

## **Value-based Benefits Subcommittee Recommendations Summary For Presentation to: Health Evidence Review Commission in January 2015**

*For specific coding recommendations and guideline wording, please see the text of the 1-8-2015 VbBS minutes.*

### **RECOMMENDED CODE MOVEMENT (effective 10/1/15 unless otherwise noted)**

- Make various straightforward coding changes and corrections
- Add liver elastography to the covered chronic hepatitis line with a new guideline
- Add diagnosis codes for overweight to the funded and unfunded lines for obesity with a guideline. Remove pharmacist management codes and inpatient observation codes from these lines. Change line titles to include overweight.
- Add diagnosis codes for tonsillar hypertrophy to a funded line
- Remove the diagnosis code for hemangioma of the GI tract from an inappropriate funded line to an appropriate unfunded line
- Added procedure codes for stereotactic body radiation therapy to the lung cancer line with a new guideline
- Add the diagnosis code for retained foreign body in the ear to a funded complications line
- Remove the procedure code for removal of retained tympanostomy tube from several funded lines and add it to a nonfunded complications line
- Add the procedure codes for intraocular injections and implants to the diabetic macular edema line for non-steroidal medications only, effective January 1, 2015
- Add the procedure codes for wearable cardiac defibrillators to six funded lines for cardiac conditions with a new guideline limiting their use

### **ITEMS CONSIDERED BUT NO RECOMMENDATIONS FOR CHANGES MADE**

- No recommendation to add fever of unknown origin (FUO) and prostate cancer staging as indications for PET scan
- No recommendation to add catheter thrombolysis for treatment of pulmonary embolism
- No recommendation to remove codes for cervical epidural steroid injections from funded lines

### **RECOMMENDED GUIDELINE CHANGES (effective 10/1/15 unless otherwise noted)**

- Various straightforward guideline note changes
- Update links to external documents in the prevention guideline note
- Modify the obesity guideline to include overweight with cardiovascular risk factors as an indication for coverage for intensive nutrition and activity counseling
- Modify the tonsillectomy guideline to specify when unilateral tonsillar hypertrophy is included on an upper, funded line
- Modify the hemangioma guideline to clarify its meaning

- Modify two guidelines referring to tympanostomy tube placements to clarify coverage of removal of these tubes. Delete the current guideline regarding removal of these tubes.
- Add a new guideline specifying when MRI, CT and radionuclide bone scans are covered for staging of prostate cancer

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

**Members Present:** Kevin Olson, MD, Chair; James Tyack, DMD; David Pollack, MD; Susan Williams, MD; Mark Gibson; Irene Crowell, RPh; Holly Jo Hodges, MD; Laura Ocker, LAc.

**Members Absent:** None

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

**Also Attending:** Wally Shaffer, DMAP; Mary Hlady, PT, Cathy Zarosinsky, Nora Stern and Susan Bamberger, OR PT Association; Vern Saboe, DC, OR Chiropractic Association; Karen Campbell and Jane Stephen, Allergan; Catriona Buist; Valerie King, Jill Scantlan, and Robyn Liu, Center for Evidence Based Policy (CEbP).

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

The meeting was called to order at 8:35 am and roll was called. Minutes from the November, 2014 VbBS meeting were reviewed and approved. Staff will post the minutes on the website as soon as possible.

Smits reviewed multiple administrative coding changes done by staff before the publication of the January 1, 2015 ICD-9/ICD-10 Prioritized List. These changes did not require a vote and there was no discussion.

Smits also reported on further staff research into transverse abdominis plane (TAP) blocks. These blocks were reviewed as part of the 2015 CPT code review. There was concern that high cost catheters might be used for these blocks; staff was directed to look into this and compose a guideline if this was the case. Staff reviewed this topic and found that these blocks are done with low cost catheters or simple injections and therefore no guideline note is needed.

