PRACTICE GUIDELINES

GUIDELINE NOTES FOR ANCILLARY AND DIAGNOSTIC SERVICES
NOT APPEARING ON THE OCTOBER 1, 2017 PRIORITIZED LIST
OF HEALTH SERVICES

GUIDELINE NOTES FOR HEALTH SERVICES
THAT APPEAR ON THE OCTOBER 1, 2017 PRIORITIZED LIST
OF HEALTH SERVICES
ANCILLARY GUIDELINE A1, NERVE BLOCKS
The Health Evidence Review Commission intends that single injection and continuous nerve blocks (CPT 64400-64450, 64461-64463, 64505-64530) should be covered services if they are required for successful completion of perioperative pain control for, or post-operative recovery from a covered operative procedure when the diagnosis requiring the operative procedure is also covered. Additionally, nerve blocks, are covered services for patients hospitalized with trauma, cancer, or intractable pain conditions, if the underlying condition is a covered diagnosis.

ANCILLARY GUIDELINE A2, SELF-MONITORING OF BLOOD GLUCOSE IN DIABETES
For patients with type 1 diabetes and those with type 2 diabetes using multiple daily insulin injections, home blood glucose monitors and related diabetic supplies are covered.

For patients with type 2 diabetes not requiring multiple daily insulin injections, 50 test strips and related supplies are covered at the time of diagnosis. For those who require diabetic medication that may result in hypoglycemia, up to 50 test strips per 90 days are covered. If there is an acute change in glycemic control or active diabetic medication adjustment, an additional 50 strips are covered.

All diabetic patients who are prescribed diabetic test strips should have a structured education and feedback program for self-monitoring of blood glucose.

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

ANCILLARY GUIDELINE A3, IVC FILTERS FOR TRAUMA
It is the intent of the Commission that inferior vena cava (IVC) filter placement (CPT 37191) and subsequent repositioning and removal (CPT 37192, 37193) are covered when medically indicated for hospitalized patients with severe trauma resulting in prolonged hospitalization.

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

ANCILLARY GUIDELINE A4, SMOKING CESSATION AND ELECTIVE SURGICAL PROCEDURES
Smoking cessation is required prior to elective surgical procedures for active tobacco users. Cessation is required for at least 4 weeks prior to the procedure and requires objective evidence of abstinence from smoking prior to the procedure.

Elective surgical procedures in this guideline are defined as surgical procedures which are flexible in their scheduling because they do not pose an imminent threat nor require immediate attention within 1 month. Reproductive (i.e. for contraceptive purposes), cancer-related and diagnostic procedures are excluded from this guideline.

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

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

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

DIAGNOSTIC GUIDELINE D1, NON-PRENATAL GENETIC TESTING GUIDELINE
A) Genetic tests are covered as diagnostic, unless they are listed below in section F1 as excluded or have other restrictions listed in this guideline. To be covered, initial screening (e.g. physical exam, medical history, family history, laboratory studies, imaging studies) must indicate that the chance of genetic abnormality is > 10% and results would do at least one of the following:
1) Change treatment,
2) Change health monitoring,
3) Provide prognosis, or
4) Provide information needed for genetic counseling for patient; or patient's parents, siblings, or children

B) Pretest and posttest genetic counseling is required for presymptomatic and predisposition genetic testing. Pretest and posttest genetic evaluation (which includes genetic counseling) is covered when provided by a suitable trained health professional with expertise and experience in genetics.

1) "Suitably trained" is defined as board certified or active candidate status from the American Board of Medical Genetics, American Board of Genetic Counseling, or Genetic Nursing Credentialing Commission.

C) A more expensive genetic test (generally one with a wider scope or more detailed testing) is not covered if a cheaper (smaller scope) test is available and has, in this clinical context, a substantially similar sensitivity. For example, do not cover CFTR gene sequencing as the first test in a person of Northern European Caucasian ancestry because the gene panels are less expensive and provide substantially similar sensitivity in that context.
D) Related to genetic testing for patients with breast/ovarian and colon/endometrial cancer or other related cancers suspected to be hereditary, or patients at increased risk to due to family history.

