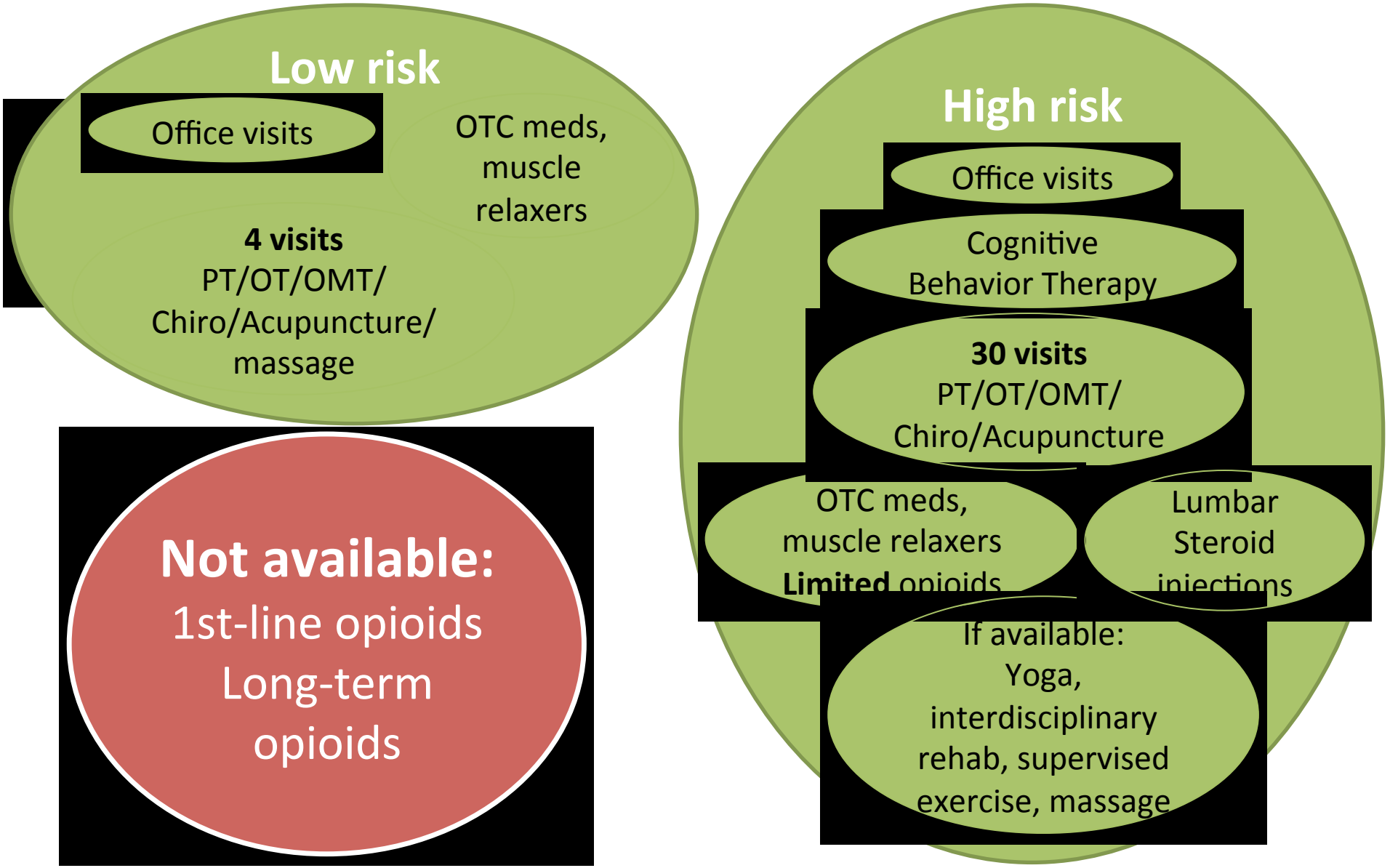
New Non-Surgical Treatment Buckets



Surgical Treatments

- Surgery available for :
  - High risk conditions
  - Conditions with good evidence that surgery helps more than conservative therapy
- Non urgent surgical conditions
  - No coverage
- Scoliosis
  - Surgery for adolescents only

