Oregon Health Authority
Quality and Health Outcomes Committee
AGENDA

MEETING INFORMATION
Meeting Date: April 12, 2021
Time: 10 a.m.–3 p.m.
Location: Webinar only
Call in information: Toll free: 888-278-0296 Passcode: 310477
Webinar: https://attendee.gotowebinar.com/register/2008241907097200142
All meeting materials are posted on the QHOC Website

Clinical Director Work Group 10 a.m.–12:30 p.m.			
TIME	**TOPIC**	**OWNER**	**MATERIALS (page #)**
10:00 a.m.	**Welcome/announcements** **Meeting format proposal**	Lisa Bui	TC TA handout (2–6)
10:15 a.m.	**Minimum standards for opioid prescribing**	Dee Weston	Presentation slides
10:40 a.m.	**HERC update**	Ariel Smits	Presentation slides Meeting packet (7–38)
11:00 a.m.	**Break**		
11:10 a.m.	**COVID-19: Vaccine update**	Dawn Mautner Lisa Bui Rex Larsen	Presentation slides
11:30 a.m.	**Vaccine community engagement**	Liliana Villanueva Michael McDaid Jameela Norton	Presentation slides
12:05 p.m.	**Vaccine complaints process**	Sarah Dobra	Presentation slides
12:15 p.m.	**Vaccination outreach to members with underlying conditions**	Dave Inbody	Presentation slides
12:30 p.m.	**Lunch**		
Quality and Performance Improvement Session 1–3 p.m.			
1:00 p.m.	**QPI Introductions**	Jenna Harms Lisa Bui	
1:10 p.m.	**Statewide PIP development**	Lisa Bui	Presentation slides Draft environmental scan (39–41)
2:10 p.m.	**QI process for COVID-19 vaccines**	Lisa Bui	
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.

OHA Transformation Center Technical Assistance for CCOs

TA index

Metrics TA

Adolescent immunizations

You Are the Key to HPV Cancer Prevention (recorded webinar)

What: The Oregon Pacific Area Health Education Center invites you to its recorded "You are the Key to HPV Cancer Prevention" webinar to learn about the adolescent HPV vaccination schedule and how to communicate with parents about the HPV vaccine.

Audience: Physicians, pharmacists, nurse practitioners, physician assistants, nurses or any other staff who work with children, adolescents and their parents in primary care settings.

Access: The recording, along with other upcoming or recorded OPAHEC webinars are available on the OPAHEC website (www.opahec.org/webinars-1) or the OPAHEC YouTube channel (www.youtube.com/channel/UC2i5b44sVLzFWHxWDKqOzZA).

Diabetes and HbA1C control

CCO-DCO community of practice discussion: oral health for patients with diabetes and HbA1C control

This facilitated discussion will bring together representatives from CCOs and DCOs to talk about moving the needle for HbA1C control and oral health exams for patients with diabetes. The objective is to share ideas and learn from each other as we discuss what is working and common barriers and brainstorm solutions.

- **May 5, 2021 11 a.m.–noon**

- Please RSVP by May 3: https://urldefense.com/v3/__https:/ohsu.ca1.qualtrics.com/jfe/form/SV_afWmF4yh0Q2PZLE__;!!OxGzbBZ6!PGa2xrRsoRwfyaZg1ChqO1ewEEW66KZZLkNTOXhiNbup6OwAThZLo5fWWX2y37diam4DnkjTn34Oaw$

Questions? Please contact Laura Ferrara ORPRN_TA@ohsu.edu

Kindergarten readiness

Marketing toolkit for promoting kindergarten readiness incentive measures

Based on CCO needs assessments, a contractor developed marketing assets 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

Questions? Contact Adrienne Mullock (Adrienne.p.mullock@dhsoha.state.or.us).

Screening, brief intervention and referral to treatment (SBIRT)

SBIRT webinar training series (February–September)

This SBIRT webinar training series is supported by the Oregon Rural Practice-based Research Network's (ORPRN) ANTECEDENT project. ANTECEDENT focuses on addressing unhealthy alcohol use in Oregon. The project team intends to work with over 80 primary care clinics and provide each clinic with the evidence and tools they need to help patients with moderate to severe alcohol use disorder through the use of screening and brief intervention and medication assisted treatment.

See flier for details: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/2021%20Webinar%20Blurb.pdf

Contact: antecedent@ohsu.edu or Alissa.Robbins@dhsoha.state.or.us

TA for clinics: addressing the increased prevalence of unhealthy alcohol (SBIRT) and opioid use

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 12 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.

Audience: Clinics across Oregon are invited to participate in these free TA opportunities. CCOs are encouraged to share details with clinics in their network.

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

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

Multiple-metric TA

Electronic clinical quality metric reporting

Support for reporting electronic clinical quality metrics

OHA and the Care Management Plus team at OHSU are offering free technical assistance to Oregon clinics for electronic clinical quality metric (eCQM) reporting. The TA can include clarifying program requirements, addressing questions about the QRDA standard, and helping you work with your EHR vendor to resolve errors and issues with reports. Assistance will be in the form of email, phone and teleconference options.

If you are interested, please fill out the registration survey at the link below. If you have additional questions, please contact Michelle Bobo at bobom@ohsu.edu.

https://ohsu.ca1.qualtrics.com/jfe/form/SV_22XbCcnkZCu9JKm

Non-metrics TA

Community advisory councils

Virtual CAC Conference: June 8–9

Registration is open for the CAC conference: https://www.eventbrite.com/e/virtual-cac-conference-tickets-146429621941

- Note: If you know of someone requiring language translation, please let Tom know as soon as possible.
- The conference will be held via Zoom. There will be a phone-only call-in # for those who are unable to join via Zoom.

Draft agenda: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/2021%20Virtual%20CAC%20Conference%20Agenda-public.pdf

Audience: CAC members and CCO staff

Contact: Tom Cogswell (thomas.cogswell@dhsoha.state.or.us)

Community health assessments and community health improvement plans

2021 CHA/CHP submission instructions and information session

Notice about June 30, 2021 CHA/CHP submission requirements and instructions:
https://www.oregon.gov/oha/HPA/dsi-tc/Documents/CHA-CHP-CCO-Official-Notice.pdf

Information session:

- April 21, 10-11 a.m.
- Register in advance for this meeting**:** https://www.zoomgov.com/meeting/register/vJItc-qqrD8sE4IBuoALgpFWG4cUkcC_Gl8

Contact: Anona Gund (anona.e.gund@dhsoha.state.or.us), Tom Cogswell (thomas.cogswell@dhsoha.state.or.us)

Collaborative CHA/CHP virtual training

CCOs, local public health, hospitals and tribal health departments that are collaboratively developing community health assessments (CHAs) and community health improvement plans (CHPs) are invited to a shared training opportunity. As a requirement through CCO 2.0, CCOs must collaborate with key partners, including local public health authorities, to develop a shared CHA and CHP. This virtual training is built on a distillation of best practices from several industries; the Mobilizing for Action through Planning and Partnerships model; and previous state CHA/CHP alignment work.

See flier with more details: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/Training%20Announcement-CHA-CHP%20Development%202021.pdf

Note: OHA is only offering training if the primary CHA/CHP partners in a region are interested in attending training together. OHA will not be offering trainings to individual organizations at this time.

Timeline: Request training by May 24, 2021; trainings held late April through June

Contact: Tom Cogswell (thomas.cogswell@dhsoha.state.or.us, 971-304-9642)

Health-related services

Examples of approved HRS expenditures

A new HRS guide provides examples of prior CCO HRS expenditures that have qualified under the requirements for HRS detailed in Oregon Administrative Rule and Code of Federal Regulations: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/HRS-Example-Approved-Expenditures.pdf

Statewide priorities and CCO investment in housing webinar

OHA invites CCOs and their partners to attend a webinar on the basics of housing in Oregon, and health-related services (HRS) investments in housing. The webinar will feature panelists from Oregon Housing and Community Services, Eastern Oregon CCO, and Health Share. Topics will include current statewide trends in housing, how housing is built and financed, and how CCOs can meaningfully invest in housing through community partnerships.

- April 30, 2021, 1–2 p.m.
- Register to attend the webinar: *https://us02web.zoom.us/meeting/register/tZAlcuqhpzsvEtIt9pflvrNjVL1seOTotoOZ*

CCO Health-Related Services Convening 2021

What: Virtual CCO HRS convening with a focus on using HRS for resilience and rebuilding after COVID-19

When: May 24 and 25, 2021 (9 a.m.–2 p.m. each day)

Audience: CCOs and partners involved with health-related services, including community benefit initiatives and flexible services. CCO staff working on HRS are the primary audience. There may be relevant sessions that CCO partners working on HRS will benefit from attending. CCOs should work with their HRS partners to determine which partners to invite.

Format: This will be a virtual convening with a mix of keynote presentations, CCO presentations and interactive sessions. CCOs will be invited to submit presentation proposals that showcase innovation, resilience or rebuilding.