1) Services are provided according to the Comprehensive Cancer Network Guidelines.
   a) Lynch syndrome (hereditary colorectal, endometrial and other cancers associated with Lynch syndrome) services (CPT 81288, 81292-81300, 81317-81319, 81435, 81436) and familial adenomatous polyposis (FAP) services (CPT 81201-81203) should be provided as defined by the NCCN Clinical Practice Guidelines in Oncology. Genetic/Familial High-Risk Assessment: Colorectal V.2.2016 (9/26/16). www.nccn.org.

b) Breast and ovarian cancer syndrome genetic testing services (CPT 81162, 81211-81217) for women without a personal history of breast, ovarian and other associated cancers should be provided to high risk women as defined by the US Preventive Services Task Force or according to the NCCN Clinical Practice Guidelines in Oncology: Genetic/Familial High-Risk Assessment: Breast and ovarian. V1.2017 (9/19/16). www.nccn.org.

c) Breast and ovarian cancer syndrome genetic testing services (CPT 81162, 81211-81217) for women with a personal history of breast, ovarian, and other associated cancers and for men with breast cancer should be provided according to the NCCN Clinical Practice Guidelines in Oncology. Genetic/Familial High-Risk Assessment: Breast and Ovarian. V1.2017 (9/19/2016). www.nccn.org.

d) PTEN (Cowden syndrome) services (CPT 81321-81323) should be provided as defined by the NCCN Clinical Practice Guidelines in Oncology. Colorectal Screening. V.2.2016 (9/26/16). www.nccn.org.

2) Genetic counseling should precede genetic testing for hereditary cancer whenever possible.
   a) Pre and post-test genetic counseling should be covered when provided by a suitable trained health professional with expertise and experience in cancer genetics. Genetic counseling is recommended for cancer survivors when test results would affect cancer screening.

   i) “Suitably trained” is defined as board certified or active candidate status from the American Board of Medical Genetics, American Board of Genetic Counseling, or Genetic Counseling Credentialing Commission.

   b) If timely pre-test genetic counseling is not possible for time-sensitive cases, appropriate genetic testing accompanied by pre- and post-test informed consent and post-test disclosure performed by a board-certified physician with experience in cancer genetics should be covered.

   i) Post-test genetic counseling should be performed as soon as is practical.

3) If the mutation in the family is known, only the test for that mutation is covered. For example, if a mutation for BRCA 1 has been identified in a family, a single site mutation analysis for that mutation is covered (CPT 81215), while a full sequence BRCA 1 and 2 (CPT 81211) analyses is not. There is one exception, for individuals of Ashkenazi Jewish ancestry with a known mutation in the family, the panel for Ashkenazi Jewish BRCA mutations is covered (CPT 81212).

4) Costs for rush genetic testing for hereditary breast/ovarian and colon/endometrial cancer is not covered.

E) Related to diagnostic evaluation of individuals with intellectual disability (defined as a full scale or verbal IQ < 70 in an individual > age 5), developmental delay (defined as a cognitive index <70 on a standardized test appropriate for children < 5 years of age), Autism Spectrum Disorder, or multiple congenital anomalies:

1) CPT 81228, Cytogenomic constitutional microarray analysis for copy number variants for chromosomal abnormalities. Cover for diagnostic evaluation of individuals with intellectual disability/developmental delay; multiple congenital anomalies; or, Autism Spectrum Disorder accompanied by at least one of the following: dysmorphic features including macro or microcephaly, congenital anomalies, or intellectual disability/developmental delay in addition to those required to diagnose Autism Spectrum Disorder.

2) CPT 81229, Cytogenomic constitutional microarray analysis for copy number variants for chromosomal abnormalities; plus cytogenetic constitutional microarray analysis for single nucleotide polymorphism (SNP) variants for chromosomal abnormalities: Cover for diagnostic evaluation of individuals with intellectual disability/developmental delay; multiple congenital anomalies; or, Autism Spectrum Disorder accompanied by at least one of the following: dysmorphic features including macro or microcephaly, congenital anomalies, or intellectual disability/developmental delay in addition to those required to diagnose Autism Spectrum Disorder; only if (a) consanguinity and/or recessive disease is suspected, or (b) uniparental disomy is suspected, or (c) another mechanism is suspected that is not detected by the copy number variant test alone.

