Oregon Health Authority

Quality and Health Outcomes Committee AGENDA

MEETING INFORMATION

Meeting Date/Time: November 8, 2021 / 10:00 a.m.– 3:00 p.m.
Location: Zoom
Call in information: 1-669-254-5252 / **Meeting ID**: 161 050 3391/ **Passcode**: 908871
Registration required: Zoom registration
On meeting day, after registered, click the join link: Zoom join link
All meeting materials are posted on the QHOC website

Clinical Director Work Group 10:00 a.m. – 12:30 p.m.			
TIME	**TOPIC**	**OWNER**	**MATERIALS (page #)**
10:00 a.m.	**Welcome & Announcements**	Holly Jo Hodges Lisa Bui	
10:05 a.m.	**COVID-19 update** ▪ **COVID-19 vaccine for pediatrics** ▪ **mAbs, home testing, + other COVID**	Kristen Dillon Dawn Mautner	
10:35 a.m.	**Pharmacy Update**	Roger Citron	
10:45 a.m.	**BiMart Pharmacy Closure Update**	Trevor Douglass	
11:00 a.m.	**HERC update** ▪ Orthodontia coverage in certain circumstances	Ariel Smits	
11:25 a.m.	**Break**	All	
11:35 a.m.	**Additional Agenda/Items from the floor**	All	
12:30 p.m.	**Lunch**		
Quality and Performance Improvement Session 1:00 p.m. – 3:00 p.m.			
1:00 p.m.	**QPI introductions/ Announcements**	Jenna Harms Laura Matola Lisa Bui	
1:10 p.m.	**2021 Parity Audit and NOABD review**	Veronica Guerra Nathan Roberts	
1:40 p.m.	**SUD statewide PIP development**	Lisa Bui Dana Peterson	
2:30 p.m.	**Items from the floor**	All	
3:00 p.m.	**Adjourn**		

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

Speaker Contact Sheet

AGENDA TOPIC	SPEAKER	CONTACT INFO
COVID-19 update	Dawn Mautner	dawn.mautner@dhsoha.state.or.us
HERC Update	Jason Gingerich	jason.d.gingerich@dhsoha.state.or.us
P&T Update	Roger Citron	roger.a.citron@dhsoha.state.or.us
BiMart Pharmacy Closure Update	Trevor Douglass	trevor.douglass@dhsoha.state.or.us
2021 Parity Audit and NOABD review	Veronica Guerra Nathan Roberts	veronica.guerra@dhsoha.state.or.us nathan.w.roberts@dhsoha.state.or.us
QHOC Website:	https://www.oregon.gov/oha/hpa/dsi/pages/quality-health-outcomes-committee.aspx	
Questions:	OHA.qualityquestions@dhsoha.state.or.us or call Lisa Bui at 971-673-3397	

OHA Transformation Center Technical Assistance for CCOs

TA index

Metrics TA

Kindergarten readiness

Marketing toolkit for promoting kindergarten readiness incentive measures

A reminder that marketing assets are available for CCOs to promote well-child (including childhood immunizations) and preventive dental visits. Our goal has been to create a set of tools that all CCOs can easily use to reach out to members and encourage them to make these important appointments for their children. The materials include a brochure, social media assets, advertising assets and more. All materials are available in English and Spanish.

Marketing assets and an introductory webinar are available here: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/kindergarten-readiness.aspx

Contact: Alissa Robbins (Alissa.Robbins@dhsoha.state.or.us)

Screening, brief intervention and referral to treatment (SBIRT)

Free clinical technical assistance for clinics addressing the increasing prevalence of unhealthy alcohol (SBIRT) and opioid use: New clinic recruitment phase open

What: The OHA Transformation Center is partnering with the Oregon Rural Practice-based Research Network (ORPRN) to support clinic technical assistance related to SBIRT for unhealthy alcohol and drug use. SBIRT is a "must-pass" incentive measure for CCOs in 2021.

This collaborative project, ANTECEDENT, can provide primary care clinics with 15 months of tailored support to implement changes to address unhealthy alcohol use at no-cost to the participating clinics. Additionally, ORPRN is offering a complementary TA opportunity regarding chronic pain management and opioid prescribing (aka PINPOINT).

See flier: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/ORPRN-SBIRT-Antecedent-Pinpoint.pdf.

When: Recruiting through November 2021

Audience: Clinics across Oregon are invited to participate in these free technical assistance opportunities.

Questions? Contact Alissa Robbins (Alissa.Robbins@dhsoha.state.or.us) or the program at ANTECEDENT@ohsu.edu).

Social-emotional health

System-level social-emotional health metric overview

The Transformation Center recently held needs assessment calls with CCOs regarding the new 2022 social-emotional health metric. The metric overview portion of these calls was recorded and is available below.

- Needs assessment notes: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/SE-needs-assessment-notes.pdf
- Metric overview
    - Recording: https://youtu.be/FsZsLcCJ8eY
    - Slides: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/Social-emotional-health-metric-overview.pdf
    - Q&A: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/Social-emotional-health-metric-Q%26A.pdf

The Transformation Center is planning a learning collaborative focused on this metric and will share more information as it's available.

Tobacco cessation

Free, quick online tobacco cessation counseling training to address higher COVID-19 risk for cigarette smokers (with CME)

What: With cigarette smokers at higher risk for COVID-19, this short online course will improve your care team's ability to help patients quit tobacco. The course focuses on brief tobacco intervention and motivational interviewing techniques.

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

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

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

Access the training: https://tcrc.rapidlearner.com/3462253711

Non-metrics TA

Child health complexity data

2021 child health complexity data reports

The 2021 children's health complexity data reports (statewide, CCO and county) are now posted to the Transformation Center website. OHA produced the reports in collaboration with OPIP and ODHS.

- Cover letter from the OHA chief medical officer and director of health analytics: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/Health-Complexity-Cover-Letter-October-2021.pdf
- View all data reports here: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Child-Health-Complexity-Data.aspx

Contact: OHA's Children's Health Policy Team (HealthComplexity.Program@dhsoha.state.or.us)

Community health assessments and improvement plans (CHA/CHP)

Updated matrix of community health priorities by agency and region

CCOs completed their first CHAs and CHPs in 2014, and all CCOs have since completed at least one additional CHA and CHP. Local public health authorities (LPHAs) may also develop and implement community health assessments and community health improvement plans, while nonprofit hospitals develop a similar community health needs assessment and implementation strategy. To support collaboration and alignment, the OHA Transformation Center, in collaboration with the OHA Public Health Division, has developed a matrix of community health priorities by agency and region: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/2021 CHA-CHIP Matrix v3 external.pdf

The matrix includes community health priorities for plans that were completed by March 2021 and will be updated at least annually. If your CCO, LPHA or hospital notes an error in the community health priorities within the matrix, please contact the Transformation Center at Transformation.Center@dhsoha.state.or.us.

COVID-19 vaccination

Virtual learning sessions: Pediatric COVID vaccines for clinics

The Oregon Health Authority (OHA) Transformation Center, in partnership with the OHA Vaccine Planning Unit, is hosting a learning session focused on pediatric COVID immunizations. As a participant, you will hear from subject matter experts and from peers on key topics such as pediatric COVID vaccine updates, how to build vaccine confidence in parents, and using equity in all planning and delivery of vaccine. Time will be reserved to answer questions from clinical staff.