Register here: https://us02web.zoom.us/meeting/register/tZYlce6pqzkjGdwo8QYMaLo5XQws7wj1732L

Office hours for health-related services reporting

CCO staff are invited to participate in office hours in support of developing the 2020 HRS Exhibit L annual report. CCO staff may join at any point during the scheduled time.

- April 13, 12:30–1:30 p.m.

Office hours will use the same GoToMeeting details (no registration needed):

- Join meeting: https://global.gotomeeting.com/join/879493445
- Phone option: 1- 669-224-3412 / Access code: 879-493-445

REALD (race, ethnicity, language and disability)

REALD lessons learned for Phase 1 organizations

This meeting series will focus on lessons learned from participants while operationalizing REALD. Please share with your operational leaders and colleagues. If you'd like to present on lessons your organization has learned, please contact Renee Harger (renee.e.harger@dhsoha.state.or.us) or Craig Mosbaek (craig.mosbaek@dhsoha.state.or.us). OHA will also reach out to Phase 1 organization to solicit presenters.

- **April 29, 1–2 p.m.:** Register here: https://www.eventbrite.com/e/reald-lessons-learned-for-phase-1-organizations-april-meeting-tickets-135384666181

Value-based payment

VBP webinar series for providers (with no-cost CME)

Primary care, behavioral health, and maternity care providers are invited to a five-part webinar series focused on increasing readiness for VBP and taking advantage of the additional flexibility VBPs offer for innovatively redesigning care models.

- **April 21, noon-1 p.m.**: What do you need to know to negotiate VBP agreements?
- **May 19, noon-1 p.m.**: Learnings from COVID-19 and how they may impact the adoption of VBPs
- **June 1, noon-1 p.m.**: VBP for behavioral health providers: How do we keep from being left out?
- **June 16, noon-1 p.m.**: VBP and maternity care: What have we learned so far?

Speakers: Art Jones, Jeanene Smith, Janet Meyer (Health Management Associates)

See flier for full details and registration: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/VBP-Webinar-Series-Spring-2021.pdf

Contact: OHA.VBP@dhsoha.state.or.us

Transformation Center technical assistance updates

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

MINUTES

HEALTH EVIDENCE REVIEW COMMISSION
Online meeting
March 11, 2021

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

Members Absent: Gary Allen, DMD; Michael Adler, MD.

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

Also Attending: Bethany Godlewski & Val King MD, MPH (Center for Evidence-based Policy); Tracy Futch, Cris Pinzon, RN; Devki Nagar (Myriad Genetics); Diane Quiring (Oregon Health Authority); Siobhan Hess.

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 1/21/2021 meeting as presented. CARRIES 8-0. *(Absent: Hodges, Kansagara)*

Director's Report

Meetings
Gingerich said we will be meeting virtually through August at least.

Legislative
He gave a brief overview of a few bills up for considerations this session, including Senate Bill 457 which, if passed, would significantly impact Commission operations. Staff are watching this bill carefully.

Gingerich reminded Commissioners that if they are testifying or advocating about a piece of legislation, to please clarify if they are speaking as a Commission or 'wearing one of their other hats.'

Coverage Guidances
The Evidence-based Guidelines Subcommittee is meeting in April; we will start our actual coverage guidance review for Deep Brain Stimulation for Epilepsy. A scoping statement for pediatric immune disorders affecting the brain that cause behavioral symptoms (PANDA/PANS) has already been out for public comment.

Subcommittee Assignments
Gingerich said Cris Pinzon has been confirmed by the Senate, with her official term beginning on March 15, 2021. She will serve on the Value-based Benefits Subcommittee (VbBS). However, if appointed it could result in a quorum of the HERC present at VBBS meetings. In order to address that situation, he asked Dr. Gary Allen, a dentist, if he would consider stepping aside to make room for Pinzon on the subcommittee. Dr. Allen agreed with the caveat that he be involved with VbBS if there are dental topics to discuss. Staff will manage that situation when it comes up.

Pinzon said she would be happy to step aside when there are dental topics to make way for Dr. Allen.

MOTION: To appoint Cris Pinzon to VbBS: Carries: 10-0.

MOTION: To remove Gary Allen from VbBS: Carries: 10-0.

Value-based Benefits Subcommittee (VbBS) Report on Prioritized List Changes
Meeting materials, pages 41-102

Ariel Smits reported the VbBS met earlier in the day, 3/11/2021. She summarized the subcommittee's recommendations.

RECOMMENDED CODE MOVEMENT (changes to the 10/1/2021 Prioritized List unless otherwise noted)
- Add a new code for administration of a monoclonal antibody for treatment of COVID-19 to a covered line
- Move the diagnosis code for osteochondritis dissecans of the knee to the covered knee surgery line and add several procedure codes to that line with a new guideline
- Delete spinal chiropractic/osteopathic manipulation procedure codes from four lines without spinal diagnoses
- Make various straightforward coding changes

RECOMMENDED GUIDELINE CHANGES (changes to the 10/1/2021 Prioritized List unless otherwise noted)
- Reaffirm the ancillary guideline regarding nerve blocks without change
- Edit the hernia guideline to allow repair of inguinal hernias that are painful, affect function or prevent employment. It also allows repair of all inguinal and femoral hernias in women. *Effective January 1, 2022*
- Edit the telemedicine guideline to simplify and remove practice guideline type wording
- Edit the prenatal genetic testing guideline to remove requirements for family or ethnic history prior to certain screening tests
- Edit the acupuncture guideline to add two additional lines with SUD diagnoses to the SUD entry
- Delete all of the coding specifications from the Prioritized List and either merge them into existing guidelines, put them into new guidelines or delete them (2 coding specifications).
- Reaffirm lack of coverage for biomarkers for prostate cancer and update the GN173 entry to reflect the current review date
- Edit the bariatric surgery guideline to remove any requirement for presurgical weight loss

Testimony:

Devki Nagar stated she was available for questions regarding genetic screening tests today and thanked the Commission for this opportunity.

MOTION: To accept the VbBS recommendations on *Prioritized List changes* as stated. See the VbBS minutes of 3/11/2021 for a full description. Carries: 10-0.

Bylaws Revisions

Meeting materials, pages 103-119
Handout

Gingerich gave a presentation from the meeting handout. He highlighted the proposed changes to the bylaws and conflict of interest policy and asked members to email him their thoughts before the next meeting. There was minimal discussion.

Public Comment

There was no additional public comment.

Adjournment

Meeting adjourned at 2:41 pm. Next meeting will be from 1:30-4:30 pm on Thursday, May 20, 2021, online.

Value-based Benefits Subcommittee Recommendations Summary
For Presentation to:
Health Evidence Review Commission on March 11, 2021

For specific coding recommendations and guideline wording, please see the text of the 3/11/2021 VbBS minutes.

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

- Add a new code for administration of a monoclonal antibody for treatment of COVID-19 to a covered line
- Move the diagnosis code for osteochondritis dissecans of the knee to the covered knee surgery line and add several procedure codes to that line with a new guideline
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- Reaffirm lack of coverage for biomarkers for prostate cancer and update the GN173 entry to reflect the current review date
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VALUE-BASED BENEFITS SUBCOMMITTEE
Clackamas Community College
Wilsonville Training Center, Rooms 111-112
Wilsonville, Oregon
March 11, 2021
9:00 AM – 1:00 PM

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

Members Absent: Gary Allen, DMD.

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

Also Attending: Diane Quiring (OHA); Bethany Godlewski (CEBP); Cristine Pinzon, RN; Melissa Stoppler MD and Melissa Wood (Exact Sciences); Jeffrey Lawrence MD; Ashley Svenson and Devki Nagar (Myriad Genetics); Conniew; Teresa Turner; Justin; Stephanie Lattig; Mimi Boumatar; TBARR; Broc Finlayson; Rashelle Kukuk; Siobhan Hess; Brian Fahs.

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

  The meeting was called to order at 9:00 am and roll was called. A quorum of members was present at the meeting. Minutes from the 1/21/21 VbBS meeting were reviewed and approved.

  Gingerich noted that Kevin Olson's term was extended by the Legislature and that Cristine Pinzon was confirmed for HERC membership, effective March 15, 2021. Ms. Pinzon attended today's meeting as an observer.

  Smits reviewed the errata document and the items discussed with leadership document. There was no discussion. The items discussed with leadership regarded the lack of coverage of cardiac PET scans. The recommendation is continued non-coverage.

- **Topic: Straightforward/Consent Agenda**

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

  Recommended Actions:
  1) Add D2928 (Prefabricated porcelain/ceramic crown – permanent tooth) to line 591 DENTAL CONDITIONS (E.G., CARIES, FRACTURED TOOTH)
     a. Advise HSD to remove D2928 from the Excluded File
  2) Ancillary Guideline 1 NERVE BLOCKS was reaffirmed without change as shown in Appendix A
  3) Advise HSD to add CPT 96127 (Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument) to the Diagnostic File and remove from the Ancillary file
  4) Remove CPT 99408 and 99409 (DAST, SBIRT) from all lines on the Prioritized List
     a. Advise HSD to add CPT 96160 and 96161 to the Diagnostic Procedures file

  MOTION: To approve the recommendations stated in the consent agenda. CARRIES 7-0.

