WPS GHA

Moderator: Noel, Dr. Ella
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6:00 PM ET

OPERATOR: This is Conference # 3668639

Operator: Good evening! My name is Kavita and I'll be your conference operator today. At this time, I would like to welcome everyone to the J8 Contractor Advisor Committee Meeting. All lines will remain open throughout the conference. To mute your line, you may do so by pressing star six on your telephone keypad. To unmute your line, press star six again. Thank you. Dr. Ella Noel, you may begin.

Ella Noel: Okay. I'd like to call this meeting to order. I'm going to take care of some business items first. The CAC meetings are now open. This will be the second one that's open. There is two phone lines - one for the CAC members who are allowed to speak during this portion of the meeting and another line for the public to listen in.

If you are a CAC member and you speak and make comments on the draft that we have present today, you are giving me implied consent to record you as this meeting is recorded and then placed on our website for other individuals to listen to in the future. If you do not want to be recorded either make no comments and send them in writing or drop off the call.
Thank you.

I'd like to welcome everybody who is attending. We need to approve the minutes from the last meeting in February. Dr. Hamburger has made a motion. Can I have somebody second. Dr. Bill has second him, and with that, we'll approve the minutes and proceed on. We have two drafts today. One is a corneal hysteresis draft DL38Q11.

There is currently an article covering this subject. It is a non-coverage draft that we are presenting today. The article will be retired when this draft goes live though there may be a coding and billing article in place of the present article. We will be taking comments on this for forty-five days after this has been posted and that comment period will end 7/14/2019 and you can send any comments that you have to WPS website – medicarepolicycomments@wpsic.com.

Corneal hysteresis - I am the lead CMD on that and I work with Melissa Jacobs, our nurse policy coordinator. This draft will be replacing article A54957 which non-covers corneal hysteresis as an updated document embracing the requirements of the 21st Century Cures Act. This draft turns out to be a non-coverage policy for all corneal hysteresis assessment as a means of risk assessments or monitoring for progression of ophthalmic disease activity.

Hysteresis is a measure of resistance to deformation to an applied force. Corneal hysteresis is a measure of the viscoelastic dampening property of the cornea and it is postulated to be a circuit for the viscoelastic dampening properties of the posterior sclera and the lamina cribrosa through which the retinal ganglion cell axon pass as they exit the eye.

Multiple articles were referenced in the draft policy. Most were observational studies. Practice guidelines do not recommend corneal hysteresis in the management or risk assessment of glaucoma, glaucoma suspect, or in ocular hypertension

A 2018 Hayes review of sixteen qualifying studies found that corneal hysteresis testing has some capacity to detect the presence of glaucoma, to predict risk for glaucoma progression and to predict responses of the glaucoma to certain types of treatments; however, the evidence is mainly comprised of very poor quality correlation studies, which lacked the rigor to determine diagnostic or prognostic accuracy.

Most of these studies did not use reliable methods to determine the accuracy of diagnosis or prognosis. No studies were identified that directly assess the clinical utility of corneal hysteresis measurements for selecting treatment of glaucoma or for impacting long-term health outcomes. In summary, corneal hysteresis is promising as a risk assessment tool in the diagnosis and management of glaucoma or corneal pathology. While the body of evidence is large, the overall quality is low.

The studies are relatively small, observational, and often confounded by a lack of treatment control, uniformly citing simple correlations, precluding cause-and-effect conclusion. It is still unclear whether corneal hysteresis provides useful additional information much less its optimal role in any diagnostic, prognostic, and treatment algorithm. The lack of level one evidence, access to proven clinical utility, no clinical practice guideline endorsement, as well as no Medicare nor commercial coverage argue

strongly against current corneal hysteresis coverage as reasonable and necessary for the treatment of Medicare patients.

I have three questions to ask those in attendance and on the phone that are CAC members. Does anyone have any comments on the quality and the quantity of literature that we used for this draft LCD? Any comments in the room? Any comments on the telephone? Kavita?

Operator: All lines are open if you have any comments.

Ella Noel: Not hearing anything on the phone lines. We'll go to question number two. Are there any concerns about the language of the draft LCD after review of the literature? Any comments from the room? Any comments from the phone?

She's got them open. Not hearing anything. We'll go to question number three. Are you aware of any pertinent literature that was missed in the review for the draft LCD? Any comments in the room? Any comments on the phone? Does anybody have any general comments about this draft in the room? Any general comments on the phone? We'll pause for a minute, Kavita, to make sure everybody has had a chance to speak up.

Operator: Okay.

Ella Noel: Okay. If you do have comments that you wish to submit to WPS, please send them before the end of the comments period, which ends in July on the 14th to medicarepolicycomments@wpsic.com. The next draft was already presented at a multi-jurisdictional CAC, but it was not presented individually to our CAC members. So we are going to present it today just so everyone is aware of this document and if you do have any comment please let us know. I will not be soliciting any questions about this one because it was extensively reviewed at the multi-jurisdictional CAC several months ago. This is DL38213, percutaneous vertebral augmentation for osteoporotic vertebral compression fracture.

This draft LCD will be replacing WPS LCD L34592. That is a limited coverage policy for the treatment of osteoporotic compression fractures as an updated document embracing the requirements of the 21st Century Cures Act. This draft LCD is a restricted coverage policy for the treatment of acute vertebral osteoporotic-induced compression fractures.

Percutaneous vertebroplasty or kyphoplasty is covered in patients meeting the conditions outlined in detail in the article and that actually should be a

policy. They should have an acute fracture. It should be symptomatic vertebral compression fracture without the presence of any excluded condition.

Numerous articles were referenced in the draft policy. The review of the evidence generally supports the premise of weight-bearing fracture immobilization to limit pain and deformity superimposed on the recent trend toward immediate focused surgical immobilization and away from prolonged general immobilization with cast bracing and bed rest and prolonged systemic pain management, especially opioid analgesics, particularly in the elderly.

The preponderance of evidence including studies, national and society guidelines, systemic reviews, and multi-specialty panel clinical care pathways and Medicare claims data, favors consideration of early percutaneous vertebral augmentation in selected patients confirmed to have an osteoporotic vertebral compression fracture.

Any general comments from any of the CAC members in the room or on the phone? Okay. So I just have some general updates, and we'll have some education. So we are done with the open part of the meeting.

So Kavita, you can release the public from the meeting and then we will go to the closed part just for the CAC members.

Operator: Okay.