This is an ongoing learning series with new topics covered each session. Space will be limited to the first 500 participants for each session. Please register for each date below and join us via Zoom:

- **11/18 –** Register here: https://www.zoomgov.com/meeting/register/vJIscemppjIoHwuB-Xih9539IiFX4GRNshY
- **12/9 –** Register here: https://www.zoomgov.com/meeting/register/vJIsfuyhrTsvGma2LeibZAdW6YYUKqIwCTw
- **12/16 –** Register here: https://www.zoomgov.com/meeting/register/vJItcuqvpzgiGrZbxCab-zgQVD3XpCt-tJ0

Audience: Vaccinators, including FQHC staff, clinical pediatric staff, family medicine staff, pharmacists
Contact: Alissa Robbins (Alissa.Robbins@dhsoha.state.or.us)

Health-related services

CCO learning collaborative: SHARE and HRS community benefit

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

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

When: First session was September 27, 4 p.m.; then 4th Monday of each month through June 2022

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

Contact: Nancy Goff (nancy055@gmail.com)

HRS office hours

CCO staff are invited to participate in general HRS office hours starting in September 2021. CCO staff may join the calls at any point during the scheduled times.

- **When**: Every other month through 2022
  - Next: November 9, 11–11:30 a.m.
  - Full schedule at https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Health-Related-Services.aspx
- **Join on your computer or mobile app** (no registration required)
  - Or call in (audio only): +1 971-277-2343
  - Phone conference ID: 895 910 664#

In lieu of services

Introduction to in lieu of services webinar

A webinar recording is available to provide an introduction to in lieu of services (ILOS), which is the new opportunity CCOs have to offer medically appropriate and cost-effective substitute services in lieu of already covered services. CCO Operations Manager David Inbody introduced the program and answered recent questions from CCOs.

- **Recording**: https://us02web.zoom.us/rec/share/JowkBn8TvJwkbPAt1OSQnmSnsvj2fZ_-HpUk4Y8Ephhq3zB7ufml4ee_B4PwRno.eSFXWz_bl2qgit6r?startTime=1631310854000
- **Slides**: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/In-Lieu-Of-Services_an%20introduction_vfinal.pdf

OHA is working to setup a website with ILOS future resources and guidance, which will be shared when available.

Patient-centered primary care homes

PCPCH learning collaborative: Standard 3.D - Comprehensive Health Assessment & Intervention

The OHA Patient-Centered Primary Care Home (PCPCH) Program is hosting a learning collaborative to help you learn from other peer practices how to meet **PCPCH Standard 3.D – Comprehensive Health Assessment & Intervention.** The intent of this standard is for PCPCHs to assess and intervene in patients' health-related social needs (HRSN) as part of routine wellness care. Health-related social needs such as housing instability, food insecurity, and exposure to interpersonal violence directly impact health outcomes.
In this learning collaborative we will hear from PCPCHs about their strategies for routine HRSN assessment, tracking HRSN referrals, as well addressing specific patient population needs with HRSN interventions. Time will be reserved for your questions about this standard. Each session will focus on one of the three measures in Standard 3.D.

- **November 19 (Noon-1 p.m.): PCPCH Measure 3.D.1**
  - This session will focus on the differences and similarities between HRSN and Social Determinants of Health (SDOH). We will also discuss the different HRSN assessment tools and strategies used by PCPCHs.

Register here: https://www.zoomgov.com/j/1607751485?pwd=ZWJQYXhaOG9kQkwydkZOczBnOFlkUT09

- **December 3 (Noon-1 p.m.): PCPCH Measure 3.D.2**
  - This session will focus on the difference between PCPCH measures 3.D.2 (HRSN referrals & coordination) and 5.E.3 (community service provider referrals & coordination). We will also discuss how PCPCHs assess and track HRSN. Register here: https://www.zoomgov.com/j/1612070372?pwd=dVlzKy9lenpuM0Q3WnR5UWFsdkZmZz09
- **December 17 (Noon-1 p.m.): PCPCH Measure 3.D.3**
  - This session will focus on strategies for how PCPCHs can analyze HRSN data and identify interventions based on patient need. Register here: https://www.zoomgov.com/j/1605168659?pwd=K2dlRnV4ejk0cGZNeldwS1I5VDRGdz09

Contact: Bernadette Lauer (Bernadette.Lauer@dhsoha.state.or.us)
Accommodation requests related to a disability should be made by the Monday preceding each session to Bernadette Lauer at Bernadette.Lauer@dhsoha.state.or.us. Every effort will be made to provide services to requests received closer to the session dates, however submitting your request as early as possible is greatly appreciated.

SHARE (supporting health for all through reinvestment)

Webinar: Two CCO approaches to SHARE in the first year

Two CCOs (Columbia Pacific CCO and PacificSource) will share their approaches to SHARE in the first year of program implementation.

- New date: November 29, 10-11 a.m.
- Register here: https://us02web.zoom.us/meeting/register/tZctce6hrTgrG9Ob64KPRJL5JMLqSxVksLZL

Columbia Pacific CCO will focus their SHARE funds on supporting the capacity building of a Healthy Homes program that is in all three counties of the CCO's service region. The program supports financially limited individuals to maintain and improve their living conditions. Program participants will be linked to health care services as needed. There will be a focus on equity and inclusion with identified sub-populations through increasing program involvement with IPV and culturally specific organizations who work to increase access to health and social care.

PacificSource Central Oregon chose to use SHARE Initiative funds to support Central Oregon FUSE (Frequent User System Entry) to increase housing placements for chronically homeless individuals and families in our community. Benefits from this project for FUSE and Emergency Housing Choice Voucher holders will include a package to incentivize leasing to participants, providing renters insurance, pre-screening, outreach materials, and a dedicated Landlord Liaison. In addition, participants of the FUSE Permanent Supportive Housing program will be eligible to access a "Landlord Mitigation Fund," which acts as additional insurance for property owners willing to lease to individuals with significant barriers.

Contact: Anne King (kinga@ohsu.edu) and Nancy Goff (nancy055@gmail.com)

CCO learning collaborative: SHARE and HRS community benefit

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

When: 4th Monday of each month through June 2022

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

Contact: Nancy Goff (nancy055@gmail.com)

Transformation and quality strategy

2022 TQS guidance documents

The 2022 TQS template and guidance documents are now posted to the Transformation Center website: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-Quality-Strategy-Tech-Assist.aspx

This includes a template, guidance document, scoring criteria, FAQ, project ID numbers, and a change log of major updates. Note: Updated example strategies will be added by November 4.

Technical assistance schedule for 2022 submissions

Webinars and office hours for 2022 submissions will begin in October. If you'd like to be added to the calendar appointments for the webinars or office hours below, please email Laura.E.Kreger@dhsoha.state.or.us. The connection details are also posted on the TQS TA page: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-Quality-Strategy-Tech-Assist.aspx

Webinars

- **Global feedback/updates:** Recording at link above
- **Access (all three components):** Recording at link above
- **Serious and persistent mental illness:** Recording at link above
- **Special health care needs:** Will be rescheduled (TBD)
- **Utilization review:** Recording at link above

Office hours (first Thursdays, 11-11:30 a.m.)