- **Topic: 2022 Biennial Review Inguinal and Femoral Hernias**

  Discussion: Smits reviewed the summary document. Walker reviewed a summary document regarding standardized tools for measuring function and pain. Pinzon asked whether these tools were available in other languages, were assessed for cultural sensitivity, and were used in non-literate populations. Walker responded that several tools were available in multiple languages; Smits noted that these tools can be verbally administered to patients with low literacy.

  The group discussed the difficulty in determining what a clinically significant score was for these various tools. The group decided to not include any specific tools in the revised guideline and to not required a "clinically significant score" as this was indeterminable.

  Schabel suggested removing the 4th criteria regarding inability to keep or maintain gainful employment as some OHP patients are not in the workforce due to retirement or other reasons. However, Hodges replied that this clause was very important to the CCOs. Smits pointed out that it was an "or" requirement, so non-working persons could qualify if they had pain or trouble with activities of daily living.

  There was significant reworking of the third clause by the subcommittee.

  Recommended Actions:
  1) Modify GN24 as shown in Appendix A

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

- **Topic: COVID codes March 2021**

  Discussion: There was no discussion about this topic.

Recommended Actions:

1) Add HCPCS M0245 (intravenous infusion, bamlanivimab and etesevimab, includes infusion and post administration monitoring) to line 399 INFLUENZA, COVID-19 AND OTHER NOVEL RESPIRATORY VIRAL ILLNESS
    a. Advise HSD to add HCPCS Q0245 (Injection, bamlanivimab and etesevimab, 2100 mg) to the Ancillary File

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

- **Topic: Simplification of Ancillary Guideline A5**

Discussion: Smits reviewed the summary document. There was a friendly amendment by staff to remove "remote monitoring devices" from the first paragraph, as remote patient monitoring was identified on specific lines in the List. There was no further discussion about this topic.

Recommended Actions:

1) Modify Ancillary Guideline A5 as shown in Appendix A

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

- **Topic: Prenatal genetic testing guideline equity edits**

Discussion: Smits reviewed the summary document.

Testimony:

Devki Nagar, a Myriad employee and genetic counselor, testified in favor of the proposed changes. These tests are standard prenatal screenings. Many patients with hemoglobinopathies (>50%) are not from a high-risk ethnic group.

Smits clarified for the subcommittee that the tests being discussed are standard prenatal screening tests offered by maternity care providers. Smits noted that the complementary changes for preconception screening in the non-prenatal genetic testing guideline were more complicated and would be discussed by the Genetic Advisory Panel at their next meeting.

Recommended Actions:

1) Modify Diagnostic Guideline D17 as shown in Appendix A

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

- **Topic: Revisions to the acupuncture guideline**

Discussion: There was no discussion about this topic.

Recommended Actions:

1) Modify GN92 as shown in Appendix A

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

- **Topic: Coding specification review 2021**

Discussion: There was no significant discussion about this topic.

Recommended Actions:

1) Delete all coding specifications on the Prioritized List
2) Modify Guideline Notes 21, 74, 106, 108, 167, and 170 as shown in Appendix A
3) Add the new guideline notes to various lines as shown in Appendix B
4) Add ICD-10 K90.89 (Other intestinal malabsorption) to line 552 OTHER NONINFECTIOUS GASTROENTERITIS AND COLITIS
5) Remove ICD10 F50.89 (Other specified eating disorder) from line 149 FEEDING AND EATING DISORDERS OF INFANCY OR CHILDHOOD
6) Delete GN42 and GN45

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

- **Topic: Biomarkers for prostate cancer**

Discussion: Smits reviewed the summary document.

Testimony:

Melissa Stoppler, MD, Exact Sciences senior advisor: Dr. Stoppler testified that the score informs the patient of their risk of high-risk disease if radical prostatectomy is done. NCCN has newly released its 2021 guideline. The recommendation to use biomarkers is now a 2A category recommendation (uniform consensus among panelists). ASCO 2020 guideline states "biomarkers are reasonable in low risk men in whom management decisions will be affected by the results." Medicare, 8 Medicaid programs (including CA and WA), and most private payers cover these tests.

Jeffrey Lawrence, MD, retired medical oncologist, former employee of Genomic Health and current consultant for Exact Sciences, declared no compensation for this testimony: Dr. Lawrence testified about his personal experience with prostate cancer. When he was diagnosed, he requested Oncotype Dx; the score helped him make a decision about treatment. He went on to have a radical prostatectomy and was found to have high risk disease at surgery. He had adjuvant radiation therapy, hormonal therapy. He is doing well now. He feels that active surveillance would have been a big mistake in his case. He noted that two studies show Oncotype Dx is equal or superior to MRI for determining a patient's risk status.

Ashley Svenson, genetic counselor and policy specialist at Myriad, the company that markets Prolaris: Ms. Svenson testified that the ASCO guideline is based on a 2019 systematic review of the literature and recommends consideration of use of these tests in specific clinical scenarios. Ms. Svenson strongly encouraged the Commission to take the ASCO recommendation into

account. MediCal, California's state Medicaid program, is evidence-based and covers these tests. An AHRQ review did not find studies on biomarkers that met inclusion criteria; the review did not find evidence of ineffectiveness. The Oregon Health Plan covers breast cancer prognostics but not prostate prognostics.

Discussion:
Brian Duty remarked that although he is a urologist, he does not currently care for prostate cancer patients. The American Urological Association/Society of Urologic Oncology guideline states that tissue-based biomarkers have not been shown to have a role in low or very low risk disease. He asked the urologic oncology providers at OHSU, who did not feel that these tests should be covered. The statewide urologic association was given this information and invited to provide testimony, and no one responded. Prostate MRI is used more commonly to help with decision making.

Olson noted that NCCN concluded that biomarkers are an acceptable test but didn't go so far as to affirmatively encourage the use of biomarker prognostics. It's one tool in a provider's toolbox.

Duty noted that there are ongoing studies of these biomarkers but the results may not be published for some time. In his department, MRI of prostate is considered to be more reliable that biomarkers; however, they have an experienced radiologist reading their prostate MRIs. He noted that prostate biopsies are random. MRI allows more for a more targeted biopsy to help guide treatment.

Schabel asked about the relative cost of MRI versus biomarkers; Melissa Wood, employed by Exact Sciences, stated that it costs $3,800 for Oncotype Dx prostate.

Hodges noted that her CCO sees some requests for these types of tests. However, she noted that patients still need the MRI.

Recommended Actions:
1) Update GN173 entry for prostate cancer gene expression tests as shown in Appendix A
2) Modify GN148 as shown in Appendix A

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

- **Topic: Pre-surgical weight loss in the bariatric surgery guideline**

Discussion: There was no discussion about this topic.
Recommended Actions:
1) Modify GN8 as shown in Appendix A

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

- **Topic: Osteochondritis dissecans of the knee**

Discussion: Smits reviewed the summary document. Schabel suggested removing criterion of skeletal maturity, as this procedure can be appropriate in children. While it is uncommon to see the condition in children, it can be important to fix.

Recommended Actions:

1) Remove ICD10 M93.26 family (Osteochondritis dissecans, knee) from line 356 RHEUMATOID ARTHRITIS, OSTEOARTHRITIS, OSTEOCHONDRITIS DISSECANS, AND ASEPTIC NECROSIS OF BONE
2) Add ICD10 M93.26 family to line 431 INTERNAL DERANGEMENT OF KNEE AND LIGAMENTOUS DISRUPTIONS OF THE KNEE, RESULTING IN SIGNIFICANT INJURY/IMPAIRMENT
3) Remove CPT 29866-29867 (Arthroscopy, knee, surgical; osteochondral autograft(s)/allograft(s) (eg, mosaicplasty)) from line 662 and modify GN173 as shown in Appendix A
4) Add CPT 29866-29867 to line 431 INTERNAL DERANGEMENT OF KNEE AND LIGAMENTOUS DISRUPTIONS OF THE KNEE, RESULTING IN SIGNIFICANT INJURY/IMPAIRMENT
5) Add a new guideline to line 431 as shown in Appendix B

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

- **Topic: Non-Spinal Chiropractic Manipulation**

Discussion: There was no discussion about this topic.

Recommended Actions:

1) Remove osteopathic and chiropractic spinal manipulation (CPT 98925-98929, 98940-98942) from the following lines:
    a. 416 PERIPHERAL NERVE ENTRAPMENT; PALMAR FASCIAL FIBROMATOSIS
    b. 418 DISORDERS OF SHOULDER, INCLUDING SPRAINS/STRAINS GRADE 4 THROUGH 6
    c. 463 OSTEOARTHRITIS AND ALLIED DISORDERS
    d. 467 BRACHIAL PLEXUS LESIONS

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

- **Public Comment:**

No additional public comment was received.