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➤ **Topic: Straightforward/Consent Agenda**

**Discussion:** There was minimal discussion about the consent agenda items.

**Recommended Actions:**

- 1) Change the title of GN 117 to INTRAOCULAR STEROID IMPLANTS FOR ~~CENTRAL~~ RETINAL VEIN OCCLUSION
- 2) Add 50820 (Ureteroileal conduit (ileal bladder), including intestine anastomosis (Bricker operation)) to line 274 CANCER OF BLADDER AND URETER
- 3) Remove 54408, 54410, 54411, 54416, 54417 (Removal of penile prosthesis components) from lines 290 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT and 413 GENDER DYSPHORIA
- 4) Remove 54406 and 54415 (Removal of penile prosthesis components) from line 413 GENDER DYSPHORIA
- 5) Move V49.71 (Below knee amputation status) from line 534 DEFORMITIES OF UPPER BODY AND ALL LIMBS to line 381 DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE LEVEL OF INDEPENDENCE IN SELF- DIRECTED CARE CAUSED BY CHRONIC CONDITIONS THAT CAUSE NEUROLOGICAL DYSFUNCTION
- 6) Add 28446 (Open osteochondral autograft, talus) to line 359 RHEUMATOID ARTHRITIS, OSTEOARTHRITIS, OSTEOCHONDRITIS DISSECANS, AND ASEPTIC NECROSIS OF BONE
- 7) Amend GN 106 Preventive Services as shown in Appendix A
- 8) Add inpatient E&M codes to Line 313 AUTISM SPECTRUM DISORDERS
- 9) Remove 96127 (Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument) from all current Prioritized List lines
- 10) Advise DMAP to place 96127 on the Ancillary List

**MOTION: To approve the recommendations stated in the consent agenda. CARRIES 8-0.**

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➤ **Topic: Liver Elastography**

**Discussion:** Smits introduced a summary document. There was some discussion about limited availability of liver elastography in non-Portland metro areas of the state. There was discussion about whether the evidence supported the staff recommendation to adopt liver elastography for those cases in which it would replace liver biopsy for determination of eligibility for medications for hepatitis C. Smits indicated that the evidence supported use of the test for

distinguishing cirrhosis from non-cirrhosis, but not for distinguishing less severe levels of liver damage/disease. The current guideline does not specify that this would be the major use of this test; however, current fee-for-service PA criteria under consideration only allows use of hepatitis C medications in those patients with cirrhosis. These PA criteria may change and the test would be allowed to be used to differentiate other stages of liver disease with the current guideline wording. The group felt that the groups making these PA criteria would be reviewing this use and leaving the guideline as written would allow faster changes in prescribing for hepatitis C drugs as evidence changes. Olson felt that the staff recommendation achieved the triple aim of lower cost, better care, and better outcomes.

Hodges recommended addition of commercial insurance guideline wording limiting use of liver elastography to every 6 months and not within 6 months of a liver biopsy. This change was accepted.

**Recommended Actions:**

- 1) Place liver elastography (CPT 91200) on line 202 CHRONIC HEPATITIS; VIRAL HEPATITIS)
- 2) Adopt a new guideline for line 202 as shown in Appendix B

**MOTION: To recommend the code placement as presented and adopt the new guideline note as amended. CARRIES 8-0.**

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➤ **Topic: Biennial Review: Low Back Pain Line Revisions**

**Discussion:** Smits reviewed the recommendations from the Low Back Pain Task Force. VbBS members asked staff about the origin/rationale for the old back pain line structure. Coffman replied that when these lines were created, the HSC felt that most patients with back pain would get better without treatment, so treatment was not necessary and two of the lines therefore were scored in the non-funded region. The old line structure was created prior to the addition of guidelines to the Prioritized List. At the time of line creation, there was no concern for the risks of opiate therapy. The current Back Pain Line Reorganization Task Force is the first multi-specialty group to specifically look at coverage of back pain and the evidence to support various treatments.

Staff reviewed that there is currently a disconnect between the coverage guidances that have been adopted that recommend various treatments for back pain and the current back pain line structure. The treatments recommended in the coverage guidance are not available to most patients due to the low prioritization of their diagnosis.

