PRIORITIZATION OF HEALTH SERVICES

A Report to the Governor and the 78th Oregon Legislative Assembly

Health Evidence Review Commission
Office of the Chief Medical Officer
Oregon Health Authority
2015

Oregon Health Authority

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Executive Summary

The 2016-17 Prioritized List of Health Services (see Appendix B) shows the final line rankings as approved by the HERC when it completed the biennial review of the list at its May 7, 2015 meeting.

Perhaps the most significant change for this biennium is the reorganization of the lines related to conditions of the spine. In 2015, the HERC approved the recommendations of a multidisciplinary task force to restructure these lines in order to improve evidence-based treatment for these conditions while reducing the amount of ineffective and potentially harmful care patients receive. The task force recommendations are aligned with several HERC coverage guidances on these topics.

Practice guidelines continue to be an increasingly important mechanism in striving to use the state's limited resources in the most effective manner. Forty-four new guidelines were developed over the past two years, eight guidelines were deleted and 55 previously existing guidelines were modified. This includes the development of guidelines in the areas of ancillary and diagnostic services as well as incorporating the recommendations of 37 coverage guidances developed by the HERC, which involve a more in-depth look at the evidence of effectiveness for certain services.

In the process of maintaining the Prioritized List over the last two years, the HERC produced four sets of interim modifications that were forwarded to the President of the Senate and Speakers of the House. None of the interim modifications made from October, 2013 through January, 2015 were determined by the Oregon Health Authority's Actuarial Services Unit to have a significant fiscal impact requiring presentation to the Oregon Legislative Emergency Board.

The Health Evidence Review Commission appreciates the opportunity to continue its work on healthcare prioritization in order to provide the most beneficial, cost-effective services to Oregon's Medicaid population.

CHAPTER ONE:

PRIORITIZATION OF HEALTH SERVICES FOR 2016-17

Charge to the Health Evidence Review Commission

HB 2100 (2011) created the Health Evidence Review Commission (HERC), combining two previously existing commissions, the Health Services Commission (HSC) and Health Resources Commission (HRC). HERC continues two decades of work, as both of the original commissions began their work in the early 1990's at the start of the Oregon Health Plan.

The Health Evidence Review Commission was established, in part, to:

> *"[D]evelop and maintain a list of health services ranked by priority, from the most important to the least important, representing the comparative benefits of each service to the population to be served. The commission shall report the prioritized list of services to the Oregon Health Authority for budget determinations by July 1 of each even-numbered year."*[1]

The Commission is composed of thirteen members. There are five physicians, including one Doctor of Osteopathy and one hospital-based physician, two consumer representatives, a public health nurse, a behavioral health representative, a dentist, a complimentary or alternative medicine provider, a pharmacy representative and a health insurance representative. The Commission relies heavily on the input from its subcommittees and ad hoc advisory panels. The HERC's Value-based Benefits Subcommittee (VbBS) reviews all potential changes to the Prioritized List and is comprised of both Commission members and other provider and stakeholder representatives.[2] The Oral Health Advisory Panel provided recommendations on the placement of new dental procedure codes. In addition, the Behavioral Health Advisory Panel provided recommendations on new behavioral health codes as well as adapting the Prioritized List to work with the updated diagnostic criteria per the new Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), which was published in 2013.

The Commission's Prioritized List of Health Services is made up of condition-treatment pairs composed of diagnosis and treatment codes used to define the services being represented. The conditions on the list are represented by two sets of codes, the coding nomenclature of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) as well as the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). The two sets of codes are necessary because Congress delayed implementation of the ICD-10-CM codeset, so staff was required to convert the Prioritized List back to ICD-9-CM. The ICD-10-CM codeset is currently scheduled to be implemented October 1, 2015. The Prioritized List will continue to use both diagnostic codesets until implementation is complete. Medical treatments are listed using codes from the American Medical Association's Current

[1] Oregon Revised Statutes (ORS) 414.690(3) and 414.690(5).
[2] A list of the Commission and VbBS membership can be found in Appendix A.

Procedural Terminology (CPT), the American Dental Association's Current Dental Terminology (CDT) and the Healthcare Common Procedure Coding System (HCPCS).

Appropriate diagnostic services are covered under OHP whether or not the final diagnosis appears in the funded region. Only after the diagnosis has been established is the list used to determine whether further treatments are covered under the plan. Therefore, diagnosis codes representing signs and symptoms and procedures codes for diagnostic procedures are not included on the List.

Also, procedure codes representing appropriate ancillary services such as prescription drugs, durable medical equipment or services such as the removal of sutures are intended to be covered if the condition which they are being used to treat lies in the funded region. Because of the volume of codes that represent ancillary services, and the fact that they are often associated with many different diagnoses, these codes do not appear on the list. In some cases the Commission has created guideline notes for specific ancillary and diagnostic services to clarify its evidence-informed intent for coverage of these services.

In addition, other procedure codes represent services not added to the List because they are not appropriate for coverage. These include codes for experimental treatments or cosmetic services. Diagnosis codes that are non-specific or do not identify a health condition or disease process are also not included on the Prioritized List.

Medical Assistance Programs (MAP) maintains electronic files to account for codes not appearing on the list and to ensure appropriate fee-for-service reimbursement. OHP providers and contracted coordinated care organizations (CCOs) have web-based access to the information in these electronic files through the Medicaid Management Information System (MMIS) so that service coverage is as uniform as possible under OHP.

The Prioritization Methodology

The prioritization methodology first defines a rank ordered list of nine broad categories of health care to establish a basic framework for the list (see Figure 1.1). Next the methodology calls for each of the line items on the Prioritized List to be assigned to one of these health care categories. Once the line items have been assigned to one of the nine categories, a list of criteria is used to sort the line items within the categories (see Figure 1.2). These measures are felt to best capture the impacts on both the individual's health and the population health that the Commission believes is essential in determining the relative importance of a condition-treatment pair.

Since not every service in Category 1 is more important than every service in Category 2 and so on, a weight is applied to each category that is then multiplied by the total criteria score for each condition-treatment pair. The category weights are shown in

FIGURE 1.1
RANK ORDER OF HEALTH CARE CATEGORIES

1) **Maternity & Newborn Care** (100) - Obstetrical care for pregnancy. *Prenatal care; delivery services; postpartum care; newborn care for conditions intrinsic to the pregnancy.*

2) **Primary Prevention and Secondary Prevention** (95) - Effective preventive services used prior to the presence of disease and screenings for the detection of diseases at an early stage. *Immunizations; fluoride treatment in children; mammograms; pap smears; blood pressure screening; well child visits; routine dental exams.*

3) **Chronic Disease Managemen**t (75) - Predominant role of treatment in the presence of an established disease is to prevent an exacerbation or a secondary illness. *Medical therapy for diabetes mellitus, asthma, and hypertension; medical/psychotherapy for schizophrenia.*

4) **Reproductive Services** (70) - Excludes maternity and infertility services. *Contraceptive management; vasectomy; tubal occlusion; tubal ligation.*

5) **Comfort Care** (65) - Palliative therapy for conditions in which death is imminent. *Hospice care; pain management.*

6) **Fatal Conditions, Where Treatment is Aimed at Disease Modification or Cure** (40) - *Appendectomy for appendicitis; medical & surgical treatment for treatable cancers; dialysis for end-stage renal disease; medical therapy for stroke; medical/psychotherapy for single episode major depression.*

7) **Nonfatal Conditions, Where Treatment is Aimed at Disease Modification or Cure** (20) - *Treatment of closed fractures; medical/psychotherapy for obsessive-compulsive disorders; medical therapy for chronic sinusitis.*

8) **Self-limiting Conditions** (5) - Treatment expedites recovery for conditions that will resolve on their own whether treated or not. *Medical therapy for diaper rash, acute conjunctivitis and acute pharyngitis.*

9) **Inconsequential Care (**1) - Services that have little or no impact on health status due to the nature of the condition or the ineffectiveness of the treatment. *Repair fingertip avulsion that does not include fingernail; medical therapy for gallstones without cholecystitis, medical therapy for viral warts.*

FIGURE 1.2
POPULATION AND INDIVIDUAL IMPACT MEASURES

Impact on Healthy Life - What is the magnitude of the benefit to the patient from the treatment as compared to no treatment for the condition, after factoring in harms associated with the treatment. *Range of 0 (no impact) to 10 (high impact).*

Impact on Suffering - To what degree does the condition result in pain and suffering? Effect on family members (e.g. dealing with a loved one with Alzheimer's disease or needing to care for a person with a life-long disability) is also factored in here. *Range of 0 (no impact) to 5 (high impact).*

Population Effects - The degree to which individuals other than the person with the illness will be affected. Examples include public health concerns due to the spread of untreated tuberculosis or public safety concerns resulting from untreated severe mental illness. *Range of 0 (no effects) to 5 (widespread effects).*

Vulnerability of Population Affected - To what degree does the condition affect vulnerable populations such as those of certain racial/ethnic descent or those afflicted by certain debilitating illnesses such as HIV disease or alcohol & drug dependence? *Range of 0 (no vulnerability) to 5 (high vulnerability).*

Tertiary Prevention - In considering the ranking of services within categories 6 and 7, to what degree does early treatment prevent complications of the disease (not including death)? *Range of 0 (doesn't prevent complications) to 5 (prevents severe complications).*

Effectiveness - To what degree does the treatment achieve its intended purpose? *Range of 0 (no effectiveness) to 5 (high effectiveness).*

Need for Medical Services - The percentage of time in which medical services would be required after the diagnosis has been established. *Percentage from 0 (services never required) to 1 (services always required).*

Net Cost - The cost of treatment for the typical case (including lifetime costs associated with chronic diseases) minus the expected costs if treatment is not provided -- including costs incurred through safety net providers (e.g., emergency departments) for urgent or emergent care related to the injury/illness or resulting complications. *Range of 0 (high net cost) to 5 (cost saving).*

parentheses after the title for each category in Figure 1.1. A total score is then calculated for each line using the following formula to sort all line items, with the lowest net cost used to break any ties:

Category Weight	X	Impact on Healthy Life + Impact on Suffering + Population Effects + Vulnerable of Population Affected + Tertiary Prevention (categories 6 & 7 only)	X	Effectiveness	X	Need for Service

Hand adjustments were applied by the Commission where the application of this methodology did not result in a ranking that reflected the importance of the service, which was the case in fewer than 5% of the line items (compared to over 70% of cases using the previous methodology).

The following example illustrates the score given to a line item as a result of this methodology.

Schizophrenic Disorders
Category 3 Weight: 75
Impact on Healthy Life Years: 8
Impact on Suffering: 4
Effects on Population: 4
Vulnerability of Population Affected: 0
Effectiveness: 3
Need for Service: 1
Net Cost: 5
Total Score: 3600

$75 \times [(8+4+4+0) \times 3 \times 1] = 3600$

Services near the top of the list as a result of this methodology include maternity care and newborn services, preventive services found to be effective by the U.S. Preventive Services Task Force, and treatments for chronic diseases such as diabetes, major depression, asthma, and hypertension, where ongoing maintenance therapy can prevent exacerbations of the disease that lead to avoidable high-intensity service utilization, morbidity, and death.

Biennial Review of the Prioritized List

The Commission conducted its twelfth biennial review of the Prioritized List of Health Services in 2013-15. Figures 1.3 through 1.6 show the line changes made in this biennial review.

- Figure 1.3 shows lines that were previously separate on nine lines of the 2015 Prioritized List but are now merged into four lines. Note there may be some instances where a relatively few diagnosis codes preliminarily mapped to the

original lines may have gone to an additional line or lines than the single merged line indicated here.

- Figure 1.4 shows three lines from the 2015 list that have been split into six lines on the 2016-17 list. Note again, there may have been a few diagnosis codes that preliminarily mapped to the original line that went to additional lines other than those indicated here.
- Figure 1.5 shows how the four lines related to back conditions have been restructured to optimize care.
- Figure 1.6 shows the two lines whose priority ranking was altered during the biennial review.
- Figure 1.7 shows the two deleted lines, for which diagnosis codes were incorporated into other existing lines or removed from the list entirely.

FIGURE 1.3
NEWLY MERGED LINES PREVIOUSLY FOUND ON SEPARATE LINES

16-17 Line	16-17 Line Description	2015 Line	2015 Line Description
331	SENSORINEURAL HEARING LOSS/ COCHLEAR IMPLANT	283	SENSORINEURAL HEARING LOSS - AGE 5 OR UNDER/ COCHLEAR IMPLANT
		423	SENSORINEURAL HEARING LOSS - OVER AGE OF FIVE/ COCHLEAR IMPLANT
337	CONDITIONS REQUIRING HYPERBARIC OXYGEN THERAPY/ HYPERBARIC OXYGEN	336	ANAEROBIC INFECTIONS REQUIRING HYPERBARIC OXYGEN/ HYPERBARIC OXYGEN
		373	TOXIC EFFECT OF GASES, FUMES, AND VAPORS REQUIRING HYPERBARIC OXYGEN/ HYPERBARIC OXYGEN
479	CHRONIC OTITIS MEDIA; OPEN WOUND OF EAR DRUM/ PE TUBES/ADENOIDECTOMY/ TYMPANOPLASTY, MEDICAL THERAPY	436	OPEN WOUND OF EAR DRUM/ TYMPANOPLASTY
		481	CHRONIC OTITIS MEDIA/ PE TUBES/ ADENOIDECTOMY/ TYMPANOPLASTY, MEDICAL THERAPY
		563	OPEN WOUND OF EAR DRUM/ MEDICAL THERAPY
554	SOMATIC SYMPTOMS AND RELATED DISORDERS/ CONSULTATION	462	FACTITIOUS DISORDERS/ CONSULTATION
		497	SOMATIZATION DISORDER, SOMATOFORM PAIN DISORDER, CONVERSION DISORDER/ MEDICAL/PSCYHOTHERAPY

FIGURE 1.4
NEWLY SPLIT LINES PREVIOUSLY FOUND ON A SINGLE LINE

16-17 Line	16-17 Line Description	2015 Line	2015 Line Description
406	BENIGN CONDITIONS OF BONE AND JOINTS AT HIGH RISK FOR COMPLICATIONS/ MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY	533	BENIGN NEOPLASM OF BONE AND ARTICULAR CARTILAGE INCLUDING OSTEOID OSTEOMAS; BENIGN NEOPLASM OF CONNECTIVE AND OTHER SOFT TISSUE/ MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY
562	BENIGN NEOPLASM OF BONE AND ARTICULAR CARTILAGE INCLUDING OSTEOID OSTEOMAS; BENIGN NEOPLASM OF CONNECTIVE AND OTHER SOFT TISSUE/ MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY		
533	FIBROMYALGIA, CHRONIC FATIGUE SYNDROME, AND RELATED DISORDERS/ MEDICAL THERAPY	612	DISORDERS OF SOFT TISSUE/ MEDICAL THERAPY
607	DISORDERS OF SOFT TISSUE/ MEDICAL THERAPY		
664	GASTROINTESTINAL CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY/ EVALUATION	669	GASTROINTESTINAL CONDITIONS AND OTHER MISCELLANEOUS CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY/ EVALUATION
665	MISCELLANEOUS CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY/ EVALUATION		

FIGURE 1.5
MOVED LINES

16-17 Line	16-17 Line Description	2015 Line	2015 Line Description
197	AUTISM SPECTRUM DISORDERS/ MEDICAL THERAPY/ BEHAVIORAL MODIFICATION INCLUDING APPLIED BEHAVIOR ANALYSIS	313	AUTISM SPECTRUM DISORDERS/ MEDICAL THERAPY/ BEHAVIORAL MODIFICATION INCLUDING APPLIED BEHAVIOR ANALYSIS
472	LYMPHEDEMA/ MEDICAL THERAPY, OTHER OPERATION ON LYMPH CHANNEL	579	LYMPHEDEMA/ MEDICAL THERAPY, OTHER OPERATION ON LYMPH CHANNEL

FIGURE 1.6
RESTRUCTURED LINES

16-17 Line	16-17 Line Description	2015 Line	2015 Line Description
351	CONDITIONS OF THE BACK AND SPINE WITH URGENT SURGICAL INDICATIONS/ SURGICAL THERAP	374	DISORDERS OF SPINE WITH NEUROLOGIC IMPAIRMENT/ MEDICAL AND SURGICAL TREATMENT
366	SCOLIOSIS/ MEDICAL AND SURGICAL THERAPY	412	SPINAL DEFORMITY, CLINICALLY SIGNIFICANT/ MEDICAL AND SURGICAL TREATMENT
407	CONDITIONS OF THE BACK AND SPINE/ RISK ASSESSMENT, PHYSICAL MODALITIES, COGNITIVE BEHAVIORAL THERAPY, MEDICAL THERAPY	545	ACUTE AND CHRONIC DISORDERS OF SPINE WITHOUT NEUROLOGIC IMPAIRMENT/ MEDICAL AND SURGICAL TREATMENT
532	CONDITIONS OF THE BACK AND SPINE WITHOUT URGENT SURGICAL INDICATIONS/ SURGICAL THERAPY	588	SPINAL DEFORMITY, NOT CLINICALLY SIGNIFICANT/ ARTHRODESIS; REPAIR; RECONSTRUCTION, MEDICAL THERAPY

FIGURE 1.7
DELETED LINES

2015 Line	2015 Line Description
478	SEXUAL DYSFUNCTION DUE TO SUBSTANCE USE
569	CONDUCTIVE HEARING LOSS/ AUDIANT BONE CONDUCTORS

The state now contracts with Coordinated Care Organizations using a global budget methodology rather than basing payments on per capita costs. Also, as part of the terms and conditions of the 1115c waiver extension granted by the Department of Health and Human Services in July 2012, Oregon is not allowed to move the funding line on the list for the duration of the five-year waiver extension. Therefore, this revised Prioritized List of Health Services was forwarded to the Oregon Health Authority's Actuarial Services Unit for an analysis of the impacts on costs for budgeting purposes, assuming the same relative funding level.

As this biennial review, completed in May, 2015, resulted in a net decrease of three lines, the new list is 665 lines long compared to the length of the 2015 list, which has 669 lines. Changes in line structure occurred both in the funded and non-funded regions of the list, but the prioritization of the line above which the funding level was drawn for the 2015 list did not change (line 475 on the new list equates to line 476 on the 2015 list). It is therefore recommended that, in accordance with the terms and conditions of

the current Medicaid waiver, the Prioritized List of Health Services for calendar years 2016-17 appearing in Appendix B be forwarded to the Centers for Medicare and Medicaid Services (CMS) with funding for lines 1-475.

Due to the Affordable Care Act, OHP has been able to eliminate the former OHP Standard benefit package and expand coverage to non-pregnant adults (known as 'the expansion population'). Per Oregon's State Plan Amendment, the expansion population receives the full OHP Plus benefit package, except that it includes additional limitations on dental services and no coverage for routine eye exams and vision hardware.

An abbreviated version of the list appears in Appendix B with line numbers and line descriptions, but no codes. Once interim modifications to the list are completed in October, 2015 the complete 2016-17 Prioritized List of Health Services will be posted on the Commission's website at www.oregon.gov/OHA/OHPR/pages/HERC/index.aspx.

Interim Modifications to the Prioritized List

In addition to the work on the biennial review of the Prioritized List, the Commission continues to maintain the list as necessary during the interim periods. The 2016-17 Prioritized List incorporates interim modifications previously reported to legislative leadership in conjunction with the prioritized lists published October 1, 2013, April 1, 2014, October 1, 2014 and January 1, 2015. These notices can be found on the Commission's Prioritized List and Archived Lists webpages.

Interim modifications are required largely to account for changes in the medical codesets on which each list is built. The Commission asked for the authority to make additional adjustments to the list during the interim period that was granted in 1991 by the following statute (emphasis added):

> *"The commission may alter the list during the interim only under the following conditions:*
>
> *a) technical changes due to errors and omission; or,*
>
> *b) changes due to advancements in medical technology or new data regarding health outcomes.*
>
> *c) To accommodate changes to clinical practice guidelines; and*
>
> *d) To add statements of intent that clarify the prioritized list.*
>
> *If a service is deleted or added and no new funding is required, the Commission shall report to the Speaker of the House of Representatives and the President of the Senate. However, if a service to be added requires increased funding to avoid discontinuing another service, the Commission must report to the Emergency Board for funding."*[3]

The Commission accepts recommendations for interim modifications from staff, other state agencies, participating health care plans, health care providers, OHP clients and

[3] ORS 414.690(7) and 414.690(8)

other interested entities. The requests are initially forwarded for consideration to the Value-based Benefits Subcommittee, which will often require at least two meetings to first hear the request and then have staff collect the necessary information in order to make a decision. A requesting party can assume it will likely take at least 3-4 months, depending on the completeness of the information initially provided and the timing of the receipt of the request in comparison to the next scheduled Commission meeting. It should also be noted that the Commission's decisions are based on what is best for the entire OHP population, not any one individual case.

In 2014 the Commission updated its process as shown in Figure 1.8 for determining when evidence is compelling enough to consider placing a new service on the Prioritized List or reviewing the placement of a service already on the list. Figure 1.9 provides an algorithm describing HERC's process for incorporating both clinical effectiveness and cost-effectiveness when evidence warrants a change to the list. Finally, Figure 1.10 describes in which instances a change will involve revising line rankings according to the prioritization methodology as part of the biennial review process described at the beginning of this chapter as opposed to when the change can be done during the interim period between biennial reviews.

As the Prioritized List attempts to match some 18,000 ICD-9-CM and 70,000 ICD-10-CM diagnosis codes with 8,000+ CPT treatment codes, the Commission is aware that some appropriate condition-treatment groupings may have been left off the list inadvertently. This is particularly anticipated to be the case after ICD-10-CM is officially implemented. As these pairings are identified through MAP's claims processing system, providers, or CCOs, the necessary changes are made to the list as interim modifications.

FIGURE 1.8
CRITERIA FOR PRIORITIZED LIST TOPIC SELECTION

The Health Evidence Review Commission will consider health services topics when evidence is presented to indicate that current condition-treatment pairings may be inappropriately ranked on the Prioritized List or that other aspects of the List require updating.

Examples:

- A new treatment is available, with acceptable evidence of its clinical effectiveness and/or cost-effectiveness. (When acceptable evidence is unavailable, the Commission may consider lower-quality evidence or expert opinion.)
- A change in community standard of care requires changes to the Prioritized List, and the change is supported by high-quality systematic reviews and/or evidence based guidelines

Topic review does not guarantee a change in the Prioritized List. In general, the Commission does not eliminate covered condition-treatment pairs or remove coverage restrictions currently in place unless there is sufficiently strong evidence to support changing current policy.

FIGURE 1.9
PROCESS FOR INCORPORATING INFORMATION ON CLINCAL INFORMATION AND COST-EFFECTIVENESS INTO THE PRIORITIZED LIST

HERC will review evidence as outlined in Figure 1.9. Evidence regarding the effectiveness of a treatment will be used according to the following algorithm:

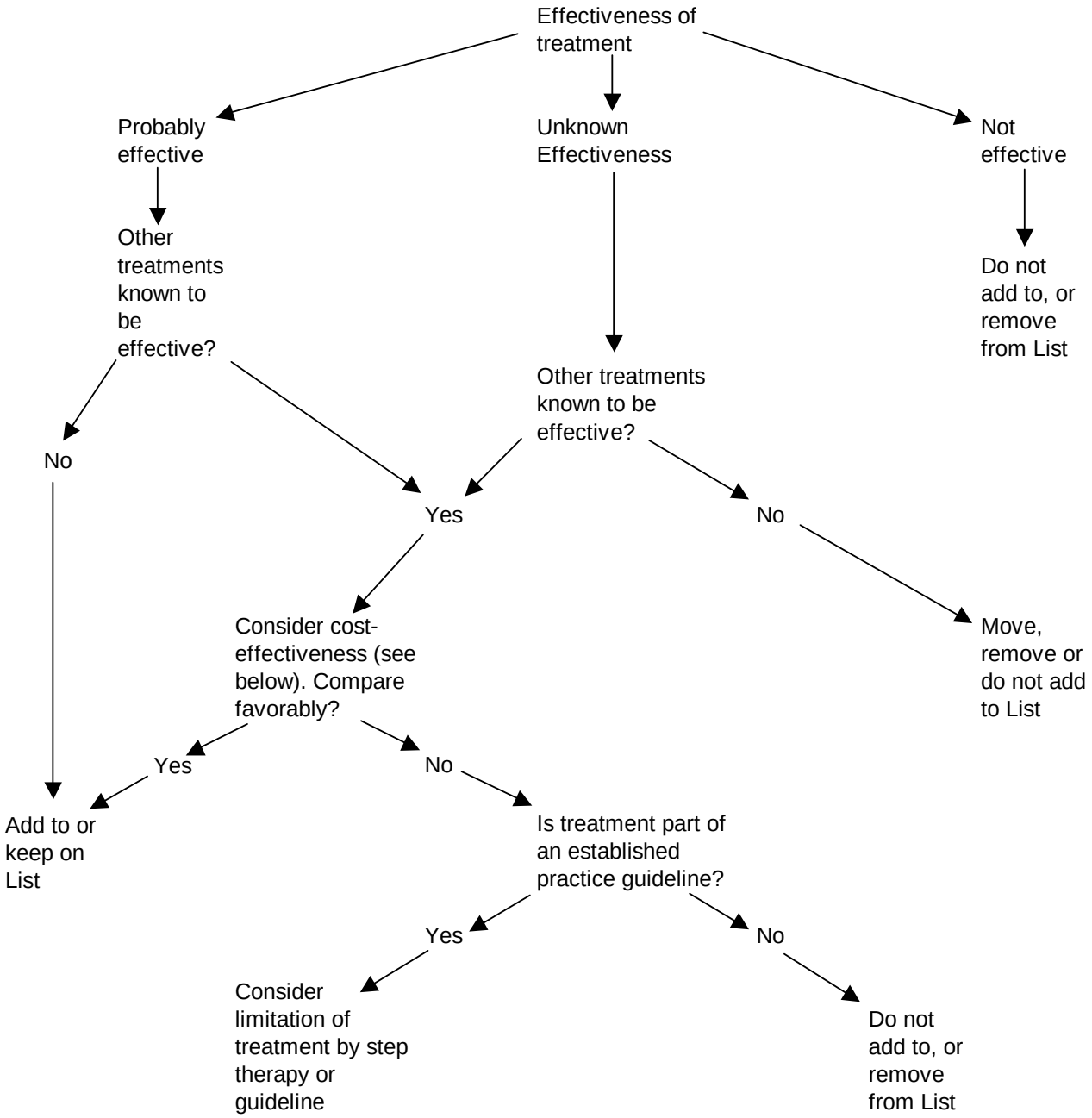


FIGURE 1.9 (CONT'D)
PROCESS FOR INCORPORATING INFORMATION ON CLINCAL INFORMATION AND COST-EFFECTIVENESS INTO THE PRIORITIZED LIST

The cost of a technology will be considered according to the grading scale below, with "A" representing compelling evidence for adoption, "B" representing strong evidence for adoption, "C" representing moderate evidence for adoption, "D" representing weak evidence for adoption and "E" being compelling evidence for rejection:

- A = more effective and cheaper than existing technology
- B = more effective and costs < $25,000/LYS or QALY > existing technology
- C = more effective and costs $25,000 to $125,000/LYS or QALY > existing technology
- D = more effective and costs > $125,000/LYS or QALY > existing technology
- E = less or equally as effective and more costly than existing technology

FIGURE 1.10
OVERVIEW OF THE HEALTH EVIDENCE REVIEW COMMISSION'S PRIORITIZATION PROCESS

Placement of a New ICD-10-CM Code

In most cases a new ICD-10-CM code will simply be a higher specificity for an existing code and will be placed on the list where its parent code already exists. In cases where the diagnosis code represents a new disease or where the code of higher specificity does not belong on the line where the existing code is placed, the code is placed on the most appropriate line according to the methodology shown in Figures 1.1 and 1.2. This will be done as an interim modification effective October 1.

Placement of a New CPT Code

Use the criteria described in Figure 1.9 to determine whether the use of the procedure is experimental and, if not, whether evidence warrants its placement on the line in which the diagnosis code for which pairing is desired exists. If evidence does not support placement at this level of priority, use the process described in Figures 1.1 and 1.2 to determine where the pairing should be placed. This will be done as an interim modification effective January 1.

Placement of a Previously Non-paired CPT Code

Use the criteria described in Figure 1.9 to determine whether the use of the procedure is experimental and, if not, whether evidence warrants its placement on the line in which the diagnosis code for which pairing is desired exists. If evidence does not support placement at this level of priority, use the process described in Figures 1.1 and 1.2 to determine where the pairing should be placed. This will be done as an interim modification unless a significant fiscal impact results.

Deletion of an Existing CPT Code

Use the criteria described in Figure 1.9 to determine whether the use of the procedure is experimental or if evidence dictates that the code should be removed from a line or the list in general. This can be done as either an interim modification or, if public or provider input is desired, as a biennial review change.

FIGURE 1.10 (CONT'D)
OVERVIEW OF THE HEALTH EVIDENCE REVIEW COMMISSION'S PRIORITIZATION PROCESS

Movement of an Existing Line Item

This can only be done during the biennial review process. Use the process described in Figures 1.1 and 1.2 to determine new placement.

Movement of an Existing ICD-10-CM/CPT or ICD-9-CM/CPT Code Pairing

This can be done either during the biennial review process or as an interim modification if there is no significant fiscal impact. Use the process described in Figures 1.1 and 1.2 to determine placement.

Creation of a New Guideline

As this is likely to result in a cost savings, a new guideline can usually be created as an interim modification.

Revision of an Existing Guideline

This can likely be done as an interim modification, but a significant change or deletion of the guideline in its entirely could potentially need to be done as a biennial review change.

Technical changes are typically made to the list only twice during a calendar year in conjunction with the publication of the Prioritized List each January and October. Implementation of these technical changes coincides with the release of new ICD-10-CM (October 1st of each year) and CPT, CDT and HCPCS codes (January 1st of each year) in order to assist MAP and the CCOs in being HIPAA compliant. Detailed documentation on all interim modifications to the Prioritized List of Health Services dating back at least three years can be found on the Commission's website.

Advancements in Medical Technology

The Commission periodically receives requests to modify the placement or content of condition-treatment pairs to reflect significant advancements in medical technology. These requests often come from medical providers and commercial developers of emerging technologies, but will be accepted from any source. HERC staff assembles needed background information and arranges to have experts testify before the Value-based Benefits Subcommittee as it prepares a recommendation for the full Commission.

If an added service is projected by the OHA's Actuarial Services Unit to have a significant fiscal impact on the OHP Medicaid Demonstration, the Commission is required to appear before the Legislative Emergency Board to request additional funding. To date, no interim modifications have been found to have such a fiscal impact.

During the 2013-2015 biennium HERC reviewed a number of issues that fall under the medical advancements category, as presented in Figure 1.11. This listing does not include services that already appeared on the Prioritized List and were reviewed to determine whether pairing them with additional indications would be appropriate.

FIGURE 1.11
MEDICAL ADVANCEMENTS REVIEWED

Technology Name/Description	Commission Action
CT angiogram	Not added to list
Coronary artery calcium screening	Not added to list
Kyphoplasty and Sacroplasty	Not added to list
Vertebroplasty	Added to list with guideline
Extracorporeal photophoresis	Added to two lines with a guideline
Applied behavioral analysis for autism spectrum disorder and self-injurious behavior	Added to two lines with two guideline notes
Lp-PLA2 assay	Not added to list
DMD (dystrophin) deletion analysis	Not added to list
Alcohol septal ablation	Added to the cardiomyopathy line with a guideline
Low frequency, non-contact, non-thermal ultrasound for wound assessment	Not added to list
Cell free fetal DNA testing	Added to line 1 PREGNANCY
Surgery for femoroacetabular impingement syndrome	Added to one line with a guideline
Amplified DNA/RNA probe for Trichomonas vaginalis	Added to the Diagnostic File
Mechanical chest wall oscillation	Not added to list
Carotid artery stenting	Added to two lines with a guideline
Mastopexy	Added to the breast cancer line
Oral health risk assessments	Added to three lines with a guideline
Screening for lung cancer	Added to Diagnostic File with a guideline
Cross sex hormone therapy and sex-reassignment surgery	Added to list with a guideline
Electronic tumor treatment fields	Not added to list
Mammography with computer-aided detection (CAD)	Removed from the list
Transurethral prostatic implants	Added to the list
Whole genome testing	Not added to list

FIGURE 1.11 (CONT'D)
MEDICAL ADVANCEMENTS REVIEWED

Technology Name/Description	Commission Action
Cryoablation of bone tumors	Not added to list
Cryoablation of liver tumors	Not added to list
Digital breast tomosynthesis	Not added to list
FTL3 testing	Added to four leukemia lines
PCA3/KLK3 ratio	Not added to list
Breast mRNA gene expression testing	Added to the breast cancer line
Growth stimulation expressed gene 2 testing	Not added to list
Liver elastography	Added to the cirrhosis line with a guideline
Corneal hysteresis determination	Not added to list
Bioimpedance spectroscopy for lymphedema assessment	Not added to list
Carotid intima media thickness testing	Not added to list
Wearable cardiac defibrillators	Added to six cardiac lines with a guideline
Catheter thrombolysis for treatment of pulmonary embolism	Not added to list
Epidural steroid injections for the cervical spine	Not added to list
Facet joint radiofrequency neurotomy	Not added to list
Laser coagulation of the prostate	Removed from the list
Prostatic urethral lifts	Removed from the list
Transurethral microwave thermotherapy	Added to the benign prostatic hypertrophy line
Uterine artery embolization	Added to list
Transurethral radiofrequency thermotherapy	Added to the benign prostatic hypertrophy line

Prioritization of Medications and Other Ancillary Services

Multiple questions have come to Commission in recent years which directly address coverage of particular medications. As discussed in the previous section, HERC considers prescription drugs to be ancillary treatments. Oregon has a process in place to evaluate the evidence on the effectiveness of medications through the reviews of the Pharmacy & Therapeutics (P&T) Committee. Prioritization of drugs on the Prioritized List can be challenging because of several factors, including Federal rebate law, which requires a pathway to coverage for drugs prescribed for FDA approved indications. Additionally, each CCO can create its own formulary based on its relationships with its pharmacy benefit manager. New drugs and new indications for existing drugs are being approved rapidly as drug technology continues to evolve.