STarT Back Tool

1) My back pain has **spread down my leg(s)** at some time in the last 2 weeks
2) I have had pain in the **shoulder** or **neck** at some time in the last 2 weeks
3) I have only **walked short distances** because of my back pain
4) In the last 2 weeks, I have **dressed more slowly** than usual because of back pain
5) It's not really safe for a person with a condition like mine to be physically active
6) **Worrying thoughts** have been going through my mind a lot of the time
7) I feel that **my back pain is terrible** and **it's never going to get any better**
8) In general I have **not enjoyed** all the things I used to enjoy
9) Overall, how **bothersome** has your back pain been in the **last 2 weeks**

Opioid Guideline

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

- During the first 6 weeks after the acute injury, flare or surgery, opioid treatment is included on these lines ONLY
  - When each prescription is limited to 7 days of treatment, For short acting opioids only,
  - When one or more alternative first line pharmacologic therapies have been tried and found not effective or are contraindicated,
  - When prescribed with a plan to keep active,
  - There is documented lack of current or prior opioid misuse or abuse.

Opioid Guideline Continued

- Treatment with opioids after 6 weeks, up to 90 days, requires the following
  - Documented evidence of improvement of function of at least thirty percent as compared to baseline based on a validated tools.
  - Must be prescribed in conjunction with active therapies
  - Verification that the patient is not high risk for opioid misuse or abuse.
  - Each prescription must be limited to 7 days of treatment and for short acting opioids only

Opioid Guideline Continued

- Further opioid treatment after 90 days may be considered ONLY when there is a significant change in status.
- 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. If a patient has developed dependence and/or addiction related to their opioids, treatment is available on line 4 SUBSTANCE USE DISORDER.

New Back Conditions Lines and Guidelines

Note: line numbers refer to the January 1, 2016 Prioritized List

Line: 351
CONDITION: CONDITIONS OF THE BACK AND SPINE WITH URGENT SURGICAL INDICATIONS
TREATMENT: SURGICAL THERAPY
ICD-9: 344.60-344.61 (cauda equina), 721.1, 721.41-721.42,721.91 (spondylosis with myelopathy); 722.7x (intervertebral disc disorder with myelopathy), 723.0 (spinal stenosis), 724.0x (spinal stenosis), 738.4, 756.11-756.12 (spondylolisthesis), V57.1,V57.2x,V57.81-V57.89
ICD-10: G83.4 (cauda equina), M43.1x (spondylolisthesis), M47.0x, M47.1x (spondylosis with myelopathy), M48.0x (spinal stenosis), M50.0x, M51.0x (intervertebral disc disorder with myelopathy), M53.2x (spinal instabilities), Q76.2 (spondylolisthesis), Z47.82 (aftercare after scoliosis surgery)
CPT: 20660-20665, 20930-20938,21720,21725,22206-22226,22532-22855,29000-29046,29710-29720,62287, 63001-63091,63170,63180-63200, 63270-63273,63295-63610,63650,63655, 63685, 97001-97004, 97022, 97110-97124, 97140, 97150, 97530, 97535 (PT/OT evaluation and treatment), 96150-4 (health and behavior assessment codes), 98966-98968, 98969, 99051, 99060, 99070,99078,99201-99215 (outpatient medical visits), 99217-99239 (hospital), 99281-99285 (ER), 99304-99337 (SNF care), 99401-99404 (risk factor reduction intervention), 99408, 99409, 99411, 99412, 99441-99444, 99446-99449 (critical care), 99605-99607
HPCPS: G0157-G0160 (PT/OT), G0396-G0397 (SBRT), G0406-G0408 (inpatient consultation), G0425-G0427 (telehealth), G0463, G0466, G0467 (FQHC), S2350-S2351 (discectomy with decompression of spinal cord)

Line: 366
CONDITION: SCOLIOSIS
TREATMENT: MEDICAL AND SURGICAL THERAPY
ICD-9: 737.3x, 737.43, V57.1,V57.2x,V57.81-V57.89
ICD-10: M41.xx
CPT: 20660-20665, 20930-20938,21720,21725,22206-22226,22532-22865,29000-29046,29710-29720,62287, 63001-63091,63170,63180-63200,63210,63295-63610,63650,63655,63685, 96127, 96150-96154 (health and behavior assessment codes), 97001-97004, 97022, 97110-97124, 97140, 97150, 97530, 97535 (PT/OT evaluation and treatment), 97760,97762, 98966-98968, 98969, 99051, 99060, 99070,99078,99201-99215 (outpatient medical visits), 99217-99239 (hospital), 99281-99285 (ER), 99304-99337 (SNF care), 99401-99404 (risk factor reduction intervention), 99408, 99409, 99411, 99412, 99441-99444, 99446-99449 (critical care), 99605-99607
HPCPS: G0157-G0160 (PT/OT), G0396-G0397 (SBRT), G0406-G0408 (inpatient consultation), G0425-G0427 (telehealth), G0463, G0466, G0467 (FQHC)

