity and Exchange – This involves your understanding of the reciprocal nature of relationships that are involved in all influencing situations. It also points to the very real exchange that goes on between parties in order to maintain that relationship and be influential.

In **Change Work** you want to align as many people as possible with the work and the gains to be made. Others you will have to ask to delay gratification and others will have to be compensated for their loss.

Follow through – Your ability to develop and use legitimate power to continuously influence others.

In **Change Work** legitimate power is both the structural power of your leadership position and more importantly the informal power that you derive from using the first five of these qualities. How you use this power to continue to push for change will be a key to success?

Leadership Lab Book

A Discovery Guide for Managing Conflict

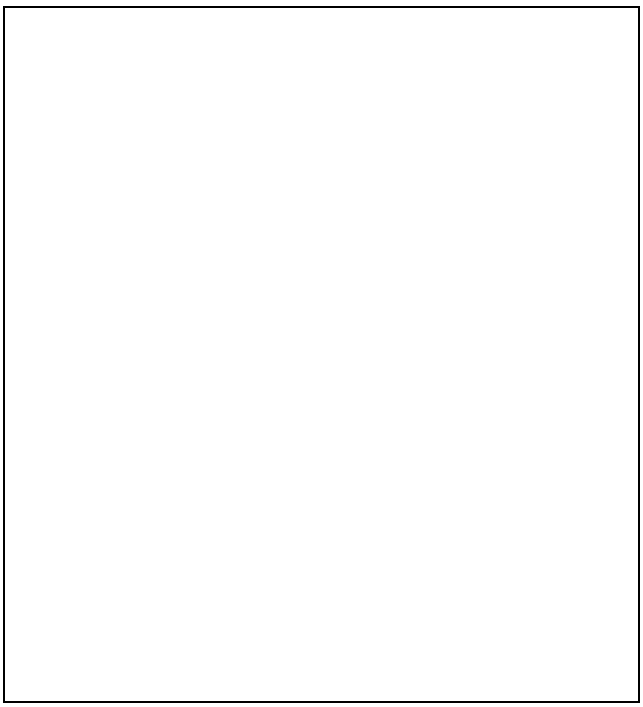
Understanding & Managing Conflict

Conflicts abound in our modern, stress filled world. They almost always represent situations in which two people or groups disagree about what is true or what is important. These different perspectives produce different maps of the world and sense of reality and, out of this confusion, conflict emerges.

These conflicts are likely to be a product of miscommunication, poor negotiation, preconceived bias, or misinformation coupled with faulty extrapolation. Regardless of the faulty basis for the conflict, it is nonetheless real and is likely to feed on itself and make more conflict.

Definition of conflict: Any situation where your concerns or desires differ from another person or group.

What are the sources of conflict in your professional world?



Exercise: Mary and Bill's Very Bad Day

Is conflict always negative? We often have conflict around our individual tolerance for conflict itself. Have you ever found yourself on one side or the other of this little drama?

> Returning from a meeting with her boss Bill, Mary is notably upset. Her friend and co-worker Sally asks hesitantly, "So how did it go?"
>
> "I can't believe him. I have laid out the best plan for action just like he asked me to. Everything has been considered and was in my strategy. But he won't commit to taking action or even discuss the issues. How many times have we been down this path? He is killing the organization with his cowardice."
>
> Sally asks if Mary had sought Bill's feedback.
>
> Responding, Mary's eyes widen and she shakes her head negatively. "Are you KIDDING me? I looked him right in the eye and said, 'Bill if there is something wrong here you owe it me to be honest.' All I got back was that usual no, no this is just fine BS. How is this going to get better without communication?"
>
> That night over dinner, Bill's wife asks how his day went. He shrugs, but she stays with it. "So what was is it this time?" she asks.
>
> He responds by recounting the meeting with Mary earlier in the day. "Oh, it is just my burning star Mary, so smart and right and so hopelessly clueless about what her pushing does to the very people she needs to bring along. She has a great plan, but feels it should have been done yesterday. She just doesn't realize she needs to move slowly to get this done."
>
> Bill's wife asks if he has given her some idea about this aspect of her work. In a moment of candor Bill allows that he has tried, but finds engaging her on anything that is less than praiseworthy usually creates more emotion than he can stand.
>
> His wife reminds him that not everyone sees the world as he does.