After the 2013 Biennial Report was delivered to the legislature the HERC voted not to include a guideline note on therapies with marginal benefit or high cost described in that report. The Commission affirmed that the P&T Committee is a better place to assess the evidence related to particular drugs. Therefore, this guideline note did not appear on the 2013-2015 Prioritized List as originally proposed.

CHAPTER TWO:

CLARIFICATIONS TO THE PRIORITIZED LIST OF HEALTH SERVICES

The Oregon Legislative Assembly allows the Commission discretion as to whether the Prioritized List would benefit from clarifying guidelines or statements of intent:

> *In order to encourage effective and efficient medical evaluation and treatment, the commission:*
>
> *(a) May include clinical practice guidelines in its prioritized list of services. The commission shall actively solicit testimony and information from the medical community and the public to build a consensus on clinical practice guidelines developed by the commission.*
>
> *(b) May include statements of intent in its prioritized list of services. Statements of intent should give direction on coverage decisions where medical codes and clinical practice guidelines cannot convey the intent of the commission.*[4]

The Commission uses practice guidelines to classify the severity of conditions that are not adequately described by an ICD-9-CM or ICD-10-CM diagnosis code alone. For a specific diagnosis there is usually a continuum of treatments: watchful waiting, treating medically, minimally invasive procedures, or the most aggressive procedures. Guidelines define what treatments are most appropriate for all or a subset of those with a condition, also factoring in cost and risks of treatment where necessary. In certain instances, the Commission has also approved guidelines for diagnostic and ancillary services to guide choice of services for procedures that do not otherwise appear on the list.

During the past biennium, the Commission created many new guideline notes, and modified others to assure the most effective use of Oregon Health Plan funds.

Type of change	Biennial Review	Interim Modifications
New guidelines	6	38
Revised guidelines	4	51
Deleted guidelines	3	5

Of the changes to guideline notes listed above, 35 were related to coverage guidances developed by the HERC. No statements of intent were added or modified during the past two years.

Interim Modification Changes to Guideline Notes

Most of the changes to guideline notes made over the last two years were done as interim modifications to the Prioritized List and have already been included in the notification letters sent to legislative leadership. The following are highlights of the more noteworthy changes:

[4] ORS 414.690(4)

- Guideline Note A2, Self-monitoring of Blood Glucose in Diabetes: This new ancillary guideline note is based on a coverage guidance, and supports appropriate use of diabetic test strips and associated supplies in conjunction with structured education and feedback programs. It is based on evidence showing benefit of frequent testing for some patients and a lack of benefit for others.
- Guideline Note D9, MRI for Breast Cancer Diagnosis: This new diagnostic guideline note was based on a coverage guidance and states that a preoperative or contralateral MRI of the breast is not covered for women who have been recently diagnosed with breast cancer based on lack of evidence of benefit.
- Guideline Note D11, MRI of the Spine (Cervical and Thoracic): An older guideline note for MRI of the spine had been replaced in response to a coverage guidance during the previous biennium with one covering low back pain only. This new diagnostic guideline note was written to clarify conditions for coverage of these services for upper back pain.
- Guideline Note D15, Computer-Aided Mammography: This new diagnostic guideline note states that computer-aided mammography is not covered because of evidence showing it did not increase cancer detection rates.
- Guideline Note 12, Treatment of Cancer with Little or No Benefit: Revisions to this guideline note were made to better align with the Affordable Care Act (ACA). The revised guideline restricts coverage of cancer for patients with such severe disease that these potentially toxic treatments are likely to increase suffering without extending life. The revised guideline requires patients and doctors to have shared decision making and that cancer care be provided following evidence-based pathways.
- Guideline Note 43, Lymphedema: The additions to the guideline note define intent to include coverage for compression stockings for lymphedema in the absence of ulcers or other complications. These treatments are a preventive measure to avoid costly complications.
- Guideline Note 108, Continuous Blood Glucose Monitoring: This new guideline note is based on a coverage guidance and defines specific criteria required for the coverage of continuous glucose monitoring for the treatment of type 1 diabetes.

Biennial Review Changes to Guideline Notes

All biennial review-related changes to guideline notes are shown below. In the case where an existing guideline has been revised, all new text is underlined and deleted text

is indicated with strikethrough. In some cases these guideline note changes also reflect changes made as interim modifications since the last biennial report.

The guideline note on advanced imaging for low back pain was modified to define radiculopathy in conjunction with other changes to lines involving conditions of the back.

DIAGNOSTIC GUIDELINE D4, ADVANCED IMAGING FOR LOW BACK PAIN

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

Electromyelography (CPT 96002-4) is not covered for non-specific low back pain.

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

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

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

* Level of evidence for diagnostic evaluation is variable

** Radiculopathic signs are defined for the purposes of this guideline as pain, weakness, or sensory deficits in a nerve root distribution.

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

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

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

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

Two cochlear implant guidelines were combined into one and the hearing threshold defining the qualification for cochlear implant was lowered to 71 dB hearing loss. The criteria involving the lack of the utility of hearing aids was defined further.

GUIDELINE NOTE 31, COCHLEAR IMPLANTATION

Line ~~283~~,331

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

A) Profound sensorineural hearing loss in both ears (defined as 71dB hearing loss or greater at 500, 1000 and 2000 Hz)

~~B) Child has reached the age of 1~~

~~C)~~B) Receive ~~little or no~~limited useful benefit from appropriately fitted hearing aids, defined as a speech discrimination score of <30% on age appropriate testing for children and as scores of 40% or less on sentence recognition test in the best-aided listening condition for adults

~~D)~~C) No medical contraindications

~~E)~~D) High motivation and appropriate expectations (both ~~child~~patient and family, when appropriate~~, and family~~)

Bilateral cochlear implants are included on this line. Simultaneous implantation appears to be more cost-effective than sequential implantation.

A new guideline note was created to define under what circumstances specific back and spinal conditions would benefit from and are included for surgical intervention. It further identifies what specific interventions would not be included.

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

Lines 351,532

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

1) Markedly abnormal reflexes
2) Segmental muscle weakness
3) Segmental sensory loss
4) EMG or NCV evidence of nerve root impingement
5) Cauda equina syndrome
6) Neurogenic bowel or bladder
7) Long tract abnormalities

Spondylolithesis (ICD-9 738.4, 756.11-756.12/ICD-10 M43.1x, Q76.2) is included on Line 351 only when it results in spinal stenosis with signs and symptoms of neurogenic claudication. Otherwise, these diagnoses are included on Line 532.

Surgical correction of spinal stenosis (ICD-9 721.1, 723.0, 724.0x/ICD-10 M48.0x) is only included on Line 351 for patients with:

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

Only decompression surgery is covered for spinal stenosis; spinal fusion procedures are not covered for this diagnosis. Otherwise, these diagnoses are included on Line 532.

For conditions on Line 532, surgical interventions may only be considered after the patient has completed at least 6 months of conservative treatment, provided according to GUIDELINE NOTE 56, NON-INTERVENTIONAL TREATMENTS FOR CONDITIONS OF THE BACK AND SPINE.

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

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

A new guideline was adopted to define when interventions, both surgical and non-surgical, would be included for the treatment of scoliosis.

GUIDELINE NOTE 41, SCOLIOSIS

Line 366

Non-surgical treatments of scoliosis (ICD-9 737.3x,737.43/ICD-10 M41.xx) are included on Line 366 when

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

Surgical treatments of scoliosis are included on Line 366

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

A new comprehensive guideline note integrating both physical and behavioral health services outlining evidence-based, nonsurgical treatments for back and spine conditions includes the treatment of low back pain and was part of the back lines restructuring.

GUIDELINE NOTE 56, NON-INTERVENTIONAL TREATMENTS FOR CONDITIONS OF THE BACK AND SPINE

Line 407

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

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

- Office evaluation and education,
- Up to 4 total visits, consisting of the following treatments: OMT/CMT, acupuncture, and PT/OT. Massage, if available, may be considered.
- First line medications: NSAIDs, acetaminophen, and/or muscle relaxers. Opioids may be considered as a second line treatment, subject to the limitations on coverage of opioids in Guideline Note 60 OPIOID PRESCRIBING FOR CONDITIONS OF THE BACK AND SPINE. See evidence table.

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

- Office evaluation, consultation and education
- Cognitive behavioral therapy. The necessity for cognitive behavioral therapy should be re-evaluated every 90 days and coverage will only be continued if there is documented evidence of decreasing depression or anxiety symptomatology, improved ability to work/function, increased self-efficacy, or other clinically significant, objective improvement.
- Prescription and over the counter medications, opioid medications subject to the limitations on coverage of opioids in Guideline Note 60 OPIOID PRESCRIBING FOR CONDITIONS OF THE BACK AND SPINE. See evidence table.
- The following evidence-based therapies, when available, are encouraged: yoga, massage, supervised exercise therapy, intensive interdisciplinary rehabilitation

- A total of 30 visits per year of any combination of the following evidence-based therapies when available and medically appropriate. These therapies are only covered if provided by a provider licensed to provide the therapy and when there is documentation of measurable clinically significant progress toward the therapy plan of care goals and objectives using evidence based objective tools (e.g. Oswestry, Neck Disability Index, SF-MPQ, and MSPQ).
    1) Rehabilitative therapy (physical and/or occupational therapy), if provided according to Guideline Note 6 REHABILITATIVE THERAPIES. Rehabilitation services provided under this guideline also count towards visit totals in Guideline Note 6
    2) Chiropractic or osteopathic manipulation
    3) Acupuncture

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

A new guideline note was adopted to limit the use of opioids for the treatment of back conditions based on the evidence of harms associated with opioid use and insufficient evidence of effectiveness for the long-term treatment of chronic low back pain.

GUIDELINE NOTE 60, OPIOID PRESCRIBING FOR CONDITIONS OF THE BACK AND SPINE

Lines 351,366,407,532

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

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

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

d) Each prescription must be limited to 7 days of treatment and for short acting opioids only

3) Further opioid treatment after 90 days may be considered ONLY when there is a significant change in status, such as a clinically significant verifiable new injury or surgery. In such cases, use of opioids is limited to a maximum of an additional 7 days. In exceptional cases, use up to 28 days may be covered, subject to the criteria in #2 above.

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

The acupuncture guideline note was modified to reflect the new line structure for back conditions and to refer to the new comprehensive and integrated guideline for treatment of back conditions. A number of interim modifications, including the addition of acupuncture as a treatment for knee arthritis, are also reflected below.

GUIDELINE NOTE 92, ACUPUNCTURE

Lines 1,208,~~374,~~407415,~~467~~543,~~545~~

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

Line 1 PREGNANCY

Acupuncture ~~(97810-97814)~~ pairs on Line 1 for the following conditions and codes.

Hyperemesis gravidarum

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

Breech presentation

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

Back and pelvic pain of pregnancy

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

Line 208 DEPRESSION AND OTHER MOOD DISORDERS, MILD OR MODERATE

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

Line ~~374 DISORDERS OF SPINE WITH NEUROLOGIC IMPAIRMENT~~407 CONDITIONS OF THE BACK AND SPINE

Acupuncture ~~(97810-97814) is included on Line 400 only for pairing with disorders of the spine with myelopathy and/or radiculopathy represented by the diagnosis codes 344.60, 722.1, 722.2, 722.7 and 724.4. Acupuncture for the treatment of these conditions is only covered, when referred, for up to 12 sessions~~is included on this line with visit limitations

as in Guideline Note 56 NON-INTERVENTIONAL TREATMENTS FOR CONDITIONS OF THE BACK AND SPINE.

Line 415 MIGRAINE HEADACHES

Acupuncture pairs on Line 415 for ICD-10-CM code G43.9/ICD-9-CM 346 Migraine, when referred, for up to 12 sessions.

Line 467 OSTEOARTHRITIS AND ALLIED DISORDERS

Acupuncture pairs on Line 467 for osteoarthritis of the knee only, when referred, for up to 12 sessions.

Line 543 TENSION HEADACHES

Acupuncture is included on Line 543 for treatment of tension headaches~~,~~ (ICD-10-CM G44.2x/ICD-9-CM 307.81), when referred, for up to 12 sessions.

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

~~Acupuncture pairs on Line 462 only with the low back diagnoses (344.60, 722.1, 722.2, 722.7, 724.4), when referred, for up to 12 sessions.~~

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

A new guideline note was adopted to specify how fibromyalgia treatment should be provided, though this condition remains below the funding line.

GUIDELINE NOTE 94, FIBROMYALGIA

Line 533

Fibromyalgia (ICD-9 729.1/ICD-10 M79.7) treatment should consist of a multi-modal approach, which should include two of more of the following:

1) medications other than opioids
2) exercise advice/programs
3) cognitive behavioral therapy

Care should be provided in the primary care setting. Referrals to specialists are generally not required. Use of opioids should be avoided due to evidence of harm in this condition.

The guideline note on epidural steroid injections for back pain was modified to specify that only lumbar injections are included and to clarify the symptoms a patient must have to qualify for the injection. Furthermore, the number of injections was limited. The list of procedures not included on these lines was removed from this guideline as it is now included in the new surgical guideline note for the new back condition lines.

GUIDELINE NOTE 105, EPIDURAL STEROID INJECTIONS FOR BACK PAIN

Lines ~~52,400,~~407~~,434,562,607,638~~

Epidural lumbar steroid injections (CPT 62311, 64483, 64484) are ~~covered~~included on these lines for patients with persistent radiculopathy due to herniated lumbar disc, where radiculopathy is ~~as~~ defined ~~in Guideline Note 37 as showing objective evidence of one or more of the following:~~pain, weakness, or sensory deficits in a nerve root distribution.

~~A) Markedly abnormal reflexes~~
~~B) Segmental muscle weakness~~
~~C) Segmental sensory loss~~
~~D) EMG or NCV evidence of nerve root impingement~~

~~E) Cauda equine syndrome~~
~~F) Neurogenic bowel or bladdert~~
~~G) Long tract abnormalitiest~~

One epidural steroid injection is included on this~~ese~~ line~~s~~; a second epidural steroid injection may be provided after 3-6 months only if objective evidence of 3 months of sustained pain relief was provided by the first injection. It is recommended that shared decision-making regarding epidural steroid injection include a specific discussion about inconsistent evidence showing moderate short-term benefits, and lack of long-term benefits. If an epidural steroid injection does not offer benefit, repeated injections should not be covered. Epidural steroid injections are not ~~covered~~included on this~~ese~~ line~~s~~ for spinal stenosis or for patients with low back pain without radiculopathy. Epidural steroid injections are only included on this line when the patient is also participating in an active therapy such as physical therapy or home exercise therapy.
~~The following interventions are not included for low back pain, with or without radiculopathy:~~

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

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

A new guideline clarifies when treatments for the diagnosis codes for benign tumors of the bone and benign conditions of joints are included. These changes reflect the biennial review change which created a new line for benign bone and joint conditions.

GUIDELINE NOTE 137, BENIGN BONE TUMORS

Lines 406,561

Treatment of benign conditions of joints (ICD-9/ICD-10 727.89/M67.8x synovial chondromatosis, ICD-9/ICD-10 228.00/D18.09 synovial hemangioma, ICD-9/ICD-10 214.8/D17.79 lipoma arborescens, ICD-9/ICD-10 727.02/D48.1 tenosynovial giant cell tumor, and ICD-9/ICD-10 719.2x/ M12.2xx villonodular synovitis) are included on Line 406 for those conditions only when there are significant functional problems of the joint due to size, location, or progressiveness of the disease. Treatment of all other benign joint conditions are included on Line 561.

Treatment of benign tumors of bones (ICD-9 213.0-213.9, 526.0-526.2, 733.2x/ICD-10 D16.00-D16.9, K09.0, K09.1, M27.1, M27.40, M27.49, M85.40-M85.69) are included on Line 406 for those neoplasms associated with pathologic fractures, at high risk of fracture, or which cause function problems including impeding joint function due to size, causing nerve compression, have malignant potential or are considered precancerous. Treatment of all other benign bone tumors are included on Line 561.

CHAPTER THREE:

RECOMMENDATIONS

The Health Evidence Review Commission is pleased to offer these recommendations to the Governor and 78th Oregon Legislative Assembly:

1. Adopt the Prioritized List of Health Services for calendar years 2016-17 appearing in Appendix B;

2. Adopt the statements of intent and practice guidelines that have been incorporated into the aforementioned Prioritized List;

3. Use the Prioritized List to delineate services that are not as important as others to determine the benefit packages under the Oregon Health Plan, with a funding level covering lines 1-475, representing the same relative funding level on the 2015 list, in accordance with the terms and conditions of Oregon's current Medicaid Waiver.

The Commission thanks the Governor and Legislature for the opportunity to serve the citizens of Oregon.

APPENDIX A:

COMMISSION AND SUBCOMMITTEE MEMBERSHIP

HEALTH EVIDENCE REVIEW COMMISSION

VALUE-BASED BENEFITS SUBCOMMITTEE

COMMISSION STAFF

Health Evidence Review Commission

Member Profiles

"The Health Evidence Review Commission is established in the Oregon Health Authority, consisting of 13 members appointed by the Governor in consultation with professional and other interested organizations, and confirmed by the Senate, as follows:

a) Five members must be physicians licensed to practice medicine in this state who have clinical expertise in the areas of family medicine, internal medicine, obstetrics, perinatal health, pediatrics, disabilities, geriatrics or general surgery. One of the physicians must be a doctor of osteopathy, and one must be a hospital representative or a physician whose practice is significantly hospital-based.

b) One member must be a dentist licensed under ORS chapter 679 who has clinical expertise in general, pediatric or public health dentistry.

c) One member must be a public health nurse.

d) One member must be a behavioral health representative who may be a social services worker, alcohol and drug treatment provider, psychologist or psychiatrist.

e) Two members must be consumers of health care who are patient advocates or represent the areas of indigent services, labor, business, education or corrections.

f) One member must be a complementary or alternative medicine provider who is a chiropractic physician licensed under ORS chapter 684, a naturopathic physician licensed under ORS chapter 685 or an acupuncturist licensed under ORS chapter 677.

g) One member must be an insurance industry representative who may be a medical director or other administrator.

h) One member must be a pharmacy representative who engages in the practice of pharmacy at a retail drug outlet."

- ORS 414.688

PHYSICIANS

Somnath Saha, MD, MPH, Chair, resides in Portland. He received his Bachelor of Science degree at Stanford University. He attended medical school and trained in internal medicine at the University of California, San Francisco. Dr. Saha completed fellowship training in the Robert Wood Johnson Clinical Scholars Program at the University of Washington in Seattle, where he also obtained a Master's degree in Public Health. He currently practices as a general internist at the Portland VA Medical Center and is a Professor of Medicine and Public Health & Preventive Medicine at Oregon Health & Science University. He is an investigator at the Oregon Evidence-based Practice Center, where he has conducted critical reviews of studies on the clinical and cost-effectiveness of diagnostic and therapeutic technologies. He also has an interest in disparities in health care delivery. His second term expires in 2017.

Gerald Ahmann, MD, resides in Salem. Currently retired, he received his BA, PhD, and MD from Duke University. After receiving his MD in 1974, he spent 2 years in medical residency at the University of Utah. He then moved to the NIH, NCI, Immunology

Branch at Bethesda, MD, where he served as Clinical Associate and then Investigator and completed his oncology fellowship training in 1980. He became an Assistant Professor at the University of Iowa Hospital and Clinics. Finally deciding that an academic career was not where God could best use him, he moved to Oregon in 1982 to the Medford Clinic to practice hematology/oncology. The Medford Clinic dissolved in 2000 and Dr. Ahmann was one of the original founders of Hematology Oncology Associates which has grown from a 4 physician group to a 10 physician group + 3 PAs. In retirement he plans to enjoy his 11 grandchildren. He has always had a strong belief in the importance of cost-effective medicine which is his primary reason in volunteering to serve on HERC. His term expires in 2015.

Wiley Chan, MD, resides in Portland. He received his Bachelor of Science and Doctor of Medicine degrees at the University of Michigan, and trained in Internal Medicine at the University of California, Los Angeles. He is board certified in Internal Medicine. Currently retired, Dr. Chan joined Kaiser Permanente Northwest (KPNW) as a primary care Internist in 1984. He has served as the KPNW Director of Guidelines and Evidence-Based Medicine since 2002, and at Kaiser Permanente's program-wide Care Management Institute, as an evidence-based medicine methodologist and Clinical Lead for the eGuidelines Project. For Kaiser Permanente's National Guideline Program, he has served roles as methodologist, clinical lead, reviewer, and guideline development team member for multiple guidelines. He is a member of the United States National Heart, Lung and Blood Institute (NHLBI) Expert Panel on Integrated Cardiovascular Disease Risk Reduction (coordinating & integrating the NHLBI dyslipidemia [ATP 4], hypertension [JNC 8] and obesity [OEP 2] guidelines) and he co-chairs the NHLBI Implementation Work Group (addressing implementation issues for all those guidelines). He spends about half his time on population-based care and the operationalization of evidence-based care in KPNW’s integrated systems. His second term expires in 2018.

Susan Williams, MD, is a board certified orthopedic surgeon in Roseburg. She is in private practice of general orthopedics and spine surgery. She is on the board of Oregon Association of Orthopedists, and Board of Councilors for the American Academy of Orthopedic Surgeons. Her second expires in 2018.

PHYSICIAN (HOSPITAL BASED)

Lisa Dodson, MD, of Portland, is a Board Certified Family Physician. In addition to being the Director of the Oregon Area Health Education Centers at Oregon Health and Science University, she provides locum tenens physician service to rural communities. Her academic interests include maternity care, chronic pain management and training physicians for rural practice. Prior to returning to OHSU in 1999 she practiced for seven years in the frontier community of John Day, Oregon. She previously served two terms on the Oregon Board of Medical Examiners. Dr. Dodson attended medical school at SUNY Stony Brook, Family Medicine residency at OHSU and faculty development fellowship at University of Washington. Resigned June 2014.

DENTIST

James Tyack, DMD FAGD MAGD, of Rainier, is President and owner of Tyack Dental Group, with clinics in Clatskanie and Astoria, Oregon. He received his Bachelor of Science degree at the University of Oregon and attended Oregon Health Sciences University School of Dentistry, graduating in 1976. Following graduation, Dr. Tyack served in the Indian Health Service in Arizona and entered private practice in 1977. Dr. Tyack is a Fellow and Master of the Academy of General Dentistry and serves as manuscript reviewer for the Academy's publication "General Dentistry." Dr. Tyack has served as adjunct faculty at OHSU School of Dentistry and Dental Director for the Family Health Center and Cowlitz County Health in Longview Washington. Dr. Tyack and his associates are currently providing the majority of dental care for Oregon Health Plan patients in Columbia and Clatsop Counties. Resigned March 2015.

PUBLIC HEALTH NURSE

Leda Garside, RN, MBA, of Lake Oswego, is a bilingual, bicultural Latina registered nurse, and is the Clinical Nurse Manager for the ¡Salud! Program, an outreach program of the Tuality Healthcare Foundation in Hillsboro. Ms. Garside completed her nursing degree at the University of Alaska in Anchorage in 1983. Her 25-year nursing career includes acute care, occupational health services and, in the last 10 years, community and public health. Ms. Garside is very active in many community outreach committees, coalitions and boards. Her career interests are: cultural competencies in health care, health promotion and prevention and facilitating access to health care to all Oregonians. She strongly believes that many things can be accomplished when there is collaboration, cooperation and commitment to better serve the needs of the community, in particular the underserved and at risk populations. Ms. Garside is a member of the National Association of Hispanic Nurses, Oregon Public Health Association, Sigma Theta Tau International Honor Society of Nursing, and the Oregon Latino Health Coalition. Her second term expires in 2016.

BEHAVIORAL HEALTH REPRESENTATIVE

Beth Kaplan Westbrook, PsyD, has practiced clinical psychology in Portland since 1991. Her previous experience was as a Dance Therapist in Washington, D.C. She received a BA from UT Austin (Psychology); an MA in Expressive Therapies (Dance Therapy) from Lesley College, Cambridge, MA and a PsyD from Pacific University (Oregon). She is certified in Child and Adolescent Psychotherapy (Washington School of Psychiatry, Washington DC) and in Group Work Training and Crisis Intervention (St. Elizabeth's Hospital, Washington, DC). Dr. Kaplan Westbrook has broad clinical experience with both inpatients and outpatients including short- and long-term psychiatric hospitals, neurological/medical units, geriatric day treatment and alternative school treatment settings. She has taught graduate level courses at Marylhurst College and Pacific University and has held service and leadership positions with the American Dance Therapy Association, School of Professional Psychology (Pacific University), Oregon Psychological Association and Portland Psychological Association. Dr. Kaplan

Westbrook is interested in promoting the overall health and well-being of all Oregonians. Her second term expires in 2017.

CONSUMER ADVOCATES

Chris Labhart is a Grant County Commissioner and presently chairs the Eastern Oregon Coordinated Care Organization Community Advisory Council. He is a retired educator of 33 years. Appointed in December, 2014, his term expires in 2016.

Mark Gibson is the Director of the Center for Evidence-based Policy at the Oregon Health and Science University, and a program officer for the Milbank Memorial Fund. In these roles he works extensively with policy makers to identify and obtain the research evidence needed to ensure that the right health services are provided to patients whether they are served by public programs or private insurers. In addition, the Center has developed advanced methods for engaging consumers and other stakeholders in policy formulation within health care systems. His term expires in 2015.

ALTERNATIVE & COMPLEMENTARY MEDICINE PROVIDER

Vern Saboe, Jr., DC, DACAN, FICC, DABFP, FACO, of Albany, is a Board Certified Chiropractic Orthopedist. Additionally he is board certified in neurology and forensic science. He previously served the Oregon Board of Chiropractic Examiners (OBCE) subcommittees on patient safety & informed consent and ratings of the scientific evidence. In 1998-2001, he served as Chair of the OBCE's Evidence Review Committee for Experimental Tests, Substances, Devices and Procedures and during these same years served the OBCE's Practice and Utilization Guidelines Consensus Committee. Dr. Saboe is past president of the American College of Chiropractic Orthopedists (2008) and serves as Oregon's Delegate to the American Chiropractic Association's (ACA) House of Delegates. He sits on the ACA's Legislative Commission and Military and Veterans Affairs Committee. He entered private practice in 1981, a practice started by his father in 1956. His term expires in 2015.

INSURANCE INDUSTRY REPRESENTATIVE

Alissa Craft, DO, MBA resided in Corvallis. She attended medical school at the Kirksville College of Osteopathic Medicine and trained in pediatrics at Phoenix Children's Hospital. She completed fellowship training in neonatal perinatal medicine at the University of California, San Diego. Dr. Craft has also completed the Costin Scholar Program in Faculty Development and the American Osteopathic Association Health Policy Fellowship. She currently is Vice Chair and Associate Professor of Pediatrics at the College of Osteopathic Medicine of the Pacific – Northwest. Her research interests include comparative outcomes, improvements in patient safety, and curricular improvements for medical education. Resigned January, 2014.

Holly Jo Hodges, MD of Eugene, is a board certified Family Medicine Physician from Eugene. Dr. Hodges is Medical Director for WVP Health Authority, working with the

Willamette Community Health Coordinated Care Organization, in Salem. She is on the board of directors of Lane County Medical Society. Her more than 20-year career includes 13 years in full-spectrum family medicine in rural Central Oregon, 8 years of working in public health in 2 Oregon Counties and 3 years of urban urgent care experience. Her term expires in 2018.

PHARMACY REPRESENTATIVE

Irene Croswell, RPh, of Tualatin, is pharmacy manager at Haggen Food and Pharmacy in Tualatin. She is Immediate Past President of the Oregon State Pharmacy Association. As Co-Founder of the Greater Oregon Coordinated MEDucation Team, she works with patients and their healthcare providers to help make the most of healthcare dollars through appropriate medication use. After graduating in 1979 with a BS in Pharmacy from University of Louisiana in Monroe, Ms. Croswell has practiced in community and mail-order pharmacy settings. She is adjunct faculty with Pacific University School of Pharmacy and precepts students from four pharmacy schools. As a passionate advocate for community engagement and involvement and collaboration supporting patient-centered care, Ms. Croswell volunteers in her community and is active with several local, state, and national organizations. Her second term expires in 2017.

Value-based Benefits Subcommittee Members

Irene Croswell, RPh
Lisa Dodson, MD (*Resigned June 2014)*
Mark Gibson
Holly Jo Hodges, MD *(Joined June 2014)*
Chris Kirk, MD *(Resigned April 2013)*
Laura Ocker, LAc
Kevin Olson, Chair, MD
David Pollack, MD
James Tyack, DMD *(Resigned March 2015)*
Susan Williams, MD

Commission Staff

DIRECTOR

Darren Coffman began his work for the state with the Health Services Commission soon after its creation in 1989 as a research analyst in a six-month limited duration position. He eventually served in that capacity for three years, playing a key role in the development of the methodology for prioritizing health services. In 1992, Mr. Coffman became the Research Manager for the Commission, took on the additional role of Acting Director in October 1996 and was named Director in April 1997. He became Director of the Health Evidence Review Commission in January 2012, which took over work on the Prioritized List of Health Services as well as health technology assessments previously done by the Health Resources Commission. He received his Bachelor of Science from the University of Oregon in computer science in 1987 and a Master of Science in statistics from Utah State University in 1989. (503-373-1616)

MEDICAL DIRECTOR

Ariel K. Smits, MD, MPH, is a family physician from Portland. She currently sees patients part time at OHSU Gabriel Park Family Health Center in addition to her work as medical director of the Commission. Dr. Smits received a bachelor's degree in Cellular and Molecular Biology from the University of Michigan, a master's of philosophy degree in Clinical Biochemistry from Cambridge University, and her doctorate of medicine from Washington University in St. Louis. She completed both a family medicine and preventive medicine residency at OHSU and subsequently completed a research fellowship at OHSU. (503-373-1647)

ASSOCIATE MEDICAL DIRECTOR

Cat Livingston, MD, MPH, is a family physician from Portland. She sees patients at OHSU Richmond Clinic in addition to serving as the Associate Medical Director for the Health Evidence Review Commission. She received her bachelor's degree from Oberlin College, with majors in neuroscience and women's health. Dr. Livingston completed her medical education at Harvard Medical School, graduating with honors; and then to OHSU to complete both a family medicine and preventive medicine residency, and Masters of Public Health. She is Board certified in both family medicine and public health and preventive medicine.

POLICY ANALYST

Jason Gingerich is a policy analyst with Oregon Health Policy and Research. He has extensive experience in healthcare as a business analyst and project manager in government and private industry. He is a certified Project Management Professional. His experience includes projects related to value-based benefit design, administrative simplification, software enhancements and insurance product implementations. (503-373-1771)

POLICY ANALYST

Denise Taray, RN, is a policy analyst with Oregon Health Policy and Research. She also works as coordinator to the Oregon Pain Management Commission. Denise has extensive experience as a licensed registered nurse with over 25 years of clinical experience from varied specialty areas. (503) 373-1605

WEBMASTER/COMMISSION SPECIALIST

Daphne Peck has over twenty years' experience as a public servant, spending much of that time working in technology, communications and management. She is the commission's webmaster and provides technical and administrative support to the administrators, staff and commission members for the Health Evidence Review Commission. (503-373-1985)

APPENDIX B:

PRIORITIZED HEALTH SERVICES

FREQUENTLY ASKED QUESTIONS:
A USER'S GUIDE TO THE PRIORITIZED LIST

LINE DESCRIPTIONS FOR THE 2016-17
PRIORITIZED LIST OF HEALTH SERVICES

STATEMENT OF INTENT AND GUIDELINE
DESCRIPTIONS FOR THE 2016-17
PRIORITIZED LIST OF HEALTH SERVICES

FREQUENTLY ASKED QUESTIONS:

A USER'S GUIDE TO THE PRIORITIZED LIST

Readers of this document have many questions when they first confront the Prioritized List. A summary of the most frequently asked questions and their answers should familiarize the reader with the format of the list, define important terms, and provide educational examples.

1) **Does the line descriptor contain every diagnosis?** Each line has a description of both a condition and treatment. For some lines there is only one condition, but for others there may be many. The line descriptor contains the most frequent condition or a cluster of conditions represented by the ICD-9-CM and ICD-10-CM codes. For example, cystic fibrosis occurs by itself on line 24, but the codes on line 211, described broadly as Zoonotic Bacterial Diseases, include plague, tularemia, anthrax, brucellosis, cat-scratch disease and other specific diseases.