- Nov. 4, Dec. 2, Jan. 6, Feb. 3, March 3

Transformation Center technical assistance updates

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

Long Haul COVID Coverage- Medicaid Guidance

- Required to cover treatment, including specialized equipment and therapies
- This includes treatment of conditions that may complicate COVID-19 recovery
- Includes pharmacological and non-pharmacological
- Medical Necessity must be decided on a case-by-case basis and particular treatment needs of individual
- Utilization Management controls should not cause unreasonable or arbitrary barriers to accessing coverage
- More guidance will need to be assessed and provided

Oregon Health Authority

Drug Use Research & Management (DURM) Program

OSU Oregon State University College of Pharmacy

Roger Citron, RPh

Oregon Health Authority

October P&T Committee
OHA Approved Recommendations

https://www.oregon.gov/OHA/HSD/OHP/Pages/PT-Committee.aspx

Approved October 13, 2021

Oncology Policy Updates

- Add the following new FDA-approved antineoplastic agents to Table 1 in the Oncology Agents prior authorization (PA) criteria:

Rylaze™ (asparaginase erwinia chrysanthemi (recombinant)-rywn)

Welireg™ (belzutifan)

https://www.orpdl.org/durm/PA_Docs/oncology.pdf

Orphan Drug Policy Updates

- Update Table 1 in the Orphan Drugs PA criteria to support medically appropriate use of Ryplazim® (plasminogen, human-tvmh) and Rezurock™ (belumosudil mesylate) based on FDA-approved labeling

https://www.orpdl.org/durm/PA_Docs/orphan_drug.pdf

Inhaled Anticholinergics Literature Scan

- Make no changes to the PMPDP based on clinical evidence

- After comparative cost consideration in executive session:

  Make Combivent® Respimat® & Incruse® Ellipta® preferred on the PMPDP (effective 1/1/22)

https://www.orpdl.org/drugs/drugclass.php?cid=1103&brand=combivent

Non-Injectable Antiepileptics Literature Scan

- Make no changes to the PMPDP based on clinical evidence

- After comparative cost consideration in executive session:

  Make no changes to the PMPDP

Biologics for Autoimmune Disorders Class Update

- Make no changes to the PMPDP based on clinical evidence
- Rename the class “Targeted Immune Modulators”
- Modify the PA criteria to include expanded ages and indications
- Update the “Multiple Sclerosis Oral Agents” PA criteria to include ozanimod in adults with moderate-to-severe ulcerative colitis
- After comparative cost consideration in executive session:

  Make Cosentyx® preferred on the PMPDP

Calcitonin Gene-Related Peptide (CGRP) Inhibitors Class Update

- Make no changes to the PMPDP based on clinical evidence
- Update the PA criteria to: clarify the difference between acute (abortive) and prophylactic (preventative) treatment; update the recommended drugs for cluster headache; and require providers assess for uncontrolled hypertension prior to initiation of therapy for applicable agents - including Aimovig®
- After comparative cost consideration in executive session:

  Make Aimovig® preferred and Emgality® non-preferred on the PMPDP

Hepatitis C, Direct-Acting Antiviral (DAA) Literature Scan

- Update the PA criteria and treatment table to include new pediatric indications and clerical updates

- After comparative cost consideration in executive session:

  Make branded Epclusa® non-preferred on the PMPDP

Pulmonary Arterial Hypertension Class Update

- Make no changes to the PMPDP based on clinical evidence
- Update the PA criteria to include expanded indications
- After comparative cost consideration in executive session:

  Make no changes to the PMPDP

Alzheimer's Disease Class Update and New Drug Evaluation

- Maintain Aduhelm™ (aducanumab) as non-preferred on the PMPDP
- Implement the proposed PA criteria after amending to:
    - Mirror mild disease as defined in studies
    - Modify renewal criteria to prevent continuation of therapy in patients with any evidence of microhemorrhage
- After comparative cost consideration in executive session:

    Make donepezil, rivastigmine, memantine, and Namzaric® preferred on the PMPDP

Topical Antiparasitic Agents Class Update and New Drug Evaluation

- Maintain Xeglyze™ (abametapir) as non-preferred on the PMPDP
- Include Soolantral® in the topical antiparasitic class and designate as non-preferred
- Make no other changes to the PMPDP based on clinical evidence
- After comparative cost consideration in executive session:

  Make Vanalice™ non-preferred on the PMPDP

December P&T Committee Meeting

- Meeting scheduled to be held 12/02/2021
- Agenda and Final Documents were posted on 11/02/2021

https://pharmacy.oregonstate.edu/drug-policy/oregon-pharmacy-therapeutics-committee/meetings-agenda

P&T Committee Vacancies

- The OHA is still looking for 2 physicians (MD or DO) interested in being considered for appointment to the Committee
- Need to be actively practicing
- Terms are for 3 years and there are 6 P&T meetings annually

https://www.oregon.gov/OHA/HSD/OHP/Pages/PT-Committee.aspx

Thank You

Oregon Health Authority

Trevor S. Douglass, DC, MPH

Director, Pharmacy Policy & Programs

BiMart → Walgreens Acquisition

- On or around September 30th, BiMart announces exit from pharmacy business.
- Permanently shuttering 37 pharmacies across the state.
- Struggled to get information from Walgreens about transition.

Timeline for Transition

- BiMart began closing its pharmacies October 18th and will finish closing its pharmacies Nov 11th.
- The following BiMart pharmacies are identified as converting to a Walgreens operated outlet:

• Eugene (18th Ave)	• Prineville
• Klamath Falls	• Veneta
• Corvallis	• Junction City
• Monmouth	• La Pine
• Stayton	

Pharmacies in Crisis

- National shortage of pharmacy technicians
- Staffing challenges due to limitations of staff
- Pharmacies are opening late and closing early
- Some closing for days at a time
- Services reduced (no vaccinations, no testing, no off-site clinics)
- People waiting hours in line and/or days to receive medications

What is being done…

- Critical Access Pharmacy analysis and status change.
- Messaging by Walgreens, CCOs and OHA
- Staffing challenges and OHA response
  - https://covidblog.oregon.gov/what-to-do-if-your-pharmacy-has-closed/
  - November 22nd

Questions

- Thoughts, additional concerns or questions?
- Don’t hesitate to text/call or email me:

Trevor.douglass@dhsoha.state.or.us

iPhone: 971-209-8491

HERC Update

Jason Gingerich

November 8, 2021

COVID Related Issues

- New directive from CMS requires coverage without limitations for all COVID and long-term COVID treatments
    - Requires individual review even if treatment is not paired or BTL
        - e.g. neuropsych testing?
    - Still allows medical necessity determinations

Behavioral Health Advisory Panel Meeting

- October 18, 2021
- Nightmare disorder
  - Add to the PTSD line
- Screening for ACEs
  - No changes recommended (no screening codes added to the list)
- SUD waiver HCPCS codes
  - Several HCPCs codes added to the substance use disorder line
- Selective mutism
  - Diagnosis moved to generalized anxiety disorder line
  - Current line struck through until 2024 Prioritized List formal deletion

November VBBS/HERC

- 2022 CPT code placements

A. Straightforward code placements
B. Codes requiring minimal discussion
C. Left atrial appendage exclusion
D. Cerebral embolic protection devices
E. Drug induced sleep endoscopy
F. Peroral endoscopic myotomy (POEM)
G. Periurethral transperineal adjustable balloon continence device
H. Laser interstitial thermal therapy (LITT) Hypoglossal nerve stimulator
I. Thermal destruction of intraosseous basivertebral nerve
J. Drug-eluting lacrimal canaliculus stents
K. Trabecular bone score
L. Genetics related code Laboratory studies
M. New vaccine codes
N. Remote therapeutic monitoring

November VBBS/HERC

- GAP/OHAP/BHAP reports
  - Handicapping malocclusion
  - D0190 dental screening by non-dental professional
  - Whole genome sequencing for infants
  - Expanded carrier screening

November VBBS/HERC

- Deletion of duplicate angioedema line
    - Strikethrough for 2021 list, delete for 2024 biennial review list
- Radiofrequency ablation and cryotherapy for select renal cell cancers
    - Adds coverage
- Pelvic congestion syndrome
    - Clarifies lack of coverage
- Cyanoacrylate vein ablation
    - Adds to varicose vein lines
-

November VBBS/HERC

- Platelet rich plasma
    - Add level III CPT to line 662/GN173
- Breast MRI
    - Combines 3 current guidelines regarding breast imaging into one, removes mammogram and ultrasound as not subject to coverage restrictions, perioperative coverage only for high risk women, adds additional coverage areas (indeterminant imaging, evaluation of possible implant rupture, etc.)
- Breast reconstruction after lumpectomy
    - Clarifies that this is a covered benefit