Use the boxes below to think thorough what Bill and Mary each contributed to this situation, both positively and negatively.

Share your list with a neighbor. How was your perception of their interaction the same? How was it different?

Why would two successful people have such different attitudes about conflict? List a few ideas that might explain these differences.

Conflict can be both positive and negative. Too much of the wrong type of conflict can tear apart an organization, team, or unit. Too little conflict may leave too much unsaid and can lead to underperformance and suppressed differences that inevitably erupt anyway — and often in a more harmful way.

The boxes below offer some insight into these differences.

How do you contribute to constructive and destructive conflict?

Managing Conflict

As a term, "conflict resolution" may be a bit of a misnomer. It is probably best to think about creating, through effective management and leadership, the best environment to manage the inevitable conflicts that will emerge and ensure that conflicts or differences are carried out in the most professional manner possible.

1. *Identify common ground*

Understanding what is shared between you and the person or group you are in conflict with is one of the first skills to learn in conflict management. This common ground might be the success of a project, workplace harmony, shared values, or individual success — basically any desire that you and the person or group both share or have in common.

Think about Mary and Bill in our story earlier. What did they have in common?

Now think about a particular person you have been or are in conflict with now. What do the two of you share?

2. *Acknowledge and address emotions*

Conflicts often emerge over basic needs, which inevitably lead us to question basic human motivations. This, in turn, can generate strong emotional reactions which only feed the conflict more. To be resolved, conflict situations need to find a constructive way to release these emotions before going forward.

Let's see how emotions play out in a role play.

What do you think the emotional issues were? Who is to blame?

These five steps will help you get mastery of your feelings:

Step 1 – Recognize your feelings; don't ignore them to keep peace.

Step 2 – Acknowledge your feelings to the other person involved.

Step 3 – When the other person tells you their feelings, acknowledge that you understand or ask them to clarify.

Step 4 – Take responsibility for your feelings; don't shift the blame.

Step 5 – If the emotions are too hot, take time to cool off.

3. *Understand the problem and identify solutions*

Hopefully the common ground and shared commitment between the two of you has gotten you through the emotional tension and some of the air has been cleared. Now it is time to use this space to mutually define the problem.
Remember that your problem is shared. The problem is not their behavior or what you think of them, but a problem you both share. Most likely there are some needs that both of you have that lie behind the problem.

Let's go back to Bill and Mary. What was is the core problem?