- **Issues for next meeting:**
-no carry over issues

- **Next meeting:**

May 20, 2021; Virtual meeting

- **Adjournment:**

The meeting adjourned at 11:45 AM.

Reaffirmed without change

ANCILLARY GUIDELINE A1, NERVE BLOCKS

The Health Evidence Review Commission intends that single injection and continuous nerve blocks (CPT 64400-64450, 64461-64463, 64505-64530) should be covered services if they are required for successful completion of perioperative pain control for, or post-operative recovery from a covered operative procedure when the diagnosis requiring the operative procedure is also covered. Additionally, nerve blocks, are covered services for patients hospitalized with trauma, cancer, or intractable pain conditions, if the underlying condition is a covered diagnosis.

ANCILLARY GUIDELINE A5, TELEHEALTH, TELECONSULTATIONS AND ONLINE/TELEPHONIC SERVICES

Telehealth services include a variety of health services provided by synchronous or asynchronous electronic communications, including secure electronic health portal, audio, or audio and video, ~~as well as remote monitoring devices~~ and clinician-to-clinician virtual consultations.

Criteria for coverage

The clinical value of the telehealth service delivered must reasonably approximate the clinical value of the equivalent services delivered in-person. Coverage of telehealth services requires the same level of documentation, medical necessity, and coverage determinations as in-person visits. ~~Specifically, covered telehealth services must meet all of the following criteria.~~

~~A) Documentation must include all of the following:~~
~~1) use model SOAP charting, or as described in program's OAR;~~
~~2) include patient history, provider assessment, treatment plan and follow-up instructions;~~
~~3) support the assessment and plan;~~
~~4) retain encounter in the patient's medical record and be retrievable.~~

~~B) Include medical decision making or service delivery (e.g. behavioral health intervention/psychotherapy, other forms of therapy).~~

~~C) Include permanent storage (online or hard copy) of the encounter.~~

~~D) Meet applicable HIPAA standards for privacy and security, except for regulations for which federal authorities are exercising enforcement discretion. (Certain requirements for encryption will not be enforced by federal authorities (or required by OHP) during the COVID-19 emergency.) This means services such as Facetime, Skype or Google Hangouts can be used for service delivery. See https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html for details.) HIPAA compliant platforms should be used whenever possible.~~

~~E) Include patient-clinician agreement of informed consent, discussed with and agreed to by the patient and documented in the medical record.~~

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

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

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

A) Prescription renewal.
B) Scheduling a test.
C) Reporting normal test results.
D) Requesting a referral.
E) Services which are part of care plan oversight or anticoagulation management (CPT codes 99339-99340, 99374-99380 or 99363-99364).
F) Services which relate to or take place within the postoperative period of a procedure provided by the physician are not separately covered. (Such a service is considered part of the procedure and is not be billed separately.)

~~***Telehealth services billed using in-person codes***~~

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

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

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

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

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

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

Covered ~~T~~telephonic and online services~~,~~ include~~ing~~ services related to evaluation, assessment and management ~~diagnostic workup~~ as well as other technology-based services (CPT 98966-98968, 99441-99443, 99421-99423, 98970-98972, ~~G2010,~~ G2012, G2061-G2063, G2251-G2252) ~~are covered for services for new and established patients.~~

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

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

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

Covered ~~Coverage of~~ interprofessional consultations include consultations delivered online, through electronic health records or by telephone (CPT 99446-99449, 99451-99452). ~~is included as follows:~~

~~*Consulting Providers (CPT 99451, 99446-99449)*~~
~~A) For new or established patients.~~
~~B) Consult must be requested by another provider.~~
~~C) Can be for a new or an exacerbated condition.~~
~~D) Cannot be reported more than 1 time per 7 days for the same patient.~~
~~E) Must report cumulative time spent, even if time occurs over multiple days.~~
~~F) Cannot be reported if a transfer of care or request for face-to-face visit occurs as a result of the consultation within the following 14 days.~~
~~G) Cannot be reported if the patient was seen by the consultant within the past 14 days.~~
~~H) The request and reason for consultation is documented in the patient's medical record.~~
~~I) Requires a minimum of 5 minutes of medical consultation, discussion and/or review.~~

~~*Requesting Providers (CPT 99452)*~~
~~A) Consult must be reported by requesting provider. (not for the transfer of a patient or request for face-to-face consult)~~
~~B) Reported only when the patient is not on site with the requesting provider at the time of consultation.~~
~~C) Cannot be reported more than 1 time per 14 days per patient.~~
~~D) Requires a minimum of 16 minutes. Includes time for referral prep and/or communicating with the consultant.~~
~~E) Can be reported with prolonged services, non-direct.~~

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

DIAGNOSTIC GUIDELINE D17, PRENATAL GENETIC TESTING

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

A) Genetic counseling (CPT 96040, HPCPS S0265) for high-risk women who have family history of inheritable disorder or carrier state, ultrasound abnormality, previous pregnancy with aneuploidy, or elevated risk of neural tube defect.
B) Genetic counseling (CPT 96040, HPCPS S0265) prior to consideration of chorionic villus sampling (CVS), amniocentesis, microarray testing, Fragile X, and spinal muscular atrophy screening

C) Validated questionnaire to assess genetic risk in all pregnant women
D) Screening ~~high-risk ethnic groups~~ for hemoglobinopathies (CPT 83020, 83021)
E) Screening for aneuploidy with any of six screening strategies [first trimester (nuchal translucency, beta-HCG and PAPP-A), integrated, serum integrated, stepwise sequential, contingency, and cell free fetal DNA testing] (CPT 76813, 76814, 81508, ~~-~~81510, 81511, 81420, 81507, 81512, 82105, 82677,84163)
F) Ultrasound for structural anomalies between 18 and 20 weeks gestation (CPT 76811, 76812)
G) CVS or amniocentesis (CPT 59000, 59015, 76945,76946, 82106, 88235, 88261-88264, 88267, 88269, 88280, 88283, 88285, 88289,88291) for a positive aneuploidy screen, maternal age >34, fetal structural anomalies, family history of inheritable chromosomal disorder or elevated risk of neural tube defect.
H) Array CGH (CPT 81228, 81229) when major fetal congenital anomalies are apparent on imaging, or with normal imaging when array CGH would replace karyotyping performed with CVS or amniocentesis in (H) above.
I) FISH testing (CPT 88271, 88272, 88274, 88275, 81171, 81172) only if karyotyping is not possible due a need for rapid turnaround for reasons of reproductive decision-making (i.e. at 22w4d gestation or beyond)
J) ~~Screening for Tay-Sachs carrier status (CPT 81255) in high-risk populations. First step is hex A, and then additional DNA analysis in individuals with ambiguous Hex A test results, suspected variant form of TSD or suspected pseudodeficiency of Hex A~~
K) Screening for cystic fibrosis carrier status once in a lifetime (CPT 81220-81224)
L) Screening for fragile X status (CPT 81243, 81244, 81171. 81172) once in a lifetime ~~in patients with a personal or family history of~~
    ~~a. fragile X tremor/ataxia syndrome~~
    ~~b. premature ovarian failure~~
    ~~c. unexplained early onset intellectual disability~~
    ~~d. fragile X intellectual disability~~
    ~~e. unexplained autism through the pregnant woman's maternal line~~
M) Screening for spinal muscular atrophy (CPT 81329) once in a lifetime
N) Screening for Canavan disease (CPT 81200), familial dysautonomia (CPT 81260), and Tay-Sachs carrier status (CPT 81255) once in a lifetime. Ashkenazi Jewish carrier panel testing (CPT 81412) is covered if the panel would replace and would be of similar or lower cost than individual gene testing including CF carrier testing.
O) Expanded carrier screening only for those genetic conditions identified above

The following genetic screening tests are not covered:

A) Serum triple screen
B) Expanded carrier screening which includes results for conditions not explicitly recommended for coverage

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

GUIDELINE NOTE 8, BARIATRIC SURGERY

Line 320

Bariatric/metabolic surgery (limited to Roux-en-Y gastric bypass, and sleeve gastrectomy) is included on Line 320 when the following criteria are met:

A) Age ≥ 18
B) The patient has obesity with a:
    1) BMI ≥ 40 OR
    2) BMI ≥ 35 with:
        a) Type 2 diabetes, OR
        b) at least two of the following other serious obesity-related comorbidities: hypertension, coronary heart disease, mechanical arthropathy in major weight bearing joint, sleep apnea
C) Repeat bariatric surgery is included when it is a conversion from a less intensive (such as gastric band or sleeve gastrectomy) to a more intensive surgery (e.g. Roux-en-Y). Repair of surgical complications (excluding failure to lose sufficient weight) are also included on this and other lines. Reversal of surgical procedures and devices is included on this line when benefits of reversal outweigh harms.
D) Participate in the following four evaluations and meet criteria as described.
    1) Psychosocial evaluation: (Conducted by a licensed mental health professional)
        a) Evaluation to assess potential compliance with post-operative requirements.
        b) Must remain free of abuse of or dependence on alcohol during the six-month period immediately preceding surgery. No current use of any nicotine product or illicit drugs and must remain abstinent from their use during the six-month observation period. Testing will, at a minimum, be conducted within 1 month of the quit date and within 1 month of the surgery to confirm abstinence from illicit drugs. Tobacco and nicotine abstinence to be confirmed in active users by negative cotinine levels at least 6 months apart, with the second test within one month of the surgery date.
        c) No mental or behavioral disorder that may interfere with postoperative outcomes[1].
        d) Patient with psychiatric illness must be stable for at least 6 months.
    2) Medical evaluation: (Conducted by OHP primary care provider)
        a) Pre-operative physical condition and mortality risk assessed with patient found to be an appropriate candidate.
        b) Optimize medical control of diabetes, hypertension, or other co-morbid conditions.
        c) Female patient not currently pregnant with no plans for pregnancy for at least 2 years post-surgery. Contraception methods reviewed with patient agreement to use effective contraception through 2nd year post-surgery.
    3) Surgical evaluation: (Conducted by a licensed bariatric surgeon associated with program[2])
        a) Patient found to be an appropriate candidate for surgery at initial evaluation and throughout period leading to surgery.
        b) Received counseling by a credentialed expert on the team regarding the risks and benefits of the procedure and understands the many potential complications of the surgery (including death) and the realistic expectations of post-surgical outcomes.
    4) Dietician evaluation: (Conducted by licensed dietician)

a) ~~Evaluation of adequacy of prior dietary efforts to lose weight. If no or inadequate prior dietary effort to lose weight, must undergo six-month clinically supervised weight reduction program (including intensive nutrition and physical activity counseling as defined by the USPSTF).~~
b) Counseling in dietary lifestyle changes
c) Counseling on post-operative dietary change requirements

E) Participate in additional evaluations:
1) Post-surgical attention to lifestyle, an exercise program and dietary changes and understands the need for post-surgical follow-up with all applicable professionals (e.g. nutritionist, psychologist/psychiatrist, exercise physiologist or physical therapist, support group participation, regularly scheduled physician follow-up visits).

[1] Many patients (>50%) have depression as a co-morbid diagnosis that, if treated, would not preclude their participation in the bariatric surgery program.
[2] All surgical services must be provided by a program with current accreditation (as a comprehensive center or low acuity center) by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP)

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

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 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.

ICD-10-CM Q82.8 (Other specified congenital malformations of skin) is included on line 426 only for Darier disease.

GUIDELINE NOTE 24, COMPLICATED HERNIAS

Lines 168,524

Complicated inguinal and femoral hernias in men are included on Line 168 if the hernia

1) causes symptoms of intestinal obstruction and/or strangulation; OR
2) is incarcerated (defined as non-reducible by physical manipulation); OR
3) causes pain and functional limitations as assessed and documented by a medical professional OR
4) Affects the patient's ability to obtain or maintain gainful employment.

Repair of inguinal and femoral hernias in women are included on Line 168 due to the different natural history of disease in this population.

Ventral hernias are included on line 524. Incarcerated ventral hernias (including incarcerated abdominal incisional and umbilical hernias) are included on Line 524, because the chronic incarceration of large ventral hernias does not place the patient at risk for impending strangulation. Ventral hernias are defined as anterior abdominal wall hernias and include primary ventral hernias (epigastric, umbilical, Spigelian), parastomal hernias and most incisional hernias (ventral incisional hernias). K42.0, K43.0, K43.3, K43.6 and K46.0 are included on Line 524 when used to designate incarcerated abdominal incisional and umbilical hernias without intestinal obstruction or gangrene.

~~**GUIDELINE NOTE 42, CHEMODENERVATION FOR CHRONIC MIGRAINE**~~

~~*Line 410*~~

~~Chemodenervation for treatment of chronic migraine (CPT 64615) is included on this line for prophylactic treatment of adults who meet all of the following criteria:~~

~~A) have chronic migraine defined as headaches on at least 15 days per month of which at least 8 days are with migraine~~
~~B) has not responded to or have contraindications to at least three prior pharmacological prophylaxis therapies (e.g. beta-blocker, anticonvulsant or tricyclic antidepressant)~~
~~C) their condition has been appropriately managed for medication overuse~~
~~D) treatment is administered in consultation with a neurologist or headache specialist.~~

~~Treatment is limited to two injections given 3 months apart. Additional treatment requires documented positive response to therapy. Positive response to therapy is defined as a reduction of at least 7 headache days per month compared to baseline headache frequency~~

~~**GUIDELINE NOTE 45, CHEMODENERVATION OF THE BLADDER**~~

~~*Line 327*~~

~~Chemodenervation of the bladder (CPT 52287) is included on this line only for treatment of idiopathic detrusor over-activity or neurogenic detrusor over-activity (ICD-10-CM N32.81) in patients who have not responded to or been unable to tolerate at least two urinary incontinence antimuscarinic therapies (e.g. fesoterodine, oxybutynin, solifenacin, darifenacin, tolterodine, trospium). Treatment is limited to 90 days, with additional treatment only if the patient shows documented positive response. Positive response to therapy is defined as a reduction of urinary frequency of 8 episodes per day or urinary incontinence of 2 episodes per day compared to baseline frequency~~

GUIDELINE NOTE 74, GROWTH HORMONE TREATMENT

Lines 40,386,469,652

Treatment with growth hormone should continue only until adult height as determined by bone age is achieved. ICD-10-CM E23.0 (Hypopituitarism) is included on lines 40 and 386 for conditions other than adult human growth hormone deficiency. ICD-10-CM E23.0 is included on line 652 only for adult human growth hormone deficiency.

GUIDELINE NOTE 92, ACUPUNCTURE

Lines 1,4,5,12,62,64,65,92,111,112,114,125,129,133,135,157,158,191,199-201,208,210,214,215,229, 234,237,238,258,259,262,271,276,286,287,294,314-316,329,342,361,396,397,402,410,420,434,463, 540,558

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

Line 1 PREGNANCY

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

Hyperemesis gravidarum

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

Acupuncture pairs with hyperemesis gravidarum when a diagnosis is made by the maternity care provider and referred for acupuncture treatment for up to 12 sessions of acupressure/acupuncture per pregnancy.

Breech presentation

ICD-10-CM: O32.1

Acupuncture (and moxibustion) is paired with breech presentation when a referral with a diagnosis of breech presentation is made by the maternity care provider, the patient is between 33 and 38 weeks gestation, for up to 6 session per pregnancy.

Back and pelvic pain of pregnancy

ICD-10-CM: O99.89
Acupuncture is paired with back and pelvic pain of pregnancy when referred by maternity care provider/primary care provider for up to 12 sessions per pregnancy.

Lines 4 SUBSTANCE USE DISORDER, 62 SUBSTANCE-INDUCED MOOD, ANXIETY, DELUSIONAL AND OBSESSIVE-COMPULSIVE DISORDERS, 65 SUBSTANCE-INDUCED DELIRIUM; SUBSTANCE INTOXICATION AND WITHDRAWAL

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

Line 5 TOBACCO DEPENDENCE

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

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

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

Line 201 CHRONIC ORGANIC MENTAL DISORDERS INCLUDING DEMENTIAS

Acupuncture is paired with the treatment of post-stroke depression only. Treatments may be billed to a maximum of 30 minutes face-to-face time and limited to 12 total sessions per year, with documentation of meaningful improvement; patients may have additional visits authorized beyond these limits if medically appropriate.

Line 361 SCOLIOSIS

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

Line 402 CONDITIONS OF THE BACK AND SPINE

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

Line 410 MIGRAINE HEADACHES

Acupuncture pairs on Line 410 for migraine (ICD-10-CM G43.0, G43.1, G43.5, G43.7, G43.8, G43.9), for up to 12 sessions per year.

Line 463 OSTEOARTHRITIS AND ALLIED DISORDERS

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

*Line 540 TENSION HEADACHES

Acupuncture is included on Line 540 for treatment of tension headaches (ICD-10-CM G44.2), for up to 12 sessions per year.

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

*Below the current funding line.

GUIDELINE NOTE 106, PREVENTIVE SERVICES

Lines 3,622

Included on Line 3 are the following preventive services:

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

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

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

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

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

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

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

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

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 8

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

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 148, BIOMARKER TESTS OF CANCER TISSUE

Lines 157,184,191,229,262,271,329

The use of tissue of origin testing (e.g. CPT 81504) is included on Line 662 CONDITIONS FOR WHICH CERTAIN INTERVENTIONS ARE UNPROVEN, HAVE NO CLINICALLY IMPORTANT BENEFIT OR HAVE HARMS THAT OUTWEIGH BENEFITS.