November VBBS/HERC

STATEMENT OF INTENT 4: ROLE OF THE PRIORITIZED LIST IN COVERAGE

- Adds clause "Services paired with an unfunded condition which adversely affects a child's ability to grow, develop or participate in school"

January VBBS/HERC

2022 HCPCS codes

Note: likely will require a 2/1/22 Prioritized List

Dorsal rhizotomy for spastic diplegic cerebral palsy

Autoimmune encephalitis placement

Actinic keratoses

Foot arthrosis

EGBS

December 2, 2021 meeting

- High Frequency Chest Wall Oscillation Devices
  - Coverage recommendation expanded to cystic fibrosis, bronchiectasis and pulmonary complications of neuromuscular diseases
  - Continued non-coverage for COPD
  - Public comment disposition

EGBS

PANDAS/PANS

- Proposal to cover IVIG and plasmapheresis if
  - Recommended by two pediatric subspecialists
  - Child has tried and failed two less intensive therapies
  - Reassess every 3 months for continued need

Your feedback or issues

HERC.info@dhsoha.state.or.us

Ariel.Smits@dhsoha.state.or.us

Thank You

MINUTES

HEALTH EVIDENCE REVIEW COMMISSION
Online Meeting
October 7, 2021

Members Present: Kevin Olson, MD, Chair; Holly Jo Hodges, MD, MBA, Vice-Chair; Gary Allen, DMD; Devan Kansagara, MD; Lynnea Lindsey, PhD; Leslie Sutton; Adriane Irwin, PharmD, Kathryn Schabel, MD; Max Kaiser, DO; Mike Collins; Deborah Espesete, LAc, MAcOM, MPH, DiplOM; Cris Pinzon, MPH, BSN, BS, RN.

Members Absent: Michael Adler, MD.

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

Also Attending: David Inbody (Oregon Health Authority); Bethany Godlewski & Val King, (OHSU Center for Evidence-based Policy); Carissa Bishop; DeAnn; John Hermes; John's iPhone; Maria Gonzalez-Cress; Kerry Potter; Renee Taylor.

Call to Order

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

Minutes Approval

MOTION: To approve the minutes of the August 12, 2021 meeting as presented. CARRIES 12-0.

Director's Report

Prioritized List
Jason Gingerich reported no errata to the Prioritized List of Health Services. Gingerich stated staff had conducted a claims analysis regarding Guideline Note A4 SMOKING CESSATION AND ELECTIVE SURGICAL PROCEDURES and reported no trend changes before and after the guideline's implementation.

Membership
Gingerich said Dr. Mike Adler and Dr. Gary Allen are both leaving the Commission at the end of the year. He said staff are actively recruiting for both Commissioners and for subcommittee members and to refer to the HERC's website for application information.

Conflicts of Interest Rule
Gingerich said that after September's rules advisory committee meeting, the new rule is posted for public comment by the Secretary of State. Once effective, staff will distribute updated conflict of interest disclosure forms for all members.

In Lieu of Services
Meeting materials Handout

David Inbody, OHA's Coordinated Care Organization (CCO) Operations Manager, gave a presentation on In Lieu of Services (ILOS).

Olson asked if there was a role for the HERC in this process. Inbody said the work HERC does complements and informs the kinds of ILOS that CCOs may want to adopt beginning in 2022.

Michael Collins asked if there has been any discussion about including this program for the Fee-For-Service (FFS) or Open Card populations, stating that a handful of the nine tribes in Oregon, including Warm Springs, is pursuing the development of an Indian Managed Care Entity (IMCE). Collins asked if they need to include this program in their contracts with the Oregon Health Authority (OHA). Inbody said they are just currently focused on the Coordinated Care Organization (CCO) population but stated it is worthwhile to consider how ILOS might be applied to FFS or the new IMCEs once this process begins in 2022. Inbody did stress it is optional for the CCOs to participate in this program and not all CCOs are participating in this first round.

Kathryn Schabel said she had confusion about the name of the program, since *in lieu* means *instead of*. She said it sounds like this program would provide additional services, so the program name is potentially a misnomer and it might be misinterpreted. Inbody said the name aligns with the federal direction; that is the language they use, and the state wanted to be consistent.

Cris Pinzon asked about medically appropriate and cost-effective services. Inbody said there is an expectation of medical oversight.

Value-based Benefits Subcommittee (VbBS) Report on Prioritized List Changes
Meeting materials, pages 50-116

Ariel Smits reported the VbBS met earlier in the day, 10/7/2021. She summarized the subcommittee's recommendations.

RECOMMENDED CODE MOVEMENT (changes to the 1/1/22 Prioritized List unless otherwise noted)
- Add Several new COVID related vaccine and treatment codes to covered lines
- Add codes to the preventive services line to allow falls prevention services
- Add several diagnosis and procedure codes to a covered line to allow treatment of acquired penile anomalies
- Add the procedure code for neurectomy for wrist arthritis to a covered line
- Add the diagnosis code for vitiligo to a covered line
- Make various straightforward coding changes

RECOMMENDED GUIDELINE CHANGES (changes to the 1/1/22 Prioritized List unless otherwise noted)
- Edit the neuropsychological testing guideline to specify that patients being considered for epilepsy surgery could be tested as part of their pre-operative work up to determine surgical candidacy
- Edit the preventive services guideline to specify coverage of falls prevention programs

- Edit the penile anomalies guideline to specify coverage for acquired anomalies after surgeries if specific criteria are met
- Add a new guideline regarding when neurectomy for wrist arthritis is covered
- Edit the severe inflammatory skin disease guideline to include vitiligo
- Edit the guideline on kyphoplasty and vertebroplasty to specify how long a patient needed to be treated with conservative management.
- Make several straightforward guideline changes

MOTION: To accept the VbBS recommendations on *Prioritized List changes* as stated. See the VbBS minutes of 10/7/2021 for a full description. Carries: 12-0.

Pinzon asked about looking at the cost-effectiveness of different options for colorectal cancer screening tests. Smits said staff are working on this internally and the topic will be on a future agenda.

Public Comment

There was no public comment.

Adjournment

Meeting adjourned at 2:30 pm. Next meeting will be from 1:30-4:30 pm on Thursday, November 18, 2021 and will be held online.

Value-based Benefits Subcommittee Recommendations Summary
For Presentation to:
Health Evidence Review Commission on October 7, 2021

For specific coding recommendations and guideline wording, please see the text of the 10/7/2021 VbBS minutes.

RECOMMENDED CODE MOVEMENT (changes to the 1/1/22 Prioritized List unless otherwise noted)

- Add several new COVID-related vaccine and treatment codes to covered lines
- Add codes to the preventive services line to allow falls prevention services
- Add several diagnosis and procedure codes to a covered line to allow treatment of acquired penile anomalies
- Add the procedure code for neurectomy for wrist arthritis to a covered line
- Add the diagnosis code for vitiligo to a covered line
- Make various straightforward coding changes

ITEMS CONSIDERED BUT NO RECOMMENDATIONS FOR CHANGES MADE

- No change in current non-coverage of wireless capsule endoscopy for esophageal or gastrointestinal motility indications
- No expansion of current coverage of continuous glucose monitoring was recommended
- No change in the current limitations on diabetic test strips was recommended
- No changes were made to lack of coverage of cranial electrical stimulation
- No change was made to lack of coverage for minimally invasive lumbar decompression for spinal stenosis
- No change was made to lack of coverage for interspinous/interlaminar process spacer devices
- No changes were made to lack of coverage of various interventions for treatment of acute and chronic pain

RECOMMENDED GUIDELINE CHANGES (changes to the 1/1/22 Prioritized List unless otherwise noted)

- Edit the neuropsychological testing guideline to specify that patients being considered for epilepsy surgery could be tested as part of their pre-operative work up to determine surgical candidacy
- Edit the preventive services guideline to specify coverage of falls prevention programs
- Edit the penile anomalies guideline to specify coverage for acquired anomalies after surgeries if specific criteria are met
- Add a new guideline regarding when neurectomy for wrist arthritis is covered
- Edit the severe inflammatory skin disease guideline to include vitiligo
- Edit the guideline on kyphoplasty and vertebroplasty to specify how long a patient needed to be treated with conservative management
- Make several straightforward guideline changes

VALUE-BASED BENEFITS SUBCOMMITTEE
Online meeting
October 7, 2021
8:00 AM – 1:00 PM

Members Present: Kevin Olson, MD, Chair (arrived 8:30 AM); Holly Jo Hodges, MD, MBA, Vice-chair; Cris Pinzon, MPH, BSN, BS, RN; Kathryn Schabel, MD; Brian Duty, MD (arrived 9:00 AM); Mike Collins; Adriane Irwin, PharmD.