Hodges spoke of the OHP Medical Directors' concern for the increased cost for the coverage in the new back pain line recommendations, and for the ability for plans in more rural areas to access the types of care included on the proposed medical line. For example, acupuncturists may not be on a smaller health plan panel. Staff indicated that the new line structure, if adopted, would not take effect until January 1, 2016. There will be actuarial review and the increased costs should be factored into the contracts with the CCOs. There was discussion that interventions such as acupuncture can be one option, but may not be required. Also, acupuncture is currently covered for many conditions on the Prioritized List and the plans have not found this coverage to be an issue. Hodges requested that staff work with the task force to change the guideline wording to indicate that modalities such as yoga are available, but not required.

Testimony was heard from Vern Saboe, DC, representing the Oregon Chiropractic Association (Dr. Saboe is also a HERC member). Dr. Saboe testified that the chiropractic association recommended that 12 visits of chiropractic care be covered, as the evidence shows that the optimal spinal manipulation number of visits is 12. This number is less than the proposed number of visits of 30 for all types of interventions. It was noted that the 30 visit number was for chiropractic care plus multiple other types of care.

Williams brought up that the evidence for the Start Back tool was to offer low risk patients just office education, not 4 visits of PT, CMT, or any other types of care; however, the task force felt that the proposed 4 visits supported the need for early education, as this type of education was better done by PTs than by busy primary care clinicians. Williams also requested that staff consider the back MRI guideline as part of the back pain task force effort.

Nora Stern, PT, testified that the biopsychosocial approach to back pain is much more effective than treatment with opiates. The older model which limited services in non-acute back pain is not accepted anymore. She also supported the addition of the 4 visits for acute low-risk back pain.

Mary Hlady, PT, from the Oregon PT Association testified that the association supports inclusion of the 4 visits for PT or other modalities for acute low back pain, and that the evidence supports this type of care to prevent chronicity of disease.

The final decision was that the VbBS agreed with the basic line structure and contents as presented. HERC staff was directed to work with the OHP Medical Directors as well as the task force and specialists to improve the proposed guidelines. HERC staff will work with the task force and experts to finalize the diagnoses and treatments to include on each line and will review line prioritization.

**Recommended Actions:**

- 1) A final back pain line recommendation will be brought to the March, 2015 VbBS meeting

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➤ **Topic: Intensive counseling for overweight with cardiovascular risk factors**

**Discussion:** Livingston reviewed the summary document. There was minimal discussion.

**Recommended Actions:**

- 1) Place ICD-9 278.02 (Overweight) and E66.3 (Overweight) on Lines 325 OBESITY (ADULT BMI ≥ 30, CHILDHOOD BMI ≥ 95 PERCENTILE) and 594 OBESITY (ADULT BMI ≥ 30, CHILDHOOD BMI ≥ 95 PERCENTILE)
- 2) Advise DMAP to remove 278.02 and E66.3 from the Excluded File
- 3) Rename Line 325 OBESITY (ADULT BMI ≥ 30, CHILDHOOD BMI ≥ 95 PERCENTILE) [and OVERWEIGHT IN ADULTS \(BMI >25\) WITH CARDIOVASCULAR RISK FACTORS](#)
- 4) Rename Line 594 OBESITY (ADULT BMI ≥ 30, CHILDHOOD BMI ≥ 95 PERCENTILE) [and OVERWEIGHT IN ADULTS \(BMI >25\)](#)
- 5) Modify Guideline Note 5 as shown in Appendix A
- 6) Remove CPT 99605-99607 (pharmacist drug management) from Line 325
- 7) Remove CPT 99356 and 99357 (Prolonged service in the inpatient or observation setting) from Line 325

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

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➤ **Topic: PET scan for fever of unknown origin**

**Discussion:** There was minimal discussion for this topic.

**Recommended Actions:**

- 1) No change to current non-pairing of PET scan with fever of unknown origin

**MOTION: To recommend no change in non-pairing of codes as presented. CARRIES 8-0.**

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➤ **Topic: Catheter thrombolysis for pulmonary embolism**

**Discussion:** There was minimal discussion for this topic.

**Recommended Actions:**

- 1) Do not add catheter thrombolysis as a treatment for pulmonary embolism.