Line: 407
CONDITION: CONDITIONS OF THE BACK AND SPINE
TREATMENT: RISK ASSESSMENT, PHYSICAL MODALITIES, COGNITIVE BEHAVIORAL THERAPY, MEDICAL THERAPY
ICD-9: 336.0,344.60-344.61,349.2,720.2,720.81,721.0-721.9,722.0-722.9,723.0,723.1, 723.4,723.6-723.9,724.0-724.9,731.0,732.0,737.0-737.2,737.40-737.42,737.8-737.9,738.4-738.5, 739.0-739.9,742.59,754.2,756.10-756.19,839.20-839.21,847.0-847.9,V57.1,V57.2x,V57.81-V57.89
ICD-10: F45.42 (Pain disorder with related psychological factors), G83.4,G95.0,M24.08,M25.78, M40.x,M42.0x,M43.00-M43.28,M43-M43.9,M45.0-M45.8,M46.1,M46.40-M46.49,M46.81-M46.89, M46.91-M46.99,M47.011-M47.16,M47.20-M47.28,M47.811-M47.9,M48.00-M48.27,M48.30-M48.38,M48.9,M49.80-M49.89,M50.00-M50.93,M51.04-M51.9,M53.2x1-M53.2x8, M53.3, M53.80-M53.9,M54.0,M54.11-M54.6,M54.81-M54.9,M62.830,M96.1,M96.2-M96.5,M99.00-M99.09,M99.12-M99.13,M99.20-M99.79,M99.83-M99.84,Q06.0-Q06.3,Q06.8-Q06.9, Q67.5,

Q76.0-Q76.4,Z47.82,S13.0xxA-S13.0xxD, S13.4xxA-S13.4xxD,S13.8xxA-S13.8xxD,S13.9xxA-S13.9xxD,S16.1xxA-S16.1xxD,S23.0xxA-S23.0xxD, S23.100A-S23.100D,S23.101A-S23.101D, S23.110A-S23.110D,S23.111A-S23.111D,S23.120A-S23.120D,S23.121A-S23.121D,S23.122A-S23.122D,S23.123A-S23.123D,S23.130A-S23.130D,S23.131A-S23.131D,S23.132A-S23.132D, S23.133A-S23.133D,S23.140A-S23.140D,S23.141A-S23.141D,S23.142A-S23.142D,S23.143A-S23.143D,S23.150A-S23.150D,S23.151A-S23.151D,S23.152A-S23.152D,S23.153A-S23.153D, S23.160A-S23.160D,S23.161A-S23.161D,S23.162A-S23.162D,S23.163A-S23.163D,S23.170A-S23.170D,S23.171A-S23.171D,S23.3xxA-S23.3xxD,S23.8xxA-S23.8xxD,S23.9xxA-S23.9xxD, S33.0xxA-S33.0xxD, S33.100A-S33.100D,S33.101A-S33.101D,S33.110A-S33.110D,S33.111A-S33.111D,S33.120A-S33.120D,S33.121A-S33.121D,S33.130A-S33.130D,S33.131A-S33.131D, S33.140A-S33.140D,S33.141A-S33.141D,S33.5xxA-S33.5xxD,S33.9xxA-S33.9xxD,S34.3xxA-S34.3xxD, S39.092A-S39.092D,S39.82xA-S39.82xD,S39.92xA-S39.92xD
CPT: 90785,90832-90838,90853 (mental health visits, counseling), 96150-4 (health and behavior assessment codes), 97001-97004, 97022, 97110-97124, 97140, 97150, 97530, 97535 (PT/OT evaluation and treatment), 97810-97814 (acupuncture), 98925-98929, 98940-98942 (OMT/CMT), 98966-98968, 98969, 99051, 99060, 99070,99078,99201-99215 (outpatient medical visits), 99281-99285 (ER), 99304-99337 (SNF care), 99340-99359, 99366-99404 (risk factor reduction intervention), 99408, 99409, 99411, 99412, 99441-99449, 99487-99490, 99605-99607
HPCPS: G0157-G0160 (PT/OT), G0396-G0397 (SBRT), G0425-G0427 (telehealth), G0463, G0466, G0467, G0469, G0470 (FQHC)