Members Absent: Regina Dehen, ND, Lac.

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

Also Attending: Bethany Godlewski (OHSU Center for Evidence-based Policy); Brandon Fair; Chris Tanaka (DEXCOM); Christine Fallabel; Cindy Seger; Dave Inbody (Oregon Health Authority) Jay Halaj; Josh Briley; Julie Dhossche (OHSU); Liz Custer; Paul Konovodoff; Renee Taylor; Sabra Leitenberger; Scott Bowen; Vishal Khemlani; YJ Shukla; Elena Burns.

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

  The meeting was called to order at 8:05 am and roll was called. A quorum of members was present at the meeting. Minutes from the August 12, 2021 VbBS meeting were reviewed and approved.

  Gingerich reported to the VBBS that staff had conducted a claims analysis to determine whether select elective procedures reduced due to the smoking cessation and elective procedures ancillary guideline and found no major changes after guideline implementation.

  Gingerich announced several open positions on HERC and its subcommittees and asked members to let colleagues and contacts know about the vacancies and encourage applications.

  Gingerich clarified current coverage on breast electrolysis for gender dysphoria. He also reported on the pending new conflicts-of-interest rule from September's rules advisory committee.

  David Inbody, Oregon Health Authority (OHA)'s CCO Operations Manager, gave a presentation on In Lieu of Services (ILOS). Members had a robust discussion of the Prioritized List's role in helping CCOs decide which ILOS to pursue. Inbody clarified that this new option will be available to CCOs beginning in 2022.

  There were no errata to report.

- **Topic: Straightforward/Consent Agenda**

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

  Recommended Actions:
  1) Remove CPT 64792 (Excision of neurofibroma or neurolemmoma; extensive) from lines 207 DEEP OPEN WOUND, WITH OR WITHOUT TENDON OR NERVE INVOLVEMENT and 528 DEFORMITIES OF UPPER BODY AND ALL LIMBS
     a. Add 64792 to line 199 CANCER OF SOFT TISSUE
  2) Add CPT 45800 (Closure of rectovesical fistula) to line 230 URINARY FISTULA
  3) Add CPT 95873 (Electrical stimulation for guidance in conjunction with chemodenervation) and 95874 (Needle electromyography for guidance in conjunction with chemodenervation) to line 410 MIGRAINE HEADACHES
  4) Modify Ancillary Guideline A4 as shown in Appendix A
  5) Modify Guideline Note 173 as shown in Appendix A
  6) Add CPT 30520 (Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft) to line 577 DEVIATED NASAL SEPTUM, ACQUIRED DEFORMITY OF NOSE, OTHER DISEASES OF UPPER RESPIRATORY TRACT
  7) Add ICD-10-CM Q67.4 (Other congenital deformities of skull, face and jaw) to line 577 DEVIATED NASAL SEPTUM, ACQUIRED DEFORMITY OF NOSE, OTHER DISEASES OF UPPER RESPIRATORY TRACT
  8) Modify Guideline Note 118 as shown in Appendix A

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

- **Topic: COVID-19 Coding Updates**

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

  Recommended Actions:
  1) Add CPT 0013A (IMM ADMN SARSCOV2 100 MCG/0.5 ML 3RD DOSE) to line 3 PREVENTION SERVICES WITH EVIDENCE OF EFFECTIVENESS
  2) Add HCPCS M0240 (Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring, subsequent repeat doses) and M0241 (Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring in the home or residence, this includes a beneficiary's home that has been made provider-based to the hospital during the covid-19 public health emergency, subsequent repeat doses) to line 399 INFLUENZA, COVID-19 AND OTHER NOVEL RESPIRATORY VIRAL ILLNESS
  3) Add CDT D0606 (molecular testing for a public health-related pathogen, including coronavirus) to the Diagnostic Procedure File
  4) Add the following CDT codes to line 3 PREVENTION SERVICES WITH EVIDENCE OF EFFECTIVENESS
     a. D1701 Pfizer-BioNTech COVID-19 vaccine administration — first dose
     b. D1702 Pfizer-BioNTech COVID-19 vaccine administration — second dose
     c. D1703 Moderna COVID-19 vaccine administration — first dose

d. D1704 Moderna COVID-19 vaccine administration — second dose
e. D1705 AstraZeneca COVID-19 vaccine administration — first dose
f. D1706 AstraZeneca COVID-19 vaccine administration — second dose
g. D1707 Janssen COVID-19 vaccine administration

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

- **Topic: Clarification of when neuropsychological testing is covered prior to epilepsy surgery**

Discussion: Smits reviewed the summary document. There was minimal discussion on this topic.

Recommended Actions:
1) Modify Diagnostic Guideline D26 as shown in Appendix A

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

- **Topic: Fall prevention programs**

Discussion: Smits reviewed the summary document. The discussion centered around the fact that people younger than age 65 can be at risk for falls due to medication or other reasons. There are standardized tools such as the STEADI that can identify people at risk for falls, or providers can identify patients based on their specific disease, having a facility fracture, or by other means. The group requested that the guideline wording be expanded to include patients younger than 65 at increased risk of falls.

Recommended Actions:
1) Add HCPCS S9451 (Exercise classes, non-physician provider, per session) to line 3 PREVENTION SERVICES WITH EVIDENCE OF EFFECTIVENESS
2) Modify Guideline Note 106 as shown in Appendix A

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

- **Topic: Continuous glucose monitoring**

Discussion: Smits reviewed the summary document. Smits noted that after the meeting materials had been sent out, there was a CCO request to clarify the continuous glucose monitoring (CGM) guideline to specify that CGM is not covered for type 2 diabetes or gestational diabetes; the group felt that this change was appropriate. There was discussion about whether CGMs could be covered in certain clinical situations; Hodges replied that medical directors can look at case by case requests and approve by exception if medically justified.

Recommended Actions:
1) Modify Guideline Note 108 as shown in Appendix A

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

- **Topic: Limits on diabetic test strips**

  Discussion: Smits reviewed the summary document. Olson noted that OHP is more limiting on test strips that Medicare. No change to current limitations on diabetic test strips was recommended.

- **Topic: Treatment of acquired penile anomalies**

  Discussion: Smits reviewed the summary document. Duty noted that the guideline would apply to adults as well as children who meet criteria. This was felt to be appropriate.

  Recommended Actions:
  1) Add to line 424 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
     a. CPT 54162 (Lysis or excision of penile post-circumcision adhesions)
     b. ICD-10-CM N48.89 (Other specified disorders of penis)
     c. ICD-10-CM T81.9XXA (Unspecified complication of procedure, initial encounter)
     d. ICD-10-CM N48.83 (Acquired buried penis)
  2) Modify Guideline Note 73 as shown in Appendix A

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

- **Topic: Neurectomy for wrist arthritis**

  Discussion: Smits reviewed the summary document. There was a question about whether this service is available in Oregon. Schabel reported that it is widely done by hand surgeons as an alternative to wrist fusion.