For early stage breast cancer, the following breast cancer genome profile tests are included on Line 191 when the listed criteria are met. One test per primary breast cancer is covered when the patient is willing to use the test results in a shared decision-making process regarding adjuvant chemotherapy. Lymph nodes with micrometastases less than 2 mm in size are considered node negative.

- Oncotype DX Breast Recurrence Score (CPT 81519) for breast tumors that are estrogen receptor positive, HER2 negative, and either lymph node negative, or lymph node positive with 1-3 involved nodes.
- EndoPredict (CPT 81522) and Prosigna (CPT 81520 or PLA 0008M) for breast tumors that are estrogen receptor positive, HER2 negative, and lymph node negative.
- MammaPrint (using CPT 81521 or HCPCS S3854) for breast tumors that are estrogen receptor or progesterone receptor positive, HER2 negative, lymph node negative, and only in those cases categorized as high clinical risk.

EndoPredict, Prosigna, and MammaPrint are not included on Line 191 for early stage breast cancer with involved axillary lymph nodes. Oncotype DX Breast Recurrence Score is not included on Line 191 for breast cancer involving four or more axillary lymph nodes or more extensive metastatic disease.

Oncotype DX Breast DCIS Score (CPT 81479) and Breast Cancer Index (CPT 81518) are included on Line 662 CONDITIONS FOR WHICH CERTAIN INTERVENTIONS ARE UNPROVEN, HAVE NO CLINICALLY IMPORTANT BENEFIT OR HAVE HARMS THAT OUTWEIGH BENEFITS.

For melanoma, BRAF gene mutation testing (CPT 81210) is included on Line 229.

For lung cancer, epidermal growth factor receptor (EGFR) gene mutation testing (CPT 81235) is included on Line 262 only for non-small cell lung cancer. KRAS gene mutation testing (CPT 81275) is not included on this line.

For colorectal cancer, KRAS gene mutation testing (CPT 81275) is included on Line 157. BRAF (CPT 81210) and Oncotype DX are not included on this line. Microsatellite instability (MSI) is included on the Line 662.

For bladder cancer, Urovysion testing is included on Line 662.

For prostate cancer, Oncotype DX Genomic Prostate Score, Prolaris Score Assay (CPT 81541), and Decipher Prostate RP (CPT 81542) are included on Line 662.

The development of this guideline note was informed by a HERC coverage guidance on Biomarkers Tests of Cancer Tissue for Prognosis and Potential Response to Treatment; the prostate-related portion of that coverage guidance was superseded by a Coverage Guidance on Gene Expression Profiling for Prostate Cancer. See https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Evidence-based-Reports.aspx.

GUIDELINE NOTE 167, CHOLECYSTECTOMY FOR CHOLECYSTITIS AND BILIARY COLIC

Lines 55,641

Cholecystectomy for cholecystitis and biliary colic are including on Line 55 when meeting the following criteria:

A) For cholecystitis, with either:
   1) The presence of right upper quadrant abdominal pain, mass, tenderness or a positive Murphy's sign, AND
   2) Evidence of inflammation (e.g. fever, elevated white blood cell count, elevated C reactive protein) OR
   3) Ultrasound findings characteristic of acute cholecystitis or non-visualization of the gall bladder on oral cholecystegram or HIDA scan, or gallbladder ejection fraction of < 35%.

B) For biliary colic (i.e. documented clinical encounter for right upper quadrant or epigastric pain with gallstones seen on imaging during each episode) without evidence of cholecystitis or other complications is included on Line 55 only when
   1) Recurrent (i.e. 2 or more episodes in a one year period) OR
   2) A single episode in a patient at high risk for complications with emergent cholecystitis (e.g. immunocompromised patients, morbidly obese patients, diabetic patients) OR
   3) When any of the following are present: elevated pancreatic enzymes, elevated liver enzymes or dilated common bile duct on ultrasound.

Otherwise, biliary colic is included on Line 641.

ICD-10 K82.8 (Other specified diseases of gallbladder) is included on Line 55 when the patient has porcelain gallbladder or gallbladder dyskinesia with a gallbladder ejection fraction <35%. Otherwise, K82.8 is included on Line 641.

GUIDELINE NOTE 170, INTRATHECAL OR EPIDURAL DRUG INFUSION

Lines 71,285,292,491

Implantation, revision and replacement of devices for intrathecal or epidural drug infusion systems is only included on these lines when the patient meets the criteria for at least one of the categories (A or B) below:

A) Placed for administration of baclofen for spasticity where all of the following (1-3) occur:
   1) The patient has had an adequate trial of non-invasive methods of spasticity control and not had adequate control of spasticity or had intolerable side effects with these methods.
   2) The spasticity is causing difficulties with at least one of the following (a, b or c):
      a) Posture or function
      b) Balance or locomotion
      c) Self-care (or ease of care by parents or caregivers)
   3) The patient has a favorable response to a trial intrathecal dosage of the anti-spasmodic drug prior to pump implantation.

B) Palliation for severe, intractable pain due to life-limiting active cancer which

1) Has not been responsive to non-invasive systemic pain control strategies or had intolerable side effects from such strategies, AND
2) Where the patient has a favorable response to a trial of an intrathecal dose of the analgesic drug prior to pump implantation

Intrathecal or epidural drug infusion pump insertion, revision, and replacement are included on Line 662 for use with chronic non-malignant pain and all other indications not listed above. See Guideline Note 173 INTERVENTIONS THAT ARE UNPROVEN, HAVE NO CLINICALLY IMPORTANT BENEFIT OR HAVE HARMS THAT OUTWEIGH BENEFITS FOR CERTAIN CONDITIONS. Removal of pumps placed for such indications is included on Line 285.

Maintenance (i.e. reprogramming, medication refill) of epidural or intrathecal medication infusion pumps for any condition is only included on these lines for patients who

A) have no significant complications with the current medication regimen or pump delivery system AND
B) are continuing to receive adequate benefit from the pump-delivered medication.

Maintenance (but not replacement) of these infusion systems may be paired with ICD-10-CM Z45.49 (Encounter for adjustment and management of other implanted nervous system device).

CPT codes 62320-62323 (Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), interlaminar epidural or subarachnoid) are only included on Lines 71 and 292 for trials of antispasmodics in preparation for placement of a baclofen pump.

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
~~29866-29867~~	~~Arthroscopy, knee, surgical; osteochondral autograft(s)/allograft(s) (eg, mosaicplasty)~~	~~Insufficient evidence of effectiveness~~	~~November 2007~~

Procedure Code	Intervention Description	Rationale	Last Review
Prostate Cancer Gene Expression tests billed with nonspecific codes (e.g. 81479, 81599, 84999)	• Oncotype DX Genomic Prostate Score • Decipher RP for prostate cancer	~~Unproven Intervention~~ Insufficient evidence of effectiveness	~~January, 2018~~ March 2021 Coverage guidance
81541	Oncology (prostate), mRNA gene expression profiling by real-time RT-PCR of 46 genes (31 content and 15 housekeeping)	~~Unproven Intervention~~ Insufficient evidence of effectiveness	~~August, 2015~~ March 2021
81542	Oncology (prostate), mRNA, microarray gene expression profiling of 22 content genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as metastasis risk score	Insufficient evidence of effectiveness	~~January 2018~~ March 2021

GUIDELINE NOTE XXX PANCREAS/KIDNEY TRANSPLANTS

Line 83

Simultaneous pancreas kidney transplant (SPT) is only included on this line for type I diabetes mellitus with end stage renal disease (E10.2). Pancreas after kidney transplant (PAK) is only included on this line for other type I diabetes mellitus with secondary diagnosis of Z94.0 (Kidney transplant status).

GUIDELINE NOTE XXX OTHER DISEASES OF VOCAL CORDS

Lines 205, 559

ICD-10 J38.3 (Other diseases of vocal cords) is included on Line 205 for treatment of abscesses and cellulitis of the vocal cords; it is included on Line 559 for treatment of spastic dysphonia.

GUIDELINE NOTE XXX OTHER INTESTINAL MALABSORPTION

Line 227,552

ICD-10-CM code K90.89 (Other intestinal malabsorption) is included on this line only for chronic steatorrhea, exudative enteropathy, and protein-losing enteropathy. Otherwise, it is included on line 552.

GUIDELINE NOTE XXX CARCINOMA IN SITU OF PENIS

Line 258

CPT 96567-96573 (Photodynamic therapy) and 96574 (Debridement of premalignant hyperkeratotic lesion) are included on this line only for pairing with ICD-10-CM D07.4 (Carcinoma in situ of penis).

GUIDELINE NOTE XXX COMPRESSION OF VEIN

Line 262,639

ICD-10-CM code I87.1 (Compression of vein) is included on line 262 for superior vena cava syndrome only. Otherwise it is included on line 639.