3) CPT 81243, 81244, Fragile X genetic testing is covered for individuals with intellectual disability/developmental delay. Although the yield of Fragile X is 3.5-10%, this is included because of additional reproductive implications.

4) A visit with the appropriate specialist (often genetics, developmental pediatrics, or child neurology), including physical exam, medical history, and family history is covered. Physical exam, medical history, and family history by the appropriate specialist, prior to any genetic testing is often the most cost-effective strategy and is encouraged.

F) Related to other tests with specific CPT codes:

1) The following tests are not covered:
   d) CPT 81287, MGMT (O-6-methylguanine-DNA methyltransferase) (eg, glioblastoma multiforme), methylation analysis
   e) CPT 81291, MTHFR (5,10-methylenetetrahydrofolate reductase) (eg, hereditary hypercoagulability) gene analysis, common variants (eg, 677T, 1298C)
   f) CPT 81330, SMPD1(sphingomyelin phosphodiesterase 1, acid lysosomal) (eg, Niemann-Pick disease, Type A) gene analysis, common variants (eg, R496L, L302P, fsP330)
   g) CPT 81350, UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1) (eg, irinotecan metabolism) gene analysis, common variants (eg, *28, *36, *37)
   h) CPT 81355, VKORC1 (vitamin K epoxide reductase complex, subunit 1) (eg, warfarin metabolism) gene analysis, common variants (eg, *1XN, *2XN, *4XN)
DIAGNOSTIC GUIDELINE D1 NON-PRENATAL GENETIC TESTING GUIDELINE (CONT’D)

i) CPT 81417, re-evaluation of whole exome sequencing
j) CPT 81425-81427, Genome sequence analysis
k) CPT 81470, 81471, X-linked intellectual disability (XLID) genomic sequence panels
l) CPT 81504, Oncology (tissue of origin), microarray gene expression profiling of > 2000 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as tissue similarity scores