Line: 532
CONDITION: CONDITIONS OF THE BACK AND SPINE WITHOUT URGENT SURGICAL INDICATIONS
TREATMENT: SURGICAL THERAPY
ICD-9: 336.0, 349.2,720.81,721.0, 721.2,721.3,721.5-721.8,721.90,722.0,722.10-722.2,722.4-722.6,722.8-722.93, 723.0, 723.1,723.4-723.9, 724.0x,731.0,732.0,737.0-737.2,737.40-737.42,737.8-737.9,738.4-738.5,742.59,754.2,756.10-756.12,839.20-839.21,V57.1,V57.2x, V57.81-V57.89
ICD-10: G95.0, M40.xx,M42.xx,M43.0x, M43.1x, M43.2x, M43.5x, M43.8x, M45.x, M46.0x-M46.9x,M47.2x,M47.8x,M47.9,M48.0x (spinal stenosis), M48.1, M48.3, M48.8, M48.9, M49.8x,M50.1x-M50.9x, M51.1x-M51.9,M53..8x,M53.9,M54.1x,M96.1-M96.5,M99.2x-M99.8x, Q67.5,Q76.0-Q76.3,Q76.4x,S13.0x,S23.0x, S23.1x, S33.0x, S33.1x,S34.3x
CPT: 20660-20665, 20930-20938,21720,21725,22206-22226,22532-22865,27035,29000-29046, 29710-29720,62287, 63001-63091,63170,63180-63200, 63270-63273,63295-63610,63650, 63655,63685,96150-96154 (health and behavior assessment codes), 97001-97004, 97022, 97110-97124, 97140, 97150, 97530, 97535 (PT/OT evaluation and treatment), 98966-98968, 98969, 99051, 99060, 99070,99078,99201-99215 (outpatient medical visits), 99217-99239 (hospital), 99281-99285 (ER), 99304-99337 (SNF care), 99401-99404 (risk factor reduction intervention), 99408, 99409, 99411, 99412, 99441-99444, 99446-99449 (critical care), 99605-99607
HPCPS: G0157-G0160 (PT/OT), G0396-G0397 (SBRT), G0406-G0408 (inpatient consultation), G0425-G0427 (telehealth), G0463, G0466, G0467 (FQHC), S2350-S2351 (discectomy with decompression of spinal cord)

GUIDELINE NOTE XXX 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 YYY 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.
- Medications, subject to the limitations on coverage of opioids in Guideline Note YYY 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 SERVICES. 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 here: http://www.oregon.gov/oha/herc/Pages/blog-low-back-non-pharmacologic-intervention.aspx

New Back Conditions Lines and Guidelines

Intervention Category*	Intervention	Acute < 4 Weeks	Subacute & Chronic > 4 Weeks
Self-care	Advice to remain active	●	●
	Books, handout	●	●
	Application of superficial heat	●	
Nonpharmacologic therapy	Spinal manipulation	●	●
	Exercise therapy		●
	Massage		●
	Acupuncture		●
	Yoga		●
	Cognitive-behavioral therapy		●
	Progressive relaxation		●
Pharmacologic therapy (Carefully consider risks/harms)	Acetaminophen	●	●
	NSAIDs	●(▲)	●(▲)
	Skeletal muscle relaxants	●	
	Antidepressants (TCA)		●
	*Benzodiazepines***	●(▲)	●(▲)
	*Tramadol, opioids***	●(▲)	●(▲)
Interdisciplinary therapy	Intensive interdisciplinary rehabilitation		●

- ● Interventions supported by grade B evidence (at least fair-quality evidence of moderate benefit, or small benefit but no significant harms, costs, or burdens). No intervention was supported by grade "A" evidence (good-quality evidence of substantial benefit).

▲ *Carries greater risk of harms than other agents in table.*

NSAIDs = nonsteroidal anti-inflammatory drugs; TCA = tricyclic antidepressants.

*These are general categories only. Individual care plans need to be developed on a case by case basis. For more detailed information please see: http://www.annals.org/content/147/7/478.full.pdf

**Associated with significant risks related to potential for abuse, addiction and tolerance. This evidence evaluates effectiveness of these agents with relatively short term use studies. Chronic use of these agents may result in significant harms.

New Back Conditions Lines and Guidelines

GUIDELINE NOTE YYY 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.

