

## Minutes

**HEALTH SERVICES COMMISSION**  
**Clackamas Community College**  
**Wilsonville Training Center, Room 111-112**  
**Wilsonville, Oregon**  
*August 11, 2011*

**Members Present:** Somnath Saha, MD, MPH, Chair; Kevin Olson, MD; Bruce Abernethy; Kathryn Weit; James Tyack, DMD, MAGD; Bob Joondeph; Lisa Dodson, MD; Lawrence Betcher, MSW, LCSW.

**Members Absent:** Dean Gubler, DO, MPH; Leda Garside; Carla McKelvey, MD; Alberto Vasquez.

**Staff Present:** Darren Coffman, Ariel Smits, MD, MPH; Cat Livingston, MD, MPH.

**Also Attending:** Kerry Silvey, Chair, Genetic Advisory Committee; Ellen Lowe, OAHHS; Allison Little, MD; Cathy Gordon, OHSU/CEbP; Joanie Sveinbjornsson, Medtionic; Rachel Gilmer, OMHS; Heidi Allen, TransActive; Vern Saboe, DC; Wally Shaffer, MD, Caroline Price and Chris Barber, DMAP.

### I. Call to Order

Dr. Som Saha, Chair, called the Health Services Commission (HSC) meeting to order at the Clackamas Community College, Wilsonville Training Center, Room 211, Wilsonville, Oregon. Mr. Darren Coffman called the roll.

### II. Approval of Minutes (March 11, 2011)

**MOTION: To approve the March 11, 2011 minutes without corrections: MOTION CARRIES 7-0.**

### III. Chair/Staff Report

Mr. Coffman reported that on Friday August 5, 2011, Governor Kitzhaber signed HB 2100, which in effect merges the Health Resources Commission and the Health Services Commission effective January 2012. The drug reviews that the Health Resources Commission were doing are not being transferred over to the Health Evidence Review Commission; instead they are being picked up by a new Pharmacy and Therapeutics Committee, that will be staffed by Tom Burns. There will be 13 members of the new Commission. Appointments are expected to take place in October with Senate confirmation in November.

Mr. Coffman requested that the full HSC meet after the usual HOSC meeting in December to assist with the transition to HERC. The date of the meeting is scheduled for the second Thursday in December. Because of the usual high volume of work at the December meeting with the 2012 CPT code review, as well as the ICD-10 work and the wrapping up of all other HSC work, there would be no new topics taken up at that meeting.

The new Pharmacy and Therapeutics (P&T) Committee will be formed in the fall. However, there will be an approximate six-month lag after a new drug or therapy is FDA approved before the committee will have a chance to review it. HSC staff wanted to discuss a possible new category of guideline stating that any medication that is FDA approved but not reviewed by the P&T committee can only be covered for FDA approved medications. The HSC felt that this type of policy was better reviewed and decided on by the P&T Committee. It was suggested that this topic could be the first order of business for the new P&T Committee.

Dr. Dodson presented a revised policy for proposing topics for HOSC/HSC review. This policy would limit public comment to five minutes per topic. To have a topic scheduled on the agenda, HSC staff must be contacted at least 6 weeks in advance of the meeting, and all literature which is to be distributed to Commission members needs to be received by staff for review at least 6 weeks in advance of the meeting. Text of this new policy can be found in Attachment A.

**Motion: To accept the proposed wording of the policy for the presentation of new evidence: Motion carries 7-0.**

#### **IV. Public Comment on effectiveness of treatment of allergic rhinitis**

Dr. Steve Kagen addressed the Commission regarding the cost-effectiveness of allergy therapy for allergic rhinitis. He presented a large amount of literature on allergic rhinitis, discussed epidemiology of allergic rhinitis and the utility of allergen immunotherapy.

The commission asked Dr. Kagen whether immunotherapy was a short or long-term treatment. Dr. Kagen responded that the studies found that the treatment is very effective from three months to 12-15 years, depending on the patient.

Dr. Saha noted that the HSC looks at both the impact on health of a condition and treatment effectiveness and that the treatment of allergic rhinitis has been visited many times over the last few years and not found to have a high priority for treatment. In general, the average patient with allergic rhinitis does not have the burden of illness that meets the criteria of the conditions that are of higher priority. If there is a good argument for cost savings then that is worth entertaining, but burden of illness would not make a difference in altering the priority. Dr. Kagen stated this is failing to cover a standard of care where you now know that it is going to cost taxpayers more over a period of time to care for these patients. It was asked how much does immunotherapy cost in general. Dr. Kagen responded that it depends on who is delivering it, but on average if the patient goes through three to five years of therapy, the cost for the first year would be the most expensive and then it goes down from there. The first year might be anywhere from \$800 to \$1500, there are different treatment remedies that are being used. Dr. Kagen reported that a single visit for allergy immunotherapy may only cost \$16. However, commissioners were concerned that the cost for such therapy in an FQHC might be much higher, given encounter-based reimbursement. The commission briefly discussed the research presented on the cost effectiveness of treating allergic rhinitis. Dr. Dodson was concerned that most of the studies used modeling rather than actual visit costs. Also, allergy medications are currently not covered in the OHP; any cost savings would need to account for the costs of these medications as well. The commission thanked Dr. Kagen for his testimony and the information presented.

## V. Subcommittee reports

### A. MHCD Subcommittee (April 20, 2011)

The subcommittee met and finalized the ICD 10-CM recommendations for mental health and chemical dependency services. The subcommittee is recommending a new guideline for Line 209, Organic Mental Disorders Including Dementias.

There is limited evidence of the effectiveness of mental health treatment of organic mental disorders. However, case management is can be critical. Effective treatments may be available for co-morbid conditions such as mood disorders. When treating co-morbid conditions associated with organic mental disorder, those conditions should be the primary diagnosis for billing purposes. The treatment of co-morbid mental health conditions should be consistent with the treatment methods, frequency, and duration normally applied to those diagnoses. Treatment of neurologic dysfunctions that may be seen in individuals with organic mental disorder are prioritized according to the four dysfunction lines found on the Prioritized List (Lines 78, 317, 372, 404).

The subcommittee also recommended the following specific coding changes:

- 1) Add code H0017 (hospital residential treatment) to line 180, Post-Traumatic Stress Disorder.
- 2) Add H0045 (respite care services) to three lines involving depression (Lines 1, 67 and 450).

**Motion: To approve the guideline and technical coding changes: Carries: 7-0**

### B. Dental Subcommittee (May 24, 2011)

Mr. Coffman summarized the changes recommended by the subcommittee to dental codes and guidelines for the HSC Biennial List to be effective January 1, 2012.

- Recommend to DMAP that CDT codes D0502 (other oral pathology procedures, by report), D7680 (treatment of facial bones fractures) be placed on the Excluded File as not used by dentists.
- Code D5999 (unspecified maxillofacial prosthesis) and D8999 (unspecified orthodontics procedure) are recommended to add to DMAP's Exclude File as a more specific code should be used.
- D5986 (fluoride gel carrier used for rampant decay) a guideline was written
- Recommend DMAP add CDT code D5991 (topical medicament carrier) to the Ancillary File.
- Delete the Urgent Dental Services, Advanced Periodontics, Advanced Endodontics, Advanced Restorative, Elective guidelines as these are already handled in DMAP administrative rules.
- Delete CDT Code D3450 (root amputation) from Line 480.
- Move CDT Code D2390 from Line 372 (Dental Conditions EG. Caries, Fractured Tooth) to Line 676 (Dental Conditions Where Treatment Results In Marginal Improvement).
- Edit Basic Periodontics and Removeable Prosthodontics guidelines as shown in Attachment B.
- Accept new guideline note for frenulectomy/frenulotomy as shown in Attachment B.

- Update Oral Surgery guideline note to be consistent with the DMAP rule (bring back final language in October).
- Create new guideline note for CDT Code D5986 (fluoride gel carrier used for rampant decay), with final language to be brought back in December.

**Motion: To approve all of the recommendations of the Dental Services Subcommittee: Carries 7-0.**

## **VII. Genetic Testing**

Dr. Livingston presented a summary document that proposed a new genetics algorithm and modifications to the genetic testing guideline. Kerry Silvey presented the Genetics Advisory Committee updated recommendations, following the HSC discussions that had occurred in January and March 2011.

The discussion revolved around the new proposed genetics algorithm and there were few concerns. It was felt that rare diseases no longer required their own box and Ms. Silvey and commissioners agreed that the rare conditions box could be removed. The new genetics algorithm was preferable to the prior one.

Discussion turned to the guideline note and the one inconsistency was around the inclusion of Fragile X. This condition does not meet the 10% criteria, however, the commissioners wanted to continue to have this as a covered genetic screening service due to the additional reproductive implications for this condition. The decision was made to add wording to the guideline that acknowledged that this is an exception.

Ms. Silvey informed commissioners that in January 2012 there will be a list of 35 genetic tests with assigned codes. These codes will be sent for the Genetics Advisory Committee to review and make recommendations on how the specific codes fit into the algorithm. See Attachment C.

**Motion: To approve the new genetic testing guideline and algorithm. Carries 7-0.**

## **VIII. Statewide Guidelines Project**

No public comment on the new topics of advanced imaging for chronic back pain & percutaneous interventions for chronic back pain.

The commission commented that the imaging has been a fairly large portion of the line zero utilization. The real issue for the commission is that large boundaries be set and nuance guidance be given.

## **IX. Low Back Pain Collaborative Guideline**

Cathy Gordon and Dr. Alison Little presented the following changes to the guideline since the last meeting made based on public comment:

- Table A – Page 4- guidelines should address next steps or guidance for clinicians regarding psychosocial risk factors. A statement was added to correct this in Italics. The fact that it is not evidence-based is noted in the footnote.
- There was a suggestion that the physical exam should include a neurological exam and that language was changed.
- Figure 1, Box 3 & 4 –referred the reader to Table 1 instead of Table 2, which has since been renamed to Table B.
- Table B - changed “Herniated Disc” to “Nerve Compression/Disorders (e.g., herniated disc with radiculopathy)”
- Figure 2 – confusion regarding step 27 – needed to remove “consider”, added a qualifier “may” to the wording.
- Table C- Interventions – reordered the interventions and added indicators after NSAIDs.