  Recommended Actions:
  1) Add CPT 64772 (Transection or avulsion of other spinal nerve, extradural) to line 356 RHEUMATOID ARTHRITIS, OSTEOARTHRITIS, OSTEOCHONDRITIS DISSECANS, AND ASEPTIC NECROSIS OF BONE Treatment: ARTHROPLASTY/ RECONSTRUCTION
  2) Add a new guideline to line 356 as shown in Appendix B

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

- **Topic: Cranial electrical stimulation**

  Discussion: Smits reviewed the summary document.

  Public testimony
  1) Josh Briley, PhD, Science and Education Director for EPI (manufacturer), clinical psychologist: Dr. Briley testified regarding his experience using Alpha Stim to treat thousands of patients. He noted that the HERC staff literature reviewed included only a small portion of the literature on Alpha Stim. He personally has seen clinically significant improvement in depression, anxiety and insomnia. User surveys show very significant improvement in symptoms as well. Alpha Stim is

very safe, side effect rate is <1% and are mild and self-limiting. This technology is also less expensive than extensive therapy and has fewer side effects than medications. It also works faster than therapy.

2) Jay Halaj, PhD, Senior Consultant for Allevia Health (manufacturer): Dr. Halaj testified that the Portland VA and other VAs cover Alpha Stim. Hundreds of practitioners use this device and thousands of patients are using it. After about 20 minutes of using the device, patients have a response and are able to push through barriers in processing trauma. It brings on a sense of calm and reduces arousal. Device use can avoid costly emergency visits for situations like panic attacks. It's also especially useful in addition treatment as a non-chemical way to reduce anxiety and insomnia from treatment in that population.

Pinzon asked the presenters if the VA has done studies on the outcomes of Alpha Stim. The response was that the VA has only done small pilot studies. The group felt that larger studies were feasible and needed before this technology should be considered for adoption to the Prioritized List.

Recommended Actions:
1) Modify Guideline Note 173 as shown in Appendix A

MOTION: To recommend the guideline note changes as presented. CARRIES 6-0. *(Abstained: Pinzon)*

- **Topic: Minimally invasive lumbar decompression for spinal stenosis**

Discussion: Smits reviewed the summary document.

Public Testimony

1) Vishal Khemlani, MD, anesthesiologist, Vertos Medical affiliate (manufacturer): Dr. Khemlani gave a brief presentation of the MILD procedure and said he has done over 150 procedures. His presentation gave an overview of the procedure's effectiveness and included patient success stories.

2) Paul Konovodoff, Director for Market Access, Vertos Medical (manufacturer): Mr. Konovodoff began his testimony by addressing cost of the MILD procedure, stating the procedure has a Medicare cost of $4,000 for an ambulatory surgical center, or $6200 for hospitals charges and $600-700 cost for the physician fee. He said that the MILD procedure is covered for 92 million lives, including many commercial lives. He said 41,000 procedures have been done nationwide and 1500 certified providers are currently doing this procedure, 15 or 20 of which are in Oregon. Ohio and Illinois Medicaid have recently added coverage. MILD has been FDA approved since 2005.

The subcommittee discussed whether there are active trials ongoing, and the testifiers indicated there are ongoing trials. Schabel asked about the risk of needing spine surgery after the 5 years the patients were observed in the studies. Khemlani stated that the effects seemed to last in his experience. He noted that the Cleveland Clinic study included in the staff review was following

patients who were initially in the MIDAS study, and so may have been followed for more than 5 years.
Schabel expressed concern that this procedure was being introduced into a patient care area in which there is no current surgical interventions. The patients that were studied for MILD were probably not candidates for fusion, and their only other options would be conservative therapy and epidural steroid injections. This makes MILD a new treatment paradigm, which may introduce more care than these patients needed.

Olson expressed concern that the patient sample sizes were small.

Schabel asked Konovodoff when he expected a non-experimental CPT or HCPCS code for the procedure to be issued; Konovodoff stated that his company is not pursuing a Category 1 CPT code designation.

Recommended Actions:
1) Add CPT 0275T and HCPCS G0276 to Line 662
2) Modify Guideline Note 173 as shown in Appendix A

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

- **Topic: Interspinous/interlaminar process spacer devices**

Discussion: Smits reviewed the summary document. There was no significant discussion on this topic.

Recommended Actions:
1) Modify Guideline Note 173 as shown in Appendix A

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

- **Topic: Vitiligo**

Discussion: Smits reviewed the summary document.

Public testimony
Drs. Julie Dhossche and Sara Leitenberger, OHSU pediatric dermatology: Dr. Dhossche began the brief invited presentation by declaring no conflicts of interest. She gave an overview on vitiligo, current therapies for repigmentation, and maintenance therapies.

The subcommittee discussed whether any step therapy requirements would be appropriate. The group decided since the only medications currently used are topical/oral steroids and tacrolimus, it was felt that step therapy would not need to be spelled out. There was also discussion about this condition being an equity issue, as it affect persons with more pigmented/darker skin to a higher degree. There was discussion about if a patient only receives partial remission with therapy, if that would be enough to reduce anxiety, depression or other negative consequences. The experts stated that in their experience, even some reduction in depigmentation can have a large effect on

psychological outcomes. Leitenberger stated that reduction of depigmentation to a small area allows the use of cosmetics or other products to cover up the area.

Recommended Actions:
1) Add ICD-10 L80 (Vitiligo) to line 426 SEVERE INFLAMMATORY SKIN DISEASE
2) Modify Guideline Note 21 as shown in Appendix A

MOTION: To recommend the code and guideline note changes as presented. CARRIES 6-0. *(Absent: Duty)*

- **Topic: Interventional therapies for treatment of acute and chronic pain**

Discussion: Smits reviewed the summary documents. There was no discussion of the treatments with no evidence of effectiveness.

For the kyphoplasty and vertebroplasty summary, Hodges noted that NICE, AAOS and other groups require a 4-to-6-week trial of conservative management prior to kyphoplasty and vertebroplasty. The group agreed to add this requirement to the guideline.

There was minimal discussion regarding radiofrequency denervation for sacroiliac pain.

Recommended Actions:
1) Add CPT 64555 (Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)) to line 662 CONDITIONS FOR WHICH CERTAIN INTERVENTIONS ARE UNPROVEN, HAVE NO CLINICALLY IMPORTANT BENEFIT OR HAVE HARMS THAT OUTWEIGH BENEFITS
2) Modify Guideline Note 173 as shown in Appendix A
3) Modify Guideline Note 37 as shown in Appendix A
4) Modify Guideline Note 109 as shown in Appendix A

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

- **Public Comment:**

No additional public comment was received.

- **Next meeting:**

November 18, 2021 as a virtual meeting

- **Adjournment:**

The meeting adjourned at 1:05 PM.

Revised Guideline Notes

ANCILLARY GUIDELINE A4, SMOKING CESSATION AND ELECTIVE SURGICAL PROCEDURES

Surgical consultation is covered for patients who actively smoke and who are referred for surgical consultations; if elective surgery is recommended based on a consultation, the requirements of this guideline note apply.

Smoking cessation is required prior to elective surgical procedures for active tobacco users. Cessation is required for at least 4 weeks prior to the procedure and requires objective evidence of abstinence from smoking prior to the procedure.

Elective surgical procedures in this guideline are defined as surgical procedures which are flexible in their scheduling because they do not pose an imminent threat nor require immediate attention within 1 month. Procedures for contraceptive/sterilization purposes, procedures targeted to active cancers (i.e. when a delay in the procedure could lead to cancer progression), ~~and~~ diagnostic procedures, and bloodless surgery (e.g. cataract surgery~~, certain skin procedures~~) are not subject to the limitations in this guideline note. This guideline applies regardless of procedure location and anesthesia type.