2) **What do the line numbers represent?** The line numbers represent the rank order of the condition-treatment pairs assigned by the Health Evidence Review Commission. Therefore the services on line item 1 are most important to provide and line item 665 the least important in terms of the benefit to be gained by the population being served.

3) **How is the funding line established?** The 78th Oregon Legislative Assembly will review the Prioritized List included in this report. Per prior agreement with the Centers for Medicare and Medicaid Services (CMS), Oregon has agreed not to move the funding line from its current relative position for the duration of the current Medicaid waiver demonstration period. If this report is accepted, the legislature will establish the funding line for this list after line 475 as part of the state budget. Upon approval from CMS, the benefit package represented by the services listed on or above that funding line will be reimbursed under the Oregon Health Plan beginning no earlier than January 1, 2016.

4) **Why do many diagnoses appear more than once?** A given diagnosis or condition may have a continuum of treatments including medical, surgical, or transplantation. All transplantations for either bone marrow or solid organs have a separate line in addition to the medical/surgical treatment. These treatments of a condition may vary in their effectiveness and/or cost and therefore receive different rankings by the Health Evidence Review Commission.

5) **What about diagnostic services?** Except for rare instances, diagnostic services are always covered and do not appear on the list. If a condition is diagnosed that appears below the funding line, the diagnostic visit and any necessary tests will be covered, but subsequent office visits and ancillary services such as home health services will not.

6) **What about preventive services?** The Oregon Health Plan encourages prevention and early intervention. Effective preventive services for adults and children are ranked on Line 3 and include services recommended by the U.S. Preventive Services Task Force (“A” and “B” Recommendations), American

Academy of Pediatrics (Bright Futures Guidelines), Health Resources and Services Administration (Women's Preventive Services) and the Advisory Committee on Immunization Practices. In addition, preventive dental services are included on Line 57.

7) **What are ancillary services and are they covered?** Ancillary services are those goods, services, and therapies that are considered to be integral to the successful treatment of a condition. They include prescription drugs, durable medical equipment, hospital care and anesthesia. Ancillary services are reimbursable when used in conjunction with a covered condition.

8) **Are prescription drugs covered for all diagnoses?** The Commission considers prescription drugs to be an ancillary service. Therefore, it is the intent of the Commission that only funded condition-treatment pairs include the coverage of prescription drugs. However, the Commission has discovered that since the diagnosis is not included with a prescription, the pharmacy has no way to determine if a drug is being prescribed for a condition falling below the funding line without requiring a manual prior authorization. Within the past few years, prescribing physicians have been asked to check a box to indicate whether or not the prescription is for the treatment of a covered condition.

9) **Are mental health care and chemical dependency services a part of the Prioritized List?** Mental health care and chemical dependency conditions are fully integrated and prioritized along with physical conditions. Mental health lines are distinguished by the listing of "psychotherapy" under the treatment description. The listing of psychotherapy represents a broad range of mental health therapies provided by different types of mental health professionals in various settings.

10) **What are statements of intent?** Statements of intent allow the Commission the ability to indicate their intent for coverage of services that cannot be easily identified by medical codes. The titles of these statements appear later in this appendix immediately following the list of lines on the Prioritized List.

11) **What are practice guidelines?** Guidelines are used to further delineate conditions where the coding system does not adequately distinguish between sub-groups that are treated differently or to indicate the most effective use of a particular treatment. See Chapter Two for further detail on new guidelines developed and existing guidelines that were modified over the last two years in conjunction with the biennial review of the list. A listing of the guideline titles is provided at the end of this appendix. This includes guidelines associated with diagnostic and ancillary services that don't appear on the Prioritized List as well as services that do appear on the list. A full listing of the practice guidelines are posted on the Commission's website.

12) **What other resources are available to answer other questions I may have?** For questions about the Prioritized List, the methodology used to create and

maintain the list or other information concerning the work of the Health Evidence Review Commission, see the Commission's web page at:

http://www.oregon.gov/oha/herc/Pages/index.aspx

For questions about plan eligibility or administration, see the home page of the Medical Assistance Programs at:

http://www.oregon.gov/OHA/healthplan/Pages/index.aspx

Or contact our office at (503) 373-1985.

LINE DESCRIPTIONS FOR THE 2016-17 PRIORITIZED LIST OF HEALTH SERVICES

PRIORITIZED LIST OF HEALTH SERVICES
Biennial List for Planned Implementation 1/1/2016-12/31/2017

Line	Condition	Treatment
1	PREGNANCY	MATERNITY CARE
2	BIRTH OF INFANT	NEWBORN CARE
3	PREVENTION SERVICES WITH EVIDENCE OF EFFECTIVENESS	MEDICAL THERAPY
4	SUBSTANCE USE DISORDER	MEDICAL/PSYCHOTHERAPY
5	TOBACCO DEPENDENCE	MEDICAL THERAPY/BRIEF COUNSELING NOT TO EXCEED 10 FOLLOW-UP VISITS OVER 3 MONTHS
6	REPRODUCTIVE SERVICES	CONTRACEPTION MANAGEMENT; STERILIZATION
7	MAJOR DEPRESSION, RECURRENT; MAJOR DEPRESSION, SINGLE EPISODE, SEVERE	MEDICAL/PSYCHOTHERAPY
8	TYPE 1 DIABETES MELLITUS	MEDICAL THERAPY
9	ASTHMA	MEDICAL THERAPY
10	GALACTOSEMIA	MEDICAL THERAPY
11	RESPIRATORY CONDITIONS OF FETUS AND NEWBORN	MEDICAL THERAPY
12	HIV DISEASE (INCLUDING ACQUIRED IMMUNODEFICIENCY SYNDROME) AND RELATED OPPORTUNISTIC INFECTIONS	MEDICAL THERAPY
13	CONGENITAL HYPOTHYROIDISM	MEDICAL THERAPY
14	PHENYLKETONURIA (PKU)	MEDICAL THERAPY
15	CONGENITAL INFECTIOUS DISEASES	MEDICAL THERAPY
16	CONGENITAL SYPHILIS	MEDICAL THERAPY
17	VERY LOW BIRTH WEIGHT (UNDER 1500 GRAMS)	MEDICAL THERAPY
18	NEONATAL MYASTHENIA GRAVIS	MEDICAL THERAPY
19	FEEDING PROBLEMS IN NEWBORNS	MEDICAL THERAPY
20	HYDROCEPHALUS AND BENIGN INTRACRANIAL HYPERTENSION	MEDICAL AND SURGICAL TREATMENT
21	SYNDROME OF "INFANT OF A DIABETIC MOTHER" AND NEONATAL HYPOGLYCEMIA	MEDICAL THERAPY
22	OMPHALITIS OF THE NEWBORN AND NEONATAL INFECTIVE MASTITIS	MEDICAL THERAPY
23	LOW BIRTH WEIGHT (1500-2500 GRAMS)	MEDICAL THERAPY
24	CYSTIC FIBROSIS	MEDICAL THERAPY
25	VESICOURETERAL REFLUX	MEDICAL THERAPY, SURGERY
26	SCHIZOPHRENIC DISORDERS	MEDICAL/PSYCHOTHERAPY
27	INTRACRANIAL HEMORRHAGES; CEREBRAL CONVULSIONS, DEPRESSION, COMA, AND OTHER ABNORMAL CERERAL SIGNS OF THE NEWBORN	MEDICAL THERAPY
28	DYSPLASIA OF CERVIX AND CERVICAL CARCINOMA IN SITU, CERVICAL CONDYLOMA	MEDICAL AND SURGICAL TREATMENT
29	BIPOLAR DISORDERS	MEDICAL/PSYCHOTHERAPY
30	TYPE 2 DIABETES MELLITUS	MEDICAL THERAPY, BARIATRIC SURGERY WITH BMI >= 35

Line	Condition	Treatment
31	DRUG WITHDRAWAL SYNDROME IN NEWBORN	MEDICAL THERAPY
32	REGIONAL ENTERITIS, IDIOPATHIC PROCTOCOLITIS, ULCERATION OF INTESTINE	MEDICAL AND SURGICAL TREATMENT
33	EPILEPSY AND FEBRILE CONVULSIONS	MEDICAL THERAPY
34	SEVERE BIRTH TRAUMA FOR BABY	MEDICAL THERAPY
35	NEONATAL THYROTOXICOSIS	MEDICAL THERAPY
36	HEMATOLOGICAL DISORDERS OF FETUS AND NEWBORN	MEDICAL THERAPY
37	SPINA BIFIDA	SURGICAL TREATMENT
38	OTHER CONGENITAL ANOMALIES OF MUSCULOSKELETAL SYSTEM	MEDICAL AND SURGICAL TREATMENT
39	TERMINATION OF PREGNANCY	INDUCED ABORTION
40	ACQUIRED HYPOTHYROIDISM, DYSHORMONOGENIC GOITER	MEDICAL AND SURGICAL TREATMENT
41	ECTOPIC PREGNANCY; HYDATIDIFORM MOLE; CHORIOCARCINOMA	MEDICAL AND SURGICAL TREATMENT
42	PRIMARY AND SECONDARY SYPHILIS	MEDICAL THERAPY
43	DISORDERS RELATING TO LONG GESTATION AND HIGH BIRTHWEIGHT	MEDICAL THERAPY
44	PANHYPOPITUITARISM, IATROGENIC AND OTHER PITUITARY DISORDERS	MEDICAL THERAPY
45	HYPOCALCEMIA, HYPOMAGNESEMIA AND OTHER ENDOCRINE AND METABOLIC DISTURBANCES SPECIFIC TO THE FETUS AND NEWBORN	MEDICAL THERAPY
46	INTUSSCEPTION, VOLVULUS, INTESTINAL OBSTRUCTION, HAZARDOUS FOREIGN BODY IN GI TRACT WITH RISK OF PERFORATION OR OBSTRUCTION	MEDICAL AND SURGICAL TREATMENT
47	CLEFT PALATE WITH AIRWAY OBSTRUCTION	MEDICAL AND SURGICAL TREATMENT, ORTHODONTICS
48	COARCTATION OF THE AORTA	SURGICAL TREATMENT
49	CORONARY ARTERY ANOMALY	REIMPLANTATION OF CORONARY ARTERY
50	RHEUMATOID ARTHRITIS AND OTHER INFLAMMATORY POLYARTHROPATHIES	MEDICAL THERAPY, INJECTIONS
51	DEEP ABSCESSES, INCLUDING APPENDICITIS AND PERIORBITAL ABSCESS	MEDICAL AND SURGICAL TREATMENT
52	CHRONIC RESPIRATORY DISEASE ARISING IN THE NEONATAL PERIOD	MEDICAL THERAPY
53	CONGENITAL HYDRONEPHROSIS	NEPHRECTOMY/REPAIR
54	PULMONARY TUBERCULOSIS	MEDICAL THERAPY
55	ACUTE PELVIC INFLAMMATORY DISEASE	MEDICAL AND SURGICAL TREATMENT
56	GONOCOCCAL INFECTIONS AND OTHER SEXUALLY TRANSMITTED DISEASES OF THE ORAL, ANAL AND GENITOURINARY TRACT	MEDICAL THERAPY
57	PREVENTIVE DENTAL SERVICES	CLEANING, FLUORIDE AND SEALANTS
58	DENTAL CONDITIONS (EG. INFECTION, PAIN, TRAUMA)	EMERGENCY DENTAL SERVICES

Line	Condition	Treatment
59	COMPLICATED STONES OF THE GALLBLADDER AND BILE DUCTS; CHOLECYSTITIS	MEDICAL AND SURGICAL TREATMENT
60	ULCERS, GASTRITIS, DUODENITIS, AND GI HEMORRHAGE	MEDICAL AND SURGICAL TREATMENT
61	BURN, FULL THICKNESS GREATER THAN 10% OF BODY SURFACE	FREE SKIN GRAFT, MEDICAL THERAPY
62	BRONCHIECTASIS	MEDICAL AND SURGICAL TREATMENT
63	END STAGE RENAL DISEASE	MEDICAL THERAPY INCLUDING DIALYSIS
64	METABOLIC DISORDERS	MEDICAL THERAPY
65	TORSION OF OVARY	OOPHORECTOMY, OVARIAN CYSTECTOMY
66	SUBSTANCE-INDUCED MOOD, ANXIETY, DELUSIONAL AND OBSESSIVE-COMPULSIVE DISORDERS	MEDICAL/PSYCHOTHERAPY
67	SPONTANEOUS ABORTION; MISSED ABORTION	MEDICAL AND SURGICAL TREATMENT
68	CONGENITAL ANOMALIES OF UPPER ALIMENTARY TRACT, EXCLUDING TONGUE	MEDICAL AND SURGICAL TREATMENT
69	SUBSTANCE-INDUCED DELIRIUM	MEDICAL/PSYCHOTHERAPY
70	LARYNGEAL STENOSIS OR PARALYSIS WITH AIRWAY COMPLICATIONS	INCISION/EXCISION/ENDOSCOPY
71	VENTRICULAR SEPTAL DEFECT	CLOSURE
72	ACUTE BACTERIAL MENINGITIS	MEDICAL THERAPY
73	ACUTE AND SUBACUTE ISCHEMIC HEART DISEASE, MYOCARDIAL INFARCTION	MEDICAL AND SURGICAL TREATMENT
74	CONGENITAL PULMONARY VALVE ANOMALIES	PULMONARY VALVE REPAIR
75	NEUROLOGICAL DYSFUNCTION IN BREATHING, EATING, SWALLOWING, BOWEL, OR BLADDER CONTROL CAUSED BY CHRONIC CONDITIONS; ATTENTION TO OSTOMIES	MEDICAL AND SURGICAL TREATMENT (EG. G-TUBES, J-TUBES, RESPIRATORS, TRACHEOSTOMY, UROLOGICAL PROCEDURES)
76	BURN, PARTIAL THICKNESS GREATER THAN 30% OF BODY SURFACE OR WITH VITAL SITE; FULL THICKNESS, LESS THAN 10% OF BODY SURFACE	FREE SKIN GRAFT, MEDICAL THERAPY
77	POLYCYTHEMIA NEONATORUM, SYMPTOMATIC	MEDICAL THERAPY
78	DERMATOMYOSITIS, POLYMYOSITIS	MEDICAL THERAPY
79	ADDISON'S DISEASE	MEDICAL THERAPY
80	HYPERTENSION AND HYPERTENSIVE DISEASE	MEDICAL THERAPY
81	PATENT DUCTUS ARTERIOSUS; AORTIC PULMONARY FISTULA/WINDOW	LIGATION
82	INJURY TO MAJOR BLOOD VESSELS OF EXTREMITIES AND NECK	LIGATION/REPAIR
83	PHLEBITIS AND THROMBOPHLEBITIS, DEEP	MEDICAL THERAPY
84	INJURY TO INTERNAL ORGANS	MEDICAL AND SURGICAL TREATMENT
85	FRACTURE OF HIP	MEDICAL AND SURGICAL TREATMENT
86	MYOCARDITIS, PERICARDITIS, AND ENDOCARDITIS	MEDICAL AND SURGICAL TREATMENT
87	DEEP OPEN WOUND OF NECK, INCLUDING LARYNX; FRACTURE OF LARYNX OR TRACHEA	REPAIR

Line	Condition	Treatment
88	DIABETES MELLITUS WITH END STAGE RENAL DISEASE	SIMULTANEOUS PANCREAS/KIDNEY (SPK) TRANSPLANT, PANCREAS AFTER KIDNEY (PAK) TRANSPLANT
89	ENDOCARDIAL CUSHION DEFECTS	REPAIR
90	CONGENITAL PULMONARY VALVE ATRESIA	SHUNT/REPAIR
91	CONGENITAL ANOMALIES OF GENITOURINARY SYSTEM	RECONSTRUCTION
92	NECROTIZING ENTEROCOLITIS IN FETUS OR NEWBORN	MEDICAL AND SURGICAL TREATMENT
93	DISCORDANT CARDIOVASCULAR CONNECTIONS	REPAIR
94	CONGENITAL MITRAL VALVE STENOSIS/INSUFFICIENCY	MITRAL VALVE REPAIR/REPLACEMENT
95	GUILLAIN-BARRE SYNDROME	MEDICAL THERAPY
96	SEVERE/MODERATE HEAD INJURY: HEMATOMA/EDEMA WITH PERSISTENT SYMPTOMS	MEDICAL AND SURGICAL TREATMENT
97	CHILDHOOD LEUKEMIAS	MEDICAL THERAPY, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY
98	UNDESCENDED TESTICLE	SURGICAL TREATMENT
99	HEREDITARY IMMUNE DEFICIENCIES	BONE MARROW TRANSPLANT
100	DIABETIC AND OTHER RETINOPATHY	MEDICAL, SURGICAL, AND LASER TREATMENT
101	BORDERLINE PERSONALITY DISORDER	MEDICAL/PSYCHOTHERAPY
102	HEART FAILURE	MEDICAL THERAPY
103	CARDIOMYOPATHY	MEDICAL AND SURGICAL TREATMENT
104	END STAGE RENAL DISEASE	RENAL TRANSPLANT
105	CONGENITAL ANOMALIES OF DIGESTIVE SYSTEM AND ABDOMINAL WALL EXCLUDING NECROSIS; CHRONIC INTESTINAL PSEUDO-OBSTRUCTION	MEDICAL AND SURGICAL TREATMENT
106	HEMOLYTIC DISEASE DUE TO ISOIMMUNIZATION, ANEMIA DUE TO TRANSPLACENTAL HEMORRHAGE, AND FETAL AND NEONATAL JAUNDICE	MEDICAL THERAPY
107	POISONING BY INGESTION, INJECTION, AND NON-MEDICINAL AGENTS	MEDICAL THERAPY
108	BOTULISM	MEDICAL THERAPY
109	TETRALOGY OF FALLOT (TOF); CONGENITAL VENOUS ABNORMALITIES	REPAIR
110	CONGENITAL STENOSIS AND INSUFFICIENCY OF AORTIC VALVE	SURGICAL VALVE REPLACEMENT/VALVULOPLASTY
111	GIANT CELL ARTERITIS, POLYMYALGIA RHEUMATICA AND KAWASAKI DISEASE	MEDICAL THERAPY
112	FRACTURE OF RIBS AND STERNUM, OPEN	MEDICAL AND SURGICAL TREATMENT
113	SUBACUTE MENINGITIS (EG. TUBERCULOSIS, CRYPTOCOCCOSIS)	MEDICAL THERAPY
114	COAGULATION DEFECTS	MEDICAL THERAPY
115	CONGENITAL HEART BLOCK; OTHER OBSTRUCTIVE ANOMALIES OF HEART	MEDICAL THERAPY

Line	Condition	Treatment
116	CANCER OF TESTIS	MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY
117	CANCER OF EYE AND ORBIT	MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY
118	APLASTIC ANEMIAS; AGRANULOCYTOSIS	BONE MARROW TRANSPLANT
119	CHRONIC MYELOID LEUKEMIA	MEDICAL THERAPY, WHICH INCLUDES CHEMOTHERAPY, RADIATION AND RADIONUCLEIDE THERAPY
120	HODGKIN'S DISEASE	BONE MARROW TRANSPLANT
121	FOREIGN BODY IN PHARYNX, LARYNX, TRACHEA, BRONCHUS AND ESOPHAGUS	REMOVAL OF FOREIGN BODY
122	NUTRITIONAL DEFICIENCIES	MEDICAL THERAPY
123	ATRIAL SEPTAL DEFECT, SECUNDUM	REPAIR SEPTAL DEFECT
124	CHOANAL ATRESIA	REPAIR OF CHOANAL ATRESIA
125	ABUSE AND NEGLECT	MEDICAL THERAPY
126	ATTENTION DEFICIT/HYPERACTIVITY DISORDERS	MEDICAL/PSYCHOTHERAPY
127	MALARIA, CHAGAS' DISEASE AND TRYPANOSOMIASIS	MEDICAL THERAPY
128	ANAPHYLACTIC SHOCK; EDEMA OF LARYNX	MEDICAL THERAPY
129	THYROTOXICOSIS WITH OR WITHOUT GOITER, ENDOCRINE EXOPHTHALMOS; CHRONIC THYROIDITIS	MEDICAL AND SURGICAL TREATMENT WHICH INCLUDES RADIATION THERAPY
130	BENIGN NEOPLASM OF THE BRAIN AND SPINAL CORD	MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY
131	ACUTE KIDNEY INJURY	MEDICAL THERAPY INCLUDING DIALYSIS
132	COMMON TRUNCUS	TOTAL REPAIR/REPLANT ARTERY
133	GRANULOMATOSIS WITH POLYANGIITIS	MEDICAL THERAPY, WHICH INCLUDES RADIATION THERAPY
134	TOTAL ANOMALOUS PULMONARY VENOUS CONNECTION	COMPLETE REPAIR
135	CRUSH INJURIES OTHER THAN DIGITS; COMPARTMENT SYNDROME; INJURIES TO BLOOD VESSEL(S) OF THE NECK	MEDICAL AND SURGICAL TREATMENT
136	OPEN FRACTURE/DISLOCATION OF EXTREMITIES	MEDICAL AND SURGICAL TREATMENT
137	CANCER OF CERVIX	MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY
138	INTERRUPTED AORTIC ARCH	TRANSVERSE ARCH GRAFT
139	HODGKIN'S DISEASE	MEDICAL THERAPY, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY
140	TRAUMATIC AMPUTATION OF LEG(S) (COMPLETE)(PARTIAL) WITH AND WITHOUT COMPLICATION	MEDICAL AND SURGICAL TREATMENT
141	OPPORTUNISTIC INFECTIONS IN IMMUNOCOMPROMISED HOSTS; CANDIDIASIS OF STOMA; PERSONS RECEIVING CONTINUOUS ANTIBIOTIC THERAPY	MEDICAL THERAPY

Line	Condition	Treatment
142	EBSTEIN'S ANOMALY	REPAIR SEPTAL DEFECT/VALVULOPLASTY/REPLACEMENT
143	GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE	MEDICAL,SURGICAL AND LASER TREATMENT
144	MYASTHENIA GRAVIS	MEDICAL THERAPY, THYMECTOMY
145	SYSTEMIC LUPUS ERYTHEMATOSUS, OTHER DIFFUSE DISEASES OF CONNECTIVE TISSUE	MEDICAL THERAPY
146	CONDITIONS INVOLVING THE TEMPERATURE REGULATION OF NEWBORNS	MEDICAL THERAPY
147	PNEUMOTHORAX AND PLEURAL EFFUSION TUBE THORACOSTOMY	SURGICAL THERAPY, MEDICAL THERAPY
148	HYPOTHERMIA	MEDICAL THERAPY, EXTRACORPOREAL CIRCULATION
149	ANEMIA OF PREMATURITY OR TRANSIENT NEONATAL NEUTROPENIA	MEDICAL THERAPY
150	ENTERIC INFECTIONS AND OTHER BACTERIAL FOOD POISONING	MEDICAL THERAPY
151	GLYCOGENOSIS	MEDICAL THERAPY
152	ACQUIRED HEMOLYTIC ANEMIAS	MEDICAL THERAPY
153	FEEDING AND EATING DISORDERS OF INFANCY OR CHILDHOOD	MEDICAL/PSYCHOTHERAPY
154	CERVICAL VERTEBRAL DISLOCATIONS/FRACTURES, OPEN OR CLOSED; OTHER VERTEBRAL DISLOCATIONS/FRACTURES, OPEN OR UNSTABLE; SPINAL CORD INJURIES WITH OR WITHOUT EVIDENCE OF VERTEBRAL INJURY	MEDICAL AND SURGICAL TREATMENT
155	DISORDERS OF MINERAL METABOLISM, OTHER THAN CALCIUM	MEDICAL THERAPY
156	NON-PULMONARY TUBERCULOSIS	MEDICAL THERAPY
157	PYOGENIC ARTHRITIS	MEDICAL AND SURGICAL TREATMENT
158	VASCULAR INSUFFICIENCY OF INTESTINE	SURGICAL TREATMENT
159	HERPES ZOSTER; HERPES SIMPLEX AND WITH NEUROLOGICAL AND OPHTHALMOLOGICAL COMPLICATIONS	MEDICAL THERAPY
160	ACROMEGALY AND GIGANTISM	MEDICAL THERAPY
161	CANCER OF COLON, RECTUM, SMALL INTESTINE AND ANUS	MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY
162	NON-HODGKIN'S LYMPHOMAS	MEDICAL THERAPY, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY
163	TOXIC EPIDERMAL NECROLYSIS AND STAPHYLOCOCCAL SCALDED SKIN SYNDROME; STEVENS-JOHNSON SYNDROME; ERYTHEMA MULTIFORME MAJOR; ECZEMA HERPETICUM	MEDICAL THERAPY
164	TRAUMATIC AMPUTATION OF ARM(S), HAND(S), THUMB(S), AND FINGER(S) (COMPLETE)(PARTIAL) WITH AND WITHOUT COMPLICATION	MEDICAL AND SURGICAL TREATMENT

Line	Condition	Treatment
165	GRANULOCYTE DISORDERS	MEDICAL THERAPY
166	BILIARY ATRESIA	LIVER TRANSPLANT
167	NON-HODGKIN'S LYMPHOMAS	BONE MARROW TRANSPLANT
168	LEUKOPLAKIA AND CARCINOMA IN SITU OF UPPER AIRWAY, INCLUDING ORAL CAVITY	INCISION/EXCISION, MEDICAL THERAPY
169	PREVENTIVE FOOT CARE IN HIGH RISK PATIENTS	MEDICAL AND SURGICAL TREATMENT OF TOENAILS AND HYPERKERATOSES OF FOOT
170	ANAL, RECTAL AND COLONIC POLYPS	MEDICAL AND SURGICAL TREATMENT
171	GONOCOCCAL AND CHLAMYDIAL INFECTIONS OF THE EYE; NEONATAL CONJUNCTIVITIS	MEDICAL THERAPY
172	COMPLICATED HERNIAS; UNCOMPLICATED INGUINAL HERNIA IN CHILDREN AGE 18 AND UNDER; PERSISTENT HYDROCELE	REPAIR
173	NON-DIABETIC HYPOGLYCEMIC COMA	MEDICAL THERAPY
174	ACUTE MASTOIDITIS	MASTOIDECTOMY, MEDICAL THERAPY
175	AMEBIASIS	MEDICAL THERAPY
176	HYPERTENSIVE HEART AND RENAL DISEASE	MEDICAL THERAPY
177	POSTTRAUMATIC STRESS DISORDER	MEDICAL/PSYCHOTHERAPY
178	GENERALIZED CONVULSIVE OR PARTIAL EPILEPSY WITHOUT MENTION OF IMPAIRMENT OF CONSCIOUSNESS	SINGLE FOCAL SURGERY
179	POLYARTERITIS NODOSA AND ALLIED CONDITIONS	MEDICAL THERAPY
180	COMMON VENTRICLE	TOTAL REPAIR
181	DISORDERS OF AMINO-ACID TRANSPORT AND METABOLISM (NON PKU); HEREDITARY FRUCTOSE INTOLERANCE	MEDICAL THERAPY
182	INTRACEREBRAL HEMORRHAGE	MEDICAL THERAPY
183	ACUTE LEUKEMIA, MYELODYSPLASTIC SYNDROME	BONE MARROW TRANSPLANT
184	URETERAL STRICTURE OR OBSTRUCTION; HYDRONEPHROSIS; HYDROURETER	MEDICAL AND SURGICAL TREATMENT
185	CONDITIONS INVOLVING EXPOSURE TO NATURAL ELEMENTS (EG. LIGHTNING STRIKE, HEATSTROKE)	MEDICAL THERAPY, BURN TREATMENT
186	SEPTICEMIA	MEDICAL THERAPY
187	FRACTURE OF PELVIS, OPEN AND CLOSED	MEDICAL AND SURGICAL TREATMENT
188	ACUTE OSTEOMYELITIS	MEDICAL AND SURGICAL TREATMENT
189	DIVERTICULITIS OF COLON	COLON RESECTION, MEDICAL THERAPY
190	RHEUMATIC MULTIPLE VALVULAR DISEASE	SURGICAL TREATMENT
191	CUSHING'S SYNDROME; HYPERALDOSTERONISM, OTHER CORTICOADRENAL OVERACTIVITY, MEDULLOADRENAL HYPERFUNCTION	MEDICAL THERAPY/ADRENALECTOMY
192	CONGENITAL TRICUSPID ATRESIA AND STENOSIS	REPAIR
193	CHRONIC ISCHEMIC HEART DISEASE	MEDICAL AND SURGICAL TREATMENT
194	NEOPLASMS OF ISLETS OF LANGERHANS	EXCISION OF TUMOR

Line	Condition	Treatment
195	CANCER OF BREAST; AT HIGH RISK OF BREAST CANCER	MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY, RADIATION THERAPY AND BREAST RECONSTRUCTION
196	HEREDITARY ANGIOEDEMA	MEDICAL THERAPY
197	AUTISM SPECTRUM DISORDERS	MEDICAL THERAPY/BEHAVIORAL MODIFICATION INCLUDING APPLIED BEHAVIOR ANALYSIS
198	HEREDITARY ANEMIAS, HEMOGLOBINOPATHIES, AND DISORDERS OF THE SPLEEN	MEDICAL THERAPY
199	ACUTE PANCREATITIS	MEDICAL THERAPY
200	SUBARACHNOID AND INTRACEREBRAL HEMORRHAGE/HEMATOMA; CEREBRAL ANEURYSM; COMPRESSION OF BRAIN	BURR HOLES, CRANIECTOMY/CRANIOTOMY
201	BURN, PARTIAL THICKNESS WITHOUT VITAL SITE REQUIRING GRAFTING, UP TO 30% OF BODY SURFACE	FREE SKIN GRAFT, MEDICAL THERAPY
202	CONGENITAL LUNG ANOMALIES	MEDICAL AND SURGICAL TREATMENT
203	CHRONIC HEPATITIS; VIRAL HEPATITIS	MEDICAL THERAPY
204	CANCER OF SOFT TISSUE	MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY
205	CANCER OF BONES	MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY
206	CHRONIC ORGANIC MENTAL DISORDERS INCLUDING DEMENTIAS	CONSULTATION/MEDICATION MANAGEMENT/LIMITED BEHAVIORAL MODIFICATION
207	SLEEP APNEA, NARCOLEPSY AND REM BEHAVIORAL DISORDER	MEDICAL AND SURGICAL TREATMENT
208	DEPRESSION AND OTHER MOOD DISORDERS, MILD OR MODERATE	MEDICAL/PSYCHOTHERAPY
209	PNEUMOCOCCAL PNEUMONIA, OTHER BACTERIAL PNEUMONIA, BRONCHOPNEUMONIA	MEDICAL THERAPY
210	SUPERFICIAL ABSCESSES AND CELLULITIS	MEDICAL AND SURGICAL TREATMENT
211	ZOONOTIC BACTERIAL DISEASES	MEDICAL THERAPY
212	DEEP OPEN WOUND, WITH OR WITHOUT TENDON OR NERVE INVOLVEMENT	MEDICAL AND SURGICAL TREATMENT
213	CANCER OF UTERUS	MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY
214	RUPTURE OF LIVER	SUTURE/REPAIR
215	CANCER OF THYROID	MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY
216	NON-SUBSTANCE-RELATED ADDICTIVE BEHAVIORAL DISORDERS	MEDICAL/PSYCHOTHERAPY
217	BULLOUS DERMATOSES OF THE SKIN	MEDICAL THERAPY

Line	Condition	Treatment
218	ACUTE PULMONARY HEART DISEASE AND PULMONARY EMBOLI	MEDICAL AND SURGICAL TREATMENT
219	CANCER OF KIDNEY AND OTHER URINARY ORGANS	MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY
220	CANCER OF STOMACH	MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY
221	PORTAL VEIN THROMBOSIS	MEDICAL AND SURGICAL TREATMENT
222	TESTICULAR CANCER	BONE MARROW RESCUE AND TRANSPLANT
223	DENTAL CONDITIONS (EG. PERIODONTAL DISEASE)	BASIC PERIODONTICS
224	PULMONARY FIBROSIS	MEDICAL AND SURGICAL TREATMENT
225	DYSLIPIDEMIAS	MEDICAL THERAPY
226	DISORDERS OF FLUID, ELECTROLYTE, AND ACID-BASE BALANCE	MEDICAL THERAPY, DIALYSIS
227	OCCUPATIONAL LUNG DISEASES	MEDICAL THERAPY
228	DISEASES AND DISORDERS OF AORTIC VALVE	MEDICAL AND SURGICAL THERAPY
229	DISORDERS OF PARATHYROID GLAND; BENIGN NEOPLASM OF PARATHYROID GLAND; DISORDERS OF CALCIUM METABOLISM	MEDICAL AND SURGICAL TREATMENT
230	ACUTE INFLAMMATION OF THE HEART DUE TO RHEUMATIC FEVER	MEDICAL THERAPY
231	RUPTURED VISCUS	REPAIR
232	INTESTINAL MALABSORPTION	MEDICAL THERAPY
233	FRACTURE OF FACE BONES; INJURY TO OPTIC AND OTHER CRANIAL NERVES	SURGICAL TREATMENT
234	MALIGNANT MELANOMA OF SKIN	MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY
235	URINARY FISTULA	SURGICAL TREATMENT
236	MYCOBACTERIA, FUNGAL INFECTIONS, TOXOPLASMOSIS, AND OTHER OPPORTUNISTIC INFECTIONS	MEDICAL THERAPY
237	HYPOPLASTIC LEFT HEART SYNDROME	REPAIR
238	ADULT RESPIRATORY DISTRESS SYNDROME; ACUTE RESPIRATORY FAILURE; RESPIRATORY CONDITIONS DUE TO PHYSICAL AND CHEMICAL AGENTS	MEDICAL THERAPY
239	ACUTE LYMPHOCYTIC LEUKEMIAS (ADULT) AND MULTIPLE MYELOMA	MEDICAL THERAPY, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY
240	LIMB THREATENING VASCULAR DISEASE, INFECTIONS, AND VASCULAR COMPLICATIONS	MEDICAL AND SURGICAL TREATMENT
241	TETANUS	MEDICAL THERAPY
242	ACUTE PROMYELOCYTIC LEUKEMIA	MEDICAL THERAPY, WHICH INCLUDES CHEMOTHERAPY, RADIATION AND RADIONUCLEIDE THERAPY
243	CANCER OF OVARY	MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY

Line	Condition	Treatment
244	SHORT BOWEL SYNDROME - AGE 5 OR UNDER	INTESTINE AND INTESTINE/LIVER TRANSPLANT
245	CONDITIONS REQUIRING HEART-LUNG AND LUNG TRANSPLANTATION	HEART-LUNG AND LUNG TRANSPLANT
246	ACUTE AND SUBACUTE NECROSIS OF LIVER; SPECIFIED INBORN ERRORS OF METABOLISM (EG. MAPLE SYRUP URINE DISEASE, TYROSINEMIA)	LIVER TRANSPLANT
247	DERMATOLOGICAL PREMALIGNANT LESIONS AND CARCINOMA IN SITU	DESTRUCT/EXCISION/MEDICAL THERAPY
248	PRIMARY ANGLE-CLOSURE GLAUCOMA	MEDICAL, SURGICAL AND LASER TREATMENT
249	CORNEAL ULCER; SUPERFICIAL INJURY OF EYE AND ADNEXA	CONJUNCTIVAL FLAP; MEDICAL THERAPY
250	TORSION OF TESTIS	ORCHIECTOMY, REPAIR
251	LIFE-THREATENING EPISTAXIS	SEPTOPLASTY/REPAIR/CONTROL HEMORRHAGE
252	RETAINED INTRAOCULAR FOREIGN BODY, MAGNETIC AND NONMAGNETIC	FOREIGN BODY REMOVAL
253	METABOLIC BONE DISEASE	MEDICAL THERAPY
254	PARKINSON'S DISEASE	MEDICAL THERAPY
255	CHRONIC PANCREATITIS	MEDICAL THERAPY
256	MULTIPLE SCLEROSIS AND OTHER DEMYELINATING DISEASES OF CENTRAL NERVOUS SYSTEM	MEDICAL THERAPY
257	PSYCHOLOGICAL FACTORS AGGRAVATING PHYSICAL CONDITION (EG. ASTHMA, CHRONIC GI CONDITIONS, HYPERTENSION)	MEDICAL/PSYCHOTHERAPY
258	ARTERIAL EMBOLISM/THROMBOSIS: ABDOMINAL AORTA, THORACIC AORTA	SURGICAL TREATMENT
259	CHRONIC OSTEOMYELITIS	MEDICAL AND SURGICAL TREATMENT
260	MULTIPLE ENDOCRINE NEOPLASIA	MEDICAL AND SURGICAL TREATMENT
261	DEFORMITIES OF HEAD	CRANIOTOMY/CRANIECTOMY
262	DISEASES OF MITRAL, TRICUSPID, AND PULMONARY VALVES	VALVULOPLASTY, VALVE REPLACEMENT, MEDICAL THERAPY
263	CANCER OF PENIS AND OTHER MALE GENITAL ORGANS	MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY
264	CANCER OF ENDOCRINE SYSTEM, EXCLUDING THYROID; CARCINOID SYNDROME	MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY
265	MULTIPLE MYELOMA	BONE MARROW TRANSPLANT
266	CANCER OF RETROPERITONEUM, PERITONEUM, OMENTUM AND MESENTERY	MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY
267	CANCER OF LUNG, BRONCHUS, PLEURA, TRACHEA, MEDIASTINUM AND OTHER RESPIRATORY ORGANS	MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY

Line	Condition	Treatment
268	CONGESTIVE HEART FAILURE, CARDIOMYOPATHY, MALIGNANT ARRHYTHMIAS, AND COMPLEX CONGENITAL HEART DISEASE	CARDIAC TRANSPLANT; HEART/KIDNEY TRANSPLANT
269	TRACHOMA	MEDICAL THERAPY
270	ACUTE, SUBACUTE, CHRONIC AND OTHER TYPES OF IRIDOCYCLITIS	MEDICAL THERAPY
271	DENTAL CONDITIONS (TIME SENSITIVE EVENTS)	URGENT DENTAL SERVICES
272	RICKETTSIAL AND OTHER ARTHROPOD-BORNE DISEASES	MEDICAL THERAPY
273	DIABETES INSIPIDUS	MEDICAL THERAPY
274	ADVANCED DEGENERATIVE DISORDERS AND CONDITIONS OF GLOBE	ENUCLEATION
275	CANCER OF BLADDER AND URETER	MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY
276	TRAUMATIC AMPUTATION OF FOOT/FEET (COMPLETE)(PARTIAL) WITH AND WITHOUT COMPLICATION	MEDICAL AND SURGICAL TREATMENT
277	LEPROSY, YAWS, PINTA	MEDICAL THERAPY
278	RETINOPATHY OF PREMATURITY	CRYOSURGERY
279	UROLOGIC INFECTIONS	MEDICAL THERAPY
280	CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA	MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY
281	INJURY TO BLOOD VESSELS OF THE THORACIC CAVITY	REPAIR
282	OTHER PSYCHOTIC DISORDERS	MEDICAL/PSYCHOTHERAPY
283	HYDROPS FETALIS	MEDICAL THERAPY
284	RETINAL DETACHMENT AND OTHER RETINAL DISORDERS	RETINAL REPAIR, VITRECTOMY
285	BUDD-CHIARI SYNDROME, AND OTHER VENOUS EMBOLISM AND THROMBOSIS	THROMBECTOMY/LIGATION
286	LIFE-THREATENING CARDIAC ARRHYTHMIAS	MEDICAL AND SURGICAL TREATMENT
287	ANOREXIA NERVOSA	MEDICAL/PSYCHOTHERAPY
288	CHRONIC OBSTRUCTIVE PULMONARY DISEASE; CHRONIC RESPIRATORY FAILURE	MEDICAL THERAPY
289	DISSECTING OR RUPTURED AORTIC ANEURYSM	MEDICAL AND SURGICAL TREATMENT
290	COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT	MEDICAL AND SURGICAL TREATMENT
291	CANCER OF VAGINA, VULVA, AND OTHER FEMALE GENITAL ORGANS	MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY
292	CANCER OF ORAL CAVITY, PHARYNX, NOSE AND LARYNX	MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY
293	OSTEOPETROSIS	BONE MARROW RESCUE AND TRANSPLANT
294	CRUSH AND OTHER INJURIES OF DIGITS	MEDICAL AND SURGICAL TREATMENT
295	ACUTE STRESS DISORDER	MEDICAL/PSYCHOTHERAPY
296	ADRENAL OR CUTANEOUS HEMORRHAGE OF FETUS OR NEONATE	MEDICAL THERAPY

Line	Condition	Treatment
297	NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS	MEDICAL AND SURGICAL TREATMENT (EG. DURABLE MEDICAL EQUIPMENT AND ORTHOPEDIC PROCEDURE)
298	ANOMALIES OF GALLBLADDER, BILE DUCTS, AND LIVER	MEDICAL AND SURGICAL TREATMENT
299	CANCER OF BRAIN AND NERVOUS SYSTEM	LINEAR ACCELERATOR, MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY
300	APLASTIC ANEMIAS	MEDICAL THERAPY
301	CATARACT	EXTRACTION OF CATARACT
302	AFTER CATARACT	DISCISSION, LENS CAPSULE
303	FISTULA INVOLVING FEMALE GENITAL TRACT	CLOSURE OF FISTULA
304	VITREOUS DISORDERS	VITRECTOMY
305	CLEFT PALATE AND/OR CLEFT LIP	EXCISION AND REPAIR VESTIBULE OF MOUTH, ORTHODONTICS
306	GOUT	MEDICAL THERAPY
307	PERTUSSIS AND DIPTHERIA	MEDICAL THERAPY
308	THROMBOCYTOPENIA	MEDICAL AND SURGICAL TREATMENT
309	VIRAL PNEUMONIA	MEDICAL THERAPY
310	DISORDERS OF ARTERIES, OTHER THAN CAROTID OR CORONARY	MEDICAL AND SURGICAL TREATMENT
311	PARALYTIC ILEUS	MEDICAL AND SURGICAL TREATMENT
312	CIRRHOSIS OF LIVER OR BILIARY TRACT; BUDD-CHIARI SYNDROME; HEPATIC VEIN THROMBOSIS; INTRAHEPATIC VASCULAR MALFORMATIONS; CAROLI'S DISEASE	LIVER TRANSPLANT, LIVER-KIDNEY TRANSPLANT
313	CHRONIC INFLAMMATORY DISORDER OF ORBIT	MEDICAL THERAPY
314	CONGENITAL DISLOCATION OF HIP; COXA VARA AND VALGA	SURGICAL TREATMENT
315	CORNEAL OPACITY AND OTHER DISORDERS OF CORNEA	KERATOPLASTY
316	HEARING LOSS - AGE 5 OR UNDER	MEDICAL THERAPY INCLUDING HEARING AIDS
317	GENDER DYSPHORIA	MEDICAL AND SURGICAL TREATMENT/PSYCHOTHERAPY
318	DISORDERS INVOLVING THE IMMUNE SYSTEM	MEDICAL THERAPY
319	CANCER OF ESOPHAGUS	MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY
320	CANCER OF LIVER	MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY
321	CANCER OF PANCREAS	MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY
322	STROKE	MEDICAL THERAPY
323	PURULENT ENDOPHTHALMITIS	VITRECTOMY
324	FOREIGN BODY IN CORNEA AND CONJUNCTIVAL SAC	REMOVAL CONJUNCTIVAL FOREIGN BODY

Line	Condition	Treatment
325	OBESITY (ADULT BMI ≥ 30, CHILDHOOD BMI ≥ 95 PERCENTILE)	INTENSIVE NUTRITIONAL/PHYSICAL ACTIVITY COUNSELING AND BEHAVIORAL INTERVENTIONS
326	DERMATOLOGIC HEMANGIOMAS, COMPLICATED	MEDICAL THERAPY
327	OTHER ANEURYSM OF PERIPHERAL ARTERY	SURGICAL TREATMENT
328	SIALOADENITIS, ABSCESS, FISTULA OF SALIVARY GLANDS	MEDICAL AND SURGICAL TREATMENT
329	CYSTICERCOSIS, OTHER CESTODE INFECTION, TRICHINOSIS	MEDICAL THERAPY
330	NON-DISSECTING ANEURYSM WITHOUT RUPTURE	SURGICAL TREATMENT
331	SENSORINEURAL HEARING LOSS	COCHLEAR IMPLANT
332	FUNCTIONAL AND MECHANICAL DISORDERS OF THE GENITOURINARY SYSTEM INCLUDING BLADDER OUTLET OBSTRUCTION	MEDICAL AND SURGICAL TREATMENT
333	DISSEMINATED INTRAVASCULAR COAGULATION	MEDICAL AND SURGICAL TREATMENT
334	CANCER OF PROSTATE GLAND	MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY
335	SYSTEMIC SCLEROSIS; SJOGREN'S SYNDROME	MEDICAL THERAPY
336	ACUTE PROMYELOCYTIC LEUKEMIA	BONE MARROW TRANSPLANT
337	CONDITIONS REQUIRING HYPERBARIC OXYGEN THERAPY	HYPERBARIC OXYGEN
338	BENIGN CEREBRAL CYSTS	DRAINAGE
339	ALCOHOLIC FATTY LIVER OR ALCOHOLIC HEPATITIS, CIRRHOSIS OF LIVER	MEDICAL THERAPY
340	SCLERITIS	MEDICAL THERAPY
341	RUBEOSIS AND OTHER DISORDERS OF THE IRIS	LASER SURGERY
342	WOUND OF EYE GLOBE	SURGICAL REPAIR
343	ACUTE NECROSIS OF LIVER	MEDICAL THERAPY
344	CHRONIC KIDNEY DISEASE	MEDICAL THERAPY INCLUDING DIALYSIS
345	HEREDITARY HEMORRHAGIC TELANGIECTASIA	EXCISION
346	RHEUMATIC FEVER	MEDICAL THERAPY
347	OTHER AND UNSPECIFIED ANTERIOR PITUITARY HYPERFUNCTION, BENIGN NEOPLASM OF THYROID GLAND AND OTHER ENDOCRINE GLANDS	MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES RADIATION THERAPY
348	DENTAL CONDITIONS (EG. CARIES, FRACTURED TOOTH)	BASIC RESTORATIVE (E.G. COMPOSITE RESTORATIONS FOR ANTERIOR TEETH, AMALGAM RESTORATIONS FOR POSTERIOR TEETH)
349	DENTAL CONDITIONS (EG. SEVERE CARIES, INFECTION)	ORAL SURGERY (I.E. EXTRACTIONS AND OTHER INTRAORAL SURGICAL PROCEDURES)
350	NEUROLOGICAL DYSFUNCTION IN COMMUNICATION CAUSED BY CHRONIC CONDITIONS	MEDICAL THERAPY
351	CONDITIONS OF THE BACK AND SPINE WITH URGENT SURGICAL INDICATIONS	SURGICAL THERAPY
352	CARDIAC ARRHYTHMIAS	MEDICAL THERAPY, PACEMAKER

Line	Condition	Treatment
353	MILD/MODERATE BIRTH TRAUMA FOR BABY	MEDICAL THERAPY
354	NON-LIMB THREATENING PERIPHERAL VASCULAR DISEASE	SURGICAL TREATMENT
355	SARCOIDOSIS	MEDICAL THERAPY
356	STRABISMUS DUE TO NEUROLOGIC DISORDER	MEDICAL AND SURGICAL TREATMENT
357	URINARY SYSTEM CALCULUS	MEDICAL AND SURGICAL TREATMENT
358	STRUCTURAL CAUSES OF AMENORRHEA	SURGICAL TREATMENT
359	PENETRATING WOUND OF ORBIT	MEDICAL AND SURGICAL TREATMENT
360	CLOSED FRACTURE OF EXTREMITIES (EXCEPT MINOR TOES)	OPEN OR CLOSED REDUCTION
361	RHEUMATOID ARTHRITIS, OSTEOARTHRITIS, OSTEOCHONDRITIS DISSECANS, AND ASEPTIC NECROSIS OF BONE	ARTHROPLASTY/RECONSTRUCTION
362	CONDITIONS OF PULMONARY ARTERY	SURGICAL TREATMENT
363	BODY INFESTATIONS (EG. LICE, SCABIES)	MEDICAL THERAPY
364	DEFORMITY/CLOSED DISLOCATION OF MAJOR JOINT AND RECURRENT JOINT DISLOCATIONS	SURGICAL TREATMENT
365	CHORIORETINAL INFLAMMATION	MEDICAL, SURGICAL, AND LASER TREATMENT
366	SCOLIOSIS	MEDICAL AND SURGICAL THERAPY
367	DYSTONIA (UNCONTROLLABLE); LARYNGEAL SPASM AND STENOSIS	MEDICAL THERAPY
368	CYST AND PSEUDOCYST OF PANCREAS	DRAINAGE OF PANCREATIC CYST
369	ACUTE SINUSITIS	MEDICAL AND SURGICAL TREATMENT
370	HYPHEMA	REMOVAL OF BLOOD CLOT
371	ALLERGIC BRONCHOPULMONARY ASPERGILLOSIS	MEDICAL THERAPY
372	ENTROPION AND TRICHIASIS OF EYELID	REPAIR
373	STREPTOCOCCAL SORE THROAT AND SCARLET FEVER; VINCENT'S DISEASE; ULCER OF TONSIL; UNILATERAL HYPERTROPHY OF TONSIL	MEDICAL THERAPY, TONSILLECTOMY/ADENOIDECTOMY
374	INTESTINAL PARASITES	MEDICAL THERAPY
375	AMBLYOPIA	MEDICAL AND SURGICAL TREATMENT
376	ENCEPHALOCELE	SURGICAL TREATMENT
377	BENIGN NEOPLASM OF RESPIRATORY AND INTRATHORACIC ORGANS	LOBECTOMY, MEDICAL THERAPY, WHICH INCLUDES RADIATION THERAPY
378	ACNE CONGLOBATA (SEVERE CYSTIC ACNE)	MEDICAL AND SURGICAL TREATMENT
379	RETINAL TEAR	LASER PROPHYLAXIS
380	CHOLESTEATOMA; INFECTIONS OF THE PINNA	MEDICAL AND SURGICAL TREATMENT
381	DISRUPTIONS OF THE LIGAMENTS AND TENDONS OF THE ARMS AND LEGS, EXCLUDING THE KNEE, RESULTING IN SIGNIFICANT INJURY/IMPAIRMENT	REPAIR
382	DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE LEVEL OF INDEPENDENCE IN SELF- DIRECTED CARE CAUSED BY CHRONIC CONDITIONS THAT CAUSE NEUROLOGICAL DYSFUNCTION	MEDICAL THERAPY (SHORT TERM REHABILITATION WITH DEFINED GOALS)

Line	Condition	Treatment
383	ESOPHAGEAL STRICTURE; ACHALASIA	MEDICAL AND SURGICAL TREATMENT
384	CHRONIC ULCER OF SKIN	MEDICAL AND SURGICAL TREATMENT
385	ESOPHAGITIS; ESOPHAGEAL AND INTRAESOPHAGEAL HERNIAS	SHORT-TERM MEDICAL THERAPY; SURGICAL TREATMENT
386	BULIMIA NERVOSA AND UNSPECIFIED EATING DISORDERS	MEDICAL/PSYCHOTHERAPY
387	LATE SYPHILIS	MEDICAL THERAPY
388	CENTRAL SEROUS CHORIORETINOPATHY	MEDICAL AND SURGICAL TREATMENT
389	DENTAL CONDITIONS (E.G. PULPAL PATHOLOGY, PERMANENT ANTERIOR TOOTH)	BASIC ENDODONTICS (I.E. ROOT CANAL THERAPY)
390	SUPERFICIAL INJURIES WITH INFECTION	MEDICAL AND SURGICAL TREATMENT
391	PITUITARY DWARFISM	MEDICAL THERAPY
392	DEFORMITY/CLOSED DISLOCATION OF MINOR JOINT AND RECURRENT JOINT DISLOCATIONS	SURGICAL TREATMENT
393	ANOGENITAL VIRAL WARTS	MEDICAL AND SURGICAL TREATMENT
394	SEPARATION ANXIETY DISORDER	MEDICAL/PSYCHOTHERAPY
395	ACUTE OTITIS MEDIA	MEDICAL AND SURGICAL TREATMENT
396	INTESTINAL DISACCHARIDASE AND OTHER DEFICIENCIES	MEDICAL THERAPY
397	PANIC DISORDER; AGORAPHOBIA	MEDICAL/PSYCHOTHERAPY
398	CROUP SYNDROME, EPIGLOTTITIS, ACUTE LARYNGOTRACHEITIS	MEDICAL THERAPY, INTUBATION, TRACHEOTOMY
399	STRABISMUS WITHOUT AMBLYOPIA AND OTHER DISORDERS OF BINOCULAR EYE MOVEMENTS; CONGENITAL ANOMALIES OF EYE; LACRIMAL DUCT OBSTRUCTION IN CHILDREN	MEDICAL AND SURGICAL TREATMENT
400	ANAL FISTULA	SPHINCTEROTOMY, FISSURECTOMY, FISTULECTOMY, MEDICAL THERAPY
401	ENDOMETRIOSIS AND ADENOMYOSIS	MEDICAL AND SURGICAL TREATMENT
402	ACUTE MYELOID LEUKEMIA	BONE MARROW TRANSPLANT AND MEDICAL THERAPY, WHICH INCLUDES CHEMOTHERAPY, RADIATION AND RADIONUCLEIDE THERAPY
403	MYELOID DISORDERS	MEDICAL THERAPY, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY
404	INFLUENZA	MEDICAL THERAPY
405	CHRONIC MYELOID LEUKEMIA	BONE MARROW TRANSPLANT
406	BENIGN CONDITIONS OF BONE AND JOINTS AT HIGH RISK FOR COMPLICATIONS	MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY
407	CONDITIONS OF THE BACK AND SPINE	RISK ASSESSMENT, PHYSICAL MODALITIES, COGNITIVE BEHAVIORAL THERAPY, MEDICAL THERAPY
408	LYMPHADENITIS	MEDICAL AND SURGICAL TREATMENT
409	UTERINE LEIOMYOMA AND POLYPS	SURGICAL TREATMENT
410	APHAKIA AND OTHER DISORDERS OF LENS	MEDICAL AND SURGICAL THERAPY

Line	Condition	Treatment
411	BILATERAL ANOMALIES OF EXTERNAL EAR WITH IMPAIRMENT OF HEARING	RECONSTRUCT OF EAR CANAL
412	DISSOCIATIVE DISORDERS	MEDICAL/PSYCHOTHERAPY
413	EPIDERMOLYSIS BULLOSA	MEDICAL THERAPY
414	DELIRIUM DUE TO MEDICAL CAUSES	MEDICAL THERAPY
415	MIGRAINE HEADACHES	MEDICAL THERAPY
416	DENTAL CONDITIONS (EG. PULPAL PATHOLOGY, PERMANENT BICUSPID/PREMOLAR TOOTH)	BASIC ENDODONTICS (I.E. ROOT CANAL THERAPY)
417	SCHIZOTYPAL PERSONALITY DISORDERS	MEDICAL/PSYCHOTHERAPY
418	BALANOPOSTHITIS AND OTHER DISORDERS OF PENIS	MEDICAL AND SURGICAL TREATMENT
419	OVERANXIOUS DISORDER; GENERALIZED ANXIETY DISORDER; ANXIETY DISORDER, UNSPECIFIED	MEDICAL/PSYCHOTHERAPY
420	TRANSIENT CEREBRAL ISCHEMIA; OCCLUSION/STENOSIS OF PRECEREBRAL ARTERIES WITHOUT OCCLUSION	MEDICAL THERAPY; THROMBOENDARTERECTOMY
421	PERIPHERAL NERVE ENTRAPMENT; PALMAR FASCIAL FIBROMATOSIS	MEDICAL AND SURGICAL TREATMENT
422	MENIERE'S DISEASE	MEDICAL AND SURGICAL TREATMENT
423	DISORDERS OF SHOULDER, INCLUDING SPRAINS/STRAINS GRADE 3 THROUGH 6	REPAIR/RECONSTRUCTION, MEDICAL THERAPY
424	CHRONIC LEUKEMIAS WITH POOR PROGNOSIS	MEDICAL THERAPY, WHICH INCLUDES CHEMOTHERAPY, RADIATION AND RADIONUCLEIDE THERAPY
425	OPPOSITIONAL DEFIANT DISORDER	MEDICAL/PSYCHOTHERAPY
426	MENSTRUAL BLEEDING DISORDERS	MEDICAL AND SURGICAL TREATMENT
427	LYMPHEDEMA	MEDICAL THERAPY, OTHER OPERATION ON LYMPH CHANNEL
428	COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT	MEDICAL AND SURGICAL TREATMENT
429	ADRENOGENITAL DISORDERS	MEDICAL AND SURGICAL TREATMENT
430	SEVERE INFLAMMATORY SKIN DISEASE	MEDICAL THERAPY
431	ACUTE PERIPHERAL MOTOR AND DIGITAL NERVE INJURY	SURGICAL THERAPY
432	NON-MALIGNANT OTITIS EXTERNA	MEDICAL THERAPY
433	VAGINITIS AND CERVICITIS	MEDICAL THERAPY
434	NONINFLAMMATORY DISORDERS AND BENIGN NEOPLASMS OF OVARY, FALLOPIAN TUBES AND UTERUS; OVARIAN CYSTS; GONADAL DYSGENISIS	MEDICAL AND SURGICAL TREATMENT
435	URETHRAL FISTULA	EXCISION, MEDICAL THERAPY
436	INTERNAL DERANGEMENT OF KNEE AND LIGAMENTOUS DISRUPTIONS OF THE KNEE, RESULTING IN SIGNIFICANT INJURY/IMPAIRMENT	REPAIR, MEDICAL THERAPY
437	PERSISTENT DEPRESSIVE DISORDER	MEDICAL/PSYCHOTHERAPY
438	HYPOSPADIAS AND EPISPADIAS	REPAIR
439	CANCER OF GALLBLADDER AND OTHER BILIARY	MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY

Line	Condition	Treatment
440	PRECANCEROUS VULVAR CONDITIONS	MEDICAL THERAPY
441	RECURRENT EROSION OF THE CORNEA	ANTERIAL STROMAL PUNCTURE, REMOVAL OF CORNEAL EPITHELIUM; WITH OR WITHOUT CHEMOCAUTERIZATION
442	STEREOTYPY/HABIT DISORDER AND SELF-ABUSIVE BEHAVIOR DUE TO NEUROLOGICAL DYSFUNCTION	CONSULTATION/MEDICATION MANAGEMENT/LIMITED BEHAVIORAL MODIFICATION
443	FOREIGN BODY IN UTERUS, VULVA AND VAGINA	MEDICAL AND SURGICAL TREATMENT
444	RESIDUAL FOREIGN BODY IN SOFT TISSUE	REMOVAL
445	VENOUS TRIBUTARY (BRANCH) OCCLUSION; CENTRAL RETINAL VEIN OCCLUSION	SURGICAL TREATMENT INCLUDING LASER SURGERY, MEDICAL THERAPY INCLUDING INJECTION
446	TRIGEMINAL AND OTHER NERVE DISORDERS	MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES RADIATION THERAPY
447	MALUNION AND NONUNION OF FRACTURE	SURGICAL TREATMENT
448	DENTAL CONDITIONS (EG. PULPAL PATHOLOGY, PERMANENT MOLAR TOOTH)	BASIC ENDODONTICS (I.E. ROOT CANAL THERAPY)
449	ADJUSTMENT DISORDERS	MEDICAL/PSYCHOTHERAPY
450	HEARING LOSS - OVER AGE OF FIVE	MEDICAL THERAPY INCLUDING HEARING AIDS
451	TOURETTE'S DISORDER AND TIC DISORDERS	MEDICAL/PSYCHOTHERAPY
452	ATHEROSCLEROSIS, AORTIC AND RENAL	MEDICAL AND SURGICAL TREATMENT
453	DEGENERATION OF MACULA AND POSTERIOR POLE	MEDICAL, SURGICAL AND LASER TREATMENT
454	REACTIVE ATTACHMENT DISORDER OF INFANCY OR EARLY CHILDHOOD	MEDICAL/PSYCHOTHERAPY
455	DISORDERS OF REFRACTION AND ACCOMMODATION	MEDICAL THERAPY
456	EXOPHTHALMOS AND CYSTS OF THE EYE AND ORBIT	SURGICAL TREATMENT
457	DENTAL CONDITIONS (EG. MISSING TEETH, PROSTHESIS FAILURE)	REMOVABLE PROSTHODONTICS (E.G. FULL AND PARTIAL DENTURES, RELINES)
458	RECTAL PROLAPSE	SURGICAL TREATMENT
459	URINARY INCONTINENCE	MEDICAL AND SURGICAL TREATMENT
460	DISORDERS OF PLASMA PROTEIN METABOLISM	MEDICAL THERAPY
461	DENTAL CONDITIONS (E.G. PULPAL PATHOLOGY, PERMANENT ANTERIOR TOOTH)	ADVANCED ENDODONTICS (E.G. RETREATMENT OF PREVIOUS ROOT CANAL THERAPY)
462	SIMPLE PHOBIAS AND SOCIAL ANXIETY DISORDER	MEDICAL/PSYCHOTHERAPY
463	ACUTE BRONCHITIS AND BRONCHIOLITIS	MEDICAL THERAPY
464	CENTRAL PTERYGIUM AFFECTING VISION	EXCISION OR TRANSPOSITION OF PTERYGIUM WITHOUT GRAFT, RADIATION THERAPY
465	BRANCHIAL CLEFT CYST; THYROGLOSSAL DUCT CYST; CYST OF PHARYNX OR NASOPHARYNX	EXCISION, MEDICAL THERAPY
466	OBSESSIVE-COMPULSIVE DISORDERS	MEDICAL/PSYCHOTHERAPY
467	OSTEOARTHRITIS AND ALLIED DISORDERS	MEDICAL THERAPY, INJECTIONS

Line	Condition	Treatment
468	ATELECTASIS (COLLAPSE OF LUNG)	MEDICAL THERAPY
469	CHRONIC SINUSITIS	MEDICAL AND SURGICAL TREATMENT
470	UTERINE PROLAPSE; CYSTOCELE	MEDICAL AND SURGICAL TREATMENT
471	BRACHIAL PLEXUS LESIONS	MEDICAL THERAPY
472	DENTAL CONDITIONS (EG. CARIES, FRACTURED TOOTH)	ADVANCED RESTORATIVE (I.E. BASIC CROWNS)
473	GONADAL DYSFUNCTION, MENOPAUSAL MANAGEMENT	OOPHORECTOMY, ORCHIECTOMY, HORMONAL REPLACEMENT FOR PURPOSES OTHER THAN INFERTILITY
474	ENCOPRESIS NOT DUE TO A PHYSIOLOGICAL CONDITION	MEDICAL/PSYCHOTHERAPY
475	ACQUIRED PTOSIS AND OTHER EYELID DISORDERS WITH VISION IMPAIRMENT	PTOSIS REPAIR
476	KERATOCONJUNCTIVITS	MEDICAL AND SURGICAL TREATMENT
477	SELECTIVE MUTISM	MEDICAL/PSYCHOTHERAPY
478	THROMBOSED AND COMPLICATED HEMORRHOIDS	HEMORRHOIDECTOMY, INCISION
479	CHRONIC OTITIS MEDIA; OPEN WOUND OF EAR DRUM	PE TUBES/ADENOIDECTOMY/TYMPANOPLASTY, MEDICAL THERAPY
480	OTOSCLEROSIS	MEDICAL AND SURGICAL TREATMENT
481	FOREIGN BODY IN EAR AND NOSE	REMOVAL OF FOREIGN BODY
482	CLOSED DISLOCATIONS/FRACTURES OF NON-CERVICAL VERTEBRAL COLUMN WITHOUT NEUROLOGIC INJURY OR STRUCTURAL INSTABILITY	MEDICAL AND SURGICAL TREATMENT
483	CONDUCT DISORDER, AGE 18 OR UNDER	MEDICAL/PSYCHOTHERAPY
484	BREAST CYSTS AND OTHER DISORDERS OF THE BREAST	MEDICAL AND SURGICAL TREATMENT
485	CYSTS OF BARTHOLIN'S GLAND AND VULVA	INCISION AND DRAINAGE, MEDICAL THERAPY
486	LICHEN PLANUS	MEDICAL THERAPY
487	RUPTURE OF SYNOVIUM	REMOVAL OF BAKER'S CYST
488	ENOPHTHALMOS	ORBITAL IMPLANT
489	BELL'S PALSY, EXPOSURE KERATOCONJUNCTIVITIS	TARSORRHAPHY
490	PERIPHERAL ENTHESOPATHIES	MEDICAL THERAPY
491	ANGIOEDEMA	MEDICAL THERAPY
492	CLOSED FRACTURE OF ONE OR MORE PHALANGES OF THE FOOT, NOT INCLUDING THE GREAT TOE	MEDICAL AND SURGICAL TREATMENT
493	DERMATOPHYTOSIS OF NAIL, GROIN, AND FOOT AND OTHER DERMATOMYCOSIS	MEDICAL AND SURGICAL TREATMENT
494	CLOSED FRACTURES OF RIBS, STERNUM AND COCCYX	MEDICAL THERAPY
495	SPASTIC DIPLEGIA	RHIZOTOMY
496	DENTAL CONDITIONS (EG. PERIODONTAL DISEASE)	ADVANCED PERIODONTICS (E.G. SURGICAL PROCEDURES AND SPLINTING)
497	HEPATORENAL SYNDROME	MEDICAL THERAPY
498	PARAPHILIAS AND OTHER PSYCHOSEXUAL DISORDERS	MEDICAL/PSYCHOTHERAPY
499	ECTROPION AND BENIGN NEOPLASM OF EYE	ECTROPION REPAIR