There were a number of comments from medical directors, clinicians, and practicing physicians. Vern Saboe of the Oregon Chiropractic Association stated there were some questions regarding Table A, under recommendation 6 and 7. He wanted to know about the “strong” versus “weak” recommendation strength between pharmacological versus nonpharmacological treatments. It was stated that the volume of evidence was the factor for this study. He commented on Figure 2 regarding radiculopathy spinal stenosis. The algorithm goes from 23-26 and appears to only be talking in terms of surgery and other invasive procedures, there is no discussion of noninvasive treatment other than a mention of shared decision making and wondered if that was even addressed. It was stated that a box could be added to the reference regarding noninvasive treatment. There also may be a typo in Figure 17 regarding the table referenced.

**MOTION: To conditionally approve the guideline as amended assuming the issues raised by Dr. Sabo are addressed as discussed. Carried 0-7.**

The discussion then turned to how to apply the Low Back Pain guideline to the Prioritized List. There was some discussion as to which line it would apply to. Adopting the LBP guideline as is would change current coverage of advanced imaging for back pain with radiation, with the current MRI guideline being more conservative. There was some controversy about adopting a new guideline focused on acute pain only, when the current MRI guideline also addresses chronic pain. More information and discussion was requested. Further decision was deferred, and the topic will be readdressed at the October 2011 meeting.

## **X. Health Equity Issues**

Dr. Livingston introduced a summary document on the burden of gender identification disorder and the effectiveness of treatment. Data is of very poor quality but a systematic review and meta-analysis shows subjective improvement in quality of life with sex reassignment (including medications, counseling, and surgery). Currently sex reassignment surgery is excluded, and only the medications for puberty suppression and cross hormone therapy are being presented for discussion.

The Office of Multicultural Health had approached the HSC asking for coverage of hormone replacement therapy for those undergoing gender transitions. Rachel Gilmer presented a number of articles and testified as to the importance of treating this minority population as well

as insuring that psychological treatments were covered. Transactive, an education and advocacy organization has also approached the HSC requesting coverage for cross-sex hormone treatment and puberty-blocking hormone treatment to be a covered service for transgender people. Heidi Allen from Transactive testified that puberty suppression was essential to social functioning later on. They estimated that there are currently over 7000 transgender persons in Oregon. Testimony was received that transgender people have higher rates of HIV, social isolation, and economic marginalization. Treatment with puberty suppression and cross-hormone therapy would enable them to better match with their chosen gender roles.

Commissioners discussed that having gender identification disorder on the same line as the sexual paraphilias was inappropriate and felt it should be on a separate line. Given the mental health component of the condition, they also felt this was appropriate for the Mental Health and Chemical Dependency Subcommittee to review and make recommendations as to appropriate splitting of lines and make ranking recommendations based on the psychiatric morbidity experienced by those with gender identification disorder and the effectiveness of treatment compared to other mental health conditions. Additionally, the puberty-blocking agents are quite different than the cross-hormone therapy and concerns were raised about the relative safety of each. Commissioners wanted the MHCD to review these issues further.

**Action:**

- 1) Take transgender discussion to the next MHCD meeting
  - a. Split Line 513
  - b. Address GnRH agonists versus cross-sex hormone therapy, safety and efficacy (and ethical issues with puberty suppression in minors)
  - c. Suggest rankings
- 2) Review at subsequent HSC meeting

**XI. HOSC report**

Smits reviewed the proposed changes from the May, June, and August HOSC meetings. There was minimal discussion of the suggestions from the May and June meetings.

Several topics which had been deferred from the August HOSC meeting were taken up.

- A) Lesions of uncertain nature: Smits introduced a document discussing the current issues with the "lesions of uncertain behavior" ICD-9 238 family is no longer usable for Medicare for skin biopsies. The suggestion was to allow the use of the 239 ICD-9 family ("neoplasms of unspecified nature"). There was minimal discussion.

**Action:**

- 1) Advise DMAP to move 239.0-239.8 to the Diagnostic List and remove from the Excluded (Never Covered) List
- 2) Do not move 239.9 (Neoplasm of unspecified nature, unspecified location)

**MOTION: To approve the actions involving lesions of unspecified nature, as discussed. Carried 0-7.**

- B) Complications of spontaneous abortion: Smits introduced a summary document with suggested line placements for various ICD-9 codes for spontaneous abortion (SAB). There was debate about whether the two spontaneous abortion lines (Line 68 for complicated and/or incomplete SABs and Line 391 for uncomplicated, complete SABs)

should be combined, as the distinction between the two was not clear. The decision was made to combine lines 68 and 391 as part of the next biennial review. All ICD-9 codes from both lines, as well as all CPT codes, will be included on the new line. The hysterectomy codes missing from line 68 should be added.

**Action:**

- 1) Add CPT codes for hysterectomy (59135, 59136, 58150, and 58152) to line 68 effective October 1st.
- 2) HSC staff will add the combining of the SAB lines to the biennial review agenda for the 2012 biennial review.

**MOTION: To approve the actions involving complications of spontaneous abortion as discussed. Carried 0-7.**

- c) PET scan guideline: Smits introduced a summary document with the final suggested PET scan guideline changes. The only change in the guideline from the June 2011 meeting was to delete testicular cancer. There was no discussion.

**MOTION: To approve the changes to the PET Scan guideline as shown in Attachment D. Carried 0-7.**

- D)
- E) Synagis guideline: Livingston introduced a summary document outlining new research on the cost-ineffectiveness of the Synagis vaccination for RSV for high risk infants. This research indicated that for every one dollar spent on Synagis, only 2.9 cents in avoidable hospitalization costs would be achieved. The Commission felt that the evidence overwhelmingly did not support the use of this treatment. There was minimal discussion.

**Action:**

- 1) Remove the CPT code for Synagis (Palivizumab), 90378, from Line 3 (Preventive Services, Birth to 10 Years of Age) and advise DMAP to place it in the Excluded File
- 2) Delete GUIDELINE NOTE 69, SYNAGIS

**MOTION: To approve the actions involving the Synagis guideline as discussed. Carried 0-7.**

*Note: Since the conclusion of the meeting, DMAP staff has indicated that prescription drugs cannot be completely excluded from OHP if they are meeting Medicaid rebate requirements. These actions on Synagis will not be made effective October 1, 2011 and the issue will be brought back to the October 13, 2011 meeting.*

**MOTION: To approve the recommendations of the Health Outcomes Subcommittee from their May and June meetings as presented in the meeting highlights of these meetings and the recommendations from topics from that mornings meeting as presented in the meeting packet, with the amendments verbally noted. Note: Please see the document at [http://www.oregon.gov/OHA/OHPR/HSC/docs/IM/10\\_11.pdf](http://www.oregon.gov/OHA/OHPR/HSC/docs/IM/10_11.pdf) for a complete listing of all changes to the Prioritized List this encompasses. Carried 0-7.**

**XI. Other Public Comment**

No further public comment was received.

## **XII. Adjournment**

The meeting was adjourned at 4:00 pm. The next meeting is scheduled for Thursday, October 13, 2011 in Room 112 of the Clackamas Community College Wilsonville Training Center.

**ATTACHMENT A**  
**HSC Policy on Acceptance of Testimony and Guidelines for Speakers & Presenters**

The Oregon Health Services Commission accepts public comment at each public meeting. Any member of the public or group may provide public comment; however, such comment is limited to 5 minutes per topic regardless of the number of persons wishing to speak to that topic and is limited to the designated time on the posted agenda. Written comment may be submitted to the Commission at any time.

Unsolicited presentations of scientific information or evidence by physicians, researchers, or advocates must be scheduled with HSC staff at least six weeks in advance of any scheduled meeting to allow for staff review and the mandatory 30 day posting of agendas. Unsolicited presentations will not be placed on an agenda unless the request is made and all materials are received at least six weeks in advance and the request is approved by HSC staff and board chair. Once approved, a maximum of 10 minutes will be allowed on the agenda for unsolicited testimony or presentations of scientific or evidence-based materials. Materials and evidence must be provided in writing, at least 6 weeks in advance of the meeting to allow for review. Guidelines for the types of evidence accepted are found below. Outside individuals and groups are encouraged to work with HSC staff to optimize the types of information presented and the requests made of the Commission. Such collaboration generally results in more effective and productive discussions with the Commission.

The Health Services Commission may solicit expert testimony on topics of interest to the Commission. When requesting such testimony, HSC staff will inform the expert of the meeting date, the time available for testimony and materials that are needed.

The Oregon Health Services Commission strives to utilize the best available evidence in decision-making. The hierarchy of evidence is found in Guidelines for Submitted Materials.

<http://www.oregon.gov/OHA/OHPR/HSC/Submitted-Materials.shtml>

## ATTACHMENT B REVISED/NEW DENTAL SERVICES GUIDELINES

### GUIDELINE NOTE XX, BASIC PERIODONTICS (*Revised*)

Only for the treatment of severe drug-induced hyperplasia (D4210, D4211). Payable only when there are pockets of 5 mm or greater (D4341, D4342).

### GUIDELINE NOTE XX, REMOVEABLE PROSTHODONTICS (*Revised*)

Must have one or more anterior teeth missing or four or more ~~missing~~ posterior teeth missing per arch with resulting space equivalent to that loss demonstrating inability to masticate. Third molars are not a consideration when counting missing teeth (D5211, D5212, ~~D5213, D5214~~).