2) The following tests are covered only if they meet the criteria in section A above AND the specified situations:
   a) CPT 81205, BCKDHB (branched-chain keto acid dehydrogenase E1, beta polypeptide) (eg, Maple syrup urine disease) gene analysis, common variants (eg, R183P, G278S, E422X); Cover only when the newborn screening test is abnormal and serum amino acids are normal
   b) Diagnostic testing for cystic fibrosis (CF)
      i) CFTR, cystic fibrosis transmembrane conductance regulator tests. CPT 81220, 81222, 81223: For infants with a positive newborn screen for cystic fibrosis or who are symptomatic for cystic fibrosis, or for clients that have previously been diagnosed with cystic fibrosis but have not had genetic testing, CFTR gene analysis of a panel containing at least the mutations recommended by the American College of Medical Genetics* (CPT 81220) is covered. If two mutations are not identified, CFTR full gene sequencing (CPT 81223) is covered. If two mutations are still not identified, duplication/deletion testing (CPT 81222) is covered. These tests may be ordered as reflex testing on the same specimen.
   c) Carrier testing for cystic fibrosis
      i) CFTR gene analysis of a panel containing at least the mutations recommended by the American College of Medical Genetics* (CPT 81220) is covered once in a lifetime.
   d) CPT 81224, CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; introm 8 poly-T analysis (eg, male infertility); Covered only after genetic counseling.
   e) CPT 81240, F2 (prothrombin, coagulation factor II) (eg, hereditary hypercoagulabality) gene analysis, 20210G>A variant: Factor 2 20210G>A testing should not be covered for adults with idiopathic venous thromboembolism; for asymptomatic family members of patients with venous thromboembolism and a Factor V Leiden or Prothrombin 20210G>A mutation; and for determining the etiology of recurrent fetal loss or placental abruption.
   f) CPT 81241, F5 (coagulation Factor V) (eg, hereditary hypercoagulabality) gene analysis, Leiden variant: Factor V Leiden testing should not be covered for: adults with idiopathic venous thromboembolism; for asymptomatic family members of patients with venous thromboembolism and a Factor V Leiden or Prothrombin 20210G>A mutation; and for determining the etiology of recurrent fetal loss or placental abruption.
   g) CPT 81256, HFE (hemochromatosis) (eg, hereditary hemochromatosis) gene analysis, common variants (eg, C282Y, H63D); Covered for diagnostic testing of patients with elevated transferrin saturation or ferritin levels. Covered for predictive testing ONLY when a first degree family member has treatable iron overload from HFE.
   h) CPT 81221, SERPINA1 (serpin peptidase inhibitor, clade A, alpha-1 antiprotease, antitrypsin, member 1) (eg, alpha-1-antitrypsin deficiency), gene analysis, common variants (eg, *S and *Z); The alpha-1-antitrypsin protein level should be the first line test for a suspected diagnosis of AAT deficiency in symptomatic individuals with unexplained liver disease or obstructive lung disease that is not asthma or in a middle age individual with unexplained dyspnea. Genetic testing of the alpha-1 phenotype test is appropriate if the protein test is abnormal or borderline. The genetic test is appropriate for siblings of people with AAT deficiency regardless of the AAT protein test results.
   i) CPT 81415-81416, exome testing: A genetic counseling geneticist consultation is required prior to ordering test
   j) CPT 81430-81431, Hearing loss (eg, nonsyndromic hearing loss, Usher syndrome, Pendred syndrome); genomic sequence analysis panel. Testing for mutations in GJB2 and GJB6 need to be done first and be negative in non-syndromic patients prior to panel testing.
   k) CPT 81440, 81460, 81465, mitochondrial genome testing: A genetic counseling geneticist or metabolic consultation is required prior to ordering test.
   l) CPT 81412 Ashkenazi Jewish carrier testing panel: panel testing is only covered when the panel would replace and would be similar or lower cost than individual gene testing including CF carrier testing.


DIAGNOSTIC GUIDELINE D2, IMPLANTABLE CARDIAC LOOP RECORDERS

Use of an implantable cardiac loop recorder (ICLR) is a covered service only when the patient meets all of the following criteria:
   1) The evaluation is for recurrent transient loss of consciousness (TLoC); and
   2) A comprehensive evaluation including 30 days of noninvasive ambulatory cardiac monitoring did not demonstrate a cause of the TLoC; and
   3) A cardiac arrhythmia is suspected to be the cause of the TLoC; and
   4) There is a likely recurrence of the TLoC within the battery longevity of the device.

ICLRs are not a covered service for evaluation of cryptogenic stroke or any other indication.

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

Need for contrast with an echocardiogram should be assessed and, if indicated, implemented at the time of the original ECHO and not as a separate procedure.
**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. Repeat imaging is only covered when there is a substantial clinical change (e.g. progressive neurological deficit) or new clinical indication for imaging (i.e. development of a new red flag condition). Repeat imaging for acute exacerbations of chronic radiculopathic pain is not covered.