The well-studied tests for confirmation of smoking cessation include cotinine levels and exhaled carbon monoxide testing. However, cotinine levels may be positive in nicotine replacement therapy (NRT) users, smokeless tobacco and e-cigarette users (which are not contraindications to elective surgery coverage). In patients using nicotine products aside from combustible cigarettes the following alternatives to urine cotinine to demonstrate smoking cessation may be considered:

- Exhaled carbon monoxide testing
- Anabasine or anatabine testing (NRT or vaping)

Certain procedures, such as lung volume reduction surgery, bariatric surgery, erectile dysfunction surgery, and spinal fusion have 6 month tobacco abstinence requirements. See Guideline Notes 8, 100, 112 and 159.

DIAGNOSTIC GUIDELINE D26, NEUROBEHAVIORAL STATUS EXAMS AND NEUROPSYCHOLOGICAL TESTING

Neurobehavioral status exams (CPT 96116 and 96121) and neuropsychological testing services (CPT 96132 and 96133) are only covered when all of the following are met:

A) Symptoms are not explained by an existing diagnosis; AND
B) When the results of such testing will be used to develop a care plan.

OR when neuropsychological testing is done as part of the pre-operative evaluation prior to epilepsy surgery as part of the process to determine if the patient is an appropriate surgical candidate or post-operative follow up after epilepsy surgery.

GUIDELINE NOTE 21, SEVERE INFLAMMATORY SKIN DISEASE

Lines 426,482,504,532,541,656

Inflammatory skin conditions included in this guideline are:

A) Psoriasis
B) Atopic dermatitis
C) Lichen planus
D) Darier disease
E) Pityriasis rubra pilaris
F) Discoid lupus
G) Vitiligo

The conditions above are included on Line 426 if severe, defined as having functional impairment as indicated by Dermatology Life Quality Index (DLQI) ≥ 11 or Children's Dermatology Life Quality Index (CDLQI) ≥ 13 (or severe score on other validated tool) AND one or more of the following:

A) At least 10% of body surface area involved
B) Hand, foot, face, or mucous membrane involvement.

Otherwise, these conditions above are included on Lines 482, 504, 532, 541 and 656.

For severe psoriasis, first line agents include topical agents, phototherapy and methotrexate. Second line agents include other systemic agents and oral retinoids and should be limited to those who fail, or have contraindications to, or do not have access to first line agents. Biologics are included on this line only for the indication of severe plaque psoriasis; after documented failure of first line agents and failure of (or contraindications to) a second line agent.

For severe atopic dermatitis/eczema, first-line agents include topical moderate- to high- potency corticosteroids and narrowband UVB. Second line agents include topical calcineurin inhibitors (e.g. pimecrolimus, tacrolimus), topical phosphodiesterase (PDE)-4 inhibitors (e.g. crisaborole), and oral immunomodulatory therapy (e.g. cyclosporine, methotrexate, azathioprine, mycophenolate mofetil, or oral corticosteroids). Use of the topical second line agents (e.g. calcineurin inhibitors and phosphodiesterase (PDE)-4 inhibitors) should be limited to those who fail or have contraindications to first line agents. Biologic agents are included on this line for atopic dermatitis only after failure of or contraindications to at least one agent from each of the following three classes: 1) moderate to high potency topical corticosteroids, 2) topical calcineurin inhibitors or topical phosphodiesterase (PDE)-4 inhibitors, and 3) oral immunomodulator therapy.

GUIDELINE NOTE 37, SURGICAL INTERVENTIONS FOR CONDITIONS OF THE BACK AND SPINE OTHER THAN SCOLIOSIS

Lines 346,529

Spine surgery is included on Line 346 only in the following circumstances:

A) Decompressive surgery is included on Line 346 to treat debilitating symptoms due to central or foraminal spinal stenosis, and only when the patient meets the following criteria:
    1) Has MRI evidence of moderate or severe central or foraminal spinal stenosis AND
    2) Has neurogenic claudication OR
    3) Has objective neurologic impairment consistent with the MRI findings. Neurologic impairment is defined as 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

Foraminal or central spinal stenosis causing only radiating pain (e.g. radiculopathic pain) is included only on Line 529.

B) Spinal fusion procedures are included on Line 346 for patients with MRI evidence of moderate or severe central spinal stenosis only when one of the following conditions are met:
1) spinal stenosis in the cervical spine (with or without spondylolisthesis) which results in objective neurologic impairment as defined above OR
2) spinal stenosis in the thoracic or lumbar spine caused by spondylolisthesis resulting in signs and symptoms of neurogenic claudication and which correlate with xray flexion/extension films showing at least a 5 mm translation OR
3) pre-existing or expected post-surgical spinal instability (e.g. degenerative scoliosis >10 deg, >50% of facet joints per level expected to be resected)

For all other indications, spine surgery is included on Line 529.

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:
- local injections (including ozone therapy injections)
- botulinum toxin injection
- intradiscal electrothermal therapy
- therapeutic medial branch block
- coblation nucleoplasty
- percutaneous intradiscal radiofrequency thermocoagulation
- percutaneous laser disc decompression
- radiofrequency denervation
- corticosteroid injections for cervical pain
- intradiscal injections, including platelet rich plasma, stem cells, methylene blue, or ozone

Corticosteroid injections for low back pain with or without radiculopathy are only included on Line 529. Diagnostic anesthetic injections for selective nerve root blocks are included on Line 529 for lumbar or sacral symptoms.

The development of this guideline note was informed by HERC coverage guidances on Percutaneous Interventions for Low Back Pain, Percutaneous Interventions for Cervical Spine Pain, Low Back Pain: Corticosteroid Injections and Low Back Pain: Minimally Invasive and Non-Cordicosteroid Percutaneous Interventions. See https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Evidence-based-Reports.aspx

GUIDELINE NOTE 73, PENILE ANOMALIES

Lines 424,433,571,658

Congenital a~~A~~nomalies of the penis (ICD-10-CM Q54.4, Q55.5 and Q55.6) are included on Line 433 only when they

A. Are associated with hypospadias, OR

B. Result in documented urinary retention, OR
C. Result in repeated urinary tract infections, OR
D. Result in recurrent infections such as meatitis or balanitis, OR
E. Involve 35 degrees of curvature or greater for conditions resulting in lateral or ventral curvature, OR
F. Involve 60 degrees of rotation or greater for conditions resulting in penile torsion, OR
G. Involve aplasia/congenital absence of the penis.

Otherwise, these diagnoses are included on Line 658

Acquired anomalies of the penis (ICD-10-CM N48.83, N48.89 or T81.9XXA) are included on line 424 only when they are the result of a prior penile procedure AND either

A. Result in a skin bridge. OR
B. Result in a buried penis; OR
C. Are associated with hypospadias, OR
D. Result in documented urinary retention, OR
E. Result in repeated urinary tract infections, OR
F. Result in recurrent infections such as meatitis or balanitis, OR
G. Involve 35 degrees of curvature or greater for conditions resulting in lateral or ventral curvature, OR
H. Involve 60 degrees of rotation or greater for conditions resulting in penile torsion.

Otherwise, these diagnoses are included on line 571 or 658.