### GUIDELINE NOTE XX, FRENULECTOMY/FRENULOTOMY (*New*)

*Line 373*

Frenulectomy/frenulotomy (D7960) is including on this line for the following situations:

1. In the presence of ankyloglossia
2. When deemed to cause gingival recession
3. When deemed to cause movement of the gingival margin when frenum is placed under tension.
4. Maxillary labial frenulectomy not covered until age 12 and above.

*Note: Guideline note numbers will be determined as the January 1, 2012 is finalized for publication.*

## ATTACHMENT C

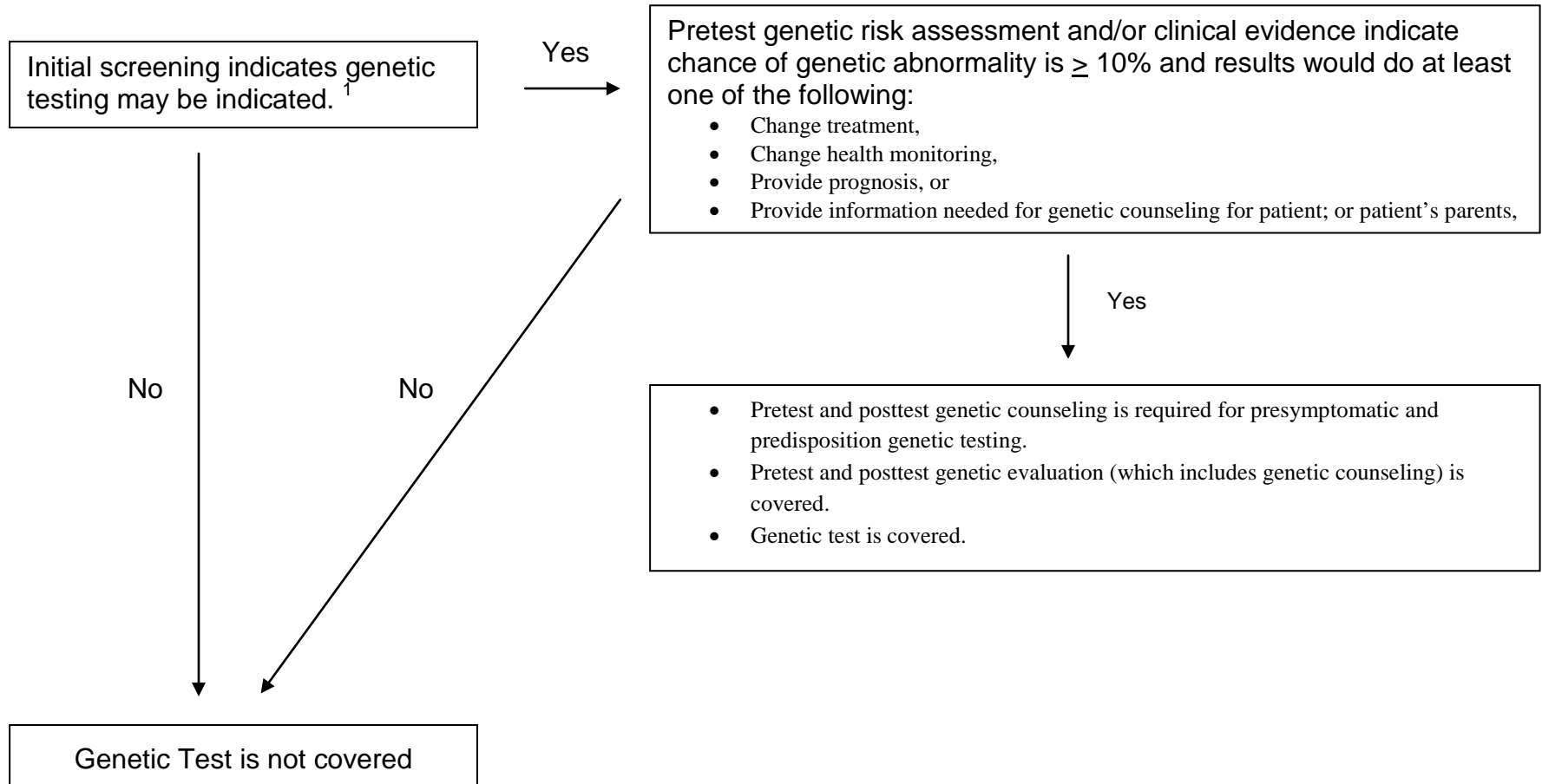
### REVISIONS TO NON-PRENATAL GENETIC TESTING GUIDELINE

#### GUIDELIN NOTE D1, NON-PRENATAL GENETIC TESTING GUIDELINE

Coverage of genetic testing in a non-prenatal setting shall be determined the algorithm shown in Figure C.1 unless otherwise specified below.

- A) Related to genetic testing for patients with breast/ovarian and colon/endometrial cancer 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) NCCN Clinical Practice Guidelines in Oncology. Colorectal Cancer Screening. V. ~~4.2006 (1/3/06)~~ 2011 (10/22/10). [www.nccn.org](http://www.nccn.org)
    - b) BRCA1/BRCA2 testing services for women without a personal history of breast and/or ovarian cancer should be provided to high risk women as defined by the US Preventive Services Task Force definition given in the Prevention Tables (see "Interventions for High Risk Populations" in the tables for ages 11 and above).
    - c) BRCA1/BRCA2 testing services for women with a personal history of breast and/or ovarian cancer 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. V.1. ~~2006 (12/14/05)~~ 2011 (4/7/11). [www.nccn.org](http://www.nccn.org)
  - 2) Genetic counseling should precede genetic testing for hereditary cancer. Very rarely, it may be appropriate for a genetic test to be performed prior to genetic counseling for a patient with cancer. If this is done, genetic counseling should be provided as soon as practical.
    - a) Pre and post-test genetic counseling by the following providers should be covered.
      - i) Medical Geneticist (M.D.) - Board Certified or Active Candidate Status from the American Board of Medical Genetics
      - ii) Clinical Geneticist (Ph.D.) - Board Certified or Active Candidate Status from the American Board of Medical Genetics.
      - iii) Genetic Counselor - Board Certified or Active Candidate Status from the American Board of Genetic Counseling, or Board Certified by the American Board of Medical Genetics.
      - iv) Advance Practice Nurse in Genetics - Credential from the Genetic Nursing Credentialing Commission.
  - 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 or 2 has been identified in a family, a single site mutation analysis for that mutation is covered, while a full sequence BRCA 1 and 2 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.
  - 4) Costs for rush genetic testing for hereditary breast/ovarian and colon/endometrial cancer is not covered.
- ~~B) Related to genetic testing for infants and children with developmental delay:~~
- ~~1) Chromosome studies and Fragile X testing is covered without a visit or consultation with a specialist.~~
- B) 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) Molecular Chromosome Analysis (also called Cytogenetic Microarray, Chromosome Microarray, Molecular Karyotyping, or Array CGH) is covered 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) Fragile X genetic testing is covered for individuals with intellectual disability/developmental delay. Although the yield for Fragile X is 3.5-10%, this is included because of additional reproductive implications.
- ~~3) 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.~~
- ~~3)4) Coverage for genetic testing for other conditions should continue to be made on a case-by-case basis according to the algorithm in Figure C-1.~~

**REVISED FIGURE C.1  
NON-PRENATAL GENETIC TESTING ALGORITHM**



1. Examples of initial screening: physical exam, medical history, family history, laboratory studies, imaging studies.

## ATTACHMENT D REVISIONS TO PET SCAN GUIDELINE

### GUIDELINE NOTE 19, PET SCAN GUIDELINES

Lines 125, ~~144~~, 166, 167, 170, 182, 207, 208, 221, 222, 243, 276, 278, 291, 311, 337

PET Scans are covered for diagnosis ~~and staging~~ of the following cancers only:

- Solitary pulmonary nodules and non-small cell lung cancer
- ~~Lymphoma~~
- ~~Melanoma~~
- ~~Colon cancer~~

~~PET scan is covered only for the initial staging of cervical cancer and only when initial MRI or CT is negative for extra-pelvic metastasis.~~

~~PET scan of head and neck cancer is only covered for~~

- ~~1. initial staging when initial MRI or CT is equivocal,~~
- ~~evaluation~~ Evaluation of cervical lymph node metastases when CT or MRI do not demonstrate an obvious primary tumor, ~~and~~
- ~~2. evaluation of suspected recurrence of head and neck cancer when CT or MRI does not demonstrate a clear cut recurrence.~~

For diagnosis, PET is covered only when it will avoid an invasive diagnostic procedure, or will assist in determining the optimal anatomic location to perform an invasive diagnostic procedure.

PET scans are covered for the initial staging of the following cancers:

- Cervical cancer only when initial MRI or CT is negative for extra-pelvic metastasis
- Head and neck cancer when initial MRI or CT is equivocal
- Colon cancer
- Esophageal cancer
- Solitary pulmonary nodule
- Non-small cell lung cancer
- Lymphoma
- Melanoma

For staging, PET is covered ~~in the following situations:~~

Clinical ~~when clinical~~ management of the patient will differ depending on the stage of the cancer identified and either:

- ~~3.~~ 1. the stage of the cancer remains in doubt after standard diagnostic work up, OR
- ~~4.~~ 2. PET replaces one or more conventional imaging studies when they are insufficient for clinical management of the patient.

Restaging is covered only for cancers for which staging is covered, ~~and for testicular~~ thyroid cancer.

~~Restaging if recurrence is not covered for cervical cancers suspected and I131 scintigraphy is negative.~~

For restaging, PET is covered after completion of treatment for the purpose of detecting residual disease, for detecting suspected recurrence or to determine the extent of a known recurrence. PET is not covered to monitor tumor response during the planned course of therapy. PET scans are NOT indicated for routine follow up of cancer treatment or routine surveillance in asymptomatic patients.

PET scans are also indicated for preoperative evaluation of the brain in patients who have intractable seizures and are candidates for focal surgery. PET scans are NOT indicated for cardiac evaluation.