Line	Condition	Treatment
500	RAYNAUD'S SYNDROME	MEDICAL THERAPY
501	CALCIUM PYROPHOSPHATE DEPOSITION DISEASE (CPPD) AND HYDROXYAPETITE DEPOSITION DISEASE	MEDICAL THERAPY
502	PHIMOSIS	SURGICAL TREATMENT
503	CERUMEN IMPACTION	REMOVAL OF EAR WAX
504	SIALOLITHIASIS, MUCOCELE, DISTURBANCE OF SALIVARY SECRETION, OTHER AND UNSPECIFIED DISEASES OF SALIVARY GLANDS	MEDICAL AND SURGICAL TREATMENT
505	CHRONIC CONJUNCTIVITIS, BLEPHAROCONJUNCTIVITIS	MEDICAL THERAPY
506	OTHER DISORDERS OF SYNOVIUM, TENDON AND BURSA, COSTOCHONDRITIS, AND CHONDRODYSTROPHY	MEDICAL THERAPY
507	ERYTHEMATOUS CONDITIONS	MEDICAL THERAPY
508	PERIPHERAL ENTHESOPATHIES	SURGICAL TREATMENT
509	NASAL POLYPS, OTHER DISORDERS OF NASAL CAVITY AND SINUSES	MEDICAL AND SURGICAL TREATMENT
510	DENTAL CONDITIONS (E.G. PULPAL PATHOLOGY, PERMANENT BICUSPID/PREMOLAR TOOTH)	ADVANCED ENDODONTICS (E.G. RETREATMENT OF PREVIOUS ROOT CANAL THERAPY)
511	CIRCUMSCRIBED SCLERODERMA	MEDICAL THERAPY
512	PERIPHERAL NERVE DISORDERS	MEDICAL THERAPY
513	DYSFUNCTION OF NASOLACRIMAL SYSTEM IN ADULTS; LACRIMAL SYSTEM LACERATION	MEDICAL AND SURGICAL TREATMENT
514	BENIGN NEOPLASM OF KIDNEY AND OTHER URINARY ORGANS	MEDICAL AND SURGICAL TREATMENT
515	VERTIGINOUS SYNDROMES AND OTHER DISORDERS OF VESTIBULAR SYSTEM	MEDICAL AND SURGICAL TREATMENT
516	ESOPHAGITIS AND GERD; ESOPHAGEAL SPASM; ASYMPTOMATIC DIAPHRAGMATIC HERNIA	MEDICAL THERAPY
517	HIDRADENITIS SUPPURATIVA; DISSECTING CELLULITIS OF THE SCALP	MEDICAL THERAPY
518	CHRONIC PROSTATITIS, OTHER DISORDERS OF PROSTATE	MEDICAL THERAPY
519	PHLEBITIS AND THROMBOPHLEBITIS, SUPERFICIAL	MEDICAL THERAPY
520	DISORDERS OF SWEAT GLANDS	MEDICAL THERAPY
521	PARALYSIS OF VOCAL CORDS OR LARYNX	INCISION/EXCISION/ENDOSCOPY
522	POSTTHROMBOTIC SYNDROME	MEDICAL THERAPY
523	FOREIGN BODY IN GASTROINTESTINAL TRACT WITHOUT RISK OF PERFORATION OR OBSTRUCTION	MEDICAL THERAPY
524	PANNICULITIS	MEDICAL THERAPY
525	ROSACEA; ACNE	MEDICAL AND SURGICAL TREATMENT
526	SEXUAL DYSFUNCTION	PSYCHOTHERAPY, MEDICAL AND SURGICAL TREATMENT
527	UNCOMPLICATED HERNIA AND VENTRAL HERNIA (OTHER THAN INGUINAL HERNIA IN CHILDREN AGE 18 AND UNDER OR DIAPHRAGMATIC HERNIA)	REPAIR

Line	Condition	Treatment
528	BENIGN NEOPLASM OF NASAL CAVITIES, MIDDLE EAR AND ACCESSORY SINUSES	EXCISION, RECONSTRUCTION
529	CHRONIC ANAL FISSURE	SPHINCTEROTOMY, FISSURECTOMY, FISTULECTOMY, MEDICAL THERAPY
530	DEFORMITIES OF UPPER BODY AND ALL LIMBS	REPAIR/REVISION/RECONSTRUCTION/RELOCATION/MEDICAL THERAPY
531	DISORDERS OF FUNCTION OF STOMACH AND OTHER FUNCTIONAL DIGESTIVE DISORDERS	MEDICAL AND SURGICAL THERAPY
532	CONDITIONS OF THE BACK AND SPINE WITHOUT URGENT SURGICAL INDICATIONS	SURGICAL THERAPY
533	FIBROMYALGIA, CHRONIC FATIGUE SYNDROME, AND RELATED DISORDERS	MEDICAL THERAPY
534	CHRONIC PELVIC INFLAMMATORY DISEASE, PELVIC PAIN SYNDROME, DYSPAREUNIA	MEDICAL AND SURGICAL TREATMENT
535	ATOPIC DERMATITIS	MEDICAL THERAPY
536	CONTACT DERMATITIS AND OTHER ECZEMA	MEDICAL THERAPY
537	HYPOTENSION	MEDICAL THERAPY
538	VIRAL, SELF-LIMITING ENCEPHALITIS, MYELITIS AND ENCEPHALOMYELITIS	MEDICAL THERAPY
539	PERIPHERAL NERVE DISORDERS	SURGICAL TREATMENT
540	DENTAL CONDITIONS (E.G. PULPAL PATHOLOGY, PERMANENT MOLAR TOOTH)	ADVANCED ENDODONTICS (E.G. RETREATMENT OF PREVIOUS ROOT CANAL THERAPY)
541	ICHTHYOSIS	MEDICAL THERAPY
542	LESION OF PLANTAR NERVE; PLANTAR FASCIAL FIBROMATOSIS	MEDICAL THERAPY, EXCISION
543	TENSION HEADACHES	MEDICAL THERAPY
544	MILD PSORIASIS ; DERMATOPHYTOSIS: SCALP, HAND, BODY, DEEP-SEATED	MEDICAL THERAPY
545	DEFORMITIES OF FOOT	FASCIOTOMY/INCISION/REPAIR/ARTHRODESIS
546	FOREIGN BODY GRANULOMA OF MUSCLE, SKIN AND SUBCUTANEOUS TISSUE	REMOVAL OF GRANULOMA
547	HYDROCELE	MEDICAL THERAPY, EXCISION
548	SYMPTOMATIC URTICARIA	MEDICAL THERAPY
549	IMPULSE DISORDERS	MEDICAL/PSYCHOTHERAPY
550	SUBLINGUAL, SCROTAL, AND PELVIC VARICES	VENOUS INJECTION, VASCULAR SURGERY
551	ASEPTIC MENINGITIS	MEDICAL THERAPY
552	TMJ DISORDER	TMJ SPLINTS
553	CHRONIC DISEASE OF TONSILS AND ADENOIDS	TONSILLECTOMY AND ADENOIDECTOMY
554	SOMATIC SYMPTOMS AND RELATED DISORDERS	CONSULTATION
555	OTHER NONINFECTIOUS GASTROENTERITIS AND COLITIS	MEDICAL THERAPY
556	HEMATOMA OF AURICLE OR PINNA AND HEMATOMA OF EXTERNAL EAR	DRAINAGE

Line	Condition	Treatment
557	MILD ECZEMATOUS AND OTHER HYPERTROPHIC OR ATROPHIC CONDITIONS OF SKIN	MEDICAL THERAPY
558	CHONDROMALACIA	MEDICAL THERAPY
559	CYST OF KIDNEY, ACQUIRED	MEDICAL THERAPY
560	DYSMENORRHEA	MEDICAL AND SURGICAL TREATMENT
561	BENIGN NEOPLASM OF BONE AND ARTICULAR CARTILAGE INCLUDING OSTEOID OSTEOMAS; BENIGN NEOPLASM OF CONNECTIVE AND OTHER SOFT TISSUE	MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY
562	SPASTIC DYSPHONIA	MEDICAL THERAPY
563	MACROMASTIA	BREAST REDUCTION
564	ALLERGIC RHINITIS AND CONJUNCTIVITIS, CHRONIC RHINITIS	MEDICAL THERAPY
565	CANCER OF LIVER AND INTRAHEPATIC BILE DUCTS	LIVER TRANSPLANT
566	BENIGN NEOPLASM AND CONDITIONS OF EXTERNAL FEMALE GENITAL ORGANS	EXCISION
567	HORDEOLUM AND OTHER DEEP INFLAMMATION OF EYELID; CHALAZION	INCISION AND DRAINAGE, MEDICAL THERAPY
568	ACUTE ANAL FISSURE	FISSURECTOMY, MEDICAL THERAPY
569	PLEURISY	MEDICAL THERAPY
570	PERITONEAL ADHESION	SURGICAL TREATMENT
571	DERMATITIS DUE TO SUBSTANCES TAKEN INTERNALLY	MEDICAL THERAPY
572	BLEPHARITIS	MEDICAL THERAPY
573	UNSPECIFIED URINARY OBSTRUCTION AND BENIGN PROSTATIC HYPERPLASIA WITHOUT OBSTRUCTION	MEDICAL THERAPY
574	OTHER COMPLICATIONS OF A PROCEDURE	MEDICAL AND SURGICAL TREATMENT
575	ANEMIAS DUE TO DISEASE	MEDICAL THERAPY
576	PERSONALITY DISORDERS EXCLUDING BORDERLINE AND SCHIZOTYPAL	MEDICAL/PSYCHOTHERAPY
577	ACUTE NON-SUPPURATIVE LABYRINTHITIS	MEDICAL THERAPY
578	DEVIATED NASAL SEPTUM, ACQUIRED DEFORMITY OF NOSE, OTHER DISEASES OF UPPER RESPIRATORY TRACT	EXCISION OF CYST/RHINECTOMY/PROSTHESIS
579	STOMATITIS AND OTHER DISEASES OF ORAL SOFT TISSUES	INCISION AND DRAINAGE, MEDICAL THERAPY
580	CAVUS DEFORMITY OF FOOT; FLAT FOOT; POLYDACTYLY AND SYNDACTYLY OF TOES	MEDICAL THERAPY, ORTHOTIC
581	INFECTIOUS MONONUCLEOSIS	MEDICAL THERAPY
582	URETHRITIS, NON-SEXUALLY TRANSMITTED	MEDICAL THERAPY
583	CONGENITAL ANOMALIES OF FEMALE GENITAL ORGANS EXCLUDING VAGINA	SURGICAL TREATMENT
584	THROMBOTIC DISORDERS	MEDICAL THERAPY
585	CANDIDIASIS OF MOUTH, SKIN AND NAILS	MEDICAL THERAPY
586	BENIGN NEOPLASM OF MALE GENITAL ORGANS: TESTIS, PROSTATE, EPIDIDYMIS	MEDICAL AND SURGICAL TREATMENT

Line	Condition	Treatment
587	ATROPHY OF EDENTULOUS ALVEOLAR RIDGE	VESTIBULOPLASTY, GRAFTS, IMPLANTS
588	DISEASE OF NAILS, HAIR AND HAIR FOLLICLES	MEDICAL THERAPY
589	OBESITY (ADULT BMI ≥ 30, CHILDHOOD BMI ≥ 95 PERCENTILE)	NON-INTENSIVE NUTRITIONAL/PHYSICAL ACTIVITY COUNSELING AND BEHAVIORAL INTERVENTIONS; BARIATRIC SURGERY FOR OBESITY WITH A SIGNIFICANT COMORBIDITY OTHER THAN TYPE II DIABETES & BMI >=35 OR BMI>=40 WITHOUT A SIGNIFICANT COMORBIDITY
590	ACUTE TONSILLITIS OTHER THAN BETA-STREPTOCOCCAL	MEDICAL THERAPY
591	CORNS AND CALLUSES	MEDICAL THERAPY
592	SYNOVITIS AND TENOSYNOVITIS	MEDICAL THERAPY
593	PROLAPSED URETHRAL MUCOSA	SURGICAL TREATMENT
594	DENTAL CONDITIONS (EG. CARIES, FRACTURED TOOTH)	ADVANCED RESTORATIVE-ELECTIVE (INLAYS,ONLAYS,GOLD FOIL AND HIGH NOBLE METAL RESTORATIONS)
595	SECONDARY AND ILL-DEFINED MALIGNANT NEOPLASMS	MEDICAL AND SURGICAL TREATMENT
596	GANGLION	EXCISION
597	EPISCLERITIS	MEDICAL THERAPY
598	DIAPER RASH	MEDICAL THERAPY
599	TONGUE TIE AND OTHER ANOMALIES OF TONGUE	FRENOTOMY, TONGUE TIE
600	INCONSEQUENTIAL CYSTS OF ORAL SOFT TISSUES	INCISION AND DRAINAGE
601	CONGENITAL DEFORMITIES OF KNEE	MEDICAL AND SURGICAL TREATMENT
602	CHRONIC PANCREATITIS	SURGICAL TREATMENT
603	HERPES SIMPLEX WITHOUT COMPLICATIONS, EXCLUDING GENITAL HERPES	MEDICAL THERAPY
604	DENTAL CONDITIONS (EG. MISSING TEETH)	COMPLEX PROSTHODONTICS (I.E. FIXED BRIDGES, OVERDENTURES)
605	CONGENITAL ANOMALIES OF THE EAR WITHOUT IMPAIRMENT OF HEARING; UNILATERAL ANOMALIES OF THE EAR	OTOPLASTY, REPAIR AND AMPUTATION
606	KELOID SCAR; OTHER ABNORMAL GRANULATION TISSUE	INTRALESIONAL INJECTIONS/DESTRUCTION/EXCISION, RADIATION THERAPY
607	DISORDERS OF SOFT TISSUE	MEDICAL THERAPY
608	MINOR BURNS	MEDICAL THERAPY
609	DISORDERS OF SLEEP WITHOUT SLEEP APNEA	MEDICAL THERAPY
610	ORAL APHTHAE	MEDICAL THERAPY
611	SPRAINS AND STRAINS OF ADJACENT MUSCLES AND JOINTS, MINOR	MEDICAL THERAPY
612	ASYMPTOMATIC URTICARIA	MEDICAL THERAPY
613	FINGERTIP AVULSION	REPAIR WITHOUT PEDICLE GRAFT
614	ABUSE OF NONADDICTIVE SUBSTANCES	MEDICAL THERAPY
615	MINOR HEAD INJURY: HEMATOMA/EDEMA WITH NO PERSISTENT SYMPTOMS	MEDICAL THERAPY

Line	Condition	Treatment
616	VIRAL WARTS EXCLUDING VENEREAL WARTS	MEDICAL AND SURGICAL TREATMENT, CRYOSURGERY
617	ACUTE UPPER RESPIRATORY INFECTIONS AND COMMON COLD	MEDICAL THERAPY
618	OTHER VIRAL INFECTIONS	MEDICAL THERAPY
619	PHARYNGITIS AND LARYNGITIS AND OTHER DISEASES OF VOCAL CORDS	MEDICAL THERAPY
620	ANOMALIES OF RELATIONSHIP OF JAW TO CRANIAL BASE, MAJOR ANOMALIES OF JAW SIZE, OTHER SPECIFIED AND UNSPECIFIED DENTOFACIAL ANOMALIES	OSTEOPLASTY, MAXILLA/MANDIBLE
621	DENTAL CONDITIONS (EG. MALOCCLUSION)	ORTHODONTIA (I.E. FIXED AND REMOVABLE APPLIANCES AND ASSOCIATED SURGICAL PROCEDURES)
622	DENTAL CONDITIONS (EG. MISSING TEETH)	IMPLANTS (I.E. IMPLANT PLACEMENT AND ASSOCIATED CROWN OR PROSTHESIS)
623	BENIGN LESIONS OF TONGUE	EXCISION
624	UNCOMPLICATED HEMORRHOIDS	HEMORRHOIDECTOMY, MEDICAL THERAPY
625	PREVENTION SERVICES WITH LIMITED OR NO EVIDENCE OF EFFECTIVENESS	MEDICAL THERAPY
626	OPEN WOUND OF INTERNAL STRUCTURES OF MOUTH WITHOUT COMPLICATION	REPAIR SOFT TISSUES
627	SEBACEOUS CYST	MEDICAL AND SURGICAL TREATMENT
628	SEBORRHEIC KERATOSIS, DYSCHROMIA, AND VASCULAR DISORDERS, SCAR CONDITIONS, AND FIBROSIS OF SKIN	MEDICAL AND SURGICAL TREATMENT
629	REDUNDANT PREPUCE	ELECTIVE CIRCUMCISION
630	CONJUNCTIVAL CYST	EXCISION OF CONJUNCTIVAL CYST
631	BENIGN NEOPLASMS OF SKIN AND OTHER SOFT TISSUES	MEDICAL THERAPY
632	DISEASE OF CAPILLARIES	EXCISION
633	BENIGN CERVICAL CONDITIONS	MEDICAL THERAPY
634	CYST, HEMORRHAGE, AND INFARCTION OF THYROID	SURGICAL TREATMENT
635	PICA	MEDICAL/PSYCHOTHERAPY
636	ACUTE VIRAL CONJUNCTIVITIS	MEDICAL THERAPY
637	MUSCULAR CALCIFICATION AND OSSIFICATION	MEDICAL THERAPY
638	SUPERFICIAL WOUNDS WITHOUT INFECTION AND CONTUSIONS	MEDICAL THERAPY
639	CHRONIC BRONCHITIS	MEDICAL THERAPY
640	GALACTORRHEA, MASTODYNIA, ATROPHY, BENIGN NEOPLASMS AND UNSPECIFIED DISORDERS OF THE BREAST	MEDICAL AND SURGICAL TREATMENT
641	BENIGN POLYPS OF VOCAL CORDS	MEDICAL THERAPY, STRIPPING
642	BENIGN NEOPLASMS OF DIGESTIVE SYSTEM	SURGICAL TREATMENT
643	VARICOSE VEINS OF LOWER EXTREMITIES WITHOUT ULCER OR INFLAMMATION	STRIPPING/SCLEROTHERAPY, MEDICAL THERAPY
644	HYPERTELORISM OF ORBIT	ORBITOTOMY

Line	Condition	Treatment
645	GALLSTONES WITHOUT CHOLECYSTITIS	MEDICAL THERAPY, CHOLECYSTECTOMY
646	GYNECOMASTIA	MASTECTOMY
647	TMJ DISORDERS	TMJ SURGERY
648	EDEMA AND OTHER CONDITIONS INVOLVING THE SKIN OF THE FETUS AND NEWBORN	MEDICAL THERAPY
649	DENTAL CONDITIONS WHERE TREATMENT IS CHOSEN PRIMARILY FOR AESTHETIC CONSIDERATIONS	COSMETIC DENTAL SERVICES
650	DENTAL CONDITIONS WHERE TREATMENT RESULTS IN MARGINAL IMPROVEMENT	ELECTIVE DENTAL SERVICES
651	AGENESIS OF LUNG	MEDICAL THERAPY
652	CENTRAL RETINAL ARTERY OCCLUSION	PARACENTESIS OF AQUEOUS
653	MENTAL DISORDERS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY	EVALUATION
654	INTRACRANIAL CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY	EVALUATION
655	INFECTIOUS DISEASES WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY	EVALUATION
656	ENDOCRINE AND METABOLIC CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY	EVALUATION
657	CARDIOVASCULAR CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY	EVALUATION
658	SENSORY ORGAN CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY	EVALUATION
659	NEUROLOGIC CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY	EVALUATION
660	DERMATOLOGICAL CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY	EVALUATION
661	RESPIRATORY CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY	EVALUATION
662	GENITOURINARY CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY	EVALUATION
663	MUSCULOSKELETAL CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY	EVALUATION
664	GASTROINTESTINAL CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY	EVALUATION
665	MISCELLANEOUS CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY	EVALUATION

STATEMENT OF INTENT AND GUIDELINE DESCRIPTIONS FOR THE 2016-17 PRIORITIZED LIST OF HEALTH SERVICES

Statements of Intent

STATEMENT OF INTENT 1: PALLIATIVE CARE

STATEMENT OF INTENT 2: DEATH WITH DIGNITY ACT

STATEMENT OF INTENT 3: INTEGRATED CARE

Guideline Notes for Ancillary and Diagnostic Services Not Appearing on the Prioritized List

ANCILLARY GUIDELINE A1, NERVE BLOCKS

ANCILLARY GUIDELINE A2, SELF-MONITORING OF BLOOD GLUCOSE IN DIABETES

ANCILLARY GUIDELINE A3, IVC FILTERS FOR TRAUMA

DIAGNOSTIC GUIDELINE D1, NON-PRENATAL GENETIC TESTING GUIDELINE

DIAGNOSTIC GUIDELINE D2, TUBERCULOSIS TESTING GUIDELINE

DIAGNOSTIC GUIDELINE D3, ECHOCARDIOGRAMS WITH CONTRAST FOR CARDIAC CONDITIONS OTHER THAN CARDIAC ANOMALIES

DIAGNOSTIC GUIDELINE D4, ADVANCED IMAGING FOR LOW BACK PAIN

DIAGNOSTIC GUIDELINE D5, NEUROIMAGING FOR HEADACHE

DIAGNOSTIC GUIDELINE D6, MRI FOR BREAST CANCER SCREENING

DIAGNOSTIC GUIDELINE D7, NEUROIMAGING IN DEMENTIA

DIAGNOSTIC GUIDELINE D8, DIAGNOSTIC TESTING FOR OBSTRUCTIVE SLEEP APNEA (OSA) IN ADULTS

DIAGNOSTIC GUIDELINE D9, MRI FOR BREAST CANCER DIAGNOSIS

DIAGNOSTIC GUIDELINE D10, MRI IN MULTIPLE SCLEROSIS

DIAGNOSTIC GUIDELINE D11, MRI OF THE SPINE (CERVICAL AND THORACIC)

DIAGNOSTIC GUIDELINE D12, UPPER ENDOSCOPY FOR GERD OR DYSPEPSIA SYMPTOMS

DIAGNOSTIC GUIDELINE D13, SCREENING FOR CAROTID ARTERY STENOSIS

DIAGNOSTIC GUIDELINE D14, LUNG CANCER SCREENING

DIAGNOSTIC GUIDELINE D15, COMPUTER-AIDED MAMMOGRAPHY

DIAGNOSTIC GUIDELINE D16, OSTEOPOROSIS SCREENING AND MONITORING IN ADULTS

DIAGNOSTIC GUIDELINE D17, PRENATAL GENETIC TESTING

DIAGNOSTIC GUIDELINE D18, ADVANCED IMAGING FOR STAGING OF PROSTATE CANCER

DIAGNOSTIC GUIDELINE D19, SPECT

Guideline Notes for Health Services That Appear on the Prioritized List

GUIDELINE NOTE 1, ROUTINE CERVICAL CANCER SCREENING

GUIDELINE NOTE 2, FETOSCOPIC SURGERY

GUIDELINE NOTE 3, PROPHYLACTIC TREATMENT FOR PREVENTION OF BREAST CANCER IN HIGH RISK WOMEN

GUIDELINE NOTE 4, TOBACCO DEPENDENCE

GUIDELINE NOTE 5, OBESITY AND OVERWEIGHT

GUIDELINE NOTE 6, REHABILITATIVE THERAPIES

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

GUIDELINE NOTE 8, BARIATRIC SURGERY

GUIDELINE NOTE 9, WIRELESS CAPSULE ENDOSCOPY

GUIDELINE NOTE 10, CENTRAL SEROUS CHORIORETINOPATHY AND POSTERIOR CYCLITIS

GUIDELINE NOTE 11, COLONY STIMULATING FACTOR (CSF) GUIDELINES

GUIDELINE NOTE 12, TREATMENT OF CANCER WITH LITTLE OR NO BENEFIT

GUIDELINE NOTE 13, HEMANGIOMAS, COMPLICATED

GUIDELINE NOTE 14, SECOND BONE MARROW TRANSPLANTS

GUIDELINE NOTE 15, HETEROTOPIC BONE FORMATION

GUIDELINE NOTE 16, CYSTIC FIBROSIS CARRIER SCREENING

GUIDELINE NOTE 17, PREVENTIVE DENTAL CARE

GUIDELINE NOTE 18, VENTRICULAR ASSIST DEVICES

GUIDELINE NOTE 19, PET SCAN GUIDELINES

GUIDELINE NOTE 20, ATTENTION DEFICIT/HYPERACTIVITY DISORDERS IN CHILDREN AGE FIVE AND UNDER

GUIDELINE NOTE 21, SEVERE INFLAMMATORY SKIN DISEASE

GUIDELINE NOTE 22, PLANNED CESAREAN DELIVERY

GUIDELINE NOTE 23, COLON CANCER SURVEILLANCE

GUIDELINE NOTE 24, COMPLICATED HERNIAS

GUIDELINE NOTE 25, MENTAL HEALTH PROBLEMS IN CHILDREN AGE FIVE AND UNDER RELATED TO NEGLECT OR ABUSE

GUIDELINE NOTE 26, BREAST CANCER SURVEILLANCE

GUIDELINE NOTE 27, SLEEP APNEA

GUIDELINE NOTE 28, MOOD DISORDERS IN CHILDREN AGE EIGHTEEN AND UNDER

GUIDELINE NOTE 29, TYMPANOSTOMY TUBES IN ACUTE OTITIS MEDIA

GUIDELINE NOTE 30, TESTICULAR CANCER

GUIDELINE NOTE 31, COCHLEAR IMPLANTATION

GUIDELINE NOTE 32, CATARACT

GUIDELINE NOTE 33, CANCERS OF ESOPHAGUS, LIVER, PANCREAS, GALLBLADDER AND OTHER BILIARY

GUIDELINE NOTE 34, ORAL SURGERY

GUIDELINE NOTE 35, SINUS SURGERY

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

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

GUIDELINE NOTE 38, SUBTALAR ARTHROEREISIS

GUIDELINE NOTE 39, ENDOMETRIOSIS AND ADENOMYOSIS

GUIDELINE NOTE 40, UTERINE LEIOMYOMA

GUIDELINE NOTE 41, SCOLIOSIS

GUIDELINE NOTE 42, DISRUPTIVE BEHAVIOR DISORDERS IN CHILDREN AGE FIVE AND UNDER

GUIDELINE NOTE 43, LYMPHEDEMA

GUIDELINE NOTE 44, MENSTRUAL BLEEDING DISORDERS

GUIDELINE NOTE 45, ADJUSTMENT REACTIONS IN CHILDREN AGE FIVE AND UNDER

GUIDELINE NOTE 46, AGE-RELATED MACULAR DEGENERATION

GUIDELINE NOTE 47, URINARY INCONTINENCE

GUIDELINE NOTE 48, FRENULECTOMY/FRENULOTOMY

GUIDELINE NOTE 49, WEARABLE CARDIAC DEFIBRILLATORS

GUIDELINE NOTE 50, PELVIC ORGAN PROLAPSE SURGERY

GUIDELINE NOTE 51, CHRONIC OTITIS MEDIA WITH EFFUSION

GUIDELINE NOTE 52, CHRONIC ANAL FISSURE

GUIDELINE NOTE 53, BASIC PERIODONTICS

GUIDELINE NOTE 54, CONDUCT DISORDER

GUIDELINE NOTE 55, PELVIC PAIN SYNDROME

GUIDELINE NOTE 56, NON-INTERVENTIONAL TREATMENTS FOR CONDITIONS OF THE BACK AND SPINE

GUIDELINE NOTE 57, MILD PSORIASIS

GUIDELINE NOTE 58, IMPULSE DISORDERS

GUIDELINE NOTE 59, DYSMENORRHEA

GUIDELINE NOTE 60, OPIOID PRESCRIBING FOR CONDITIONS OF THE BACK AND SPINE

GUIDELINE NOTE 61, HOSPITALIZATION FOR ACUTE VIRAL INFECTIONS

GUIDELINE NOTE 62, NEGATIVE PRESSURE WOUND THERAPY

GUIDELINE NOTE 63, HYDROCELE REPAIR

GUIDELINE NOTE 64, PHARMACIST MEDICATION MANAGEMENT

GUIDELINE NOTE 65, TELEPHONE AND EMAIL CONSULTATIONS

GUIDELINE NOTE 66, CERVICAL DYSPLASIA

GUIDELINE NOTE 67, ENZYME REPLACEMENT THERAPY

GUIDELINE NOTE 68, HYSTEROSCOPIC BILATERAL FALLOPIAN TUBE OCCLUSION

GUIDELINE NOTE 69, ELECTROCONVULSIVE THERAPY (ECT)

GUIDELINE NOTE 70, HEART-KIDNEY TRANSPLANTS

GUIDELINE NOTE 71, HIP RESURFACING

GUIDELINE NOTE 72, ELECTRONIC ANALYSIS OF INTRATHECAL PUMPS

GUIDELINE NOTE 73, CONGENITAL CHORDEE

GUIDELINE NOTE 74, GROWTH HORMONE TREATMENT

GUIDELINE NOTE 75, APPLIED BEHAVIOR ANALYSIS FOR AUTISM SPECTRUM DISORDER

GUIDELINE NOTE 76, LIVER ELASTOGRAPHY

GUIDELINE NOTE 77, TIPS PROCEDURE

GUIDELINE NOTE 78, HEPATIC METASTASES

GUIDELINE NOTE 79, BREAST RECONSTRUCTION

GUIDELINE NOTE 80, REPAIR OF NOSE TIP

GUIDELINE NOTE 81, RECONSTRUCTION OF THE NOSE

GUIDELINE NOTE 82, EARLY INTERVENTION FOR PSYCHOSIS

GUIDELINE NOTE 83, HIP CORE DECOMPRESSION

GUIDELINE NOTE 84, MEDICAL NUTRITION THERAPY FOR EPILEPSY

GUIDELINE NOTE 85, ELECTIVE INDUCTION OF LABOR

GUIDELINE NOTE 86, ORGANIC MENTAL DISORDERS

GUIDELINE NOTE 87, INFLUENZA

GUIDELINE NOTE 88, USE OF PROGESTERONE CONTAINING IUDS FOR NON-CONTRACEPTIVE INDICATIONS

GUIDELINE NOTE 89, REPAIR OF HIDDEN PENIS

GUIDELINE NOTE 90, COGNITIVE REHABILITATION

GUIDELINE NOTE 91, SILVER COMPOUNDS FOR DENTAL CARIES

GUIDELINE NOTE 92, ACUPUNCTURE

GUIDELINE NOTE 93, IMPLANTABLE GNRH ANALOG THERAPY

GUIDELINE NOTE 94, FIBROMYALGIA

GUIDELINE NOTE 95, IMMUNE MODIFYING THERAPIES FOR MULTIPLE SCLEROSIS

GUIDELINE NOTE 96, TREATMENT OF BENIGN NEOPLASM OF URINARY ORGANS

GUIDELINE NOTE 97, MANAGEMENT OF ACROMIOCLAVICULAR JOINT SPRAIN

GUIDELINE NOTE 98, SIGNIFICANT INJURIES TO LIGAMENTS AND TENDONS

GUIDELINE NOTE 99, ROUTINE PRENATAL ULTRASOUND

GUIDELINE NOTE 100, SMOKING AND SPINAL FUSION

GUIDELINE NOTE 101, ARTIFICIAL DISC REPLACEMENT

GUIDELINE NOTE 102, REPETITIVE TRANSCRANIAL MAGNETIC STIMULATION

GUIDELINE NOTE 103, BONE ANCHORED HEARING AIDS

GUIDELINE NOTE 104, VISCOSUPPLEMENTATION OF THE KNEE

GUIDELINE NOTE 105, EPIDURAL STEROID INJECTIONS FOR BACK PAIN

GUIDELINE NOTE 106, PREVENTIVE SERVICES

GUIDELINE NOTE 107, HYPERBARIC OXYGEN

GUIDELINE NOTE 108, CONTINUOUS BLOOD GLUCOSE MONITORING

GUIDELINE NOTE 109, VERTEBROPLASTY, KYPHOPLASTY, AND SACROPLASTY

GUIDELINE NOTE 110, CHRONIC PELVIC INFLAMMATORY CONDITIONS

GUIDELINE NOTE 111, INTRA-AORTIC BALLOON PUMPS

GUIDELINE NOTE 112, LUNG VOLUME REDUCTION SURGERY

GUIDELINE NOTE 113, DISEASES OF LIPS

GUIDELINE NOTE 114, FEMOROACETABULAR IMPINGEMENT SYNDROME

GUIDELINE NOTE 115, EXTRACORPOREAL PHOTOPHERESIS

GUIDELINE NOTE 116, INTRAOCULAR STEROID TREATMENTS

GUIDELINE NOTE 117, INTRAOCULAR STEROID IMPLANTS FOR RETINAL VEIN OCCLUSION

GUIDELINE NOTE 118, OBSTRUCTIVE SLEEP APNEA DIAGNOSIS AND TREATMENT FOR CHILDREN

GUIDELINE NOTE 119, CAROTID ENDARTERECTOMY

GUIDELINE NOTE 120, PEDIATRIC TRIGGER THUMB

GUIDELINE NOTE 121, CONCUSSION AND POST CONCUSSION SYNDROME

GUIDELINE NOTE 122, ORAL HEALTH RISK ASSESSMENT IN MEDICAL SETTINGS

GUIDELINE NOTE 123, DENTAL FILLINGS FOR POSTERIOR TEETH

GUIDELINE NOTE 124, ALCOHOL SEPTAL ABLATION

GUIDELINE NOTE 125, CAROTID ARTERY STENTING

GUIDELINE NOTE 126, APPLIED BEHAVIOR ANALYSIS INTERVENTIONS FOR SELF-INJURIOUS BEHAVIOR

GUIDELINE NOTE 127, GENDER DYSPHORIA

GUIDELINE NOTE 128, FOREIGN BODIES IN THE GI TRACT

GUIDELINE NOTE 129, FECAL INCONTINENCE

GUIDELINE NOTE 130, BLEPHAROPLASTY

GUIDELINE NOTE 131, HYPOTONY

GUIDELINE NOTE 132, ACNE CONGLOBATA

GUIDELINE NOTE 133, ACUTE PERIPHERAL MOTOR AND DIGITAL NERVE INJURY

GUIDELINE NOTE 134, NEONATAL NASOLACRIMAL DUCT OBSTRUCTION

GUIDELINE NOTE 135, SEVERE INFLAMMATORY SKIN DISEASE

GUIDELINE NOTE 136, COLLAPSED VERTEBRA

GUIDELINE NOTE 137, BENIGN BONE TUMORS

GUIDELINE NOTE 138, OBSTRUCTIVE AND REFLUX UROPATHY

GUIDELINE NOTE 139, FRENOTOMY FOR TONGUE-TIE IN NEWBORNS

GUIDELINE NOTE 140, BREASTFEEDING SUPPORT AND SUPPLIES

GUIDELINE NOTE 141, LARYNGEAL STENOSIS OR PARALYSIS WITH AIRWAY COMPLICATIONS

GUIDELINE NOTE 142, STEREOTACTIC BODY RADIATION THERAPY

GUIDELINE NOTE 143, TREATMENT OF UNILATERAL HEARING LOSS

GUIDELINE NOTE 144, PROTON PUMP INHIBITOR THERAPY FOR GASTROESOPHAGEAL REFLUX DISEASE (GERD)

GUIDELINE NOTE 145, TREATMENTS FOR BENIGN PROSTATE ENLARGEMENT WITH LOWER URINARY TRACT SYMPTOMS

GUIDELINE NOTE146, ABLATION PROCEDURES FOR ATRIAL FIBRILLATION

GUIDELINE NOTE 147, IVC FILTERS FOR ACTIVE PULMONARY EMBOLISM(PE)/DEEP VEIN THROMBOSIS (DVT)

APPENDIX C

COVERAGE GUIDANCES

Coverage guidances are evidence-based reports that include recommendations to payers and providers on the best use of health resources for Oregonians. The following coverage guidances have been approved by the Health Evidence Review Commission through May 2015 (approval date noted in parentheses). After approval, coverage guidances are reviewed every two years to determine if new evidence would result in a change in recommendation. Those guidances that have been reaffirmed as a result of such a re-review are also noted in the parentheses; none of the recommendations required changing based on new evidence. Those coverage guidances followed by an asterisk (*) resulted in changes made to the Prioritized List.