**MOTION: To recommend no change in the non-pairing as presented.  
CARRIES 8-0.**

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➤ **Topic: Unilateral tonsillar hypertrophy**

**Discussion:** Smits introduced the summary document. It was noted that ICD-9 code 474.10 as well as 474.11 should be placed on both line 395 and 574. Rather than add a new guideline, the subcommittee decided to add the proposed wording to existing Guideline Note 36. It was thought that adding the coverage clarification to this guideline would keep all the guidelines around tonsillectomy in one place, which would be easier to find and understand by the plans and other partners.

**Recommended Actions:**

- 1) Add ICD-9 474.10/ICD-10 J35.3 (Hypertrophy of tonsil with adenoids) to line 395 STREPTOCOCCAL SORE THROAT AND SCARLET FEVER; VINCENT'S DISEASE; ULCER OF TONSIL; UNILATERAL HYPERTROPHY OF TONSIL.
- 2) Modify GN 36 as shown in Appendix A

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

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➤ **Topic: Hemangiomas**

**Discussion:** There was minimal discussion for this topic.

**Recommended Actions:**

- 1) Remove 228.04 (Hemangioma of intra-abdominal structures) from line 130 BENIGN NEOPLASM OF THE BRAIN AND SPINAL CORD and add to line 647 BENIGN NEOPLASMS OF DIGESTIVE SYSTEM
- 2) Modify GN13 as shown in appendix A

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

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➤ **Topic: Stereotactic Body Radiation Therapy (SBRT)**

**Discussion:** Livingston introduced a summary document. The subcommittee felt the option to add SBRT to the lung cancer line alone with a guideline was the preferred strategy. There was discussion about whether to include “peripheral lesions” in the guideline. It was felt that it would be beyond the ability of OHP medical directors to determine what lesions were peripheral vs central. This portion of the guideline was struck. There was also discussion about whether wording should be added to the guideline to allow use for patients who refuse surgery. It was felt that “inoperable” should be interpreted to include patients who refuse surgery as well as patients who are not surgical candidates.

**Recommended Actions:**

- 1) Add CPT 32701, 77373, and 77435 (Stereotactic body radiation therapy) to line 266 CANCER OF LUNG, BRONCHUS, PLEURA, TRACHEA, MEDIASTINUM AND OTHER RESPIRATORY ORGANS
- 2) Add a new guideline to line 266 as shown in Appendix B

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

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➤ **Topic: Cochlear implant guidelines**

**Discussion:** Smits introduced the summary document. The subcommittee requested clarification of what various levels of hearing loss represent. Unable to hear sounds below 70db means that a person cannot hear speech. Unable to hear sounds below 90db means that a person effectively has no hearing (profoundly deaf). Hearing aids may not be effective for persons with hearing loss of 70db. The subcommittee requested that HERC staff work with Dr. Warren and/or other community ENTs to determine why 70db is used as a cut-off for cochlear implants in some guidelines/FDA approval and why 90db is used as a cut off for implants in other guidelines, specifically the NICE guideline reviewed at the meeting. Specifically, the subcommittee wanted additional information on why NICE chose 90db as a cut off and whether NICE considered the 70-90 db range in their guideline. Staff was also charged with finding other evidence regarding the effectiveness of cochlear implants for persons with hearing thresholds between 70-90db.

There was discussion about why the current guideline differentiates between pre- and post-lingual adults. Livingston indicated that the ICD-10 ENT group reviewed the cochlear implant guideline and specifically made changes to differentiate pre- and postlingual adults. HERC staff will review these meeting notes to determine the rationale, and will discuss this with Dr. Warren and/or other community ENTs.