GUIDELINE NOTE ZZZ SURGICAL INTERVENTIONS FOR CONDITIONS OF THE BACK AND SPINE

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:

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

Spondylolithesis (ICD-9 738.4, 756.11-756.12 / ICD-10 M43.1x, Q76.2) is included on line S1 only when it results in spinal stenosis with signs and symptoms of neurogenic claudication. Otherwise, these diagnoses are included on line S2.

Surgical correction of spinal stenosis (ICD-9 721.1, 723.0, 724.0x / ICD-10 M48.0x) is only included on lines S1 and S2 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.

Otherwise, these diagnoses are included on line S2. Only decompression surgery is covered for spinal stenosis; spinal fusion procedures are not covered for this diagnosis.

For conditions on line S2, surgical interventions may only be considered after the patient has completed at least 6 months of conservative treatment, provided according to Guideline Note XXX NON-INTERVENTIONAL TREATMENTS FOR CONDITIONS OF THE BACK AND SPINE.

The following interventions are not covered due to lack of evidence of effectiveness for 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

New Back Conditions Lines and Guidelines

GUIDELINE NOTE AAA SCOLIOSIS

Line 366

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

1) only for children and adolescents (age 21 and younger) with
2) a spinal curvature of greater than 45 degrees

.

New Back Conditions Lines and Guidelines

Recommended Changed to Current Guidelines

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[1]	Additional studies[1]
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 ~~-~~signs[2] present >1 month • Severe/progressive neurologic deficits (such as foot drop), progressive motor weakness	MRI[3]	Consider EMG/NCV
Spinal stenosis	• Radiating leg pain • Older age • Pain usually relieved with sitting (Pseudoclaudication a weak predictor)	None	None
	• Spinal stenosis symptoms present >1 month	MRI[4]	Consider EMG/NCV

New Back Conditions Lines and Guidelines

[1] Level of evidence for diagnostic evaluation is variable

[2] Radiculopathic signs are defined for the purposes of this guideline ~~is defined~~ as ~~the presence of~~ ~~as in Guideline Note 37 with~~ ~~any 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 equina syndrome,~~
~~F. Neurogenic bowel or bladder~~
~~G. Long tract abnormalities~~

[3] Only if patient is a potential candidate for surgery or, if indicated, lumbar epidural steroid injection (see guideline note 105)

[4] 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.

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

New Back Conditions Lines and Guidelines

GUIDELINE NOTE 72, ELECTRONIC ANALYSIS OF INTRATHECAL PUMPS
Lines ~~374,545,~~ 351, 366, 532, *612*
Electronic analysis of intrathecal pumps, with or without programming (CPT codes 62367-~~62368~~62370), is included on these lines only for pumps implanted prior to April 1, 2009

GUIDELINE NOTE 92, ACUPUNCTURE
Lines 1,207,414,468,546,407
Inclusion of acupuncture (CPT 97810-97814) on the Prioritized List has the following limitations:

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

Hyperemesis gravidarum
ICD-10-CM code: O21.0, O21.1
Acupuncture pairs with hyperemesis gravidarum when a diagnosis is made by the maternity care provider and referred for acupuncture treatment for up to 2 sessions of acupressure/acupuncture.

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

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

Line 207 DEPRESSION AND OTHER MOOD DISORDERS, MILD OR MODERATE
Acupuncture is paired with the treatment of post-stroke depression only. Treatments may be billed to a maximum of 30 minutes face-to-face time and limited to 15 total sessions, with documentation of meaningful improvement.

Line 407 CONDITIONS OF THE BACK AND SPINE
Acupuncture is included this line with visit limitations as in Guideline Note XXX.

Line 414 MIGRAINE HEADACHES
Acupuncture pairs on Line 414 for ICD-10-CM code G43.9 Migraine, when referred, for up to 12 sessions.

Line 468 OSTEOARTHRITIS AND ALLIED DISORDERS
Acupuncture pairs on Line 468 for osteoarthritis of the knee only, when referred, for up to 12 sessions.

Line 546 TENSION HEADACHES
Acupuncture is included on Line 546 for treatment of tension headaches G44.2x, when referred, for up to 12 sessions.