Indications for a Planned Cesarean Section* (6/14/2012, reaffirmed 11/13/2014)

Knee Arthroscopy for Osteoarthritis* (6/14/2012, reaffirmed 11/13/2014)

Low Back Pain - Pharmacologic Interventions (6/14/2012, reaffirmed 11/13/2014)

MRI for Breast Cancer Screening* (6/14/2012, reaffirmed 11/13/2014)

Advanced Imaging for Low Back Pain* (8/9/2012)

Artificial Disk Replacement* (8/9/2012, reaffirmed 11/13/2014)

Hip Resurfacing* (8/9/2012, reaffirmed 11/13/2014)

Lumbar Discography (8/9/2012, reaffirmed 11/13/2014)

Neuroimaging in Dementia* (8/9/2012, reaffirmed 11/13/2014)

Nonpharmacologic Interventions for Treatment Resistant Depression* (8/9/2012, reaffirmed 11/13/2014)

Management of Chronic Otitis Media with Effusion in Children* (10/11/2012, reaffirmed 11/13/2014)

Percutaneous Interventions for Low Back Pain* (10/11/2012, reaffirmed 11/13/2014)

Routine Ultrasound in Pregnancy* (10/11/2012, reaffirmed 11/13/2014)

Viscosupplementation for Osteoarthritis of the Knee* (10/11/2012, reaffirmed 11/13/2014)

Continuous Blood Glucose Monitoring In Diabetes Mellitus* (5/9/2013)

Diagnosis of Sleep Apnea in Adults* (5/9/2013)

MRI for Breast Cancer Diagnosis* (5/9/2013)

Vertebroplasty, Kyphoplasty and Sacroplasty Final* (5/9/2013)

Cervical Cancer Screening* (8/8/2013)

Coronary Artery Calcium Scoring (8/8/2013)

Coronary Computed Tomography Angiography (8/8/2013)

Induction of Labor* (8/8/2013)

Management of Recurrent Acute Otitits Media in Children* (8/8/2013)

Neuroimaging for Headache* (8/8/2013)

PET Scan for Breast Cancer (8/8/2013)

Carotid Endarterectomy* (12/5/2013)

Self-Monitoring of Blood Glucose for Type 1 & 2 Diabetes* (12/5/2013)

Treatment of Attention Deficit Hyperactivity Disorder* (12/5/2013)

Femoroacetabular Impingement Syndrome* (1/9/2014)

Treatment of Sleep Apnea in Adults* (1/9/2014)

Upper Endoscopy for GERD* (1/9/2014)

Prenatal Genetic Testing* (3/13/2014)

Use of DXA in Screening for and Monitoring of Osteoporosis* (6/12/2014)

Indications for Hyperbaric Oxygen Therapy* (11/13/2014)

Low Back Pain: Non-Pharmacologic Non-Invasive Interventions* (11/13/2014)

Ablation for Atrial Fibrillation* (1/8/2015)

Advanced Imaging in Staging of Prostate Cancer* (1/8/2015)

Nuclear Cardiac Imaging for Screening, Diagnosis or Risk Stratification of Coronary Artery Disease* (1/8/2015)

Alternatives of Transurethral Resection of the Prostate (TURP)* (3/12/2015)

Inferior Vena Cava Filters for Prevention of Pulmonary Embolism* (3/12/2015)

Percutaneous Interventions for Cervical Spine Pain* (3/12/2015)

Coronary Artery Revascularization for Stable Angina* (5/7/2015)

APPENDIX D

APPLIED BEHAVIOR ANALYSIS FOR AUTISM SPECTRUM DISORDER

SENATE BILL 365 (2013)

EVALUATION OF EVIDENCE

PRIORITIZED LIST CHANGES

SENATE BILL 365 (2013)

Enrolled
Senate Bill 365

Sponsored by Senators BATES, EDWARDS; Senators DEVLIN, HASS, JOHNSON, Representatives CONGER, MCLANE, PARRISH (Presession filed.)

CHAPTER .....

AN ACT

Relating to treatment for autism spectrum disorders; creating new provisions; amending ORS 676.610, 676.612, 676.613, 676.622, 676.625, 676.992, 743A.190 and 750.055; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. Section 2 of this 2013 Act is added to and made a part of the Insurance Code.

SECTION 2. (1) As used in this section and sections 3 and 3a of this 2013 Act:

(a)(A) "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce significant improvement in human social behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior and that is provided by:

(i) A licensed health care professional registered under section 3 of this 2013 Act;

(ii) A behavior analyst or an assistant behavior analyst licensed under section 3 of this 2013 Act; or

(iii) A behavior analysis interventionist registered under section 3 of this 2013 Act.

(B) "Applied behavior analysis" excludes psychological testing, neuropsychology, psychotherapy, cognitive therapy, sex therapy, psychoanalysis, hypnotherapy and long-term counseling as treatment modalities.

(b) "Autism spectrum disorder" has the meaning given that term in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) published by the American Psychiatric Association.

(c) "Diagnosis" means medically necessary assessment, evaluation or testing.

(d) "Health benefit plan" has the meaning given that term in ORS 743.730.

(e) "Medically necessary" means in accordance with the definition of medical necessity that is specified in the policy or certificate for the health benefit plan and that applies to all covered services under the plan.

(f) "Treatment for autism spectrum disorder" includes applied behavior analysis for up to 25 hours per week and any other mental health or medical services identified in the individualized treatment plan, as described in subsection (6) of this section.

(2) A health benefit plan shall provide coverage of:

(a) The screening for and diagnosis of autism spectrum disorder by a licensed neurologist, pediatric neurologist, developmental pediatrician, psychiatrist or psychologist, who has experience or training in the diagnosis of autism spectrum disorder; and

(b) Medically necessary treatment for autism spectrum disorder and the management of care, for an individual who begins treatment before nine years of age, subject to the requirements of this section.

(3) This section does not require coverage for:

(a) Services provided by a family or household member;

(b) Services that are custodial in nature or that constitute marital, family, educational or training services;

(c) Custodial or respite care, equine assisted therapy, creative arts therapy, wilderness or adventure camps, social counseling, telemedicine, music therapy, neurofeedback, chelation or hyperbaric chambers;

(d) Services provided under an individual education plan in accordance with the Individuals with Disabilities Education Act, 20 U.S.C. 1400 et seq.;

(e) Services provided through community or social programs; or

(f) Services provided by the Department of Human Services or the Oregon Health Authority, other than employee benefit plans offered by the department and the authority.

(4) An insurer may not terminate coverage or refuse to issue or renew coverage for an individual solely because the individual has received a diagnosis of autism spectrum disorder or has received treatment for autism spectrum disorder.

(5) Coverage under this section may be subject to utilization controls that are reasonable in the context of individual determinations of medical necessity. An insurer may require:

(a) An autism spectrum disorder diagnosis by a professional described in subsection (2)(a) of this section if the original diagnosis was not made by a professional described in subsection (2)(a) of this section.

(b) Prior authorization for coverage of a maximum of 25 hours per week of applied behavior analysis recommended in an individualized treatment plan approved by a professional described in subsection (2)(a) of this section for an individual with autism spectrum disorder, as long as the insurer makes a prior authorization determination no later than 30 calendar days after receiving the request for prior authorization.

(6) If an individual is receiving applied behavior analysis, an insurer may require submission of an individualized treatment plan, which shall include all elements necessary for the insurer to appropriately determine coverage under the health benefit plan. The individualized treatment plan must be based on evidence-based screening criteria. An insurer may require an updated individualized treatment plan, not more than once every six months, that includes observed progress as of the date the updated plan was prepared, for the purpose of performing utilization review and medical management. The insurer may require the individualized treatment plan to be approved by a professional described in subsection (2)(a) of this section, and to include the:

(a) Diagnosis;

(b) Proposed treatment by type;

(c) Frequency and anticipated duration of treatment;

(d) Anticipated outcomes stated as goals, including specific cognitive, social, communicative, self-care and behavioral goals that are clearly stated, directly observed and continually measured and that address the characteristics of the autism spectrum disorder; and

(e) Signature of the treating provider.

(7)(a) Once coverage for applied behavior analysis has been approved, the coverage continues as long as:

(A) The individual continues to make progress toward the majority of the goals of the individualized treatment plan; and

(B) Applied behavior analysis is medically necessary.

(b) An insurer may require periodic review of an individualized treatment plan, as described in subsection (6) of this section, and modification of the individualized treatment plan

if the review shows that the individual receiving the treatment is not making substantial clinical progress toward the goals of the individualized treatment plan.

(8) Coverage under this section may be subject to requirements and limitations no more restrictive than those imposed on coverage or reimbursement of expenses arising from the treatment of other medical conditions under the policy or certificate, including but not limited to:

(a) Requirements and limitations regarding in-network providers; and

(b) Provisions relating to deductibles, copayments and coinsurance.

(9) This section applies to coverage for up to 25 hours per week of applied behavior analysis for an individual if the coverage is first requested when the individual is under nine years of age. This section does not limit coverage for any services that are otherwise available to an individual under ORS 743A.168 or 743A.190, including but not limited to:

(a) Treatment for autism spectrum disorder other than applied behavior analysis or the services described in subsection (3) of this section.

(b) Applied behavior analysis for more than 25 hours per week; or

(c) Applied behavior analysis for an individual if the coverage is first requested when the individual is nine years of age or older.

(10) Coverage under this section includes treatment for autism spectrum disorder provided in the individual's home or a licensed health care facility or, for treatment provided by a licensed health care professional registered with the Behavior Analysis Regulatory Board or a behavior analyst or assistant behavior analyst licensed under section 3 of this 2013 Act, in a setting approved by the health care professional, behavior analyst or assistant behavior analyst.

(11) An insurer that provides coverage of applied behavior analysis in accordance with a decision of an independent review organization that was made prior to January 1, 2016, shall continue to provide coverage, subject to modifications made in accordance with subsection (7) of this section.

(12) ORS 743A.001 does not apply to this section.

SECTION 3. (1) There is created, within the Oregon Health Licensing Agency, the Behavior Analysis Regulatory Board consisting of seven members appointed by the Governor, including:

(a) Three members who are licensed by the board;

(b) One member who is a licensed psychiatrist or developmental pediatrician, with experience or training in treating autism spectrum disorder;

(c) One member who is a licensed psychologist registered with the board;

(d) One member who is a licensed speech-language pathologist registered with the board; and

(e) One member of the general public who does not have a financial interest in the provision of applied behavior analysis and does not have a ward or family member who has been diagnosed with autism spectrum disorder.

(2) Not more than one member of the Behavior Analysis Regulatory Board may be an employee of an insurer.

(3) The term of office of each member is four years, but a member serves at the pleasure of the Governor. Before the expiration of the term of a member, the Governor shall appoint a successor whose term begins on November 1 next following. A member is eligible for reappointment. If there is a vacancy for any cause, the Governor shall make an appointment to become immediately effective for the unexpired term.

(4) A member of the Behavior Analysis Regulatory Board is entitled to compensation and expenses as provided in ORS 292.495.

(5) The Behavior Analysis Regulatory Board shall select one of its members as chairperson and another as vice chairperson, for such terms and with duties and powers necessary for the performance of the functions of such offices as the board determines.

(6) A majority of the members of the Behavior Analysis Regulatory Board constitutes a quorum for the transaction of business.

(7) The Behavior Analysis Regulatory Board shall meet at least once every three months at a place, day and hour determined by the board. The board may also meet at other times and places specified by the call of the chairperson or of a majority of the members of the board.

(8) In accordance with ORS chapter 183, the Behavior Analysis Regulatory Board shall establish by rule criteria for the:

(a) Licensing of:

(A) Behavior analysts; and

(B) Assistant behavior analysts; and

(b) Registration of:

(A) Licensed health care professionals; and

(B) Behavior analysis interventionists.

(9) The criteria for the licensing of a behavior analyst must include, but are not limited to, the requirement that the applicant:

(a) Be certified by the Behavior Analyst Certification Board, Incorporated, as a Board Certified Behavior Analyst; and

(b) Have successfully completed a criminal records check.

(10) The criteria for the licensing of an assistant behavior analyst must include, but are not limited to, the requirement that the applicant:

(a) Be certified by the Behavior Analyst Certification Board, Incorporated, as a Board Certified Assistant Behavior Analyst;

(b) Be supervised by a behavior analyst who is licensed by the Behavior Analysis Regulatory Board; and

(c) Have successfully completed a criminal records check.

(11) The criteria for the registration of a behavior analysis interventionist must include, but are not limited to, the requirement that the applicant:

(a) Have completed coursework and training prescribed by the Behavior Analysis Regulatory Board by rule;

(b) Receive ongoing oversight by a licensed behavior analyst or a licensed assistant behavior analyst, or by another licensed health care professional approved by the board; and

(c) Have successfully completed a criminal records check.

(12) In accordance with applicable provisions of ORS chapter 183, the Behavior Analysis Regulatory Board shall adopt rules:

(a) Establishing standards and procedures for the licensing of behavior analysts and assistant behavior analysts and for the registration of licensed health care professionals and behavior analysis interventionists in accordance with this section;

(b) Establishing guidelines for the professional methods and procedures to be used by individuals licensed and registered under this section;

(c) Governing the examination of applicants for licenses and registrations under this section and the renewal, suspension and revocation of the licenses and registrations; and

(d) Establishing fees sufficient to cover the costs of administering the licensing and registration procedures under this section.

(13) The Behavior Analysis Regulatory Board shall issue a license to an applicant who:

(a) Files an application in the form prescribed by the board;

(b) Pays fees established by the board; and

(c) Demonstrates to the satisfaction of the board that the applicant meets the criteria adopted under this section.

(14) The Behavior Analysis Regulatory Board shall establish the procedures for the registration of licensed health care professionals and behavior analysis interventionists.

(15) All moneys received by the Behavior Analysis Regulatory Board under subsection (13) of this section shall be paid into the General Fund of the State Treasury and credited to the Oregon Health Licensing Agency Account.

(16) An individual who has not been licensed or registered by the Behavior Analysis Regulatory Board in accordance with criteria and standards adopted under this section may not claim reimbursement for services described in section 2 of this 2013 Act under a health benefit plan or under a self-insured health plan offered by the Public Employees' Benefit Board or the Oregon Educators Benefit Board.

SECTION 3a. (1) Notwithstanding the composition of the Behavior Analysis Regulatory Board specified in section 3 of this 2013 Act, for the period beginning on the operative date of section 3 of this 2013 Act and ending on October 31, 2015, the board shall consist of seven members appointed by the Governor, including:

(a) Three members who are certified by the Behavior Analyst Certification Board, Incorporated, as Board Certified Behavior Analysts;

(b) One member who is a licensed psychiatrist or developmental pediatrician and who has experience or training in applied behavior analysis;

(c) One member who is a licensed psychologist and who has experience in the diagnosis or treatment of autism spectrum disorders;

(d) One member who is a licensed speech-language pathologist and who has experience or training in applied behavior analysis; and

(e) One member of the general public who does not have a financial interest in the provision of applied behavior analysis and does not have a ward or family member who has been diagnosed with autism spectrum disorder.

(2) Notwithstanding the term of office specified by section 3 of this 2013 Act, if members first appointed to the Behavior Analysis Regulatory Board under this section continue to serve after October 31, 2015, the board shall adopt a method for establishing the terms of office of board members so that the terms of office do not all expire on the same date.

SECTION 4. Notwithstanding section 3 (16) of this 2013 Act, an individual actively practicing applied behavior analysis on the effective date of this 2013 Act may continue to claim reimbursement from a health benefit plan, the Public Employees' Benefit Board or the Oregon Educators Board for services provided without a license before January 1, 2016.

SECTION 5. The Oregon Health Licensing Agency may take any action before November 1, 2013, that is necessary for the agency to implement the provisions of sections 3 and 3a of this 2013 Act on and after November 1, 2013.

SECTION 6. Not later than August 30, 2013, the Health Evidence Review Commission shall begin the process of evaluating applied behavior analysis, as defined in section 2 of this 2013 Act, as a treatment for autism spectrum disorder, as defined in section 2 of this 2013 Act, for the purpose of updating the list of health services recommended under ORS 414.690. Any adjustments to the list of health services that result from the evaluation process must be implemented not later than:

(1) October 1, 2014, if the adjustments do not require the development of new medical coding; and

(2) April 1, 2015, if the adjustments require the development or adoption of new medical coding.

SECTION 7. ORS 743A.190 is amended to read:

743A.190. (1) A health benefit plan, as defined in ORS 743.730, must cover for a child enrolled in the plan who is under 18 years of age and who has been diagnosed with a pervasive developmental disorder all medical services, including rehabilitation services, that are medically necessary and are otherwise covered under the plan.

(2) The coverage required under subsection (1) of this section, including rehabilitation services, may be made subject to other provisions of the health benefit plan that apply to covered services, including but not limited to:

(a) Deductibles, copayments or coinsurance;

(b) Prior authorization or utilization review requirements; or

(c) Treatment limitations regarding the number of visits or the duration of treatment.

(3) As used in this section:

(a) "Medically necessary" means in accordance with the definition of medical necessity that is specified in the policy, certificate or contract for the health benefit plan and that applies uniformly to all covered services under the health benefit plan.

(b) "Pervasive developmental disorder" means a neurological condition that includes [*Asperger's syndrome,*] autism **spectrum disorder**, developmental delay, developmental disability or mental retardation.

(c) "Rehabilitation services" means physical therapy, occupational therapy or speech therapy services to restore or improve function.

(4) The provisions of ORS 743A.001 do not apply to this section.

(5) The definition of "pervasive developmental disorder" is not intended to apply to coverage required under ORS 743A.168 **or section 2 of this 2013 Act**.

SECTION 8. ORS 750.055, as amended by section 3, chapter 21, Oregon Laws 2012, is amended to read:

750.055. (1) The following provisions of the Insurance Code apply to health care service contractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:

(a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.844 to 731.992, 731.870 and 743.061.

(b) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.592, not including ORS 732.582.

(c) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

(d) ORS chapter 734.

(e) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, 743.100 to 743.109, 743.402, 743.472, 743.492, 743.495, 743.498, 743.499, 743.522, 743.523, 743.524, 743.526, 743.527, 743.528, 743.529, 743.549 to 743.552, 743.560, 743.600 to 743.610, 743.650 to 743.656, 743.764, 743.804, 743.807, 743.808, 743.814 to 743.839, 743.842, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.894, 743.911, 743.912, 743.913, 743.917, 743A.010, 743A.012, 743A.020, 743A.034, 743A.036, 743A.048, 743A.058, 743A.062, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144, 743A.148, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.185, 743A.188, 743A.190 and 743A.192 and section 2, chapter 21, Oregon Laws 2012**, and section 2 of this 2013 Act**.

(f) The provisions of ORS chapter 744 relating to the regulation of insurance producers.

(g) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

(h) ORS 743A.024, except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act unless the patient is referred by a physician associated with a group practice health maintenance organization.

(i) ORS 735.600 to 735.650.

(j) ORS 743.680 to 743.689.

(k) ORS 744.700 to 744.740.

(L) ORS 743.730 to 743.773.

(m) ORS 731.485, except in the case of a group practice health maintenance organization that is federally qualified pursuant to Title XIII of the Public Health Service Act and that wholly owns and operates an in-house drug outlet.

(2) For the purposes of this section, health care service contractors shall be deemed insurers.

(3) Any for-profit health care service contractor organized under the laws of any other state that is not governed by the insurance laws of the other state is subject to all requirements of ORS chapter 732.

(4) The Director of the Department of Consumer and Business Services may, after notice and hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025 and 750.045 that are deemed necessary for the proper administration of these provisions.

SECTION 9. Section 10 of this 2013 Act is added to and made a part of ORS chapter 343.

SECTION 10. (1) Section 2 of this 2013 Act does not limit, replace or affect any obligation of a school district to provide services under an individualized education program to a child with a disability in accordance with the Individuals with Disabilities Education Act, 20 U.S.C. 1400 et seq., or other publicly funded programs to assist individuals with autism spectrum disorder.

(2) Any governmental or educational entity providing services as required under the Individuals with Disabilities Education Act, 20 U.S.C. 1400 et seq., as amended, or other state or federal law requiring the provision of services to individuals with disabilities, is prohibited from reducing, eliminating or shifting required services to coverage provided under section 2 of this 2013 Act.

SECTION 11. In the manner prescribed in ORS chapter 183 for contested cases, the Oregon Health Licensing Agency may impose a form of discipline listed in ORS 676.612 against any person licensed or registered under section 3 of this 2013 Act for any of the prohibited acts listed in ORS 676.612 and for any violation of a rule adopted under section 3 of this 2013 Act.

SECTION 12. ORS 676.610 is amended to read:

676.610. (1)(a) The Oregon Health Licensing Agency is under the supervision and control of a director, who is responsible for the performance of the duties, functions and powers and for the organization of the agency.

(b) The Director of the Oregon Department of Administrative Services shall establish the qualifications for and appoint the Director of the Oregon Health Licensing Agency, who holds office at the pleasure of the Director of the Oregon Department of Administrative Services.

(c) The Director of the Oregon Health Licensing Agency shall receive a salary as provided by law or, if not so provided, as prescribed by the Director of the Oregon Department of Administrative Services.

(d) The Director of the Oregon Health Licensing Agency is in the unclassified service.

(2) The Director of the Oregon Health Licensing Agency shall provide the boards, councils and programs administered by the agency with such services and employees as the agency requires to carry out the agency's duties. Subject to any applicable provisions of the State Personnel Relations Law, the Director of the Oregon Health Licensing Agency shall appoint all subordinate officers and employees of the agency, prescribe their duties and fix their compensation.

(3) The Director of the Oregon Health Licensing Agency is responsible for carrying out the duties, functions and powers under ORS 675.360 to 675.410, 676.605 to 676.625, 676.992, 678.710 to 678.820, 680.500 to 680.565, 687.405 to 687.495, 687.895, 688.701 to 688.734, 688.800 to 688.840, 690.005 to 690.235, 690.350 to 690.415, 691.405 to 691.485 and 694.015 to 694.185 **and sections 3 and 11 of this 2013 Act** and ORS chapter 700.

(4) The enumeration of duties, functions and powers in subsection (3) of this section is not intended to be exclusive or to limit the duties, functions and powers imposed on or vested in the Oregon Health Licensing Agency by other statutes.

SECTION 13. ORS 676.612 is amended to read:

676.612. (1) In the manner prescribed in ORS chapter 183 for contested cases and as specified in ORS 675.385, 678.780, 680.535, 687.445, 688.734, 688.836, 690.167, 690.407, 691.477, 694.147 and 700.111 **and section 11 of this 2013 Act**, the Oregon Health Licensing Agency may refuse to issue or renew, may suspend or revoke or may otherwise condition or limit a certificate, license, permit or registration to practice issued by the agency or may discipline or place on probation a holder

of a certificate, license, permit or registration for commission of the prohibited acts listed in subsection (2) of this section.

(2) A person subject to the authority of a board, council or program listed in ORS 676.606 commits a prohibited act if the person engages in:

(a) Fraud, misrepresentation, concealment of material facts or deception in applying for or obtaining an authorization to practice in this state, or in any written or oral communication to the agency concerning the issuance or retention of the authorization.

(b) Using, causing or promoting the use of any advertising matter, promotional literature, testimonial, guarantee, warranty, label, insignia or any other representation, however disseminated or published, that is false, misleading or deceptive.

(c) Making a representation that the certificate, license, permit or registration holder knew or should have known is false or misleading regarding skill or the efficacy or value of treatment or remedy administered by the holder.

(d) Practicing under a false, misleading or deceptive name, or impersonating another certificate, license, permit or registration holder.

(e) Permitting a person other than the certificate, license, permit or registration holder to use the certificate, license, permit or registration.

(f) Practicing with a physical or mental condition that presents an unreasonable risk of harm to the holder of a certificate, license, permit or registration or to the person or property of others in the course of performing the holder's duties.

(g) Practicing while under the influence of alcohol, controlled substances or other skill-impairing substances, or engaging in the illegal use of controlled substances or other skill-impairing substances so as to create a risk of harm to the person or property of others in the course of performing the duties of a holder of a certificate, license, permit or registration.

(h) Failing to properly and reasonably accept responsibility for the actions of employees.

(i) Employing, directly or indirectly, any suspended, uncertified, unlicensed or unregistered person to practice a regulated occupation or profession subject to the authority of the boards, councils and programs listed in ORS 676.606.

(j) Unprofessional conduct, negligence, incompetence, repeated violations or any departure from or failure to conform to standards of practice in performing services or practicing in a regulated occupation or profession subject to the authority of the boards, councils and programs listed under ORS 676.606.

(k) Conviction of any criminal offense, subject to ORS 670.280. A copy of the record of conviction, certified by the clerk of the court entering the conviction, is conclusive evidence of the conviction. A plea of no contest or an admission of guilt shall be considered a conviction for purposes of this paragraph.

(L) Failing to report any adverse action, as required by statute or rule, taken against the certificate, license, permit or registration holder by another regulatory jurisdiction or any peer review body, health care institution, professional association, governmental agency, law enforcement agency or court for acts or conduct similar to acts or conduct that would constitute grounds for disciplinary action as described in this section.

(m) Violation of a statute regulating an occupation or profession subject to the authority of the boards, councils and programs listed in ORS 676.606.

(n) Violation of any rule regulating an occupation or profession subject to the authority of the boards, councils and programs listed in ORS 676.606.

(o) Failing to cooperate with the agency in any investigation, inspection or request for information.

(p) Selling or fraudulently obtaining or furnishing any certificate, license, permit or registration to practice in a regulated occupation or profession subject to the authority of the boards, councils and programs listed in ORS 676.606, or aiding or abetting such an act.

(q) Selling or fraudulently obtaining or furnishing any record related to practice in a regulated occupation or profession subject to the authority of the boards, councils and programs listed in ORS 676.606, or aiding or abetting such an act.

(r) Failing to pay an outstanding civil penalty or fee that is due or failing to meet the terms of any order issued by the agency that has become final.

(3) For the purpose of requesting a state or nationwide criminal records check under ORS 181.534, the agency may require the fingerprints of a person who is:

(a) Applying for a certificate, license, permit or registration that is issued by the agency;

(b) Applying for renewal of a certificate, license, permit or registration that is issued by the agency; or

(c) Under investigation by the agency.

(4) If the agency places a holder of a certificate, license, permit or registration on probation under subsection (1) of this section, the agency, in consultation with the appropriate board, council or program, may determine and at any time modify the conditions of the probation.

(5) If a certificate, license, permit or registration is suspended, the holder may not practice during the term of suspension. Upon the expiration of the term of suspension, the certificate, license, permit or registration may be reinstated by the agency if the conditions of suspension no longer exist and the holder has satisfied all requirements in the relevant statutes or administrative rules for issuance, renewal or reinstatement.

SECTION 14. ORS 676.613 is amended to read:

676.613. (1) In addition to all other remedies, when it appears to the Oregon Health Licensing Agency that a person is engaged in, has engaged in or is about to engage in any act, practice or transaction that violates any provision of ORS 675.360 to 675.410, 676.617, 678.710 to 678.820, 680.500 to 680.565, 687.405 to 687.495, 688.701 to 688.734, 688.800 to 688.840, 690.005 to 690.235, 690.350 to 690.415, 691.405 to 691.485 or 694.015 to 694.185 **or section 3 of this 2013 Act** or ORS chapter 700, the agency may, through the Attorney General or the district attorney of the county in which the act, practice or transaction occurs or will occur, apply to the court for an injunction restraining the person from the act, practice or transaction.

(2) A court may issue an injunction under this section without proof of actual damages. An injunction issued under this section does not relieve a person from any other prosecution or enforcement action taken for violation of statutes listed in subsection (1) of this section.

SECTION 15. ORS 676.622 is amended to read:

676.622. (1) A transaction conducted through a state or local system or network that provides electronic access to the Oregon Health Licensing Agency information and services is exempt from any requirement under ORS 675.360 to 675.410, 676.605 to 676.625, 676.992, 680.500 to 680.565, 687.405 to 687.495, 688.701 to 688.734, 688.800 to 688.840, 690.005 to 690.235, 690.350 to 690.415, 691.405 to 691.485 and 694.015 to 694.185 **and section 3 of this 2013 Act** and ORS chapter 700, and rules adopted thereunder, requiring an original signature or the submission of handwritten materials.

(2) Electronic signatures subject to ORS 84.001 to 84.061 and facsimile signatures are acceptable and have the same force as original signatures.

SECTION 16. ORS 676.625 is amended to read:

676.625. (1) The Oregon Health Licensing Agency shall establish by rule and shall collect fees and charges to carry out the agency's responsibilities under ORS 676.605 to 676.625 and 676.992 and any responsibility imposed on the agency pertaining to the boards, councils and programs administered and regulated by the agency pursuant to ORS 676.606.

(2) The Oregon Health Licensing Agency Account is established in the General Fund of the State Treasury. The account shall consist of the moneys credited to the account by the Legislative Assembly. All moneys in the account are appropriated continuously to and shall be used by the Oregon Health Licensing Agency for payment of expenses of the agency in carrying out the duties, functions and obligations of the agency, and for payment of the expenses of the boards, councils and programs administered and regulated by the agency pursuant to ORS 676.606. The agency shall keep

a record of all moneys credited to the account and report the source from which the moneys are derived and the activity of each board, council or program that generated the moneys.

(3) Subject to prior approval of the Oregon Department of Administrative Services and a report to the Emergency Board prior to adopting fees and charges credited to the account, the fees and charges may not exceed the cost of administering the agency and the boards, councils and programs within the agency, as authorized by the Legislative Assembly within the agency's budget, as the budget may be modified by the Emergency Board.

(4) All moneys credited to the account pursuant to ORS 675.405, 676.617, 680.525, 687.435, 688.728, 688.834, 690.235, 690.415, 691.479, 694.185 and 700.080 **and section 3 of this 2013 Act**, and moneys credited to the account from other agency and program fees established by the agency by rule, are continuously appropriated to the agency for carrying out the duties, functions and powers of the agency under ORS 676.605 to 676.625 and 676.992 **and section 3 of this 2013 Act**.

(5) The moneys received from civil penalties assessed under ORS 676.992 shall be deposited and accounted for as are other moneys received by the agency and shall be for the administration and enforcement of the statutes governing the boards, councils and programs administered by the agency.