**Recommended Actions:**

- 1) HERC staff will review ICD-10 ENT meeting notes, confer with Dr. Warren and other experts, and look for evidence for use of cochlear implants between 70-90 db and will bring this topic back to a future VbBS meeting
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➤ **Topic: Retained tympanostomy tube guideline**

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

**Recommended Actions:**

- 1) Remove CPT 69424 (Ventilating tube removal requiring general anesthesia) from all current lines (lines 174, 290, 317, 379, 394 and 481).
- 2) Add CPT 69424 to Line 427 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
- 3) Remove ICD-9 385.83 (RETAINED FOREIGN BODY OF MIDDLE EAR) from line 379 CHOLESTEATOMA; INFECTIONS OF THE PINNA and add to Line 427
- 4) Add ICD-10 H74.8xX (Other specified disorders of middle ear and mastoid) to Line 427
- 5) Delete Guideline Note 76 RETAINED TYMPANOSTOMY TUBES
- 6) Modify Guideline Notes 29 and 51 as shown in Appendix A

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

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➤ **Topic: Intraocular steroid implants**

**Discussion:** Smits introduced the summary materials. Ms. Campbell and Ms. Stephens from Allergan gave testimony regarding their concerns with no coverage of the CPT code for intraocular injections for use with any medication (i.e. anti-VEGF). Delaying a change will mean that patients will not receive needed treatments and may suffer further vision damage. However, the subcommittee members felt that this topic should be dealt with in the context of reviewing intraocular steroids for diabetic macular edema, which is scheduled for the March VBBS meeting. Staff indicated that any changes made prior to August will go into effect October 1, 2015. Several suggestions were made to the proposed guideline, including adding “injections” as well as implants, as some steroid medications are delivered by injection.

The subcommittee decided that the injection/implant CPT codes should be added to line 100 instead as an errata to allow non-steroidal medications to be used immediately. It is the intent of the VbBS to not cover steroid medications for

conditions on line 100, but no formal guideline was adopted at this meeting. Staff will further research the use of steroids for diabetic macular edema and bring back revised recommendations and a revised guideline regarding intraocular steroids for the next VBBS meeting.

**Recommended Actions:**

- 1) Add CPT 67027 (Implantation of intravitreal drug delivery system) and 67028 (Intravitreal injection of a pharmacologic agent) to line 100 DIABETIC AND OTHER RETINOPATHY as an errata effective January 1, 2015
- 2) It is the intent of the VbBS that these codes not be used for steroidal medications until further review
- 1) HERC staff will further research intraocular steroids for diabetic eye conditions and bring back recommendations and a revised guideline note (if applicable) to the next VbBS meeting

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

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➤ **Topic: Wearable cardiac defibrillators**

**Discussion:** Smits introduced the summary document on wearable cardiac defibrillators (WCDs). The subcommittee felt that the guideline that seemed to best fit the evidence was the 2<sup>nd</sup> option in the summary. They clarified the last sentence by removing reference to “other situations in which ICDs are not indicated.”

**Recommended Actions:**

- 1) Add CPT 93745 (Initial set-up and programming by a physician or other qualified health care professional of wearable cardioverter-defibrillator includes initial programming of system, establishing baseline electronic ECG, transmission of data to data repository, patient instruction in wearing system and patient reporting of problems or events) and HCPCS K0606-K0609 (DME items for wearable cardioverter-defibrillator) to the following lines with implantable cardiac defibrillators:
  - a. 73 ACUTE AND SUBACUTE ISCHEMIC HEART DISEASE, MYOCARDIAL INFARCTION
  - b. 103 CARDIOMYOPATHY, HYPERTROPHIC MUSCLE
  - c. 115 CONGENITAL HEART BLOCK; OTHER OBSTRUCTIVE ANOMALIES OF HEART
  - d. 193 CHRONIC ISCHEMIC HEART DISEASE
  - e. 286 LIFE-THREATENING CARDIAC ARRHYTHMIAS
  - f. 350 CARDIAC ARRHYTHMIAS
- 2) Advise DMAP to remove CPT 93745 and HCPCS K0606-K0609 from the Ancillary File

- 3) Adopt a new guideline regarding wearable cardiac defibrillators as shown in Appendix B

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

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➤ **Topic: Coverage Guidance—Percutaneous interventions for cervical spine pain**