GUIDELINE NOTE 106, PREVENTIVE SERVICES

Lines 3,622

Included on Line 3 are the following preventive services:

A) US Preventive Services Task Force (USPSTF) "A" and "B" Recommendations in effect and issued prior to January 1, 2021 ~~2020~~.
   1) http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/
      a) Treatment of falls prevention with exercise interventions is included on Line 292.
   2) USPSTF "D" recommendations are not included on this line or any other line of the Prioritized List.
B) American Academy of Pediatrics (AAP) Bright Futures Guidelines:
   1) http://brightfutures.aap.org. Periodicity schedule available at http://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity Schedule_FINAL.pdf.
      a) Bright Futures is the periodicity schedule for screening for EPSDT for the Oregon Health Plan.
   2) Screening for lead levels is defined as blood lead level testing and is indicated for Medicaid populations at 12 and 24 months. In addition, blood lead level screening of any child between ages 24 and 72 months with no record of a previous blood lead screening test is indicated.
C) Health Resources **and Services Administration (HRSA) Women's Preventive Services-Required Health Plan Coverage Guidelines a**s updated by HRSA in December 2019. Available at https://www.hrsa.gov/womens-guidelines-2019 as of September 4, 2020.

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

Colorectal cancer screening is included on Line 3 for average-risk adults aged 45 to 75, using one of the following screening programs:

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

CT colonography CPT 74263), FIT-DNA (CPT 81528) and mSEPT9 (HCPCS G0327) are included on line 502 CONDITIONS FOR WHICH INTERVENTIONS RESULT IN MARGINAL CLINICAL BENEFIT OR LOW COST-EFFECTIVENESS.

Colorectal cancer screening for average-risk adults aged 76 to 85 is covered only after informed decision making between patients and clinicians which includes consideration of the patient's overall health, prior screening history, and preferences.

Supervised evidence-based exercise programs for fall prevention for persons age 65 and older OR younger patients who are at increased risk of falls are included on line 3 using CPT 98961 or 98962 or HCPCS S9451. HCPCS S9451 is only included on Line 3 for the provision of supervised exercise therapy for fall prevention. Programs should be culturally tailored/culturally appropriate when feasible.

Note: CPT code 96110 (Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument) can be billed in addition to other CPT codes, such as evaluation and management (E&M) codes or preventive visit codes.

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

GUIDELINE NOTE 108, CONTINUOUS GLUCOSE MONITORING

Line 1, 8, 27

Real-time (personal) continuous glucose monitoring (CGM) is included on Line 8 for:

A) Adults with type 1 diabetes mellitus not on insulin pump management:
   1) Who have received or will receive diabetes education specific to the use of CGM AND
   2) Who have used the device for at least 50% of the time at their first follow-up visit AND
   3) Who have baseline HbA1c levels greater than or equal to 8.0%, frequent or severe hypoglycemia, or impaired awareness of hypoglycemia (including presence of these conditions prior to initiation of CGM).
B) Adults with type 1 diabetes on insulin pump management (including the CGM-enabled insulin pump):

1) Who have received or will receive diabetes education specific to the use of CGM AND
2) Who have used the device for at least 50% of the time at their first follow-up visit.

C) Women with type 1 diabetes who are pregnant or who plan to become pregnant within six months without regard to HbA1c levels.

D) Children and adolescents under age 21 with type 1 diabetes:
1) Who have received or will receive diabetes education specific to the use of CGM AND
2) Who have used the device for at least 50% of the time at their first follow-up visit.

CPT 95250 and 95251 (Ambulatory continuous glucose monitoring) are included on this line for services related to real-time continuous glucose monitoring but not retrospective (professional) continuous glucose monitoring.

Continuous glucose monitors are not covered for people with type 2 diabetes or gestational diabetes.

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

GUIDELINE NOTE 109, VERTEBROPLASTY, KYPHOPLASTY, AND SACROPLASTY

Line 478

Vertebroplasty and kyphoplasty are not included on this line (or any other line) for the treatment of routine osteoporotic compression fractures.

Vertebroplasty and kyphoplasty are only included on this line for the treatment of vertebral osteoporotic compression fractures when they are considered non-routine and meet all of the following conditions:

A) The patient is hospitalized under inpatient status due to pain that is primarily related to a well-documented acute fracture, and
B) The severity of the pain prevents unassisted ambulation, and
C) The pain is not adequately controlled with oral or transcutaneous medication, and
D) The patient must have failed an appropriate 4-to-6 week trial of conservative management.

Sacroplasty is not included on these or any lines of the Prioritized List for coverage consideration.

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

GUIDELINE NOTE 118 SEPTOPLASTY

Lines 42,119,246,287,465,506,525,577

Septoplasty is included on these lines when

A) The septoplasty is done to address symptomatic septal deviation or deformity which
1) Fails to respond to a minimum 6 week trial of conservative management (e.g. nasal corticosteroids, decongestants, antibiotics); AND
2) Results in one or more of the following:
a. Persistent or recurrent epistaxis, OR

b. Documented recurrent sinusitis felt to be due to a deviated septum and the patient meets criteria for sinus surgery in Guideline Note 35, SINUS SURGERY; OR

c. Nasal obstruction with documented absence of other causes of obstruction likely to be responsible for the symptoms (for example, nasal polyps, tumor, etc.) [note: this indication is included only on line ~~506~~ 577]; OR

B) Septoplasty is performed in association with cleft lip or cleft palate repair or repair of other congenital craniofacial anomalies; OR

C) Septoplasty is performed as part of a surgery for a neoplasm or facial trauma involving the nose.

Septoplasty is not covered for obstructive sleep apnea.

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

Line 662

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

Procedure Code	Intervention Description	Rationale	Last Review
0275T G0276	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method under indirect image guidance (eg, fluoroscopic, CT), single or multiple levels, unilateral or bilateral; lumbar Blinded procedure for lumbar stenosis, PILD, or placebo control, performed in an approved coverage with evidence development (CED) clinical trial	Insufficient evidence of effectiveness	October 2021
22867-22870 C1821	Insertion of interlaminar/ interspinous process stabilization/ distraction device, without fusion, including image guidance when performed, with open decompression, lumbar Interspinous process distraction device (implantable)	Insufficient evidence of effectiveness	~~November, 2016~~ October 2021

Procedure Code	Intervention Description	Rationale	Last Review
64555	Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)	Insufficient evidence of effectiveness	October 2021
64625	Anesthetic or steroid injection and/or radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance	Insufficient evidence of effectiveness	~~November 2019~~ October 2021
64633-64634	Radiofrequency ablation of the cervical and thoracic spine	Insufficient evidence of benefit	~~March, 2015~~ October 2021
64635-64636 C9752, C9753	Radiofrequency ablation of the lumbar and sacral spine	Insufficient evidence of benefit	~~November, 2014~~ ~~Coverage guidance~~ October 2021
64640	Destruction by neurolytic agent; other peripheral nerve or branch	Insufficient evidence of effectiveness	~~March 2020~~ October 2021
~~90875-90876~~ ~~90901~~	~~Individual psychophysiological therapy incorporating biofeedback training by any modality~~ ~~Biofeedback training by any modality~~	~~Insufficient evidence of effectiveness~~	~~January 2021~~
91111	Capsule endoscopy, esophagus	~~No~~ Insufficient evidence of effectiveness	~~December, 2012~~ October 2021
91112	Gastrointestinal transit and pressure measurement	Insufficient evidence of effectiveness	~~December, 2012~~ October 2021
97014, 97032, 0278T, E0720, E0730, G0283	Transcutaneous electrical nerve stimulation (TENS), frequency specific microcurrent therapy, microcurrent electrical stimulation, and all similar therapies; Scrambler therapy; all similar transcutaneous electrical neurostimulation therapies	Insufficient evidence of effectiveness for chronic pain and all other indications	January 2020 for TENS October 2021 for cranial electrical stimulation

New Guideline Notes

GUIDELINE NOTE XXX PARTIAL WRIST NEURECTOMY

Line 356

CPT 64772 is only included on this line for partial wrist neurectomy and is only covered when the alternative is wrist arthrodesis.