SECTION 17. ORS 676.992 is amended to read:

676.992. (1) Except as provided in subsection (3) of this section, and in addition to any other penalty or remedy provided by law, the Oregon Health Licensing Agency may impose a civil penalty not to exceed $5,000 for each violation of the following statutes and any rule adopted thereunder:

(a) ORS 688.701 to 688.734 (athletic training);

(b) ORS 690.005 to 690.235 (cosmetology);

(c) ORS 680.500 to 680.565 (denture technology);

(d) ORS 687.405 to 687.495 (direct entry midwifery);

(e) ORS 690.350 to 690.415 (tattooing, electrolysis, body piercing, dermal implanting and scarification);

(f) ORS 694.015 to 694.185 (dealing in hearing aids);

(g) ORS 688.800 to 688.840 (respiratory therapy and polysomnography);

(h) ORS chapter 700 (environmental sanitation);

(i) ORS 676.617 (single facility licensure);

(j) ORS 675.360 to 675.410 (sex offender treatment);

(k) ORS 678.710 to 678.820 (nursing home administrators);

(L) ORS 691.405 to 691.485 (dietitians); [*and*]

(m) ORS 676.612 (prohibited acts)**; and**

(n) Section 3 of this 2013 Act (applied behavior analysis).

(2) The agency may take any other disciplinary action that it finds proper, including but not limited to assessment of costs of disciplinary proceedings, not to exceed $5,000, for violation of any statute listed in subsection (1) of this section or any rule adopted under any statute listed in subsection (1) of this section.

(3) Subsection (1) of this section does not limit the amount of the civil penalty resulting from a violation of ORS 694.042.

(4) In imposing a civil penalty pursuant to this section, the agency shall consider the following factors:

(a) The immediacy and extent to which the violation threatens the public health or safety;

(b) Any prior violations of statutes, rules or orders;

(c) The history of the person incurring a penalty in taking all feasible steps to correct any violation; and

(d) Any other aggravating or mitigating factors.

(5) Civil penalties under this section shall be imposed as provided in ORS 183.745.

(6) The moneys received by the agency from civil penalties under this section shall be paid into the General Fund of the State Treasury and credited to the Oregon Health Licensing Agency Account established under ORS 676.625. Such moneys are continuously appropriated to the agency for

the administration and enforcement of the laws the agency is charged with administering and enforcing that govern the person against whom the penalty was imposed.

SECTION 18. Section 3 of this 2013 Act and the amendments to ORS 676.610, 676.612, 676.613, 676.622, 676.625 and 676.992 by sections 12 to 17 of this 2013 Act become operative November 1, 2013.

SECTION 19. Section 3 of this 2013 Act is amended to read:

Sec. 3. (1) There is created, within the Oregon Health Licensing Agency, the Behavior Analysis Regulatory Board consisting of seven members appointed by the Governor, including:

(a) Three members who are licensed by the board;

(b) One member who is a licensed psychiatrist or developmental pediatrician, with experience or training in treating autism spectrum disorder;

(c) One member who is a licensed psychologist registered with the board;

(d) One member who is a licensed speech-language pathologist registered with the board; and

(e) One member of the general public who does not have a financial interest in the provision of applied behavior analysis and does not have a ward or family member who has been diagnosed with autism spectrum disorder.

(2) Not more than one member of the Behavior Analysis Regulatory Board may be an employee of an insurer.

(3) The term of office of each member is four years, but a member serves at the pleasure of the Governor. Before the expiration of the term of a member, the Governor shall appoint a successor whose term begins on November 1 next following. A member is eligible for reappointment. If there is a vacancy for any cause, the Governor shall make an appointment to become immediately effective for the unexpired term.

(4) A member of the Behavior Analysis Regulatory Board is entitled to compensation and expenses as provided in ORS 292.495.

(5) The Behavior Analysis Regulatory Board shall select one of its members as chairperson and another as vice chairperson, for such terms and with duties and powers necessary for the performance of the functions of such offices as the board determines.

(6) A majority of the members of the Behavior Analysis Regulatory Board constitutes a quorum for the transaction of business.

(7) The Behavior Analysis Regulatory Board shall meet at least once every three months at a place, day and hour determined by the board. The board may also meet at other times and places specified by the call of the chairperson or of a majority of the members of the board.

(8) In accordance with ORS chapter 183, the Behavior Analysis Regulatory Board shall establish by rule criteria for the:

(a) Licensing of:

(A) Behavior analysts; and

(B) Assistant behavior analysts; and

(b) Registration of:

(A) Licensed health care professionals; and

(B) Behavior analysis interventionists.

(9) The criteria for the licensing of a behavior analyst must include, but are not limited to, the requirement that the applicant:

(a) Be certified by the Behavior Analyst Certification Board, Incorporated, as a Board Certified Behavior Analyst; and

(b) Have successfully completed a criminal records check.

(10) The criteria for the licensing of an assistant behavior analyst must include, but are not limited to, the requirement that the applicant:

(a) Be certified by the Behavior Analyst Certification Board, Incorporated, as a Board Certified Assistant Behavior Analyst;

(b) Be supervised by a behavior analyst who is licensed by the Behavior Analysis Regulatory Board; and

(c) Have successfully completed a criminal records check.

(11) The criteria for the registration of a behavior analysis interventionist must include, but are not limited to, the requirement that the applicant:

(a) Have completed coursework and training prescribed by the Behavior Analysis Regulatory Board by rule;

(b) Receive ongoing oversight by a licensed behavior analyst or a licensed assistant behavior analyst, or by another licensed health care professional approved by the board; and

(c) Have successfully completed a criminal records check.

(12) In accordance with applicable provisions of ORS chapter 183, the Behavior Analysis Regulatory Board shall adopt rules:

(a) Establishing standards and procedures for the licensing of behavior analysts and assistant behavior analysts and for the registration of licensed health care professionals and behavior analysis interventionists in accordance with this section;

(b) Establishing guidelines for the professional methods and procedures to be used by individuals licensed and registered under this section;

(c) Governing the examination of applicants for licenses and registrations under this section and the renewal, suspension and revocation of the licenses and registrations; and

(d) Establishing fees sufficient to cover the costs of administering the licensing and registration procedures under this section.

(13) The Behavior Analysis Regulatory Board shall issue a license to an applicant who:

(a) Files an application in the form prescribed by the board;

(b) Pays fees established by the board; and

(c) Demonstrates to the satisfaction of the board that the applicant meets the criteria adopted under this section.

(14) The Behavior Analysis Regulatory Board shall establish the procedures for the registration of licensed health care professionals and behavior analysis interventionists.

(15) All moneys received by the Behavior Analysis Regulatory Board under subsection (13) of this section shall be paid into the General Fund of the State Treasury and credited to the Oregon Health Licensing Agency Account.

[*(16) An individual who has not been licensed or registered by the Behavior Analysis Regulatory Board in accordance with criteria and standards adopted under this section may not claim reimbursement for services described in section 2 of this 2013 Act under a health benefit plan or under a self-insured health plan offered by the Public Employees' Benefit Board or the Oregon Educators Benefit Board.*]

SECTION 20. ORS 743A.190, as amended by section 7 of this 2013 Act, is amended to read:

743A.190. (1) A health benefit plan, as defined in ORS 743.730, must cover for a child enrolled in the plan who is under 18 years of age and who has been diagnosed with a pervasive developmental disorder all medical services, including rehabilitation services, that are medically necessary and are otherwise covered under the plan.

(2) The coverage required under subsection (1) of this section, including rehabilitation services, may be made subject to other provisions of the health benefit plan that apply to covered services, including but not limited to:

(a) Deductibles, copayments or coinsurance;

(b) Prior authorization or utilization review requirements; or

(c) Treatment limitations regarding the number of visits or the duration of treatment.

(3) As used in this section:

(a) "Medically necessary" means in accordance with the definition of medical necessity that is specified in the policy, certificate or contract for the health benefit plan and that applies uniformly to all covered services under the health benefit plan.

(b) "Pervasive developmental disorder" means a neurological condition that includes autism spectrum disorder, developmental delay, developmental disability or mental retardation.

(c) "Rehabilitation services" means physical therapy, occupational therapy or speech therapy services to restore or improve function.

(4) The provisions of ORS 743A.001 do not apply to this section.

(5) The definition of "pervasive developmental disorder" is not intended to apply to coverage required under ORS 743A.168 [*or section 2 of this 2013 Act*].

SECTION 21. ORS 750.055, as amended by section 3, chapter 21, Oregon Laws 2012, and section 8 of this 2013 Act, is amended to read:

750.055. (1) The following provisions of the Insurance Code apply to health care service contractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:

(a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.844 to 731.992, 731.870 and 743.061.

(b) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.592, not including ORS 732.582.

(c) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

(d) ORS chapter 734.

(e) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, 743.100 to 743.109, 743.402, 743.472, 743.492, 743.495, 743.498, 743.499, 743.522, 743.523, 743.524, 743.526, 743.527, 743.528, 743.529, 743.549 to 743.552, 743.560, 743.600 to 743.610, 743.650 to 743.656, 743.764, 743.804, 743.807, 743.808, 743.814 to 743.839, 743.842, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.894, 743.911, 743.912, 743.913, 743.917, 743A.010, 743A.012, 743A.020, 743A.034, 743A.036, 743A.048, 743A.058, 743A.062, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144, 743A.148, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.185, 743A.188, 743A.190 and 743A.192 and section 2, chapter 21, Oregon Laws 2012[*, and section 2 of this 2013 Act*].

(f) The provisions of ORS chapter 744 relating to the regulation of insurance producers.

(g) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

(h) ORS 743A.024, except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act unless the patient is referred by a physician associated with a group practice health maintenance organization.

(i) ORS 735.600 to 735.650.

(j) ORS 743.680 to 743.689.

(k) ORS 744.700 to 744.740.

(L) ORS 743.730 to 743.773.

(m) ORS 731.485, except in the case of a group practice health maintenance organization that is federally qualified pursuant to Title XIII of the Public Health Service Act and that wholly owns and operates an in-house drug outlet.

(2) For the purposes of this section, health care service contractors shall be deemed insurers.

(3) Any for-profit health care service contractor organized under the laws of any other state that is not governed by the insurance laws of the other state is subject to all requirements of ORS chapter 732.

(4) The Director of the Department of Consumer and Business Services may, after notice and hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025 and 750.045 that are deemed necessary for the proper administration of these provisions.

SECTION 22. Section 2 of this 2013 Act is repealed January 2, 2022.

SECTION 23. Sections 2 and 10 of this 2013 Act and the amendments to ORS 743A.190 and 750.055 by sections 7 and 8 of this 2013 Act apply to health benefit plan policies and certificates:

(1) Offered by the Public Employees' Benefit Board or the Oregon Educators Benefit Board for coverage beginning on or after January 1, 2015; and

(2) Other than for plans offered by the Public Employees' Benefit Board or the Oregon Educators Benefit Board, for coverage beginning on or after January 1, 2016.

SECTION 24. The amendments to section 3 of this 2013 Act by section 19 of this 2013 Act and the amendments to ORS 743A.190 and 750.055 by sections 20 and 21 of this 2013 Act become operative January 2, 2022.

SECTION 25. This 2013 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2013 Act takes effect on its passage.

Passed by Senate June 29, 2013

.....
Robert Taylor, Secretary of Senate

.....
Peter Courtney, President of Senate

Passed by House July 1, 2013

.....
Tina Kotek, Speaker of House

Received by Governor:

.....M.,....., 2013

Approved:

.....M.,....., 2013

.....
John Kitzhaber, Governor

Filed in Office of Secretary of State:

.....M.,....., 2013

.....
Kate Brown, Secretary of State

EVALUATION OF EVIDENCE

HEALTH EVIDENCE REVIEW COMMISSION (HERC)

EVALUATION OF EVIDENCE: APPLIED BEHAVIOR ANALYSIS FOR AUTISM SPECTRUM DISORDERS

Approved 8/14/2014

BACKGROUND

Oregon Senate Bill 365 was passed by the Oregon legislature in the 2013 regular session. That bill directs the Health Evidence Review Commission to evaluate applied behavior analysis (ABA) as a treatment for autism spectrum disorder (ASD) for the purposes of updating the prioritized list of health services. The bill also establishes requirements for state-regulated health plans to approve and manage autism treatment, including ABA therapy and any other medical or mental health services identified in an individualized treatment plan. The law applies to patients who seek care before age nine, covering up to 25 hours of ABA per week, and continuing as long as medically necessary. Health plans that provide coverage to OEBB and PEBB are required to begin coverage in 2015, and all other health plans are required to begin coverage in 2016. Applied behavior analysis is defined in the bill as the following:

The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce significant improvement in human social behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior and that is provided by:

> (i) A licensed health care professional registered under section 3 of this 2013 Act;
>
> (ii) A behavior analyst or an assistant behavior analyst licensed under section 3 of this 2013 Act; or
>
> (iii) A behavior analysis interventionist registered under section 3 of this 2013 Act.

“Applied behavior analysis” excludes psychological testing, neuropsychology, psychotherapy, cognitive therapy, sex therapy, psychoanalysis, hypnotherapy and long-term counseling as treatment modalities.

For details of the public process used to develop this evaluation of evidence, see http://www.oregon.gov/oha/herc/Pages/blog-ABA.aspx

EVIDENCE SOURCES

Warren, Z., Veenstra-VanderWeele, J., Stone, W., Bruzek, J.L., Nahmias, A.S., Foss-Feig, J.H., et al. (2011). *Therapies for children with autism spectrum disorders. Comparative effectiveness review no. 26.* (Prepared by the Vanderbilt Evidence-based Practice Center under Contract No. 290-2007-10065-I). AHRQ Publication No. 11-EHC029-EF. Rockville, MD: Agency for Healthcare Research and Quality. April 2011. Retrieved from http://effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productid=651

Update of Warren 2011 in draft form:

Therapies for children with autism spectrum disorder – Behavioral interventions update. Draft Comparative Effectiveness Review. Rockville, MD: Agency for Healthcare Research and Quality. Retrieved January 27, 2014, from http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayProduct&productID=1845

Lounds Taylor, J., Dove, D., Veenstra-VanderWeele, J., Sathe, N.A., McPheeters, M.L., Jerome, R.N., et al. (2012). *Interventions for adolescents and young adults with Autism Spectrum Disorders. Comparative Effectiveness Review No. 65.* (Prepared by the Vanderbilt Evidence-based Practice Center under Contract No. 290-2007-10065-I.) AHRQ Publication No. 12-EHC063-EF. Rockville, MD: Agency for Healthcare Research and Quality. Retrieved from http://effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?productid=1197&pageaction=displayproduct

Maglione, M., Motala, A., Shanman, R., Newberry, S., Schneider Chafen, J., & Shekelle, P. (2012). *AHRQ Comparative Effectiveness Review Surveillance Program: Therapies for Children with Autism Spectrum Disorders, 2nd Assessment.* Rockville, MD: Agency for Healthcare Research and Quality. Retrieved from http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=1536

Oono, I.P., Honey, E.J., & McConachie, H. (2013). Parent-mediated early intervention for young children with autism spectrum disorders (ASD). *Cochrane Database of Systematic Reviews*, Issue 4. Retrieved from http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009774.pub2/abstract

- *List of included studies in Oono 2013 provided in Appendix D*

Glossary Sources

Agency for Healthcare Research and Quality (AHRQ) Effective Health Care Program. (n.d.). Glossary of terms. Retrieved from http://effectivehealthcare.ahrq.gov/index.cfm/glossary-of-terms/

National Cancer Institute (NCI) at the National Institutes of Health (NIH). (n.d.). NCI dictionary of cancer terms. Retrieved from http://www.cancer.gov/dictionary

The summary of evidence in this document is derived directly from these evidence sources, and portions are extracted verbatim.

SUMMARY OF EVIDENCE

Clinical Background

The following clinical background summary is extracted from the update to the Warren 2011 report (AHRQ draft, 2014).

> Autism spectrum disorder (ASD) is a neurodevelopmental disorder marked by impaired social communication and social interaction accompanied by atypical patterns of behavior and interest. ASD is differentiated from other developmental disorders by significant impairments in social interaction and communication, along with restrictive, repetitive, and stereotypical behaviors and activities. Social communication and social interaction features include deficits in social-emotional reciprocity (e.g., deficits in joint attention, atypical social approach and response, conversational challenges, reduced sharing of interest, emotions, and affect), deficits in nonverbal communication (e.g., atypical eye contact, reduced gesture use, limited use of facial expressions in social interactions, challenges understanding nonverbal communication), and deficits in forming and maintaining relationships (e.g., diminished peer interest, challenges joining in play, difficulties adjusting behavior to social context). ASD features of restricted, repetitive patterns of behavior, interests, or activities may include stereotyped motor mannerisms, use of objects, or speech (e.g., simple motor stereotypies, repetitive play, echolalia, and formal or idiosyncratic speech); insistence on sameness, inflexible adherence to routines, or ritualized patterns of behavior (e.g., distress at small changes, rigid patterns of thought and behavior, performance of everyday activities in ritualistic manner); intense preoccupation with specific interests (e.g., strong attachment to objects, circumscribed or perseverative topics of interest); and sensory sensitivities or interests (e.g., hyper- or hypo-reactivity to pain and sensory input, sensitivity to noise, visual fascination with objects or movement). These symptoms cause impairment across many areas of functioning and are present early in life. However, impairments may not be fully evident until environmental demands exceed children's capacity. They also may

> be masked by learned compensatory strategies later in life. Many children with ASD may also have intellectual impairment or language impairment, and the disorder may be associated with known medical, genetic, or environmental factors. (p. ES-1)
>
> The prevalence of ASD in the United States is 11.3 cases per 1,000 (or 1 in 88) children living in the communities surveyed, with rate estimates varying widely by region of the country, sex, and race/ethnicity. Considerably more males (1 in 54) than females (1 in 252) are affected. For some individuals, the core symptoms of ASD (impairments in communication and social interaction and restricted/repetitive behaviors and interests) may improve with intervention and maturation; however, core deficits typically translate into varying developmental presentations that remain throughout the lifespan. Longitudinal studies indicate that adults with ASD struggle to obtain adaptive independence. (p. 1)
>
> Treatments for ASD include behavioral, educational, medical, allied health, and complementary approaches. Individual goals for treatment vary for different children and may include combinations of therapies. For many individuals, core symptoms of ASD (impairments in communication and social interaction and restricted/repetitive behaviors and interests) may improve with intervention and over time5-8; however, deficits typically remain throughout the lifespan. Chronic management—often using multiple treatment approaches—may be required to maximize ultimate functional independence and quality of life. (p. ES-1)

This review of the evidence addresses only behavioral interventions for ASDs that utilize principles of applied behavior analysis (ABA).

> ABA is an umbrella term describing principles and techniques used in the assessment, treatment and prevention of challenging behaviors and the promotion of new desired behaviors. The goal of ABA is to teach new skills, promote generalization of these skills, and reduce challenging behaviors with systematic reinforcement. The principles and techniques of ABA existed for decades prior to specific application and study within ASDs. (AHRQ draft, 2014, p. 5)

Interventions that utilize the principles of ABA include comprehensive treatments referred to as Early Intensive Behavioral and Developmental Interventions (EIBI). Two of these intensive treatments have been manualized (i.e., have published treatment manuals to facilitate replication): the UCLA/Lovaas model and the Early Start Denver Model (ESDM). There are other treatment approaches that also incorporate ABA principles, and may be intensive in nature, but have not been manualized. A third particular set of interventions include those using the principles of ABA to focus on key

pivotal behaviors rather than global improvements. These approaches emphasize parent training as a modality for treatment delivery (e.g., Pivotal Response Training, Hanen More than Words, social pragmatic intervention, etc.) and may focus on specific behaviors such as initiating or organizing activity or on core social communication skills.

Play-/interaction-based interventions may employ ABA principles and are included in this review. These interventions use interactions between children and adults (either parents or researchers) to improve outcomes such as imitation or joint attention skills or the ability of the child to engage in symbolic play. They include teaching parents how to interact differently with their children within daily routines and interactions, often using standard behavior management strategies.

Evidence Review

Children Ages Two to Twelve

EIBI and Other ABA Interventions

Warren (2011)

The Warren (2011) AHRQ review included all study designs as long as there were at least 10 participants. A total of 30 discrete studies were included, with the largest study population being 78 participants. The longest duration of treatment in any included study was three years. The mean age of children at intake in the included studies ranged from 21 to 66 months for EIBI interventions and from 42 months to 10.8 years for other ABA interventions. Authors reach the following conclusions:

> The evidence suggests that early intensive behavioral and developmental intervention (EIBI) may improve core areas of deficit for individuals with ASDs; however, randomized controlled trials (RCTs) are few and include small numbers of participants. In addition, there are no direct comparison trials. “Within this category, studies of UCLA/Lovaas-based interventions report greater improvements in cognitive performance, language skills, and adaptive behavior skills than broadly defined eclectic treatments available in the community. However, strength of evidence is currently low” (Warren, 2011, p. ES-7). In addition, the consistency of benefit is lacking, in that “not all children demonstrate rapid gains, and many children continue to display substantial impairment” (Warren, 2011, p. ES-7). Although positive results are reported for the effects of intensive interventions that use a developmental framework, such as ESDM, evidence for this type of intervention is currently insufficient because few studies have been published to date.

Less intensive interventions focusing on providing parent training for bolstering social communication skills and managing challenging behaviors have also been studied. Some interventions have shown short-term gains in social communication and language use, but the current evidence base for such treatment remains insufficient. Strength of evidence is also considered insufficient for play- and interaction-based approaches.

Only one study was identified that directly addressed whether there are any modifiers of outcomes for different ABA-based behavioral approaches. It examined the impact of which provider (parent vs. professional) delivered the UCLA/Lovaas protocol-based interventions. There was no significant difference in outcomes for children receiving the intervention in a clinical setting vs. at home from highly trained parents.

Other potential correlates that warrant further study because of conflicting data include pretreatment IQ and language skills, and age of initiation of treatment (with earlier age potentially associated with better outcomes). “Social responsiveness and imitation skills have been suggested as skills that may correlate with improved treatment response in UCLA/Lovaas treatment, whereas ‘aloof’ subtypes of ASDs may be associated with less robust changes in IQ. Other studies have seen specific improvement in children with PDD-NOS vs. Autistic Disorder diagnoses, which may be indicative of baseline symptom differences. However, many other studies have failed to find a relationship between autism symptoms and treatment response” (Warren, 2011, p. ES-8).

“Research on very young children is preliminary, with four studies identified. One good-quality RCT suggested benefit from the use of ESDM in young children, with improvements in adaptive behavior, language, and cognitive outcomes. Diagnostic shifts within the autism spectrum were reported in close to 30 percent of children but were not associated with clinically significant improvements in Autism Diagnostic Observation Schedule severity scores or other measures” (Warren, 2011, p. ES-9).

There was no evidence identified in the Warren review that addressed treatment effectiveness in specific subgroups such as race, ethnicity, gender or socioeconomic status, other than age. Details of all comparative studies that reported comparative statistics are provided in the table below.

Table 1. Comparative Studies included in Warren 2011

Author	Study Design	Intervention Intensity	Intervention Duration	Summary of Outcome
Smith 2000	RCT, intensive vs. parent training	Intensive: 30 hrs/wk with therapist, 5	intensive: 2-3 yrs	Intensive group had improved IQ, developmental

Author	Study Design	Intervention Intensity	Intervention Duration	Summary of Outcome
		hrs/wk with parents X 3 months Parent: taught techniques from Lovaas manual 2 sessions/wk	parent: 3-9 mos	scores compared to parent training, as well as in 1 communication score, but not in 3 others, and no sig diff in adaptive function MIXED
Drew 2002	RCT, parent training vs. local services (ST, OT, ABA, home worker)	Parent: 6.3 hrs/wk Local: 3.5 hrs/wk	Not specified; follow up at 1 year	No sig diff between groups in cognitive[1] outcomes. parent group had some better communication outcomes MIXED
Aldred 2004	RCT, social communication intervention vs. routine care (not described)	Intervention: monthly treatment sessions X 6 months (time not specified), then less frequent for another 6 months Control: routine care	1 year	Intervention group had better language scores, parent synchrony. No diff in shared attention MIXED
Eikeseth 2002/ 2007	Non-randomized CT, Lovaas behavioral treatment vs. eclectic (TEACCH, sensory-motor therapies, ABA)	Lovaas: 28 hrs/wk Eclectic: 29 hrs/wk	Not specified; first follow up at 1 year	Lovaas group had sig more improvement than eclectic in IQ, communication, adaptive behavior at both 1 and 8 year follow up for most measures POSITIVE
Reed 2007	Non-randomized CT, high intensity ABA vs. low intensity ABA	High: mean 30 hrs/wk Low: mean 13 hrs/wk	Not specified	No diff in autism severity, adaptive behavior. Mixed result for cognitive, with high intensity scoring better on one measure but not another MIXED
Howard 2005	Prospective cohort, intensive ABA vs. intensive eclectic (delivered in school) vs. non-intensive public early intervention	ABA: 25-30 hrs/wk for age <3, 35-40 for age >3 plus parent training Intensive eclectic: not specified Public EI: not specified	Follow up at 14 mos	ABA group had sig higher scores than mean of the other two groups for all outcome measures except motor skills POSITIVE

[1] Educational, cognitive, and academic outcomes are reported together and noted as "cognitive" unless specified otherwise.

Remington 2007	Prospective cohort, home-based early intervention (parent delivered with tutors) vs. local education standard treatment	EI: mean 26 hrs/wk Control: not specified	2 years	EI group had sig higher scores for most outcomes, including social skills, communication, adaptive behavior, cognitive function POSITIVE
Cohen 2006	Prospective cohort, EIBI (Lovaas) vs. services from public school (parent choice)	Intervention: 35-40 hrs/wk, 47 wks/yr Control: not specified	3 years	Intervention group had higher IQ, were more likely in regular classroom and had higher adaptive scores; no sig diff in communication POSITIVE
Stahmer 2001	Prospective cohort, parent information support group and education course on PRT vs. education course only (control)	2 hrs/week for intervention group vs 1 hr/wk for control	12 weeks	Sig more parents in the intervention group correctly used PRT techniques, and their children had improved communication POSITIVE
Zachor 2007 (appears to be a subset of Itzchak 2009)	Prospective cohort, behavioral vs. eclectic	Behavioral: 1 to 1 35 hrs/wk Eclectic: special ed teacher, various therapists (OT, ST), parent training, at least 16 hrs/wk	Not specified	Sig improved overall severity, communication behavioral group compared to eclectic, no sig diff in social skills POSITIVE
Hayward 2009/ Eikeseth 2009	Prospective cohort, clinic based vs. parent managed	Clinic: 37 hrs/week Parent: 34 hrs/week (mean supervision hrs/mo = 5)	1 year	No differences between groups in communication, adaptive behavior, cognitive/academic NEGATIVE
Eldevik 2006	Retrospective cohort, low intensity behavioral (Lovaas) vs. eclectic (alternative communication, TEACCH, sensory-motor, ABA	Behavioral: 12 hrs/wk Eclectic: not specified	Behavioral: 20 mos Eclectic: 21 mos	Behavior group had mixed outcomes on cognitive measures (better on some measures, no diff on others), better communication scores, fewer problem behaviors. no diff in adaptive scores MIXED
Reed 2007	Retrospective cohort, ABA vs. special nursery vs. portage (parent training)	ABA: mean 30 hrs/wk Special nursery: mean 12 hrs/wk Portage: mean 8 hrs/wk	Not specified	27 diff outcomes measures reported on, no sig diffs on 18. ABA group had better scores than one or the other of the comparators for the following measures: 2 of 3 overall ratings, 4 of 8 communication scores, 3 of 7 behavior scores. There

				were no diffs in motor skills scores, cognitive scores, comorbidities MIXED

In summary, the intensity of experimental interventions ranged from less than two hours per week to 40 hours per week. For the control interventions, intensity was often not specified, but was as high as 34 hours per week. Of those studies showing a mostly positive outcome for the intervention, intensity ranged from 26 to 40 hours per week, with the exception of the Stahmer study, which was a very narrowly focused intervention aimed at teaching parents a specific skill.

With regard to duration, five studies did not specify the length of the intervention period. The shortest study was 12 weeks, while the longest was 3 years. Of those studies showing a mostly positive outcome for the intervention, duration ranged from no more than a year to three years, with the exception of the Stahmer study.

The following limitations of the evidence were noted by the report authors:

> A high proportion of studies in this review (36 percent) fail to use a comparison group, and while substantial strides have been made in the analysis of single-subject designs, these are not ideal for assessing effectiveness at a population level, nor are they appropriate for comparative effectiveness research. They are, however, used frequently in the behavioral literature, and so we address our decisions regarding them here. Because there is no separate comparison group in these studies they would be considered case reports (if only one child included) or case series (multiple children) under the rubric of the EPC study designs. Case reports and case series can have rigorous evaluation of pre- and post-measures, as well as strong characterization of the study participants.
>
> Studies using this design that included at least 10 children were included in the review. Studies of this type can be helpful in assessing response to treatment in very short time frames and under very tightly controlled circumstances, but they typically do not provide information on longer term or functional outcomes. They are useful in serving as demonstration projects, yielding initial evidence that an intervention merits further study, and, in the clinical environment, they can be useful in identifying whether a particular approach to treatment is likely to be helpful for a specific child. Our goal was to identify and review the best evidence for assessing the efficacy and effectiveness of therapies for children with ASD, with an eye toward their utility in the clinical setting, and for the larger population of children with ASD. By definition, “populations” in single-subject design studies are likely to be idiosyncratic and therefore not to provide information that is generalizable.

Nonetheless, even in studies with a comparison group, sample size is frequently insufficient to draw conclusions, and larger, multisite trials are needed across all treatment types. Furthermore, the choice of comparison groups in the studies that employed a group design was uneven. A number of studies used comparison groups that were inappropriate for observing group differences in treatment effect (e.g., comparing treatment in children with autism to the effects of the treatment in typically developing peers or to children with a different developmental disorder), and for those studies we could only use the pre-post case series data available in the group with autism, limiting the ability to comment on effectiveness.

We encourage investigators to provide adequate detail as they describe their interventions to allow for replicable research. In ideal circumstances, investigators publish and reference treatment manuals, but many studies made general references to their use of an underlying approach (e.g., ABA) without specifying the ways in which they used the technique or modifications they made to the original, published use of it. Lack of detail about the intervention makes it difficult to assess the applicability of individual studies, to synthesize groups of studies or to replicate studies.

Characterization of the study population was often inadequate, with 125 of 159 studies failing to use or report “gold standard” diagnostic measures (clinical DSM-IV-based diagnosis plus ADI-R and/or ADOS) for the participants. Because ASDs are spectrum disorders, it is difficult to assess the applicability of interventions when the population in which they were studied is poorly defined or described. Authors often do not consider diagnostic criteria in selecting participants for their studies; nor do they fully describe the children who do participate. We recommend that investigators fully describe participants in their study, both diagnostically and otherwise. In addition, because the myriad causes of ASDs are unknown, even children with the same diagnosis may have distinct genetic or other “causes” that could affect treatment effectiveness. Ideally, future research will better characterize participants genotypically and phenotypically.

We identified more than 100 distinct outcome measures used in this literature base, not accounting for subscales. The use of so many and such disparate outcome measures makes it nearly impossible to synthesize the effectiveness of the interventions, and we recommend a consistent set of rigorously evaluated outcome measures specific to each intended target of treatment to move comparative effectiveness research forward and to provide a sense of expected outcomes of the interventions. At the same time, the means for assessing outcomes should include increased focus on use of observers or reporters masked to the intervention status of the participant, and where some outcomes

are measured in a masked fashion but others not, more emphasis should be placed on those that are.

There also was a strong tendency for authors to present data on numerous outcomes without adjusting for multiple comparisons, and to fail to report the outcome that was the primary outcome of *a priori* interest and on which sample size calculations were based (when they were present). This may suggest a level of selective reporting bias in which results are published on a select group of outcomes that show the most effect. We attempted, but were unable, to identify a clear primary intended outcome in almost all of the papers.

Duration of treatment and follow up was generally short, with few studies providing data on long-term outcomes after cessation of treatment. Future studies should extend the follow up period and assess the degree to which outcomes are durable. Few studies adequately accounted for concomitant interventions that might confound observed effectiveness and this should be standardized in future research. (Warren, 2011, p. 124-125)

[Evidence Source]

Maglione (2012)

Surveillance of the literature pertaining to the Warren report was conducted by AHRQ in January 2012 and October 2012 (Maglione, 2012). Conclusions pertaining to ABA therapies that address the currency of the 2011 report are presented below:

- Original conclusions regarding low strength of evidence for Early Intensive Behavioral Interventions (EIBI) are possibly out of date due to new RCTs and long-term follow-up of previously included studies.
- Original conclusion regarding insufficient evidence for parent training is possibly out of date due to several new RCTs.
- For Key Question 2 [what are the modifiers of outcome for different treatments or approaches (frequency, duration or intensity of treatment, characteristics of child or family, training of therapy provider)], conclusions are still valid, with the exception of impact of provider type, which may possibly be out of date. (p. ii)

[Evidence Source]

AHRQ Draft Report Update (2014)

Given this evidence of additional research, AHRQ elected to update the Warren report, focusing only on behavioral interventions. They published their draft report in January 2014. A summary of the findings is below:

> We included 51 unique studies comprising 37 randomized trials and 14 nonrandomized, comparative studies (16 good, 31 fair, and 4 poor quality) published since the prior review. The quality of studies improved compared with that reported in the earlier review. Young children receiving high intensity applied behavior analysis-based early intervention over extended time frames commonly displayed substantial improvement in cognitive functioning and language skills relative to community controls. The magnitude of these effects varied across studies, potentially reflecting poorly understood modifying characteristics related to subgroups of children. Early intensive parent training programs modified parenting behaviors during interactions; however, data were more limited about their ability to improve developmental skills beyond language gains for some children. Social skills interventions varied in scope and intensity and showed some positive effects on social behaviors for older children in small studies. Evidence for play/interaction-based approaches suggested that joint attention interventions may be useful for young and preschool children with ASD when targeting joint attention skills; data on the effects of such interventions in other areas were limited. (AHRQ draft, 2014, p. v)

Of the 51 included studies, 25 addressed interventions included in this report (EIBI except when delivered as an educational intervention, symbolic play and joint attention interventions, parent training). Three studies addressed EIBI, 12 studies addressed parent training, nine studies addressed play and/or interaction based approaches and one evaluated the addition of parent training to individuals using risperidone. Some characteristics of the included studies are reported in the table below:

Table 2 Summary of new studies from AHRQ draft report update

Intervention Type	Intensity Range	Duration Range	Age Range
EIBI (excluding educational interventions)	15 to 26 hours/week[2]	24 months	15 to 54 months
Parent training	30 minutes sessions X 10 to 30 hours/week home based ABA[3]	12 weeks to 2 years	18 to 66 months

[2] The study with 15 hours included an additional 16 hours of parent delivered treatment
[3] The study that included 30 hours/week of home based ABA compared this group to three other interventions: special ed classroom (mean 13 hours/week), low-intensity, home based manualized intervention (mean 8 hours/week) and 1:1 behavioral intervention that included a 5 day parent training component (mean 13 hours/week). This study found no significant differences in cognitive or adaptive scores between groups, but did find differences in educational outcomes favoring the intensive ABA group.