**Discussion:** Smits introduced the summary document, and reviewed the history of discussion on this topic at VbBS and HERC. Shaffer discussed the HTAS deliberations on this coverage guidance. He noted that HTAS decided to recommend coverage of cervical epidural steroid injections based on one RCT which showed benefit versus intramuscular injection. Shaffer acknowledged that the literature did find evidence of short term harm for epidural steroid injections and no long term benefit (all benefits seen were short term). One paper reviewed found lower surgery rates in patients receiving epidural steroid injections. Expert testimony from Dr. David Sibell was also found to be convincing, as was additional literature that Dr. Sibell supplied to HTAS. The HTAS decision to support epidural steroid injections was based on the short term benefits seen compared to intramuscular injections and reduced surgery rates. HTAS also looked at other guidelines, including WA HTA and Medicare guidelines, and come up with restrictive criteria for coverage.

Gibson felt that basing the majority of the HTAS decision on one retrospective cohort study was not acceptable. Hodges expressed concern about how the evidence for cervical epidural steroid injections compared to the evidence for other treatments under consideration for coverage in the back pain line review. Livingston noted that based on her brief review, PT, CMT and several other modalities under consideration had at least moderate quality and strength of evidence to support them.

The subcommittee was in agreement on not covering facet joint injections or medial branch blocks for the cervical spine. The other modalities under consideration (radiofrequency neurotomy and epidural steroid injection) should be considered as part of the back pain line restructuring effort. HERC staff was directed to make a summary of the level of evidence supporting various treatments for back pain, such as PT, CBT, CMT, etc. and bring this summary back to the next meeting for consideration as part of the back pain line restructuring effort.

**Recommended Actions:**

- 1) Add 63210 (Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement,

- includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic) to the Non-Covered Table
- 2) Advise DMAP to remove 63210 from the Ancillary List
  - 3) Keep 64490-64492 (Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (flouro or CT), cervical) and 64633 and 64634 (Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single or additional facet joints) on the Non-Covered List
  - 4) Add an entry to the new Non-Covered Table for CPT 63210, 64633-64634, 64479-64480, 64490-64495

**MOTION: To approve the recommended changes to the Prioritized List as presented based on the draft August 2014 coverage guidance scheduled for review by HERC at their January 1, 2015 meeting. FAILED 4-1 (Nay: Pollack; Abstained (3): Croswell, Ocker, Williams) [Note: HERC bylaws state that motions must pass with a majority of votes of members present; therefore, this motion failed]**

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➤ **Topic: Coverage Guidance—Advanced imaging for staging of prostate cancer**

**Discussion:** Smits introduced the summary document. The subcommittee agreed with the recommendation to not add prostate cancer as an indication for PET imaging. The subcommittee added a definition of low risk prostate cancer, based on Table 1 from the coverage guidance. There was some concern about the low level of evidence supporting the use of some of the imaging modalities. However, it was noted that coverage for these imaging modalities was already part of the Prioritized List and therefore evidence of lack of effectiveness or harm was required to remove coverage.

**Recommended Actions:**

- 1) Do not add PET imaging to line 333 CANCER OF PROSTATE GLAND.
- 2) Adopt a new diagnostic guideline regarding imaging for staging of prostate cancer as shown in Appendix B

**MOTION: To approve the recommended changes to the Prioritized List as amended based on the draft November 2014 coverage guidance scheduled for review by HERC at their January, 2105 meeting. CARRIES 8-0.**

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➤ **Public Comment:**

No additional public comment was received.

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➤ **Issues for next meeting:**

- Intraocular steroids for diabetic macular edema
- Tobacco cessation coverage guideline
- Prenatal testing guideline
- Incentivizing wellness
- PPIs for treatment of GERD
- Craniofacial anomaly codes and OSA tx failure
- Benign joint conditions
- Unilateral hearing loss
  - BAHA hearing aid guideline
- Intraocular steroids for diabetic macular edema
- Cochlear implant guidelines
- Back pain line reorganization

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➤ **Next meeting:**

March 12, 2015 at Clackamas Community College, Wilsonville Training Center,  
Wilsonville Oregon, Rooms 111-112.