GUIDELINE NOTE XXX CATHETER DIRECTED THROMBOLYSIS

Line 280

Catheter directed thrombolysis (CPT 37212-37214) is not paired on this line with peripheral DVT (ICD-10-CM I82.6, I82.7, I82.A, I82.B, I82.8, I82.9).

GUIDELINE NOTE XXX BENIGN NEOPLASM OF PAROTID GLAND

Line 287,627

ICD-10-CM code D11.0 (Benign neoplasm of parotid gland) is included on line 287 only for parotid gland pleomorphic adenomas. Otherwise it is included on line 627.

GUIDELINE NOTE XXX KNEE ARTHROSCOPY

Line 356

Knee arthroscopy (29871, 29873-29876, 29884-29887) is not included on this line when paired with osteoarthritis/osteoarthrosis of the knee (M17.0-M17.9).

GUIDELINE NOTE XXX OTHER SPECIFIED EATING DISORDER

Line 381,631

ICD-10 F50.89 (Other specified eating disorder) is included on Line 381 for psychogenic loss of appetite. ICD-10 F50.89 is included on Line 631 for pica in adults and for all other diagnoses using this code.

GUIDELINE NOTE XXX IMPLANTATION OF INTRAVITREAL DRUG DELIVERY SYSTEM

Line 383

CPT 67027 (Implantation of intravitreal drug delivery system) is included on this line for use with medications other than intraocular steroid implants.

GUIDELINE NOTE XXX ORTHOPTIC AND/OR PLEOPTIC TRAINING

Line 393

CPT 92065 (Orthoptic and/or pleoptic training) is included on Line 393 only for pairing with ICD-10 H50.31 (Intermittent monocular esotropia), H50.32 (Intermittent alternating esotropia), H50.33 (Intermittent monocular exotropia), and H50.34 (Intermittent alternating exotropia).

GUIDELINE NOTE XXX WIGS

Line 424,586

ICD-10-CM codes L58.0 (Acute radiodermatitis), L64.0 (Drug-induced androgenic alopecia) and L65.8 (Other specified nonscarring hair loss) are only included on this line for pairing with HCPC A9282 (Wig). Otherwise these ICD10 codes are included on line 586.

GUIDELINE NOTE XXX PLANTAR FASCIA INJECTION

Line 539

CPT 20550 (Plantar fascia injection) only appears on this line for corticosteroid injections. The treatment is appropriate to the condition, but has limited evidence of effectiveness.

GUIDELINE NOTE XXX CERVICOGENIC HEADACHE

Line 540

Osteopathic manipulative treatment and chiropractic manipulative treatment (CPT 98926-98929, 98940-98943) pair on this line only with cervicogenic headache (R51).

GUIDELINE NOTE XXX CHEMODENERVATION

Lines 292,327,351,362,378,393,410,517

Inclusion of chemodenervation on the Prioritized List has the following limitations for the lines specified below:

Line 292 NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS

Chemodenervation with botulinum toxin injection (CPT 64642-64647) is included on this line for treatment of upper and lower limb spasticity (ICD-10-CM codes G24.02, G24.1, G35, G36.0, I69.03-I69.06 and categories G71, and G80-G83.)

Line 327 FUNCTIONAL AND MECHANICAL DISORDERS OF THE GENITOURINARY SYSTEM INCLUDING BLADDER OUTLET OBSTRUCTION

Chemodenervation of the bladder (CPT 52287) is included on this line only for treatment of idiopathic detrusor over-activity or neurogenic detrusor over-activity (ICD-10-CM N32.81) in patients who have not responded to or been unable to tolerate at least two urinary incontinence antimuscarinic therapies (e.g. fesoterodine, oxybutynin, solifenacin, darifenacin, tolterodine, trospium). Treatment is limited to 90 days, with additional treatment only if the patient shows documented positive response. Positive response to therapy is defined as a reduction of urinary frequency of 8 episodes per day or urinary incontinence of 2 episodes per day compared to baseline frequency

Line 351 STRABISMUS DUE TO NEUROLOGIC DISORDER

Chemodenervation with botulinum toxin injection (CPT 67345) is included on this line for the treatment of strabismus due to other neurological disorders (ICD-10 H50.89).

Line 362 DYSTONIA (UNCONTROLLABLE); LARYNGEAL SPASM

Chemodenervation with botulinum toxin injection (CPT 64612, 64616) is included on this line only for treatment of blepharospasm (ICD-10-CM G24.5), spasmodic torticollis (ICD-10-CM G24.3), and other fragments of torsion dystonia (ICD-10-CM G24.9)

Line 378 ESOPHAGEAL STRICTURE; ACHALASIA

Chemodenervation with botulinum toxin injection (CPT 43201) is included on this line for treatment of achalasia (ICD-10 K22.0)

Line 393 STRABISMUS WITHOUT AMBLYOPIA AND OTHER DISORDERS OF BINOCULAR EYE MOVEMENTS; CONGENITAL ANOMALIES OF EYE; LACRIMAL DUCT OBSTRUCTION IN CHILDREN

Chemodenervation with botulinum toxin injection (CPT 67345) is included on this line for the treatment of strabismus due to other neurological disorders (ICD-10 H50.89).

Line 410 MIGRAINE HEADACHES

Chemodenervation for treatment of chronic migraine (CPT 64615) is included on this line for prophylactic treatment of adults who meet all of the following criteria:

E) have chronic migraine defined as headaches on at least 15 days per month of which at least 8 days are with migraine
F) has not responded to or have contraindications to at least three prior pharmacological prophylaxis therapies (e.g. beta-blocker, anticonvulsant or tricyclic antidepressant)
G) their condition has been appropriately managed for medication overuse
H) treatment is administered in consultation with a neurologist or headache specialist.

Treatment is limited to two injections given 3 months apart. Additional treatment requires documented positive response to therapy. Positive response to therapy is defined as a reduction of at least 7 headache days per month compared to baseline headache frequency

Line 517 DISORDERS OF SWEAT GLANDS

Chemodenervation with botulinum toxin injection (CPT 64650, 64653) is included on this line for the treatment of axillary hyperhidrosis and palmar hyperhidrosis (ICD-10 L74.52, R61)

GUIDELINE NOTE XXX OSTEOCHONDRAL ALLOGRAFT/AUTOGRAFT TRANSPLANTATION (OAT) OF THE KNEE

Line 431

Osteochondral Allograft/Autograft Transplantation (OAT) is included on this line only when ALL of the following conditions are met:

1) The patient is younger than age 50; AND
2) There is no malignancy, degenerative or inflammatory arthritis in the joint; AND
3) The patient has focal full thickness lesions (Grade III or IV) of the weight bearing surface with absent degenerative changes of the surrounding articular cartilage (Outerbridge grade II or less) and normal appearing cartilage around the defect; AND
4) The patient is not a candidate for total knee replacement; AND
5) The patient has failed standard conservative treatment including medication management and completed course of physical therapy; AND
6) The patient has normal knee alignment and stability

All (33) coding specifications were deleted from the Prioritized List:

Line 3
~~CPT code 96110 can be billed in addition to other CPT codes, such as evaluation and management (E&M) codes or preventive visit codes.~~

Line 8
~~CPT 95250 and 95251 are included on this line for services related to real-time continuous glucose monitoring but not retrospective (professional) continuous glucose monitoring.~~

Line 40
~~ICD-10-CM E23.0 is included on this line for conditions other than adult human growth hormone deficiency.~~

Line 55
~~ICD-10 K82.8 (Other specified diseases of gallbladder) is included on Line 55 when the patient has porcelain gallbladder or gallbladder dyskinesia with a gallbladder ejection fraction.~~

Line 71
~~CPT codes 62320-3 are only included on Lines 71 and 292 for trials of antispasmodics in preparation for placement of a baclofen pump.~~

Line 83
~~SPK included for type I diabetes mellitus with end stage renal disease (E10.2), PAK only included for other type I diabetes mellitus with secondary diagnosis of Z94.0.~~

Line 174
~~CPT 61885 is included on this line only for vagal nerve stimulation. It is not included on this line for deep brain stimulation.~~

Line 205
~~ICD-10 J38.3 is included on Line 205 for treatment of abscesses and cellulitis of the vocal cords; it is included on Line 559 for treatment of spastic dysphonia.~~

Line 227
~~ICD-10-CM code K90.89 (Other intestinal malabsorption) is included on this line only for chronic steatorrhea, exudative enteropathy, and protein-losing enteropathy.~~

Line 258
~~CPT 96567, 96573 and 96574 are included on this line only for pairing with ICD-10-CM D07.4.~~

Line 262
~~ICD-10-CM code I87.1 is included on this line for superior vena cava syndrome only.~~

Line 280

~~Catheter directed thrombolysis (CPT 37212-37214) is not paired on this line with peripheral DVT (ICD-10-CM I82.6, I82.7, I82.A, I82.B, I82.8, I82.9).~~