## Minutes

**HEALTH SERVICES COMMISSION  
Clackamas Community College  
Wilsonville Training Center, Room 211  
Wilsonville, Oregon  
March 10, 2011**

**Members Present:** Somnath Saha, MD, MPH, Chair; Bruce Abernethy; Kathryn Weit; (arrived at 11:45 am); Carla McKelvey, MD (teleconference 10:00-11:45 am and 1:30 to 3:30 pm); James Tyack, DMD, MAGD; Leda Garside; Bob Joondeph; Larry Betcher, MSW, LCSW.

**Members Absent:** Lisa Dodson, MD; Kevin Olson, MD; K. Dean Gubler, DO, MPH; Alberto Vasquez.

**Staff Present:** Darren Coffman; Ariel Smits, MD, MPH; Catherine Livingston, MD, MPH; Jason Gingerich; Dorothy Allen, Kathy Kirk, RN.

**Also Attending:** Caroline Price, Wally Shaffer, MD, Isabel Bickel, Carol Camfield, Alex Blair, and Shauna Jones, Division of Medical Assistance Programs (DMAP); Chris Kirk, MD, OHP Medical Directors; Joanie Sveinbjornsson, LHNW LLP; Dena Scarce, Medtronic; Christina Baumann, MD, Nichole Yonke, Sarah Present, Doug Lincoln and Valerie King, MD, Elizabeth Steiner, MD, OHSU; David Pass, MD, Health Resources Commission; Laura Saddler, Pubic Health Division; David Rohrer, OHA; Kerry Silvey, Chair, Genetic Advisory Committee; Karen Kovak, MS, CGC, OHSU; Robert Nickel, MD, Developmental Pediatrician (teleconference).

*Information Session at 10:10 -10:20 am*

### I. Call to Order

Dr. Som Saha, Chair, called the Health Services Commission (HSC) meeting to order at 10:20 am at the Clackamas Community College, Wilsonville Training Center, Room 211, Wilsonville, Oregon. Mr. Darren Coffman called the roll.

### II. Approval of Minutes (January 13, 2011)

**MOTION: To approve the January 13, 2011 minutes without corrections: MOTION CARRIES. 7-0.**

### III. Chair's Report

During an informational session, Dr. Saha shared his recent experience presenting information about Oregon's work on value-based benefit design to an [Institute of Medicine](#) (IOM) with Dr. Jeanene Smith, OHP's Administrator. The IOM is often commissioned by Congress to issue reports on health topics and they currently have a committee assessing the viability of different options in developing of the federal essential health benefits package. He mentioned it appears Oregon is well ahead of most other states in using evidence to help define benefits.

#### **IV. Director's Report**

Mr. Coffman mentioned [HB 2100](#) has been through a first hearing. If passed, the proposed legislation would combine the HSC and the Health Resources Commission, into a single Health Evidence Review Commission (HERC), effective January 1, 2012, among other [HB 2009 \(2009\)](#) "fixes."

He acknowledged the item in the Governor's Proposed Budget calling for 38 lines of the Prioritized List to be cut that will be debated in the Legislature. Darren noted the [Biennial List's](#) line 511 is the actuarial equivalent of the [current list](#) line 502. Any changes to the benefit package will have to be reviewed and accepted by CMS.

Mr. Bob Joondeph noted anxiety disorder is on the list of cuts and expressed concern about the possible ramifications. Dr. Saha pointed out the several hundred-thousands of Oregon citizens who have no health coverage at all and asked how many current OHP clients would have to be removed from coverage in order to fund those 38 lines. Mr. Larry Betcher, who is a member of the Mental Health Care & Chemical Dependency (MHCD) Subcommittee, noted the members looked at rescoring the obsessive compulsive disorder line but when they looked at the scores given and conditions above and below it, they decided it was appropriately scored and placed. The subcommittee will be making some recommendations on scoring changes that would affect the ranking of anxiety disorders. Mr. Coffman asked the HSC clinical staff to identify the probable consequences of cutting those 38 lines.

Lastly, Mr. Coffman introduced Kathy Kirk, as the new Pain Management Commission coordinator.

#### **V. Clinical Services Report**

Drs. Smits and Livingston waived their reports.

#### **VI. Oregon Guidelines Project**

Mr. Coffman reported OHP's HSC and HRC staff has been involved in a collaborative process between the Health Leadership Council, the Center for Evidence-based Policy and other stakeholders to create balanced, evidence based clinical guidelines. The initial focus is on use in public programs as a way to use resources more wisely and the hope is to produce 10 guidelines over the next year; hopefully private insurers would adopt the guidelines as well.

Dr. Valerie King, of OHSU's Center for Evidence-based Policy (CEbP) informed the Commission about the process and steps toward completion:

- Narrow topics to discrete clinical areas that can be addressed by a guideline
- Develop PICO (Patient/Problem, Intervention, Comparison and Outcome) and key questions
- Search MED core sources for existing high quality evidence and guidelines
- Briefly summarize evidence and guidelines identified
- Criteria will guide further development:
  - a. An existing guideline must address at least one key question
  - b. The guideline must be publically available (free)

- c. The guideline need not be U.S. based
- d. The guideline must be no more than 5 years old and still considered current by its developer
- Center assesses quality of the guidelines using the CEbP modification of the AGREE II (Appraisal of Guidelines for Research & Evaluation) instrument. The CEbP will use two reviewers.

*Develop guidelines:*

- Guideline development will be guided by the [Adapté process](#) and will generally fall into two categories:
  - a. Good or fair quality guideline(s) exists - decide on selection of single “best” guideline vs. development of a recommendation matrix with selection of consistent recommendations across several guidelines
  - b. No guideline exists - state creates a guideline from evidence review and expert/stakeholder panel
- Identify and invite target users and other stakeholders for external review
- External review by target users and other stakeholders for validity, usefulness, applicability and suggested changes
- Consultation with original guideline developers is recommended to obtain feedback (if changes are made) and to ascertain how to acknowledge source documents and/or obtain permission for use
- Format final guideline - Issues include selection of final format and decisions about derivative products for target user groups
- Public vetting, with final presentation/approval at Health Services Commission meeting

*Next steps at the discretion of the State:*

- Develop an updating plan
- Develop a plan to distribute and implement the guideline

There will be a 30-day comment period following a draft guideline’s presentation. The total time to complete the development of a guideline will be 27 to 54 weeks. Topics must be sequenced as the same stages cannot be worked on concurrently for multiple topics.

The state is already collaborating with HSC and Q-Corp on a separate guideline development process on the medical management and imaging of acute low back pain and there will likely be a draft guideline resulting from that process available in May.

Dr. Saha asked about the Commission’s role in this process. Mr. Coffman stated the HSC is the main conduit for public comment and will review draft guideline as well as hear public comment. Assuming the process results in good evidence-based guidelines, the Health Policy Board is looking for the HSC to endorse them and incorporate them into the prioritized list.

Dr. Cat Livingston noted the topics (listed below) were chosen based in a review of OEBC (Oregon Educator’s Benefit Board) and OHP data and are examples of highest expenditure data and high cost-high variation and issues brought forth by the medical directors group.

Dr. David Pass, Health Resources Commission, added help is needed to winnow down topics.

Dr. Saha noted the many services on the current list of topics (See Attachment A) fall into Line Zero (diagnostics account for 1/3<sup>rd</sup> of OHP expenditures) and evidence-based guidelines would be incredibly valuable. He expressed his desire for guidelines which are very clear and define precisely when usage was appropriate. The Commission often creates usage/coverage

guidelines that continually need refining. He stated this process seems a way to do a more thorough job of creating guidelines.

Dr. King emphasized the importance of crafting key question but also remembering there will always be patients for whom the guideline does not apply.

Mr. Joondeph asked if the HSC would be using this process to evaluate *new* procedures or services. He cautioned that he could see where someone might feel aggrieved by this type of coverage decision process. An Attorney General review might be appropriate.

It was noted there are no proposed topics for mental health and only one for dental services. Dr. James Tyack noted dental care organizations might suggest appropriate topics. Mr. Jason Gingerich suggested it might also be helpful to review dental claims information by HCPCS code. Dr. Saha added that resource-waste should be a factor in consideration. Managed care plan directors may have be most equipped to help identify those areas.

Dr. Chris Kirk added he and the other medical directors would like guidance in areas where there are no guidelines available.

Dr, Wally Shaffer noted health plans could implement utilization controls, which are not transparent, but doing so does not necessarily lead to uniformity in care. The CEBP will develop guidelines but the Commission will determine coverage issues.

Ms. Caroline Price asked how the guideline development would connect to DMAP policies. Dr. Shaffer clarified the HSC will develop criteria but implementation is still covered by DMAP processes.

Dr. King noted as it takes 27 to 54 weeks to complete one guideline, she hopes there will rolling admission process will develop but clearly 10 guidelines cannot be completed at once. The Oregon Health Policy Board allocated a finite budget for this process.

Mr. Joondeph suggested looking at end-of-life care.

## **VII. DMAP issues**

### *Chronic Disease Self-Management Education*

At the January 2011 Health Services Commission meeting, the Commission voted (10-0) to add the following chronic disease self-management education procedure codes to 6 chronic disease lines:

**98960** (Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient, can include caregiver/family, each 30 minutes; individual patient); **98961** (2-4 patients) and **98962** (5-8 patients) to lines:

- 9 Major Depression, Recurrent
- 11 Asthma
- 12 Hypertension And Hypertensive Disease
- 33 Type II Diabetes Mellitus
- 108 Heart Failure
- 195 Chronic Ischemic Heart Disease

Dr. Wally Shaffer and staff from the Division of Medical Assistance Programs (DMAP) brought forward concerns regarding feasibility of implementing the approved Commission's decision.