4. *Set a course of action*

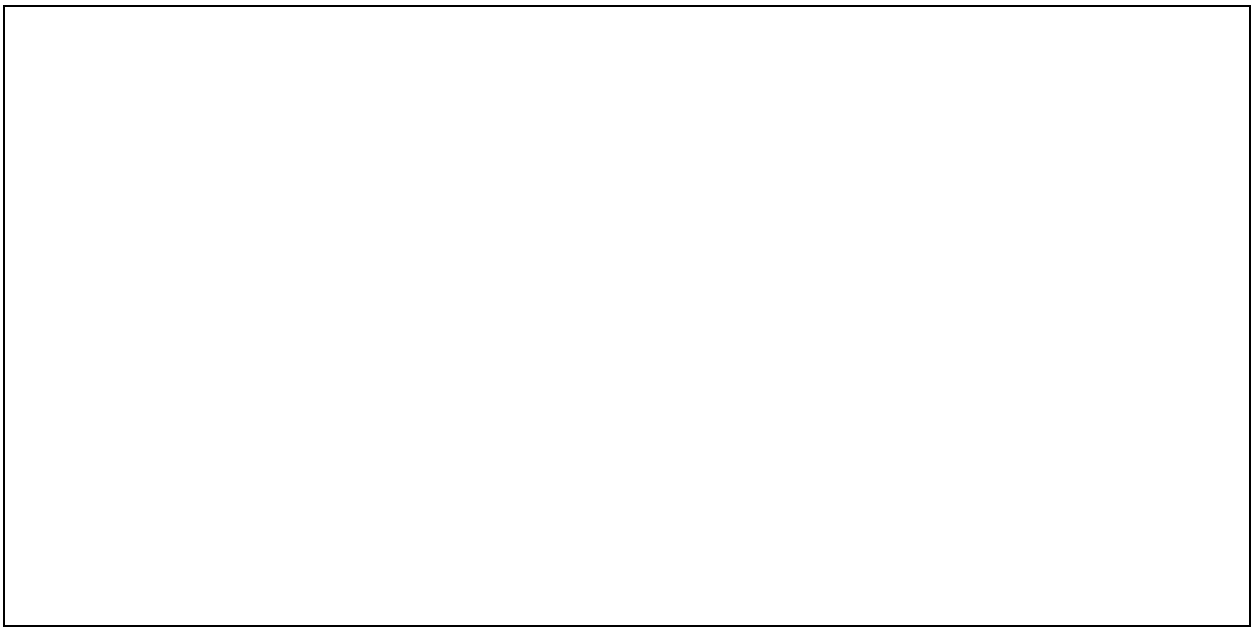
Once you have defined the problem and come up with solutions, it is essential to have everyone agree on a course of action to follow in order to address the problem.

A written summary of what each party is to do is a great first step. This is an excellent opportunity to summarize the expectations of both parties in a follow-up email. Remember that it is essential to send it as a draft and encourage input to the final agreement from all relevant parties. Think of it less as a contract and more as a way to improve understanding. It is always better to focus on actions in the future, than perceived faults in the past.

Factoring Conflict

Factoring the conflict means breaking it down into its core elements, deciding what outcomes you desire, and choosing a strategy based on this analysis. A useful tool for thinking about conflict is the Thomas-Kilmann Conflict Mode Instrument. The Instrument allows for two dimensions or drivers for conflict: assertive and cooperative behavior.

Figure 2.1
Thomas-Kilmann Conflict Mode Instrument



Competing is assertive and uncooperative. You try to satisfy your own concerns at the other person's expense.

Collaborating is assertive and cooperative. You try to find a win-win solution that completely satisfies both people's concerns.

Compromising is an intermediate step between assertiveness and cooperativeness. You try to find an acceptable settlement that only partially satisfies both people's concerns.

Avoiding is unassertive and uncooperative. You sidestep the conflict without trying to satisfy either person's concerns.

Accommodating is unassertive and cooperative. You attempt to satisfy the other person's concerns at the expense of your own.

Effective leaders respond to conflict in a variety of ways and develop their strategy in ways that lead to outcomes that are desirable. All too often leaders rely on one approach to conflict that becomes their default strategy. Such an approach is too narrow for the complex demands that most leaders face. One way to develop an effective approach to conflict is to frame the strategy by asking six key questions.

The questions to consider when dealing with conflict are:

1. How is power distributed and how might it change?

2. How important is my relationship with the other person? Am I willing to give it up over the conflict?

3. Am I certain about how to get to the best quality solution or outcome? Or is it just my idea? Can the best outcome be reached through some form of collaboration?

4. How important is the issue to me? And is my valuation legitimate? How much does the other person value this?

5. Do I need the other person's ongoing buy-in? What if I win, but really lose because I no longer have their engagement?

6. How much time do we have to resolve this?

It is hard to remember even the best suggestions in moment of high emotions, but here are some things to try to remember:

- Balance reason and emotion
- Question, listen, and try to understand
- Separate noise from signal
- Increase two-way communication
- Remain reliable
- Practice persuasion, not coercion
- Strive for mutual acceptance
- Choose the best conflict strategy
- Don't push unless you have to
- Use "firm flexibility" when resistance occurs

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