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**

<table>
<thead>
<tr>
<th>Possible cause</th>
<th>Key features on history or physical examination</th>
<th>Imaging</th>
<th>Additional studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>• History of cancer with new onset of LBP</td>
<td>MRI</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>• Unexplained weight loss</td>
<td></td>
<td>ESR</td>
</tr>
<tr>
<td></td>
<td>• Failure to improve after 1 month</td>
<td>Lumbosacral plain radiography</td>
<td></td>
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<tr>
<td></td>
<td>• Age &gt;50 years</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Symptoms such as painless neurologic deficit, night pain or pain increased in supine position</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Multiple risk factors for cancer present</td>
<td>Plain radiography or MRI</td>
<td></td>
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<tr>
<td>Spinal column infection</td>
<td>• Fever</td>
<td>MRI</td>
<td>ESR and/or CRP</td>
</tr>
<tr>
<td></td>
<td>• Intravenous drug use</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Recent infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cauda equina syndrome</td>
<td>• Urinary retention</td>
<td>MRI</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>• Motor deficits at multiple levels</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Fecal incontinence</td>
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<td></td>
<td>• Saddle anesthesia</td>
<td></td>
<td></td>
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<tr>
<td>Vertebral compression fracture</td>
<td>• History of osteoporosis</td>
<td>Lumbosacral plain radiography</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>• Use of corticosteroids</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Older age</td>
<td></td>
<td></td>
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<tr>
<td>Ankylosing spondylitis</td>
<td>• Morning stiffness</td>
<td>Anterior-posterior pelvis plain radiography</td>
<td>ESR and/or CRP, HLA-B27</td>
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<tr>
<td></td>
<td>• Improvement with exercise</td>
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<tr>
<td></td>
<td>• Alternating buttock pain</td>
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<tr>
<td></td>
<td>• Awakening due to back pain during the second part of the night</td>
<td></td>
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<tr>
<td></td>
<td>• Younger age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nerve compression/disorders (e.g. herniated disc with radiculopathy)</td>
<td>• Back pain with leg pain in an L4, L5, or S1 nerve root distribution present &lt; 1 month</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>• Positive straight-leg-raise test or crossed straight-leg-raise test</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Radiculopathic signs$^2$ present &gt;1 month</td>
<td>MRI$^3$</td>
<td>Consider EMG/NCV</td>
</tr>
<tr>
<td></td>
<td>• Severe/progressive neurologic deficits (such as foot drop), progressive motor weakness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spinal stenosis</td>
<td>• Radiating leg pain</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>• Older age</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Pain usually relieved with sitting</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Pseudoclaudication a weak predictor)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Spinal stenosis symptoms present &gt;1 month</td>
<td>MRI$^3$</td>
<td>Consider EMG/NCV</td>
</tr>
</tbody>
</table>

Level of evidence for diagnostic evaluation is variable

$^2$Radiculopathic signs are defined for the purposes of this guideline as the presence of any of the following:

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

$^3$Only if patient is a potential candidate for surgery

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.

DIAGNOSTIC GUIDELINE D4, ADVANCED IMAGING FOR LOW BACK PAIN, (CONT’D)
The development of this guideline note was informed by a HERC coverage guidance. See http://www.oregon.gov/oha/HPA/CSI-HERC/Pages/Evidence-based-Reports.aspx.

DIAGNOSTIC GUIDELINE D5, NEUROIMAGING FOR HEADACHE
Neuroimaging is not covered in patients with a defined tension or migraine type of headache, or a variation of their usual headache (e.g. more severe, longer in duration, or not responding to drugs).

Neuroimaging is covered for headache when a red flag* is present.

*The following represent red flag conditions for underlying abnormality with headache:

A) New onset or change in headache in patients who are aged over 50
B) Thunderclap headache: rapid time to peak headache intensity (seconds to 5 minutes)
C) Focal neurological symptoms (e.g. limb weakness, lack of coordination, numbness or tingling)
D) Non-focal neurological symptoms (e.g altered mental status, dizziness)
E) Abnormal neurological examination
F) Headache that changes with posture
G) Headache wakening the patient up (Nota bene migraine is the most frequent cause of morning headache)
H) Patients with risk factors for cerebral venous sinus thrombosis
I) Jaw claudication
J) Nuchal rigidity
K) New onset headache in a patient with a history of human immunodeficiency virus (HIV) infection
L) New onset headache in a patient with a history of cancer
M) Cluster headache, paroxysmal hemicrania, short-lasting unilateral neuralgiform headache attacks with conjunctival injection and tearing (SUNCT), or short-lasting unilateral neuralgiform headache attacks with cranial autonomic features (SUNA).