Intervention Type	Intensity Range	Duration Range	Age Range
Play/Interaction Based Interventions[4]	20 minutes 2X/day, 5 days/week to 3 hours/week[5]	6 to 12 weeks	21 to 82 months
Parent Training in addition to Risperidone	11 sessions + boosters, 1 home visit	16 weeks	4 to 14 years

With regard to the impact of intensity or duration on treatment effectiveness, the authors report the following:

- In a retrospective cohort study of EIBI, treatment duration was not determined to be a significant predictor of outcome after controlling for other variables.
- In one parent training RCT evaluating ESDM (12 one hour sessions plus treatment as usual), total intervention hours (range zero to 16 hours/week, mean 1.5 hours/week for intervention group vs. 3.7 hours/ week for control) were associated with improved developmental and vocabulary scores, as was younger child age.

With regard to strength of the evidence, the authors reach the following conclusions:

> A growing evidence base suggests that children receiving early intensive behavioral and developmental interventions (e.g., many hours of intervention a week over the course of 1-2 years) show substantial improvements in cognitive and language skills over time compared with children receiving low-intensity interventions, community controls, and eclectic non-ABA based intervention approaches. With this growing literature, our confidence (strength of evidence) in the effects of ABA-based early intensive approaches on cognitive and language outcomes is moderate, based on the need for additional research that identifies which groups of children benefit the most from specific high intensity approaches. Our strength of evidence in these high intensity interventions to affect adaptive behavior skills, social skills, and core ASD symptom severity is low. At present it is challenging to understand which high intensity variants most robustly impact these domains for specific children and in general the impact of these skill domains is less consistent.
>
> A growing evidence base suggests that children receiving early joint attention-related intervention in combination with other interventions show substantial

[4] Typically delivered in addition to other treatment as usual
[5] Four of the studies did not report treatment intensity

improvements in joint attention and language skills over time. Within this growing literature, our confidence (strength of evidence) in this effect is moderate, based on the need for additional research that identifies which groups of children benefit the most from this approach and how this intervention relates to other ongoing concurrent offered interventions. Results from a variety of play-based interventions also suggest that young children often display short-term improvements in early play, imitation, language, and social interaction skills. However, our confidence in these estimates is low, and substantial evidence that these short-term improvements are linked to broader indices of change over time is lacking (AHRQ draft, p. 75).

The evidence base for parent training interventions is moderate for their impact on early language and communication skills and low for impact on ASD symptom severity and early cognition. There is not yet sufficient data from this literature base to understand impact on adaptive behavior skills. Available studies indicate variable responses, with modest improvement for some children in some approaches, but limited improvement in other parent training paradigms. (AHRQ draft, 2014, p. 67)

Parent-mediated Early Intervention

Oono (2013)

A review of parent-mediated early intervention in children less than seven was completed by the Cochrane Collaboration in April 2013 (Oono, 2013). It included 17 RCTs (one of which was identified in the AHRQ surveillance report, and eight of which were included in the original Warren report) and drew the following conclusions:

Overall, we did not find statistical evidence of gains from parent-mediated approaches in most of the primary outcomes assessed (most aspects of language and communication - whether directly assessed or reported; frequency of child initiations in observed parent-child interaction; child adaptive behaviour; parents' stress), with findings largely inconclusive and inconsistent across studies. However, the evidence for positive change in patterns of parent-child interaction was strong and statistically significant (shared attention: standardized mean difference (SMD) 0.41; 95% confidence interval (CI) 0.14 to 0.68, P value < 0.05; parent synchrony: SMD 0.90; 95% CI 0.56 to 1.23, P value < 0.05). Furthermore, there is some evidence suggestive of improvement in child language comprehension, reported by parents (vocabulary comprehension: mean difference (MD 36.26; 95% CI 1.31 to 71.20, P value < 0.05). In addition, there was evidence suggesting a reduction in the severity of children's autism characteristics (SMD -0.30, 95% CI -0.52 to -0.08, P value < 0.05). However, this evidence of change in children's skills and difficulties as a consequence of parent-mediated intervention is uncertain, with small effect sizes and wide CIs,

and the conclusions are likely to change with future publication of high-quality RCTs. (Oono, 2013, p. 2)

This conclusion differs from that of the AHRQ draft report, for unclear reasons. It may be because Oono 2013 limited their population to children less than seven, or it may be that the AHRQ draft included more recent studies, since there is nearly a year difference in the literature search end dates (July 2013 for the AHRQ draft and August 2012 for Oono 2013). It also may be variable interpretation of the strength of the evidence by different authors. Indeed, the Oono 2013 review does find a statistically significant benefit in language comprehension and autism severity, outcomes that the AHRQ draft authors assess as having moderate and low strength of evidence respectively. However, Oono 2013 downgrades these findings because they are based on parent self report, and have small effect sizes and wide confidence intervals.

[Evidence Source]

Adolescents and Young Adults (Ages 13 to 30)

Lounds (2012)
Only one poor quality case series evaluated ABA-based intensive behavioral therapy, precluding conclusions regarding efficacy in this age group (Lounds, 2012).

[Evidence Source]

Evidence Summary

Based on the evidence presented in this document (Warren, 2011; AHRQ draft, 2014; Oono, 2013), there is moderate strength of evidence that EIBI improves cognitive and language skills, and low strength of evidence that EIBI improves adaptive behavior skills, social skills, and core symptoms of autism, although improvements are inconsistent. Parent-mediated early intervention improves early language and communication skills, including shared attention and parent synchrony (moderate strength of evidence), and may have some impact on autism symptom severity and early cognition (low strength of evidence). Play-/interaction-based interventions improve child joint attention and language skills (moderate strength of evidence) and play, imitation and social interaction skills (low strength of evidence). The evidence is insufficient to evaluate the effectiveness of ABA on children and adolescents older than twelve. The evidence is insufficient to determine whether there are any factors that modify the effectiveness of ABA therapy.

GRADE-INFORMED FRAMEWORK

The HERC develops recommendations by using the concepts of the Grading of Recommendations Assessment, Development and Evaluation (GRADE) system. GRADE is a transparent and structured process for developing and presenting evidence and for carrying out the steps involved in developing recommendations. There are four elements that determine the strength of a recommendation, as listed in the table below. The HERC reviews the evidence and makes an assessment of each element, which in turn is used to develop the recommendations. Balance between desirable and undesirable effects, and quality of evidence, are derived from the evidence presented in this document, while estimated relative costs, values and preferences are assessments of the HERC members.

Indication/Intervention	Balance between desirable and undesirable effects	Quality of evidence	Resource allocation	Values and preferences	Recommendation
Children aged 1 to 12 years at initiation					
Early Intensive Behavioral Interventions	Benefit on cognitive and language skills	Moderate	High	Low variability	Recommendation for coverage (strong recommendation)
	Benefit on adaptive behavior, social skills and overall autism severity	Low	High	Low variability	
Parent training interventions	Increased joint attention and parent synchrony, and improved early language and communication skills	Moderate	Moderate	Low variability	Recommendation for coverage (strong recommendation)
	Lessened overall severity of autism and improved early cognition	Low	Moderate	Low variability	
Play/interaction-based interventions (including joint attention interventions)	Improvements in joint attention and language skills	Moderate	Low	Low variability	Recommendation for coverage (strong recommendation)
	Short-term improvements in play, imitation, social skills	Low	Low	Low variability	
Adolescents and young adults					
ABA	Unknown	Insufficient	Moderate for focused, high	Low variability	Recommend noncoverage of

Indication/Intervention	Balance between desirable and undesirable effects	Quality of evidence	Resource allocation	Values and preferences	Recommendation
			for more comprehensive		intensive ABA therapies *(weak recommendation)* Recommendation for coverage for specific problem behaviors with focused interventions *(weak recommendation)*

Note: GRADE framework elements are described in Appendix A

SUMMARY CONCLUSIONS

Children ages 1 to 12

Applied behavior analysis (ABA), including early intensive behavioral intervention (EIBI), is recommended for coverage[6] for treatment of autism spectrum disorder[7] (*strong recommendation*).

> Rationale: This strength of recommendation was based on sufficient (moderate quality) evidence and expert input, including testimony on parent/caregiver values and preferences. The evidence does not lead to a direct determination of optimal intensity. Studies of EIBI ranged from 15-40 hours per week. Through Oregon's Senate Bill 365, other payers are mandated to cover a minimum of 25 hours per week of ABA. There is no evidence that increasing intensity of therapy yields improved outcomes. Studies for these interventions had a duration from less than one year up to 3 years.

Initial coverage of EIBI should be provided for up to six months. Ongoing coverage should be based on demonstrated progress towards meaningful predefined objectives (objectives should be achieved as a result of the EIBI, over and beyond gains that would be expected to arise from maturation alone) using standardized, multimodal assessments, no more frequently than every six months *(strong recommendation).* Examples of such assessments include Vineland, IQ tests (Mullen, WPPSI, WISC-R), language measures, behavior checklists (CBCL, ABC), and autistic symptoms measures (SRS).

> Rationale: Ensuring that patients are making meaningful progress is important to ensure quality outcomes and effective use of resources. The six month assessment was chosen based on expert input and subcommittee deliberation to allow for sufficient time for progress while not being burdensome to providers and plans.

If EIBI is not indicated, has been completed, or there is not sufficient progress toward multidimensional goals, then less intensive behavioral ABA-based interventions (such as parent training, play/interaction based interventions, and joint attention interventions) are recommended for coverage to address core symptoms of autism and/or specific problem areas *(strong recommendation).* Initial coverage should be provided for six months. Ongoing coverage should be based on demonstrated progress towards meaningful predefined objectives or emergence of new problem behaviors.

[6] These conclusions apply to the Oregon Health Plan as governed by the Prioritized List of Health Services and to no other health plan.
[7] Autism spectrum disorder should be diagnosed by a qualified health care professional according to DSM-5 criteria.

Rationale: Not all autistic children require comprehensive therapy and less intensive interventions will be appropriate for many, or appropriate for those who have completed intensive intervention. Evidence supports these less intensive interventions in this age group. Effective interventions from the research literature had lower intensity than EIBI, usually a few hours per week to a maximum of 16 hours per week, divided into daily, twice-daily or weekly sessions, over a period of several months.

Parent/caregiver involvement and training is recommended to be a component of treatment *(strong recommendation).*

Rationale: Evidence and expert input indicated that parental involvement in ABA is a key part of effective treatment. Parent delivered therapy is effective.

Individuals ages 13 and older

Intensive ABA is not recommended for coverage for treatment of autism spectrum disorder in persons ages 13 and older (*weak recommendation*).

Rationale: There is insufficient evidence to support intensive ABA treatment at older ages.

For individuals age 13 and older, targeted behavioral interventions, including focused ABA*, are recommended for coverage for up to 6 months, only to address specific problem behaviors (*weak recommendation*). Behaviors eligible for coverage include those which place the member at risk for harm or create significant daily issues related to care, education, or other important functions. The interventions should involve predefined behavioral objectives that would result in socially important and sustainable outcomes for the individual. Ongoing coverage should be based on demonstrated progress towards meaningful predefined objectives with ongoing proof of medical appropriateness, or emergence of new problem behaviors.

Rationale: According to the trusted evidence source, there is insufficient evidence to support ABA-based interventions in this age group. Public comment and some expert testimony involved submission of many single subject research design studies to support treatment in this age group, but the quality of this evidence did not meet predetermined criteria for inclusion. The subcommittee agreed that problem behaviors can be challenging to the individual, caregivers, and society and it is reasonable to consider targeted interventions for specific problem behaviors as long as there are clear objectives, progress toward meaningful predefined goals and ongoing proof of medical appropriateness. The

net result was to recommend targeted interventions including ABA-based treatments for limited intensity to address problem behaviors. Very low quality evidence is available to illustrate needed intensity and duration of intervention. In the single-subject research design literature, frequency and duration of interventions were highly variable, with session duration ranging from 30 seconds to 3 hours, number of sessions ranging from a total of three to 8 times a day, and duration ranging from 1 to 20 weeks. These interventions were often conducted in inpatient or residential settings and studies often included patients with intellectual disabilities, some of which were not diagnosed with autism. Six months was chosen based on expert testimony and subcommittee discussion that more frequent assessments would potentially be burdensome to providers and plans.

Parent/caregiver involvement and training is encouraged *(weak recommendation)*

Note: The evidence for the treatment of conditions comorbid with autism spectrum disorder is beyond the scope of this evidence summary.

POLICY LANDSCAPE

No quality measures were identified when searching the National Quality Measures Clearinghouse pertaining to autism and applied behavior analysis.

This report is prepared by the Health Evidence Review Commission (HERC), HERC staff, and subcommittee members. The evidence summary is prepared by the Center for Evidence-based Policy at Oregon Health & Science University (the Center). This document is intended to guide HERC in making informed decisions about the prioritization of health care services for the Oregon Health Plan.

The Center is not engaged in rendering any clinical, legal, business or other professional advice. The statements in this document do not represent official policy positions of the Center. Researchers involved in preparing this document have no affiliations or financial involvement that conflict with material presented in this document.

Appendix A. GRADE Element Descriptions

Element	Description
Balance between desirable and undesirable effects	The larger the difference between the desirable and undesirable effects, the higher the likelihood that a strong recommendation is warranted. The narrower the gradient, the higher the likelihood that a weak recommendation is warranted
Quality of evidence	The higher the quality of evidence, the higher the likelihood that a strong recommendation is warranted
Resource allocation	The higher the costs of an intervention—that is, the greater the resources consumed—the lower the likelihood that a strong recommendation is warranted
Values and preferences	The more values and preferences vary, or the greater the uncertainty in values and preferences, the higher the likelihood that a weak recommendation is warranted

Strong recommendation

In Favor: The subcommittee is confident that the desirable effects of adherence to a recommendation outweigh the undesirable effects, considering the quality of evidence, cost and resource allocation, and values and preferences.

Against: The subcommittee is confident that the undesirable effects of adherence to a recommendation outweigh the desirable effects, considering the quality of evidence, cost and resource allocation, and values and preferences.

Weak recommendation

In Favor: the subcommittee concludes that the desirable effects of adherence to a recommendation probably outweigh the undesirable effects, considering the quality of evidence, cost and resource allocation, and values and preferences, but is not confident.

Against: the subcommittee concludes that the undesirable effects of adherence to a recommendation probably outweigh the desirable effects, considering the quality of evidence, cost and resource allocation, and values and preferences, but is not confident.

Quality of evidence across studies for the treatment/outcome

High = Further research is very unlikely to change our confidence in the estimate of effect.

Moderate = Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.

Low = Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.

Very low = Any estimate of effect is very uncertain.

Appendix B. Potentially Applicable Codes

CODES	DESCRIPTION
ICD-9 Diagnosis Codes	
299.00	Autistic disorder, current or active state
299.01	Autistic disorder, residual state
299.10	Childhood disintegrative disorder, current or active state
299.11	Childhood disintegrative disorder, residual state
299.80	Other specified pervasive developmental disorders, current or active state
299.81	Other specified pervasive developmental disorders, residual state
299.90	Unspecified pervasive developmental disorder, current or active state
299.91	Unspecified pervasive developmental disorder, residual state
ICD-10 Diagnosis Codes	
F84.0	Autistic disorder
F84.2	Rett's syndrome
F84.3	Other childhood disintegrative disorder
F84.5	Asperger's syndrome
F84.8	Other pervasive developmental disorders
ICD-9 Volume 3 (Procedure Codes)	
None	
Procedure Codes	
Until July, 2014, no specific procedure codes exist for Applied Behavior Analysis. The list below provides examples of how various state Medicaid agencies covering ABA instruct providers to bill. Temporary codes shown in italics will be available starting July, 2014.	
90834	Psychotherapy, 45 min
90837	Psychotherapy, 60 min
0359T	*Behavior identification assessment, by the physician or other qualified health care professional, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report*
0360T	*Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; first 30 minutes of technician time, face-to-face with the patient*
0361T	*…additional 30 minutes*
0362T	*Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; first 30 minutes of technician(s) time, face-to-face with the patient*
0363T	*… additional 30 minutes*
0364T	*Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; first 30 minutes of technician time*
0365T	*…additional 30 minutes*

CODES	DESCRIPTION
0366T	*Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; first 30 minutes of technician time*
0367T	*….additional 30 minutes*
0368T	*Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; first 30 minutes of patient face-to- face time*
0369T	*Adaptive behavior treatment with protocol modification, additional 30 minutes*
0370T	*Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)*
0371T	*Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)*
0372T	*Adaptive behavior treatment social skills group, administered by physician or other qualified health care professional face-to-face with multiple patients*
0373T	*Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); first 60 minutes of technicians' time, face-to-face with patient*
0374T	*each additional 30 minutes of technicians' time face-to-face with patient (List separately in addition to code for primary procedure)*
G1076	Activity therapy, such as music, dance, art or play not for recreation, related to the care and treatment of patient's disabling mental health problems (45 min or more)
G1077	Training and educational services related to the care and treatment of patient's disabling mental health problems (45 min or more)
H0002	Behavioral health screening to determine eligibility for admission to treatment program
H0004	Behavioral health counseling and therapy, per 15 minutes
H0031	Mental health assessment by non-physician
H0032	Mental health service plan development by non-physician
H2000	Comprehensive multidisciplinary evaluation
H2010	Comprehensive medication services, per 15 minutes
H2019	Therapeutic behavioral service, per 15 minutes
H2020	Therapeutic behavioral service, per diem
H2027	Psychoeducational service, per 15 min
T1023	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter
T1024	Evaluation and treatment by an integrated, specialty team contracted to provide coordinated care to multiple or severely handicapped children, per encounter
T1027	Family training and counseling for child development, per 15 min
T2013	Habilitation, educational, waiver, per hour
T2026	Specialized childcare, waiver, per diem

Note: Inclusion on this list does not guarantee coverage

Appendix C. HERC Guidance Development Framework

HERC Guidance Development Framework Principles

This framework was developed to assist with the decision making process for the Oregon policy-making body, the HERC and its subcommittees. It is a general guide, and must be used in the context of clinical judgment. It is not possible to include all possible scenarios and factors that may influence a policy decision in a graphic format. While this framework provides a general structure, factors that may influence decisions that are not captured on the framework include but are not limited to the following:

- Estimate of the level of risk associated with the treatment, or any alternatives;
- Which alternatives the treatment should most appropriately be compared to;
- Whether there is a discrete and clear diagnosis;
- The definition of clinical significance for a particular treatment, and the expected margin of benefit compared to alternatives;
- The relative balance of benefit compared to harm;
- The degree of benefit compared to cost; e.g., if the benefit is small and the cost is large, the committee may make a decision different than the algorithm suggests;
- Specific indications and contraindications that may determine appropriateness;
- Expected values and preferences of patients

Oregon Health Authority

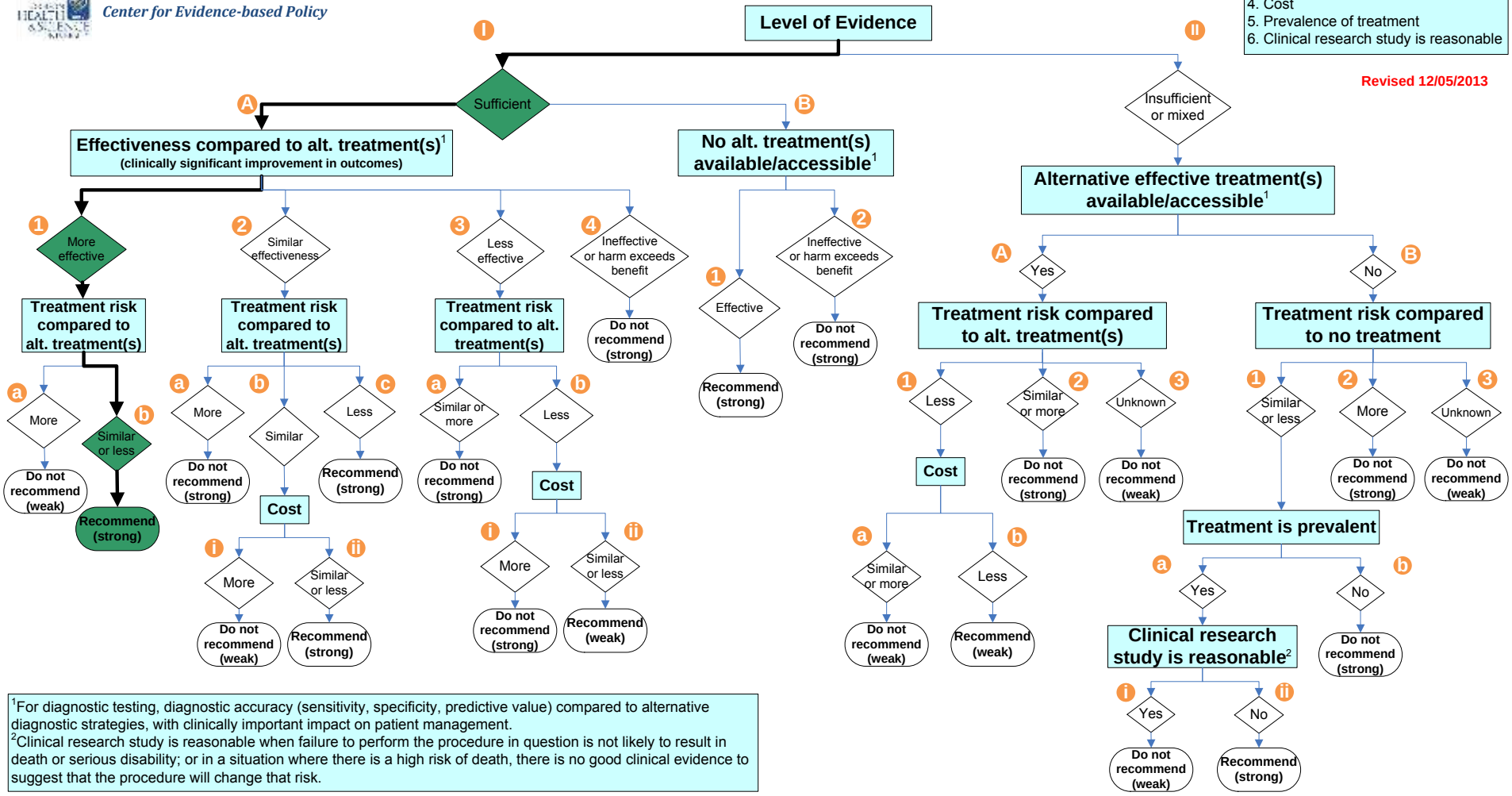
Center for Evidence-based Policy

HERC Guidance Development Framework

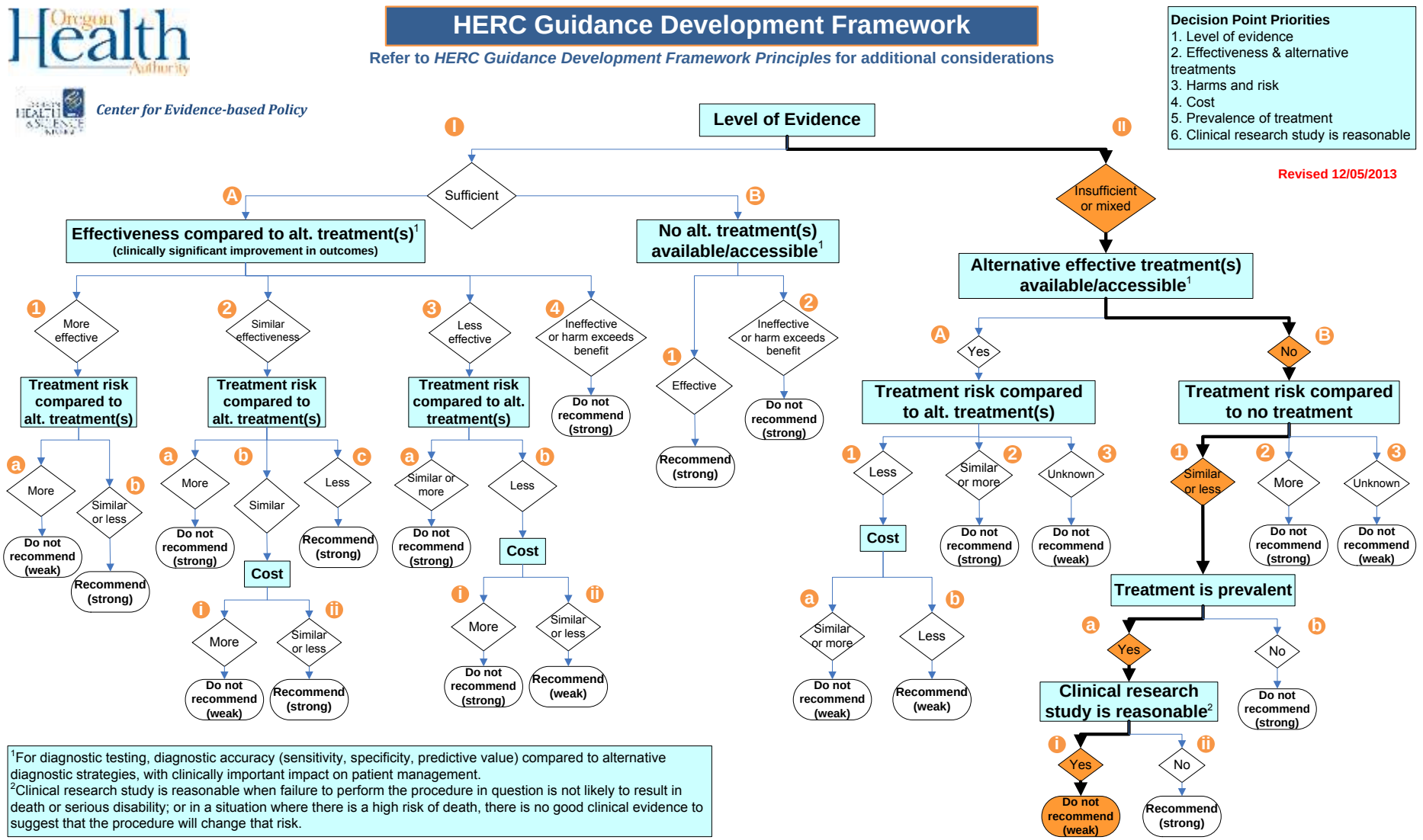
Refer to *HERC Guidance Development Framework Principles* for additional considerations

Decision Point Priorities
1. Level of evidence
2. Effectiveness & alternative treatments
3. Harms and risk
4. Cost
5. Prevalence of treatment
6. Clinical research study is reasonable

Revised 12/05/2013



[1]For diagnostic testing, diagnostic accuracy (sensitivity, specificity, predictive value) compared to alternative diagnostic strategies, with clinically important impact on patient management.
[2]Clinical research study is reasonable when failure to perform the procedure in question is not likely to result in death or serious disability; or in a situation where there is a high risk of death, there is no good clinical evidence to suggest that the procedure will change that risk.



[1]For diagnostic testing, diagnostic accuracy (sensitivity, specificity, predictive value) compared to alternative diagnostic strategies, with clinically important impact on patient management.
[2]Clinical research study is reasonable when failure to perform the procedure in question is not likely to result in death or serious disability; or in a situation where there is a high risk of death, there is no good clinical evidence to suggest that the procedure will change that risk.

Appendix D. Key References from Evidence Sources

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PRIORITIZED LIST CHANGES

Oregon Health Plan Prioritized List Changes
Applied Behavior Analysis for Autism Spectrum Disorder

The Health Evidence Review Commission approved the following changes to the Prioritized List of Health Services on August 14, 2014, based on the evidence evaluation on Applied Behavior Analysis for Autism Spectrum Disorder. The changes will take effect for the Oregon Health Plan on January 1, 2015.

1) Replaced the current guideline note75 with a new one:

GUIDELINE NOTE 75 APPLIED BEHAVIOR ANALYSIS FOR AUTISM SPECTRUM DISORDER
Line 313

Applied behavior analysis (ABA), including early intensive behavioral intervention (EIBI), represented by CPT codes 0359T-0374T, is included on line 313 for the treatment of autism spectrum disorders.

Individuals ages 1-12

Intensive interventions
Specifically, EIBI (for example, UCLA/Lovaas or Early Start Denver Model), is included on this line.

For a child initiating EIBI therapy, EIBI is included for up to six months. Ongoing coverage is based on demonstrated progress towards meaningful predefined objectives (objectives should be achieved as a result of the EIBI, over and beyond gains that would be expected to arise from maturation alone) using a standardized, multimodal assessment, no more frequently than every six months. Examples of such assessments include Vineland, IQ tests (Mullen, WPPSI, WISC-R), language measures, behavior checklists (CBCL, ABC), and autistic symptoms measures (SRS).

The evidence does not lead to a direct determination of optimal intensity. Studies of EIBI ranged from 15-40 hours per week. Through Oregon's Senate Bill 365, other payers are mandated to cover a minimum of 25 hours per week of ABA. There is no evidence that increasing intensity of therapy yields improved outcomes. Studies for these interventions had a duration from less than one year up to 3 years.

Less intensive ABA-based interventions
If EIBI is not indicated, has been completed, or there is not sufficient progress toward multidimensional goals, then less intensive ABA-based interventions (such as parent training, play/interaction based interventions, and joint attention interventions) are included on this line to address core symptoms of autism and/or specific problem areas. Initial coverage is

provided for six months. Ongoing coverage is based on demonstrated progress towards meaningful predefined objectives, with demonstration of medical appropriateness and/or emergence of new problem behaviors. Effective interventions from the research literature had lower intensity than EIBI, usually a few hours per week to a maximum of 16 hours per week, divided into daily, twice-daily or weekly sessions, over a period of several months.

Parent/caregiver involvement
Parent/caregiver involvement and training is recommended as a component of treatment.

Individuals ages 13 and older

Intensive ABA is not included on this line.

Targeted ABA-based behavioral interventions to address problem behaviors are included on this line. The quality of evidence is insufficient to support these interventions in this population. However, due to strong caregiver values and preferences and the potential for avoiding suffering and expense in dealing with unmanageable behaviors, targeted interventions may be reasonable. Behaviors eligible for coverage include those which place the member at risk for harm or create significant daily issues related to care, education, or other important functions. Ongoing coverage is based on demonstrated progress towards meaningful predefined objectives, with demonstration of medical appropriateness and/or emergence of new problem behaviors.

Very low quality evidence is available to illustrate needed intensity and duration of intervention. In the single-subject research design literature, frequency and duration of interventions were highly variable, with session duration ranging from 30 seconds to 3 hours, number of sessions ranging from a total of three to 8 times a day, and duration ranging from 1 to 20 weeks. These interventions were often conducted in inpatient or residential settings and studies often included patients with intellectual disabilities, some of which were not diagnosed with autism.

Parent/caregiver involvement and training is encouraged.

2) Added CPT 0359T-0374T (adaptive behavior assessments and treatments) to 1/1/15 line 313 AUTISM SPECTRUM DISORDERS
3) Changed the treatment description of 1/1/15 line 313 to: ~~CONSULTATION/MEDICATION MANAGEMENT/LIMITED BEHAVIORAL MODIFICATION~~ MEDICAL THERAPY/BEHAVIORAL MODIFICATION INCLUDING APPLIED BEHAVIORAL ANALYSIS

4) Rescore and reprioritize the autism spectrum line on the biennial list planned for 1/1/16 implementation as shown below

Scoring proposal (scoring for current line 313 in parentheses)
Category: 3 (3)
HL: 5 (5)
Suffering: 4 (4)
Population effects: 2 (1)
Vulnerable population: 0 (0)
Tertiary prevention: ()
Effectiveness: 3 (2)
Need for service: 0.7 (0.7)
Net cost: 1 (3)
Score: 1733 (1050)

Approximate new line placement: 199