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➤ **Adjournment:**

The meeting adjourned at 1:25 PM.

## Appendix A

### Revised Guideline Notes

#### **GUIDELINE NOTE 5, OBESITY AND OVERWEIGHT**

*Line 325*

Medical treatment of [overweight \(with known cardiovascular risk factors\) and obesity](#) is limited to accepted intensive counseling on nutrition and ~~exercise~~[physical activity](#), provided by health care professionals. Intensive counseling is defined as face to face contact more than monthly. Visits are not to exceed more than once per week. Intensive counseling visits (once every 1-2 weeks) are covered for 6 months. Intensive counseling visits may continue for longer than 6 months as long as there is evidence of continued weight loss [or improvement in cardiovascular risk factors based on the intervention](#). Maintenance visits are covered no more than monthly after this intensive counseling period.

[Known cardiovascular risk factors in overweight persons for which this therapy is effective include: hypertension, dyslipidemia, impaired fasting glucose, or the metabolic syndrome.](#)

Pharmacological treatments are not intended to be included as services on this line.

#### **GUIDELINE NOTE 13, HEMANGIOMAS, COMPLICATED**

*Lines 326, [636](#)*

[Dermatologic H](#)emangiomas ([ICD-9 228.01](#)) are ~~covered~~ [included](#) on ~~this~~ line [326](#) when they are ulcerated, infected, recurrently hemorrhaging, or function-threatening (e.g. eyelid hemangioma). [Otherwise, they are included on line 636.](#)

#### **GUIDELINE NOTE 29, TYMPANOSTOMY TUBES IN ACUTE OTITIS MEDIA**

*Line 394*

Tympanostomy tubes (69436) are only included on this line as treatment for 1) recurrent acute otitis media (three or more episodes in six months or four or more episodes in one year) that fail appropriate medical management, 2) for patients who fail medical treatment secondary to multiple drug allergies or who fail two or more consecutive courses of antibiotics, or 3) complicating conditions (immunocompromised host, meningitis by lumbar puncture, acute mastoiditis, sigmoid sinus/jugular vein thrombosis by CT/MRI/MRA, cranial nerve paralysis, sudden onset dizziness/vertigo, need for middle ear culture, labyrinthitis, or brain abscess). Patients with craniofacial anomalies, Down's syndrome, cleft palate, and patients with speech and language delay may be considered for tympanostomy if unresponsive to appropriate medical treatment or having recurring infections (without needing to meet the strict "recurrent" definition above).

## Appendix A

Removal of retained tympanostomy tubes requiring anesthesia (CPT code 69424) or as an office visit, is included on line 427 as a complication, pairing with 385.83/ H74.8xX.

### **GUIDELINE NOTE 36, ADENOTONSILLECTOMY FOR INDICATIONS OTHER THAN OBSTRUCTIVE SLEEP APNEA**

*Lines 49,84,395,574*

Tonsillectomy/adenotonsillectomy is an appropriate treatment for patients with:

- A) Five documented attacks of strep tonsillitis in a year or 3 documented attacks of strep tonsillitis in each of two consecutive years where an attack is considered a positive culture/screen and where an appropriate course of antibiotic therapy has been completed;
- B) Peritonsillar abscess requiring surgical drainage; or,
- C) Unilateral tonsillar hypertrophy in adults; unilateral tonsillar hypertrophy in children with other symptoms suggestive of malignancy.

See Guideline Note 118 for diagnosis and treatment of obstructive sleep apnea in children.

ICD-9 474.10 and 474.11/ICD-10 J35.1 and J35.3 are included on line 395 only for 1) unilateral tonsillar hypertrophy in adults and 2) unilateral tonsillar hypertrophy in children with other symptoms suggestive of malignancy. Bilateral tonsillar hypertrophy and unilateral tonsillar hypertrophy in children without other symptoms suggestive of malignancy are included only on line 574.

### **GUIDELINE NOTE 51, CHRONIC OTITIS MEDIA WITH EFFUSION**

*Line 481*

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

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

## Appendix A

For the child who has had chronic OME and who has a hearing deficiency in the better-hearing ear of 25 dB or greater, myringotomy with tube insertion is recommended after a total of 4 to 6 months of effusion with a documented hearing deficit.