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

DIAGNOSTIC GUIDELINE D6, BREAST CANCER SCREENING IN ABOVE-AVERAGE RISK WOMEN
Annual screening mammography and annual screening MRI are covered only for women at above-average risk of breast cancer. This coverage, beginning at 30 years of age, includes women who have one or more of the following:

• Greater than 20% lifetime risk of breast cancer
• BRCA1 or BRCA2 gene mutation, or who have not been tested for BRCA but have a first-degree relative who is a BRCA carrier
• A personal history or a first-degree relative diagnosed with Bannayan-Riley-Ruvalcaba syndrome, Cowden syndrome, or Li-Fraumeni syndrome
• Other germline gene mutations known to confer a greater than 20% lifetime risk of breast cancer

For women with a history of high dose chest radiation (≥ 20 Gray) before the age of 30, annual screening MRI and annual screening mammography are covered beginning 8 years after radiation exposure or at age 25, whichever is later.

For women with both a personal history and a family history of breast cancer, annual mammography, annual breast MRI and annual breast ultrasound are covered.

For women with increased breast density, supplemental screening with breast ultrasound, MRI, or digital breast tomosynthesis is not covered.

Breast PET-CT scanning and breast-specific gamma imaging are not covered for breast cancer screening.

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

DIAGNOSTIC GUIDELINE D7, NEUROIMAGING IN DEMENTIA
Neuroimaging is covered:

A) To rule out reversible causes of dementia (tumors, normal pressure hydrocephalus and chronic subdural hematoma) via structural neuroimaging only

Neuroimaging is not covered:

A) For screening of asymptomatic patients for dementia
B) To predict progression of the risk of developing dementia in patients with mild cognitive impairment
C) For screening, diagnosis, or monitoring of dementia, with functional neuroimaging (PET, SPECT or fMRI)

The development of this guideline note was informed by a HERC coverage guidance. See http://www.oregon.gov/oha/HPA/CSI-HERC/Pages/Evidence-based-Reports.aspx.
ANCILLARY/DIAGNOSTIC GUIDELINE NOTES FOR THE
OCTOBER 1, 2017 PRIORITIZED LIST OF HEALTH SERVICES

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

Type I PSG is covered when used to aid the diagnosis of OSA in patients who have clinical signs and symptoms indicative of OSA if performed attended in a sleep lab facility.

OHP clients should have access to least one of the alternatives listed below:

1) Type II or Type III sleep testing devices when used to aid the diagnosis of OSA in patients who have clinical signs and symptoms indicative of OSA if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility.

2) Type IV sleep testing devices measuring three or more channels, one of which is airflow, when used to aid the diagnosis of OSA in patients who have signs and symptoms indicative of OSA if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility.

3) Sleep testing devices measuring three or more channels that include actigraphy, oximetry, and peripheral arterial tone, when used to aid the diagnosis of OSA in patients who have signs and symptoms indicative of OSA if performed unattended in or out of a sleep lab facility or attended in a sleep lab facility.

CPAP titration should be performed as part of the diagnostic study, if possible.

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

DIAGNOSTIC GUIDELINE D9, MRI FOR BREAST CANCER DIAGNOSIS

In women with recently diagnosed breast cancer, preoperative or contralateral MRI of the breast is not a covered service.

DIAGNOSTIC GUIDELINE D10, MRI IN MULTIPLE SCLEROSIS

MRI is a diagnostic test for multiple sclerosis and should not be used for routine monitoring of disease.

MRI may be considered in the following circumstances:

A) Suspected drug failure in the setting of clinical relapse in patients with objective changes in neurological status or documented new clinical symptoms such as urinary urgency or cognitive changes.

B) Evaluation of a clear objective progression in clinical symptoms in patients with previously relapsing disease to rule out ongoing inflammatory disease when conversion to secondary progressive MS is suspected.

C) Patients who require enhanced pharmacovigilance, including

1) Yearly monitoring for patients treated with natalizumab who are JCV seropositive

2) One MRI for patients who switch from natalizumab to other therapeutics (including fingolimod, alemtuzumab and dimethyl fumarate) one year after the switch from natalizumab

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

MRI of the cervical and thoracic spine is covered in the following situations:

1) Recent onset of major or progressive neurologic deficit (objective evidence of markedly abnormal reflexes, dermatomal muscle weakness, dermatomal sensory loss, EMG or NCV evidence of nerve root impingement), suspected cauda equina syndrome (loss of bowel or bladder control or saddle anesthesia), or neurogenic claudication in patients who are potential candidates for surgery;

2) Clinical or radiological suspicion of neoplasm; or,

3) Clinical or radiological suspicion of infection.