Under the Oregon Health Plan (OHP), most chronic disease management services that would be billed under these codes would be provided in a Federally Qualified Health Center (FQHC). Due to federal rules, OHP cannot reimburse FQHC's for these services without paying the full encounter rate for each patient who participates in such an education program for each session (\$150-250 each x number of people attending session). Under this reimbursement structure, it would not be cost effective to provide these services under the Oregon Health Plan.

Mr. Coffman explained any time the Commission approves a change to the list, DMAP decides, when the change should be implemented. Occasionally, DMAP finds a procedure or service is too costly or unmanageable to put into practice, such as when the Commission voted to add after-hours billing codes to the list. Those codes remain on the list but the billing codes are not available for payment. He stated the codes could be left on the list, with the understanding they would not be paid.

Though the Commission's intent would be to cover such services if an appropriate reimbursement arrangement could be reached, leaving the codes on the list would serve little more than a symbolic gesture and may be confusing to providers and others who might examine the list. In absence of suitable reimbursement arrangement, a vote was called not to add CPT codes 90960-98962.

**MOTION: To not add the chronic disease self-management codes (98960-98962) to the Prioritized List effective April 1, 2011 and delay their addition until there are more appropriate reimbursement strategies. Recommend to DMAP those codes be placed on their Excluded File. MOTION PASSES: 7-0.**

## **VIII. Overview of Biennial Review**

### *Mental Health Care & Chemical Dependency Subcommittee Biennial Review*

Mr. Coffman explained the next biennial review will encompass the ICD-10-CM conversion. The MHCD has reviewed the mental health care and chemical dependency codes over the last several months. At first, staff used the General Equivalence Mapping (GEM) to try to predict on which line the new codes would land. GEMs are a tool that can be used to convert data from ICD-9-CM to ICD-10-CM and vice versa. At first staff had the subcommittee focus on those codes whose mapping was questionable or ambiguous, which proved not very effective. Next they tried reviewing each line in its entirety as it was mapped and this process was much more effective and is recommended for reviewing the physical health lines.

In general it was felt ICD-10-CM did little to help the prioritization process in distinguishing between multiple conditions that now fall under the same ICD-9-CM codes. Instead, for example, ICD-10-CM turned what were previously 30 substance abuse related codes into nearly 300, including many that would never be used. Subsequently, the MHCD created two new substance abuse lines (Abuse of Nonaddictive Substances and Other Disorders Due to Substances) where conditions such as F55.0 Abuse of antacids, F55.1 Abuse of herbal or folk remedies and F11.90 Opioid use, unspecified, uncomplicated, F12.29 Cannabis dependence with unspecified cannabis-induced disorder were placed, respectively.

Dr. Saha asked if those new "nuisance" diagnoses should be excluded from the list. Mr. Coffman explained it is most appropriate to prioritize codes on the list to the degree possible, based on the matrix scoring, so that providers and plans can easily see what is expected to be

covered. Mr. Bruce Abernethy contributed we should spend as little time as possible on activities that do not add value to the process.

#### *Next Steps*

Staff will meet with specialty groups (i.e. internal medicine, ophthalmology, pediatrics etc), and follow the same review process used for the MHCD lines. Commissioners are invited to join in the series of meetings. Dr. Saha asked the subgroups to only bring larger issues to the Health Outcomes Subcommittee (HOSC) as they are discovered as opposed to reviewing every single code placement.

## **IX. Genetics Algorithm Discussion**

Dr. Livingston stated this topic was discussed at the last HSC meeting where Ms. Kerry Silvey, GAC Chair and a Public Health Genetics Specialist, gave the advisory committee's recommendations for updating the non-prenatal genetic testing algorithm. The Commission had a number of lingering questions and invited Ms. Silvey back to address them. An ethicist was also requested.

#### *Genetics Advisory Committee Recommendations*

Ms. Silvey introduced Ms. Karen Kovak, another genetic councilor, Dr. Elizabeth Steiner, an ethicist from OHSU and Dr. Robert Nickel, a developmental pediatrician (teleconference).

The panel then addressed the questions from January 13, 2011 meeting:

#### ***What evidence was reviewed by the Genetics Advisory Committee to make the recommendations?***

(Study abstracts can be found [on the HSC's website](#), pages 110-112, 123-125)

1. Guideline from the American College of Medical Genetics, 2010 (Manning)
2. Consensus statement from the International Standard Cytogenomic Array Consortium (Miller)
3. Guideline from the American Academy of Pediatrics, 2006 (Moeschler)
4. Guideline from the American Academy of Neurology, 2003 (Shevell)
5. Article from *Genetics in Medicine*, 2008 (Saam)
6. Article from *Pediatrics*, 2019 (Shen)
7. Article by EGAPP (Evaluation of Genomic Applications in Practice and Prevention) workgroup (Botkin)

#### ***What is the diagnostic yield for patients with developmental delay/intellectual disability, multiple congenital anomalies, and autism spectrum disorders?***

- Developmental delay/intellectual disability - 17-29% are found to have the condition after testing
- Multiple congenital anomalies - Depends on what the anomalies are. Overall, is over 10%
- Autism Spectrum Disorder - ~ 7%
- The chance increases if the person has additional diagnoses, e.g. mental retardation (22%), dysmorphic features (63%), seizures (22%)
- No abnormal cytogenetic microarray (CMA) results were found in 31 patients with Asperger disorder

#### ***Why should the cytogenetic microarrays tests not have to fit the algorithm?***

- In 2007, the Genetics Advisory Committee recommended and the HSC agreed that chromosome studies and Fragile X testing to determine the etiology of developmental delay/mental retardation be covered as recommended by the American Academy of

Pediatrics and American Academy of Neurology even though the diagnostic yield was less than 10%.

- The committee is now recommending that CMA testing be covered because the diagnostic yield is higher than when using the older methods. If the HSC also adopts the change to add prognosis to the Non-Prenatal Genetic Testing Algorithm, CMA analysis for developmental delay/intellectual disability and multiple congenital anomalies would fit the algorithm. Spelling this out in the Guideline Note D-1 would make this policy clear to providers, managed care plan directors, and clients.

CMA testing is recommended as a first-line test in the initial postnatal evaluation of individuals with the following:

- Multiple anomalies not specific to a well-delineated genetic syndrome
- Apparently non-syndromic developmental delay/intellectual disability
- Autism spectrum disorder (ASD)

***Why is autism spectrum disorder included?***

- ASD can have many different underlying causes, sometimes it is part of a broader condition, and sometimes it is the only condition a person has. The GAC agreed determining the etiology of ASD will guide discussion of prognosis and recurrence risks, including options for prenatal diagnosis, for the client, siblings, and the client's parents and can eliminate the need for other testing. Even if the results are negative, prognosis, recurrence risk, and options for prenatal diagnosis can be discussed in light of the negative test results using observed population data.

***Do different types of mutations, or genetic abnormality versus no identified genetic abnormality, have different prognostic/treatment outcomes?***

- Yes. Prognosis and treatment outcomes depend upon the genetic change detected.

***For family and reproductive implications, are the implications for the individual being tested or for the parents?***

- There can be implications for the patient, parents, or both depending on the circumstance.
- When testing is done to determine the recurrence risk for a family member of the affected individual, it is almost always most efficient to test the affected person first. If testing the family member is needed to calculate their recurrence risk, testing the affected person first may allow a less expensive test to be done on the family member.

***What percentage of mutations detected by microarray are heritable?***

- Most mutations detected are sporadic (not heritable). The likelihood a specific mutation in a specific person is heritable depends upon the mutation detected.

***Autism is a spectrum disorder that may range from eccentric genius to individuals with significant impairment across all modalities. Does this test tell us anything about where on the autism spectrum?***

- Generally, no.

***Are there implications for ability to be insured in the future?***

- Individuals with developmental delay/intellectual disability, multiple congenital anomalies, or autism spectrum disorders insurance underwriting decisions can be made based on their functional diagnosis or presence of congenital anomalies regardless of genetic testing results
- The federal Genetic Information Nondiscrimination Act (GINA) should prevent discrimination in health insurance and in the workplace based on genetic test results for

people without symptoms of a medical condition, e.g. parents who are carriers for a genetic condition

**What amount does Medicaid actually pay for the test?**

- In 2009 costs ranged from \$488 to \$2,376. Prices for CMA studies are decreasing.

**Ethics discussion - Elizabeth Steiner, MD, OHSU**

Dr. Elizabeth Steiner, a family physician who has earned a Certificate in Bioethics from the Joint OHSU / PSU program, and completed the Interprofessional Ethics Fellowship at the OHSU Center for Ethics in Healthcare began by stating children are not able to provide informed consent; therefore this type of testing becomes an ethical decision. Some of the questions which should be asked are:

- Does the testing affect prognosis?
- Does it provide a direct benefit for the patient?
- Would a genetic diagnosis improve the child's situation or make it worse?
- Is there a potential for negative stereotyping which could be detrimental to the child?
- How capable are the children of understanding the implications of the genetic testing/diagnosis?
- How does it change their self-perception and potential, how they look at themselves and their world?

Dr. Steiner observed genetic testing is an evolving science and that is one reason it is hard. Further, she remarked most family practice doctors are equipped to handle 90% of their patient's needs; they must rely on specialties for the other 10%. For issues this complex, she feels patients should have access to genetic counseling.

Finally, from a bioethics prospective, it is a challenge to figure out the social justice which are based on the principles of equality and solidarity, that understands and values human rights, and that recognizes the dignity of every human being and distributive justice, which guides the allocation of the benefits and burdens of economic activity implications. Which decisions save resources? Does the decision affect the care of only a small group? Are there broader implications?

*Discussion:*

Dr. McKelvey remarked families are looking for direction and clarified there is no urgency in getting the tests.

With regards to ethical implications of genetic testing being used to determine reproductive or family implications, Ms. Kovack, a certified practicing genetic counselor, noted most parents have questions about the care for living children with genetic conditions. Dr. Nickel agreed and added a specific diagnosis allows the family to focus on the issues and to help them follow-through with appropriate treatment and interventions.