New Back Conditions Lines and Guidelines

GUIDELINE NOTE 105, EPIDURAL STEROID INJECTIONS FOR LOW BACK PAIN

Line 407

Epidural lumbar steroid injections (CPT 62311, 64483, 64484) are included on this line for patients with persistent radiculopathy due to herniated lumbar disc, where radiculopathy is defined as lower extremity pain in a nerve root distribution, with or without weakness or sensory deficits. ~~showing objective evidence of one or more of the following:~~

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

One epidural steroid injection is included on ~~these lines~~ this line; 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. Epidural lumbar steroid injections are not included on ~~these lines~~ this line 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 development of this guideline note was informed by a HERC coverage guidance. See http://www.oregon.gov/oha/herc/Pages/blog-percutaneous-low-back.aspx

New Back Conditions Lines and Guidelines

Deleted Guidelines

~~GUIDELINE NOTE 37, DISORDERS OF SPINE WITH NEUROLOGIC IMPAIRMENT~~

~~Lines 374,545~~

~~Diagnoses are included on Line 374 when objective evidence of neurologic impairment or radiculopathy is present, as defined as:~~

~~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~~

~~Otherwise, disorders of spine not meeting these criteria (e.g. pain alone) fall on Line 545.~~

~~GUIDELINE NOTE 41, SPINAL DEFORMITY, CLINICALLY SIGNIFICANT~~

~~Line 412~~

~~Clinically significant scoliosis is defined as curvature greater than or equal to 25 degrees or curvature with a documented rapid progression. Clinically significant spinal stenosis is defined as having MRI evidence of moderate to severe central or foraminal spinal stenosis in addition to a history of neurogenic claudication, or objective evidence of neurologic impairment consistent with MRI findings (see Guideline Note 37).~~

~~GUIDELINE NOTE 56, ACUTE AND CHRONIC DISORDERS OF SPINE WITHOUT NEUROLOGIC IMPAIRMENT~~

~~Line 545~~

~~Disorders of spine without neurologic impairment include any conditions represented on this line for which objective evidence of one or more of the criteria stated in Guideline Note 37 is not available~~

~~GUIDELINE NOTE 60, SPINAL DEFORMITY, NOT CLINICALLY SIGNIFICANT~~

~~Line 588~~

~~Scoliosis not defined as clinically significant included curvature less than 25 degrees that does not have a documented progression of at least 10 degrees~~

~~GUIDELINE NOTE 94, EVALUATION AND MANAGEMENT OF LOW BACK PAIN~~

~~Lines 374,545~~

~~Procedures for the evaluation and management of low back pain are included on these lines when provided subject to the State of Oregon Evidence-based Clinical Guidelines dated 10/2011 located at:~~
~~http://www.oregon.gov/oha/OHPR/pages/herc/evidence-based-guidelines.aspx~~.

New Back Conditions Lines and Guidelines

Miscellaneous coding changes required

1) Advise DMAP to remove ICD-9 724.3 (Sciatica), ICD-10 M41.40 (Neuromuscular scoliosis, site unspecified), M41.50 (Other secondary scoliosis, site unspecified), M54.3-M54.4 (Sciatica) from the Diagnostic List
2) Advise DMAP to remove 22830 (Exploration of spinal fusion) from the Diagnostic List
3) Place 63210 (Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic) on lines 75 NEUROLOGICAL DYSFUNCTION IN BREATHING, EATING, SWALLOWING, BOWEL, OR BLADDER CONTROL CAUSED BY CHRONIC CONDITIONS; ATTENTION TO OSTOMIES and 297 NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS
    a. Advise DMAP to remove 63210 from the Ancillary List
4) Remove ICD-9 754.1/ICD-10 Q68.0 (Congenital musculoskeletal deformities of sternocleidomastoid muscle) from line 545 ACUTE AND CHRONIC DISORDERS OF SPINE WITHOUT NEUROLOGIC IMPAIRMENT and ICD-9 756.3/ICD-10 Q76.6-Q76.9 (Other anomalies of ribs and sternum) and ICD-10 Q68.0 (Congenital musculoskeletal deformities of sternocleidomastoid muscle) from lines 412 SPINAL DEFORMITY, CLINICALLY SIGNIFICANT and 588 SPINAL DEFORMITY, NOT CLINICALLY SIGNIFICANT and place on line 534 DEFORMITIES OF UPPER BODY AND ALL LIMBS
5) Note: the Taskforce did not recommend coverage of facet joint injections for the cervical or lumbar spine.
    a. Keep 64490-64492 (Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (flouro or CT), cervical) and 64633 and 64634 (Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single or additional facet joints) on the Non-Covered List
    b. Lumbar facet joint injection currently is on the Non-Covered List