DIAGNOSTIC GUIDELINE D12, UPPER ENDOSCOPY FOR GERD OR DYSPEPSIA SYMPTOMS

Upper endoscopy for uninvestigated dyspepsia or GERD symptoms is covered for:

Patients less than 50 years of age with persistent symptoms following advice on lifestyle modifications and completion of an appropriate course of twice daily PPI therapy or an H. pylori test and treat protocol.

Patients 50 years of age and older

Patients with “alarm symptoms” including, but not limited to, iron deficiency anemia or weight loss

Upper endoscopy is not covered for patients with previous upper endoscopy with non-malignant findings (other than Barrett’s esophagus) in the absence of significant new symptoms.

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

DIAGNOSTIC GUIDELINE D13, SCREENING FOR CAROTID ARTERY STENOSIS

Screening for carotid artery stenosis (CPT 93880) in the general primary care population is not a covered service.

The development of this guideline note was informed by a HERC coverage guidance. See http://www.oregon.gov/oha/HPA/CSI-HERC/Pages/Evidence-based-Reports.aspx.
DIAGNOSTIC GUIDELINE D14, LUNG CANCER SCREENING

Low dose computed tomography is included for annual screening for lung cancer in persons aged 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery. Current smokers should be offered evidence based smoking cessation interventions.

DIAGNOSTIC GUIDELINE D15, COMPUTER-AIDED MAMMOGRAPHY

Computer-aided mammography is not intended to be a covered service.

DIAGNOSTIC GUIDELINE D16, OSTEOPOROSIS SCREENING AND MONITORING IN ADULTS

Osteoporosis screening by dual-energy X-ray absorptiometry (DXA) is covered only for women aged 65 or older, and for men or younger women whose 10-year risk of major osteoporotic fracture is equal to or greater than 9.3 percent.

Fracture risk should be assessed by the World Health Organization’s FRAX tool or similar instrument.

Routine osteoporosis screening by DXA is not covered for men.

The frequency of subsequent monitoring for development of osteoporosis should not be based on DXA scores alone. If rapid change in bone density is expected, more frequent DXA scanning is appropriate (for example, in patients taking glucocorticoids, those with a history of rapid weight loss, those with medical conditions that could result in secondary osteoporosis, etc.).

If there has been no significant change in an individual's risk factors, monitoring by repeat DXA scanning is covered only at the following frequencies:

- once every two years for those with osteoporosis or advanced osteopenia (T-score of -2.00 or lower)
- once every four years for moderate osteopenia (T-score between -1.50 and -1.99)
- once every ten years for mild osteopenia (T-score between -1.01 and -1.49).
- once every fifteen years for those with normal bone density

Repeat testing is only covered if the results will influence clinical management. For purposes of monitoring osteoporosis medication therapy, testing at intervals of less than two years is not covered.