Dr. Kirk stated it would be helpful for the medical directors to have information on diagnostic yield threshold. Ms. Silvey offered to supply that information.

Ms. Silvey stated the cost for a chromosome test plus Fragile X test costs more than the cost of the cytogenetic microarray test. A staff review of coding for CMA at the meeting revealed the cost is less than \$470; however subsequent research found Medicaid pays closer to \$2,000 per test,

although expectations are the cost will decrease over time. Commissioners expressed concern this would be added to “line zero.”

Dr. Saha expressed his concerns about exempting this test from the algorithm, stating he has no way to justify the high cost with little or no resulting change in outcome and feels the threshold should be 10%. Currently the Legislature is considering raising the funded region 38 lines [*Note: discovered to be 39 lines since the meeting*] and now is not the time to add more expense. Further he noted there are parameters for the use of PET scans and MRIs, other diagnostic services. He felt this genetic test should not be exempt from the 10% threshold and suggests not accepting the GAC’s proposed wording in the algorithm (“Results will may provide prognosis or change course of tx or surveillance”) and remove clause III.A from their recommended changes to Diagnostic Guideline Note D3:

- III. Related to diagnostic evaluation of individuals with intellectual disability, autism spectrum disorder, and multiple congenital anomalies:
  - A. Cytogenetic Microarrays (also called “Array CGH” or “molecular karyotyping”) is covered without a visit or consultation with a specialist and in most cases is the appropriate first tier test. Coverage of chromosome studies and Fragile X studies for the diagnostic evaluation of intellectual disability, autism spectrum disorder, and multiple congenital anomalies should be determined on a case-by-case basis according to the algorithm in Figure C.1.

The next set of changes will not go into effect until October 2011. No decision was reached today. Staff will bring back draft language to revise the algorithm in May.

## **X. Conflict of Interest Forms**

The Commission members reviewed sample forms and discussed the type of self-imposed Conflict of Interest (COI) forms that would be most suitable. There are no statutory requirements for a commission member to sign one. Most agree a suitable COI form would ask for members to disclose information that constituted a conflict and would extend to subcommittees as well.

Given the possible merger with the HRC, this discussion was tabled until the outcome of the legislation is known.

## **XI. Other Business**

There was no other business at this time.

## **XII. Public Comment**

No public comment was offered at this time.

## **XII. Adjournment**

Dr. Saha adjourned the meeting of the Health Services Commission at 3:30 p.m.

## ATTACHMENT A

### Oregon Guidelines Project Topics Being Considered:

#### Advanced imaging:

- Chronic back pain (MRI, CT and discograms)
- Cardiac disease (coronary CT for calcium score, MR Angiogram, Spectroscopy)
- Chronic pain/dysfunction in peripheral joints (MRI for shoulders, knees, hips)
- PET scans for cancers

#### Coronary Artery Disease

- Cardiac treatment (Stents versus optimal medical therapy, Stent types: drug eluting versus bare metal)

#### Maternity Care

- Contraception
- Ultrasound in low risk pregnancy
- Elective induction of labor (less than 39 weeks? And/or include 39-41 wks?)

#### Musculoskeletal and joint disease

- Hip arthroplasty (Indications, Comparison of prostheses)
- Knee arthroplasty (Indications, Comparison of prostheses)
- Spinal injections (epidural, facet, other?)
- Spinal fusion (Foraminal v. central stenosis, Instrumented fusion (fusion cage) versus not (grafting))

#### Other

- Upper Endoscopy (Indications GERD and dyspepsia)
- Preventing readmission for CHF in the first 30 days after hospitalization
- Preventing readmission for COPD in the first 30 days after hospitalization
- Crowns
- Laser based treatment for venous disease

## Minutes

**HEALTH SERVICES COMMISSION  
Clackamas Community College  
Wilsonville Training Center, Room 211  
Wilsonville, Oregon  
January 13, 2011**

**Members Present:** Somnath Saha, MD, MPH, Chair; Kevin Olson, MD; K. Dean Gubler, DO, MPH; Bruce Abernethy; Kathryn Weit (arrived at 1:07 pm); Carla McKelvey, MD; James Tyack, DMD, MAGD; Leda Garside (Arrived at 11:45 am); Bob Joondeph (arrived at 12:35 pm); Alberto Vasquez.

**Members Absent:** Lisa Dodson, MD; Larry Betcher, MSW, LCSW.

**Staff Present:** Darren Coffman; Ariel Smits, MD, MPH; Catherine Livingston, MD, MPH; Jason Gingerich; Dorothy Allen.

**Also Attending:** Caroline Price, Wally Shaffer, MD, Isabel Bickel, Susan Good, Carol Camfield, Division of Medical Assistance Programs (DMAP); Chris Kirk, MD, OHP Medical Directors; Laura Saddler, Cara Railspack, Christina Oliver, Public Health Division; Beryl Fletcher, Oregon Dental Association; Ann Neilson, Amgen; Kerry Silvey, Chair, Genetic Advisory Committee (via teleconference).

### I. Call to Order

Dr. Som Saha, Chair, called the Health Services Commission (HSC) meeting to order at 11:30 pm at the Clackamas Community College, Wilsonville Training Center, Room 211, Wilsonville, Oregon. Mr. Darren Coffman called the roll.

### II. Approval of Minutes (August 12, 2010)

**MOTION: To approve the August 12, 2010 minutes without corrections: MOTION CARRIES. 7-0.**

### III. Chair's Report

Dr. Saha waived his report.

### IV. Director's Report

Mr. Coffman reports in the interest of involving the public and stakeholders, staff will be posting our meeting minutes and highlights in draft from within two weeks of a meeting. We also are creating a webpage that will list of continuing and upcoming topics and an ICD-10-CM webpage to solicit comments from interested parties.

#### Concurrent Treatment with Hospice Care for Children

A provision in the new federal health care reform law was brought to the attention of HSC staff after last August's HSC meeting requiring that children under 21 receiving Medicaid and CHIP be allowed to

receive concurrent hospice care and curative care. As it was not known if this could have a further impact on the advanced cancer guideline revised at the August meeting, staff spoke with Dr. Saha about delaying the implementation of those changes so as not to have two sets of revisions to the guideline within a six-month period. DMAP sent a formal request to CMS for clarification on the impact of the new law in September and the response received early in the week only asked for a clarifying question. Upon further research staff feels that the new law will not likely impact Oregon under its waiver and recommends proceeding with the previously approved changes to the advanced cancer guideline with an April 1, 2011 implementation. If a CMS reply indicates further changes will be necessary to the guideline staff will bring the issue back for discussion at a future meeting. One related change that still needs to be made is to the Palliative Care Statement of Intent, changing the reference to reflect that Guideline Note 12 is no longer a statement of intent. Please see **Attachment A** for details.

## **V. Clinical Services Report**

Drs. Smits and Livingston waived their reports.

## **VI. Obesity Related Treatments**

Dr. Ariel Smits reported that the HOSC has reviewed and recommends loosening the restriction on where bariatric surgery may be performed to include centers that are seeking excellence certification. Currently there is very restricted (to no) access for OHP patients with the current restrictions in place due to capacity issues at the Centers of Excellence and location convenience for the patients.

### **Task Force on Bariatric Surgery Centers of Excellence**

See **Attachment B** for changes to footnote 2 of Guideline Note 7, Bariatric Surgery for Obesity with Comorbid Type II Diabetes & BMI >35.

Mr. Coffman stated, given limited state resources, the question of repeated bariatric surgeries has been raised by the OHP medical directors. The members discussed how there are already codes that would allow complications to be addressed and agree that old, obsolete procedures that have been reversed do not fall under this guideline. Dr. Saha led a discussion to refine the proposed language to:

### **Repeated Bariatric Surgeries**

See **Attachment B** for the addition of a new Section 3 and changes to footnote 4 reflecting new criteria for patients seeking bariatric surgery who have had a previous procedure.

**MOTION: Approve amends to the Bariatric Surgery Guideline to allow procedures to be performed at centers that are seeking excellence certification and excluding coverage of repeat procedures as shown in Attachment B. MOTION CARRIES. 7-0.**

## **VI. Health Outcomes Subcommittee Report**

The following discussion involved potential interim modifications to the Prioritized List that will go into effect on April 1, 2011, if approved. Drs. Smits, Saha and Livingston explain the following recommendations.

### **2011 CPT Codes**

Please see **Attachment C** for a full list of recommendations.

### **2011 HCPCS and CDT Codes**

The HOSC reviewed new HCPCS codes and recommendations of the Dental Services Subcommittee for placement of new dental codes. Please see **Attachment D** for a full list of recommendations.