Adenoidectomy is not indicated at the time of first pressure equalization tube insertion. It may be indicated in children over 3 years who are having their second set of tubes.

Tube insertion should be covered for patients with craniofacial anomalies, Down's syndrome, cleft palate and patients with speech and language delay along with co-morbid hearing loss.

Removal of retained tympanostomy tubes requiring anesthesia (CPT code 69424) or as an office visit, is included on line 427 as a complication, pairing with 385.83/ H74.8xX.

### **~~GUIDELINE NOTE 76, RETAINED TYMPANOSTOMY TUBES~~**

~~—Lines 174,290,379,394,481~~

~~Removal of retained tympanostomy tubes under anesthesia, if indicated (CPT code 69424 Ventilating tube removal requiring general anesthesia) or as part of an office visit, are intended to be covered for Line 481 diagnoses with the Line 379 ICD-9 code 385.83 Retained foreign body of middle ear.~~

### **GUIDELINE NOTE 106, PREVENTIVE SERVICES**

*Line 3*

Included on this line are the following preventive services:

1. US Preventive Services Task Force (USPSTF) “A” and “B” Recommendations (as of May 2012):  
<http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>
2. American Academy of Pediatrics (AAP) Bright Futures Guidelines (published 2008):  
~~[http://brightfutures.aap.org/pdfs/Guidelines\\_PDF/20-Appendices\\_PeriodicitySchedule.pdf](http://brightfutures.aap.org/pdfs/Guidelines_PDF/20-Appendices_PeriodicitySchedule.pdf)~~  
[http://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule\\_FINAL.pdf](http://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf)
3. Health Resources and Services Administration (HRSA) Women's Preventive Services - Required Health Plan Coverage Guidelines: (approved with Affordable Care Act on March 23, 2010)  
<http://www.hrsa.gov/womensguidelines/>
4. Immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP) ~~and approved for the Oregon Immunization Program:~~  
~~<http://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/ImmunizationProviderResources/Documents/DMA Pvactable.pdf>~~  
<http://www.cdc.gov/vaccines/schedules/hcp/index.html>

## Appendix B

### New Guideline Notes

#### GUIDELINE XXX LIVER ELASTOGRAPHY

*Line 202*

Liver elastography (CPT 91200) is included on this line only when the non-invasive test would replace liver biopsy for determination of eligibility for medications for chronic hepatitis C. Performance of liver elastography more than twice per year or within six months following a liver biopsy is not included on this line.

#### GUIDELINE NOTE XXX STEREOTACTIC BODY RADIATION THERAPY

*Line 266*

Stereotactic body radiation therapy (CPT 32701, 77373, 77435) is included on Line 266 only for early stage non-small cell lung cancer in medically inoperable patients.

#### GUIDELINE NOTE XXX WEARABLE CARDIAC DEFIBRILLATORS

*Lines 73,103,115,193,286,350*

Wearable cardiac defibrillators (WCDs; CPT 93745, HCPCS E0617, K0606-K0609) are included on these lines for patients at high risk for sudden cardiac death who meet the medical necessity criteria for an implantable cardioverter defibrillator (ICD) but are unable to have an ICD implanted due to medical condition (e.g. ICD explanted due to infection with waiting period before ICD reinsertion or current medical condition contraindicates surgery). WCDs are not included on these lines for use during the waiting period for ICD implantation after myocardial infarction, coronary bypass surgery, or coronary artery stenting.

#### DIAGNOSTIC GUIDELINE DXX, ADVANCED IMAGING FOR STAGING OF PROSTATE CANCER

MRI is covered for men with histologically proven prostate cancer if knowledge of the T or N stage could affect management. CT of the pelvis is covered only when MRI is contraindicated. Radionuclide bone scanning is not covered in men with low risk localized prostate cancer. Low risk is defined as PSA <10 ng/ml and Gleason score ≤6 and clinical stage T1-T2a.