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

DIAGNOSTIC GUIDELINE D17, PRENATAL GENETIC TESTING

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

A) Genetic counseling (CPT 96040, HPCPS S0265) for high risk women who have family history of inheritable disorder or carrier state, ultrasound abnormality, previous pregnancy with aneuploidy, or elevated risk of neural tube defect.
B) Genetic counseling (CPT 96040, HPCPS S0265) prior to consideration of chorionic villus sampling (CVS), amniocentesis, microarray testing, Fragile X, and spinal muscular atrophy screening
C) Validated questionnaire to assess genetic risk in all pregnant women
D) Screening high risk ethnic groups for hemoglobinopathies (CPT 83020, 83021)
E) Screening for aneuploidy with any of five screening strategies [first trimester (nuchal translucency, beta-HCG and PAPP-A), integrated, serum integrated, stepwise sequential, and contingency] (CPT 76813, 76814, 81508-81511)
F) Cell free fetal DNA testing (CPT 81420, 81507) for evaluation of aneuploidy in women who have an elevated risk of a fetus with aneuploidy (maternal age >34, family history or elevated risk based on screening).
G) Ultrasound for structural anomalies between 18 and 20 weeks gestation (CPT 76811, 76812)
H) CVS or amniocentesis (CPT 59000, 59015,82106, 88235, 88267, 88269, 88280, 88285) for a positive aneuploidy screen, maternal age >34, fetal structural anomalies, family history of inheritable chromosomal disorder or elevated risk of neural tube defect.
I) Array CGH (CPT 81228, 81229) when major fetal congenital anomalies are apparent on imaging, or with normal imaging when array CGH would replace karyotyping performed with CVS or amniocentesis in #8 above.
J) FISH testing (CPT 88271, 88275) only if karyotyping is not possible due a need for rapid turnaround for reasons of reproductive decision-making (i.e. at 22w4d gestation or beyond)
K) Screening for Tay-Sachs carrier status (CPT 81255) in high risk populations. First step is hex A, and then additional DNA analysis in individuals with ambiguous Hex A test results, suspected variant form of TSD or suspected pseudodeficiency of Hex A
L) Screening for cystic fibrosis carrier status once in a lifetime (CPT 81220-81224)
M) Screening for fragile X status (CPT 81243, 81244) in patients with a personal or family history of
   a. fragile X tremor/ataxia syndrome
   b. premature ovarian failure
   c. unexplained early onset intellectual disability
   d. fragile X intellectual disability
   e. unexplained autism through the pregnant woman's maternal line
N) Screening for spinal muscular atrophy (CPT 81401) once in a lifetime
O) Screening those with Ashkenazi Jewish heritage for Canavan disease (CPT 81200), familial dysautonomia (CPT 81260), and Tay-Sachs carrier status (CPT 81255). Ashkenazi Jewish carrier panel testing (CPT 81412) is covered if the panel would replace and would be of similar or lower cost than individual gene testing including CF carrier testing.
P) Expanded carrier screening only for those genetic conditions identified above.

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DIAGNOSTIC GUIDELINE D17, PRENATAL GENETIC TESTING, (CONT'D)
The following genetic screening tests are not covered:
A) Serum triple screen
B) Screening for thrombophilia in the general population or for recurrent pregnancy loss
C) Expanded carrier screening which includes results for conditions not explicitly recommended for coverage

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

DIAGNOSTIC GUIDELINE D18, ADVANCED IMAGING FOR STAGING OF PROSTATE CANCER
MRI is covered for men with histologically proven prostate cancer if knowledge of the T or N stage could affect management. CT of the pelvis is covered only when MRI is contraindicated.

Radionuclide bone scanning is not covered in men with low risk localized prostate cancer. Low risk is defined as PSA <10 ng/ml and Gleason score <=6 and clinical stage T1-T2a.

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

DIAGNOSTIC GUIDELINE D19, SPECT
SPECT (CPT 78451, 78452) is not covered for screening for coronary artery disease in asymptomatic patients.

Stress SPECT (78451, 78452 in conjunction with stress testing) is only covered for diagnosis or risk stratification of coronary artery disease when a stress ECHO is contraindicated, is unavailable or would provide suboptimal imaging (i.e. pre-existing cardiomyopathy, baseline regional wall motion abnormalities, left bundle branch block, paced rhythm, unsuitable acoustic windows due to body habitus, or inability to exercise with inability to utilize dobutamine.)

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

DIAGNOSTIC GUIDELINE D20, OPHTHALMOLOGY DIAGNOSTIC VISITS
Ophthalmology diagnostic visits (CPT 92002, 92004, 92012, 92014, 92081-92083, 92100, 92140, 92133, 92134) are covered for the evaluation of serious eye symptoms such as sudden vision loss or eye pain.

DIAGNOSTIC GUIDELINE D21, PHARMACOGENETICS TESTING FOR PSYCHIATRIC MEDICATION MANAGEMENT
Pharmacogenetics testing for management of psychiatric medications is not a covered service.