Line 287
~~ICD-10-CM code D11.0 is included on this line only for parotid gland pleomorphic adenomas.~~

Line 292
~~Chemodenervation with botulinum toxin injection (CPT 64642-64647) is included on this line for treatment of upper and lower limb spasticity (ICD-10-CM codes G24.02, G24.1, G35, G36.0, I69.03-I69.06 and categories G71, and G80-G83.)~~

~~CPT codes 62320-3 are only included on Lines 71 and 292 for trials of antispasmodics in preparation for placement of a baclofen pump.~~

Line 327
~~ICD-10-CM codes N40.1 and N40.3 are only included on this line when post-void residuals are at least 150 cc's.~~

Line 351
~~Chemodenervation with botulinum toxin injection (CPT 67345) is included on this line for the treatment of strabismus due to other neurological disorders (ICD-10 H50.89).~~

Line 356
~~Knee arthroscopy (29871, 29873-29876, 29884-29887) is not included on this line when paired with osteoarthritis/osteoarthrosis of the knee (M17.0-M17.9).~~

Line 362
~~Chemodenervation with botulinum toxin injection (CPT 64612, 64616) is included on this line only for treatment of blepharospasm (ICD-10-CM G24.5), spasmodic torticollis (ICD-10-CM G24.3), and other fragments of torsion dystonia (ICD-10-CM G24.9).~~

Line 378
~~Chemodenervation with botulinum toxin injection (CPT 43201) is included on this line for treatment of achalasia (ICD-10 K22.0).~~

Line 381
~~ICD-10 F50.89 is included on Line 381 for psychogenic loss of appetite. ICD-10 F50.89 is included on Line 631 for pica in adults and for all other diagnoses using this code.~~

Line 383
~~CPT 67027 (Implantation of intravitreal drug delivery system) is included on this line for use with medications other than intraocular steroid implants.~~

Line 386
~~ICD-10-CM E23.0 is included on this line for conditions other than adult human growth hormone deficiency.~~

Line 393
~~CPT 92065 is included on Line 393 only for pairing with ICD-10 H50.31 intermittent monocular esotropia), H50.32 (Intermittent alternating esotropia), H50.33 (Intermittent monocular exotropia), and H50.34 (Intermittent alternating exotropia).~~

~~Chemodenervation with botulinum toxin injection (CPT 67345) is included on this line for the treatment of strabismus due to other neurological disorders (ICD-10 H50.89).~~

Line 424
~~ICD-10-CM codes L58.0, L64.0 and L65.8 are only included on this line for pairing with HCPC A9282.~~

Line 426
~~ICD-10-CM Q82.8 is included on this line only for Darier disease.~~

Line 444
~~ICD-10-CM codes Z71.89, Other specified counseling, and Z63.4 Disappearance and death of family member are only included in this line when identified as secondary diagnoses with a primary diagnosis of F43.8, Other reactions to severe stress.~~

Line 517
~~Chemodenervation with botulinum toxin injection (CPT 64650, 64653) is included on this line for the treatment of axillary hyperhidrosis and palmar hyperhidrosis (ICD-10 L74.52, R61).~~

Line 539
~~CPT 20550 only appears on this line for corticosteroid injections. The treatment is appropriate to the condition, but has limited evidence of effectiveness.~~

Line 540
~~Osteopathic manipulative treatment and chiropractic manipulative treatment (CPT 98926-98929, 98940-98943) pair on this line only with cervicogenic headache (R51).~~

Line 559
~~ICD-10 J38.3 is included on Line 205 for treatment of abscesses and cellulitis of the vocal cords; it is included on Line 559 for treatment of spastic dysphonia.~~

Line 631
~~ICD-10 F50.89 is included on Line 381 for psychogenic loss of appetite. ICD-10 F50.89 is included on Line 631 for pica in adults and for all other diagnoses using this code.~~

Line 641
~~ICD-10 K82.8 (Other specified diseases of gallbladder) is included on Line 55 when the patient has porcelain gallbladder or gallbladder dyskinesia with a gallbladder ejection fraction.~~

Line 652
~~ICD-10-CM E23.0 is included on this line only for adult human growth hormone deficiency.~~

Environmental scan: behavioral health services for children and adolescents

Contract requirement or program	Description	Population	Statewide/region	CCOs
Access to evidence-based dyadic treatment	Parent and child treated together	Age 8 and younger	Statewide	All
Immediate intake and assessment	Based on timely access standards	Birth through age 5	Statewide	All
Children in subacute/residential/day treatment	Psychological eval every 12 months; caregiver not prevented from attending due to SDOH	Unknown	Statewide	All
Intensive care coordination	If placed in a correctional facility solely for stabilizing a BH condition; if placed out of CCO service area in behavior rehabilitation service programs under Child Welfare; if received care in ED, acute inpatient psychiatric care or sub-acute care	Age 17 and younger	Statewide	All
Social-emotional screening	Periodic screening in primary care; concerns timely addressed	Birth through age 5	Statewide	All
Wraparound supports	Care planning process that results in a unique set of community services and supports individualized for a youth and family	Age 17 and younger	Statewide	All
System of care	and community-based child and youth BH services. Must support the leadership and involvement of youth and families at all levels of the SOC governance structure, both culturally and linguistically appropriate; inclusion and collaboration of community partners and system partners to ensure youth and families have access to necessary supports and services.		Statewide	All
Child and Adolescent Needs and Strengths Comprehensive Screening (CANS)	Supports level of care and service planning. Administer to each member in Fidelity Wraparound upon entrance, every 90 days, and upon completion. Administer to every youth in Child Welfare within 60 days of entering foster care.	Age 17 and younger	Statewide	All
Intensive In-Home Behavioral Health Treatment (IIBHT)	Community-based services that are delivered in the home, school, or other community location. Member eligible if they have a primary mental health diagnosis on the Prioritized List and require intensive services to provide for community stabilization, to prevent facility-based care, or as step-down to	Age 20 and younger	Statewide	All
Integrated Care for Kids (InC	Early identification; integrated care coordination and case management; health information exchange; alternative payment models	Birth to age 21	Crook, Deschutes, Jefferson, Marion	PacificSource-Central, PacificSource Marion Polk

Environmental scan: behavioral health services for children and adolescents

Child health complexity data	System-level data to assess medical and social complexity	Birth to age 20	Statewide (data by county, CCO and statewide)	All CCOs have data available
Universally offered home visiting benefit (part of the CCO contract January 2022)	Offered to all families of newborns. It is an upstream intervention that is a protective factor for early childhood health and wellbeing. A nurse home visitor conducts a comprehensive assessment with the family in their home 3-4 weeks after the baby is home. The family receives support, education and referrals to identified and desired services. If needed, the family can receive up to 2 additional visits.	Newborns 3 weeks to 6 months	Spring/summer 2021: Marion, Washington, Linn, Benton, Lincoln, Deschutes, Crook, and Jefferson	None yet. Starting January 2022, CCOs in the communities where services are offered will be required to reimburse providers for the services their members receive.
Rapid Access BH strategies at CMHPs and COA organizations	Planning phase, looking at rule changes needed, stakeholder group	All (not specific ages)		
Mental health expansion grant (school-based health centers)	BH integration in primary care	School-age youth (5-21)	78 SBHCs in 25 counties	SBHCs required to bill CCOs
Direct mental health in schools			17 counties	
SBHC - required depression screening metric	Certified SBHCs are required to offer depression screening, also a SBHC key performance measure	Metric is for ages 12-21; SBHCs serve school-age youth (5-21)	78 SBHCs in 25 counties	SBHCs required to bill CCOs
Bill in session to expand SBHC (mobile and telehealth)	HB 2591 would expand SBHCs (10 planning grants) plus pilot 3 mobile SBHCs and 3 telehealth SBHCs; would inherently expand BH capacity	School-age youth (5-21)	Unknown - grants across the state	
Community health assessment requirements to meet needs of children and adolescents	CCOS are required to analyze: - Sufficiency and effectiveness of existing programs to support health/treatment of children & adolescents - Sufficiency of existing funding sources to meet the health needs of children & adolescents - Whether existing school-based health resourcess are capable of meeting the specific pediatric and adolescent health care needs within their CCO area		Statewide	All

Environmental scan: behavioral health services for children and adolescents

Community health improvement requirements to meet needs of children and adolescents	–Baseline data on integration of SBHCs within the health system –Plan for improving integration of services –Plan for improving promotion and provision of primary care, behavioral health and oral health –Priorities, goals and strategies that address: funding sources; effective services to address the effects of childhood trauma; recommendations for improving appropriate, suitable School Based Health Care networks; integrating services; appropriate and accesible services (including BH)		Statewide	All
Big 6 - suicide prevention strategies in schools				
Early psychosis program (EASA)		14+		
Mobile response and crisis services (OHA applied for SAMHSA grant)	How do connections happen for children/adolescents?			
Pilot of social-emotional screening metric		0-5		