### **October 2010 Recommendations**

### **Wrist and elbow arthrotomy**

*Please note that the changes to these arthrotomy codes were inadvertently incorporated into the October 1, 2010 Prioritized List. The HSC approved the changes exactly as they were prematurely added so no correction is necessary.*

Add CPT codes:

24006 Arthrotomy, elbow, with capsular excision for capsular release,

25105 Arthrotomy, wrist joint, with joint exploration, without or without biopsy, with or without removal of loose or foreign body and

25107 Arthrotomy, distal radioulnar joint incl. repair of triangular cartilage, complex to lines:

- 161 Pyogenic Arthritis
- 217 Deep Open Wound, With or Without Tendon or Nerve Involvement
- 296 Deformity/Closed Dislocation Of Joint
- 381 Rheumatoid Arthritis, Osteoarthritis, Osteochondritis Dissecans, and Aseptic Necrosis of Bone
- 541 Deformities of Upper Body and All Limbs

Add CPT code 24000 Arthrotomy, elbow, including exploration, drainage, or removal of foreign body to lines:

- 217 Deep Open Wound, With or Without Tendon or Nerve Involvement
- 296 Deformity/Closed Dislocation Of Joint
- 381 Rheumatoid Arthritis, Osteoarthritis, Osteochondritis Dissecans, and Aseptic Necrosis of Bone
- 541 Deformities of Upper Body and All Limbs

Add CPT code 24101 Arthrotomy, elbow, with joint exploration, with or without biopsy, with or without removal of loose or foreign body to lines:

- 161 Pyogenic Arthritis
- 217 Deep Open Wound, With or Without Tendon or Nerve Involvement
- 381 Rheumatoid Arthritis, Osteoarthritis, Osteochondritis Dissecans, and Aseptic Necrosis of Bone and
- Advise DMAP to remove code from the Diagnostic File

Add CPT code 24102 Arthrotomy, elbow, with synovectomy to lines:

- 161 Pyogenic Arthritis
- 217 Deep Open Wound, With or Without Tendon or Nerve Involvement
- 296 Deformity/Closed Dislocation Of Joint
- 541 Deformities of Upper Body and All Limbs

Add CPT code 25101 Arthrotomy, wrist joint, with joint exploration, without or without biopsy, with or without removal of loose or foreign body to lines:

- 296 Deformity/Closed Dislocation Of Joint
- 381 Rheumatoid Arthritis, Osteoarthritis, Osteochondritis Dissecans, and Aseptic Necrosis of Bone
- 541 Deformities of Upper Body and All Limbs and
- Advise DMAP to remove code from the Diagnostic File

Add CPT code 25109

Excision of tendon, forearm and /or wrist, flexor or extensor to lines:

- 161 Pyogenic Arthritis
- 217 Deep Open Wound, With or Without Tendon or Nerve Involvement
- 296 Deformity/Closed Dislocation Of Joint
- 381 Rheumatoid Arthritis, Osteoarthritis, Osteochondritis Dissecans, and Aseptic Necrosis of Bone

### **Growth Hormone Treatment Guideline**

Please see Attachment B for the revised guideline to include treatment related to chronic kidney disease in children.

**Hamartoses** are disorders involving nonneoplastic tissue overgrowth. The diagnosis code was recently discovered to be unfunded.

- Add ICD-9-CM code 759.6, Other hamartoses, to Line 317 Neurological Dysfunction in Posture and Movement Caused by Chronic Conditions
- Advise DMAP to remove code 759.6 from the Excluded (Never Covered) File
- Consider creating a new line for this condition with the next biennial review

### **Stereotactic Body Radiation Therapy**

A review of the literature shows while it appears promising, this treatment is still in the experimental stage. No change is recommended for current coverage for SBRT.

## **Guidelines**

### **Guidelines vs. Coding Specifications**

The Prioritized List currently has multiple coding specifications associated with various lines. There are also numerous guidelines which give clarification of the HSC's intent for coverage. Recently, the distinction between these two types of List modifications was discussed. As there is no clear distinction or definition of either and DMAP has indicated that coding specifications carry more weight in hearings than guidelines due to being part of the Prioritized List itself, the HSC staff agreed to review all current guidelines and identify any that could be made into coding specifications.

The HOSC recommends coding specifications should be straightforward statements which apply to only one line. Examples of coding specifications include 1) definitions of which conditions included in one ICD-9 code are intended to be included on a line and 2) statements that a certain CPT code is included on a line only for pairing with a particular ICD-9 code.

Guidelines should be statements which are more qualitative in nature which may apply to one or more lines. Examples of guidelines include 1) the degree of a condition with must be present for treatment to be covered, 2) associated conditions which must be present for treatment to be covered, and 3) limitations of coverage.

Guideline Notes 29 (Mastocytosis), 69 (Intestinal malabsorption), and 84 (Parotid gland pleomorphic adenoma) are recommended to become coding specifications. It was noted that Guideline Note 48 (services for space maintenance and periodontal maintenance) will be deleted with the next biennial review as part of the recommendations of the Dental Services Subcommittee. Please see **Attachment E**.

### **Acute and Chronic Otitis Media**

Based on discussion and literature review, create a new guideline "Tympanostomy Tubes In Acute Otitis Media," (see **Attachment A**), which will become the new Guideline Note 29 and amend the existing Guideline Note 51, Chronic Otitis Media (see **Attachment B**).

## **December 2010 Recommendations**

**Left ventricular assist devices (LVAD) as destination therapy:** The HOSC will reconsider LVADs as destination therapy at their August, 2011 meeting after better cost figures are obtained.

**Growth Hormone Treatment for CF:** It is not recommended that cystic fibrosis be added as an indication for growth hormone treatment.

**Extracorporeal circulation** or extracorporeal membrane oxygenation (ECMO): This procedure is considered standard of care for neonatal infants who meet certain criteria.

Advise DMAP to place CPT codes 33960 (Prolonged extracorporeal circulation) and 33961 (Prolonged extracorporeal circulation each add'l 24 hrs) on the Ancillary File and remove them from lines:

- 14 Other Respiratory Conditions Of Fetus And Newborn
- 87 Injury To Internal Organs
- 97 Transposition Of Great Vessels
- 111 Congenital Anomalies Of Digestive System And Abdominal Wall Excluding Necrosis;Chronic Intestinal Pseudo-Obstruction
- 154 Hypothermia

**Cholesteatoma** is a type of skin cyst located in the middle ear, usually after a trauma or infection, that heals poorly. Cholesteatomas also may be found on the tympanic membrane. These usually are associated with chronic infection of the middle ear. CPT code 69540, Excision of aural polyp, is a routine part of tympanostomy (included on line 402) and should not be coded separately for this procedure. No change recommended.

**Diabetes**

Add ICD-9-CM codes 250.51 Diabetes mellitus with ophthalmic manifestations type I not stated as uncontrolled and 250.53 Type I Diabetes with ophthalmic manifestations to line

- 10 Type I Diabetes Mellitus

**Guidelines**

The HOSC recommends the following changes to Diagnostic Guideline D4, MRI Of the Spine, Guideline Note 24, Complicated Hernias (**Attachment B**) and a new guideline created for coverage of Synagis (**Attachment A**). In addition, CPT code 90378 was added to line 3.

**Negative Pressure Wound Therapy (NPWT)** is a technique where a foam dressing is inserted into the wound and a drainage tube is placed in the dressing, then attached to a small vacuum unit that applies suction to the wound, removing excess blood and fluid. The aim is to create an environment that allows the wound to heal faster. Negative pressure wound therapy can be used for periods ranging from days to a few weeks.

Recommend to DMAP that the physician fee CPT codes for NPWT (97605 and 97606) be placed on the Ancillary File and removed from the Excluded File and add the ancillary guideline as shown in **Attachment A**.

**Line 209 Name Change**

The MHCD recommends the name of Line 209 be changed to “**CHRONIC ORGANIC MENTAL DISORDERS INCLUDING DEMENTIAS.**”

**Implantation of Neurostimulator Electrodes, Cranial Nerve**

Add CPT codes 61885, Insertion or replacement of cranial nerve neurostimulator, and 61888, Revision or removal of cranial neurostimulator pulse generator or receiver, to line:

- 459 Trigeminal and Other Nerve Disorders.

Add CPT Code 64553 (Percutaneous implantation of neurostimulator electrodes, cranial nerve) to:

- 182 Generalized Convulsive or Partial Epilepsy Without Mention Of Impairment of Consciousness
- 459 Trigeminal and Other Nerve Disorders

**Facial Lipodystrophy Syndrome**

Delete ICD-9-CM code 272.6 (Lipodystrophy syndrome) from line 66, Metabolic Disorders Including Hyperlipidemia, and add to line 675, Dermatological Conditions with No or Minimally Effective Treatments or No Treatment Necessary.

**January 2011 Recommendations**

**Epididymectomy** refers to the removal of the epididymis (a narrow, tightly-coiled tube connecting the efferent ducts from the rear of each testicle to its vas deferens, part of the male reproductive

system and is present in all male amniotes). Add CPT codes 54860 (Epididymectomy, unilateral) and 54861 (Epididymectomy, bilateral) to Line 290, Urologic Infections.

**Other disorders of lipid metabolism:** ICD-9-CM code 272.8 contains a varied collection of diagnoses for which no treatment is necessary or no treatments are effective and the conditions are not metabolic disorders.

- Remove 272.8 (Other disorders of lipid metabolism) from Line 66, Metabolic Disorders Including Hyperlipidemia
- Place 272.8 on Line 678, Musculoskeletal Conditions with no or Minimally Effective Treatments or No Treatment Necessary

**Ketotic hypoglycemia:** ICD-9-CM code 251.2 (Hypoglycemia, unspecified) is currently on Line 671, Endocrine and Metabolic Conditions with No or Minimally Effective Treatments or No Treatment Necessary. Additionally, ICD-9-CM code 251.1 (Other specified hypoglycemia), which includes hyperinsulinism, drug induced hypoglycemia, and hyperplasia of pancreatic islet beta cells NOS, is also on Line 671 and therefore non-covered. More specific codes for hypoglycemia are located on Lines 10 (Type I Diabetes Mellitus), 92 (Disorders of Pancreatic Endocrine Secretion) and 176 (Non-Diabetic Hypoglycemic Coma). The HOSC does not recommend any coding changes as the non-specific codes are properly placed on line 671.

#### **Chronic disease self management**

Recommendation: Without a guideline, add CPT codes 98960 (Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient, can include caregiver/family, each 30 minutes; individual patient), 98961 (2-4 patients) and 98962 (5-8 patients) to lines:

- 9 Major Depression, Recurrent
- 11 Asthma
- 12 Hypertension And Hypertensive Disease
- 33 Type II Diabetes Mellitus
- 108 Heart Failure
- 195 Chronic Ischemic Heart Disease

**Posterior tibial tendonitis:** ICD-9-CM code 726.72 commonly leads to acquired adult flat foot, which is an unfunded condition. Little evidence is available to support that treatment of posterior tibial tendonitis may prevent progression to acquired flat foot. The HOSC recommends no changes to current placement on lines 508 and 522 (Peripheral Enthesopathies).

**Peroneal nerve compression:** ICD-9-CM code 355.3 is currently placed only on unfunded lines 525 (Peripheral Nerve Disorders), 548 (Peripheral Nerve Disorders), and 627 (Sprains and Strains of Adjacent Muscles and Joints, Minor). Based on evidence review and discussion, the HOSC recommends:

- Add ICD-9-CM code 355.3, peroneal nerve compression, to line 434 (Peripheral Nerve Entrapment) and
- Delete from lines 525, 548, and 627

**Botulinum Toxin for Migraine Therapy:** CPT codes 64612-64614 were approved by the FDA in October 2010. Evidence reviews show little or no efficacy, leading the HOSC to recommend no change to the current list.

### **Guidelines**

#### **Prevention Lines/Tables**

Dr. Livingston stated that staff has been comparing our prevention tables to the U.S. Preventive Services Task Force (USPSTF) A&B recommendations and has discussed this issue at the HOSC several times and is now seeking direction from the HSC.

One suggestion was to eliminate the tables and divide the codes for prevention services on the list into a higher (A&B recommendations) and lower line (other), as appropriate. However, most of the CPT and HCPCS codes are already on the diagnostic list and there are not necessarily ICD-9-CM codes for many screening conditions. Additionally, DMAP staff find the tables useful when reporting to the Centers for Medicare & Medicaid Services (CMS). Another suggestion is to simply include the USPSTF A&B recommendations in the statements of intent section of the list without an association to line items.

Dr. Saha pointed out that the HSC's purpose is to set *coverage* guidelines not clinical guidelines and sees no value in including recommended non-billable services such as various counseling recommendations on the list. If we include this, it should be very clear that these are the USPSTF recommendations and not relevant to coverage. Further, he would like to have preventive services not studied by the USPSFT to undergo a review.

Dr. Carla McKelvey suggested adding CPT and ICD-9-CM codes to the updated table of USPSTF A&B recommendations. Staff will complete this work, in addition to separating codes into two lines, and continue to review with the HOSC. As the USPSFT defers all immunization recommendations to the Advisory Committee on Immunization Practices (ACIP), Dr. Wally Shaffer suggests including a references to ACIP in these tables. These changes *will not* take effect on April 1, 2011.

**ESA guideline:** Please see **Attachment B** for the guideline amendments first recommended in October and further amended in December, 2010 and January 2011 on when treatment of ESAs can be discontinued.

### Straightforward Items

Recommendations for straightforward items from October & December 2010 and January 2011 can be found in **Attachment F**.

**Thromboendarterectomy:** CPT codes 35301-35372 are on inconsistent lines on the Prioritized List. After staff review, HOSC recommends:

- Add the codes to the lines indicated by a red underlined ~~X~~
- Delete the codes from lines indicated by a crossed out blue X

CPT Code	Code Description	Line 250	Line 306	Line 307	Line 347	Line 348	Line 375
35301	Thromboendarterectomy, carotid, vertebral, subclavian		X	X	X	<del>X</del>	
35302	Thromboendarterectomy, superficial femoral artery	<del>X</del>	X	X	X		X
35303	Thromboendarterectomy, popliteal artery	<del>X</del>	X	X	X		X
35304	Thromboendarterectomy, tibioperoneal trunk artery	<del>X</del>	X	X	X		X
35305	Thromboendarterectomy, tibial or peroneal artery, initial vessel	<del>X</del>	X	X	X		X
35306	Each additional tibial or peroneal artery	<del>X</del>	X	X	X		X
35311	Thromboendarterectomy, subclavian, innominate	<del>X</del>	X	X	X		<del>X</del>
35321	Thromboendarterectomy, axillary-brachial	<del>X</del>		X	<del>X</del>	X	<del>X</del>
35331	Thromboendarterectomy, abdominal aorta		X	X	X		
35341	Thromboendarterectomy, mesenteric, celiac, or renal		X	X	X		
35351	Thromboendarterectomy, iliac	<del>X</del>	X	X	X		<del>X</del>
35355	Thromboendarterectomy, iliofemoral	<del>X</del>		X	<del>X</del>		<del>X</del>
35361	Thromboendarterectomy, combined aortoiliac	<del>X</del>		X	<del>X</del>		X
35363	Thromboendarterectomy, combined aortoiliofemoral	<del>X</del>		X	<del>X</del>		<del>X</del>
35371	Thromboendarterectomy, common femoral	<del>X</del>		X	<del>X</del>		X
35372	Thromboendarterectomy, deep femoral	X		X	<del>X</del>		<del>X</del>

Line: 250 Peripheral Vascular Disease, Limb Threatening Infections, And Vascular Complications  
 Line: 306 Dissecting or Ruptured Aortic Aneurysm

Line: 307 Complications of a Procedure Always Requiring Treatment  
Line: 347 Non-Dissecting Aneurysm without Rupture  
Line: 348 Arterial Aneurysm of Neck  
Line: 375 Atherosclerosis, Peripheral

### **Postconcussion syndrome**

At the December meeting, HOSC members heard testimony about the evolving treatment of concussions and postconcussion syndrome. Post-concussion syndrome is the only diagnosis on Line 575. By definition, postconcussion syndrome is a concussion with persistent symptoms lasting more than 3 months, making the diagnosis would always qualify for placement Line 100. If 310.2 is added to Line 100, Line 575 becomes redundant. Recommendations:

- Rename Line 100 ~~Severe/Moderate~~ Head Injury: Hematoma/Edema With ~~Loss Of Consciousness~~ Persistent Symptoms; Compound/ Depressed Fractures Of Skull
- Rename Line 631 ~~Minor~~ Head Injury: Hematoma/Edema with ~~Loss Of Consciousness~~ No Persistent Symptoms
- Add ICD-9-CM code 850.0 (Concussion with no loss of consciousness) to line 100. Keep 850.0 on line 631
- Add ICD-9-CM 310.2 (Postconcussion syndrome) to line 100
- Add CPT code 96118 (Neuropsychological testing, per hour or psychologist or physician time) to line 100
- The head injury lines will be reviewed during the next biennial review
- Delete Line 575, Postconcussion Syndrome, which will appear crossed out until it is permanently deleted on the Jan. 2012 biennial review list.

## **VII. OHA/Legislative Update**

Dr. Jeanene Smith, Oregon Health Policy & Research (OHPR) Administrator, briefed the Commission on the [Oregon Health Policy Board's \(OHPB\) Action Plan](#) as it involves an Value-Based Essential Benefit Package. We know that health care costs are unsustainable. The Board has involved the citizens of Oregon by holding community meetings and soliciting other public comments including Twitter® and Facebook® as well as stakeholders being a part of committees, sub-committees, work groups and task forces.

Everyone seems to be facing the same challenges:

- cost of health care and coverage is too high,
- outcomes are unsatisfactory,
- care is fragmented.

The Board recommends a Triple Aim approach:

- Improve the lifelong health of all Oregonians,
- Increase the quality, reliability and availability of care for all Oregonians, and
- Lower or contain the cost of care so it is affordable for everyone.

As part of 8 key strategies in the action plan, they direct that a value-based benefit design be used to develop benefit packages that remove barriers to preventive care and effective chronic disease management. A plan is being developed to use such benefit packages within OHA programs.

Federal reform makes a significant investment in access to health insurance coverage; there is a need to pair that with changing the way we deliver and pay for health care and shifting our focus to prevention as outlined in the Board's foundational strategies for action.

Other OHPB documents the HSC might find interesting in:

**Focus Group** reaction to the Value-base Benefit Package:

[December 14, 2010: VBBP Attachment A](#)

[December 14, 2010: VBBP Attachment B](#)

[December 14, 2010: VBBP DRAFT Report](#)

**Health Improvement Plan** is a series of recommendations to improve the lifelong health of Oregonians  
[November 9, 2010: DRAFT Health Improvement Plan Report](#)

The HSC role's in continued benefit and guideline design is still coming into focus but at the very least there will be some staff work and oversight from this body.

With the Oregon Health Authority severing from Department of Human Services, there has been some thought about program efficiencies, which has led to legislation that would change the way the HSC operates. If the legislation passes ([HB 2100](#)) as written, the HSC will merge with the Health Resources Commission (HRC), creating the Health Evidence Review Commission (HERC). The work currently done by the HRC will become a subcommittee of HERC, just as the HOSC (and other subcommittees) will.

## **VIII. Genetics Advisory Committee Report**

Ms. Kerry Silvey, GAC Chair, via conference call, reported the committee met on September 23, 2010 to review the Non-Prenatal Genetic Testing Guideline and algorithm. They suggest adding chromosome microarray testing and changing the language the diagnostic evaluation of "developmental delay" to "individuals with intellectual disability, autism spectrum disorder, or multiple congenital anomalies." It is a bit more expensive but has a higher diagnostic yield. The committee suggests only covering Fragile X testing if they patient meets the algorithm criteria. Testing using the chromosome microarray would not require use of the algorithm. Dr. Saha questioned why this \$2,000 test would need to be exempted from the algorithm. Ms. Silvey explained that the algorithm requires a 10% yield (likelihood that a patient will test positive) and the new test does not meet that threshold for some of the conditions it diagnoses.

Ms. Kathryn Weit questioned the inclusion of autism spectrum disorder, as there are currently no genetic markers for the conditions and wondered how the testing would affect treatment. Ms. Silvey shared there are multiple genes that appear to cause autism in small numbers of people and the test results would only be useful for monitoring.

Dr. Kirk, speaking for the OHP medical directors, stated that they are interested in knowing which tests will alter or guide the plan of care. He believes that the GAC recommendations are in direct conflict with the Oregon Administrative Rule (OAR) guiding diagnostic testing, which states the testing must be medically necessary and have a health impact.

Mr. Bob Joondeph voiced ethics concerns over this information being used to make reproductive decisions post-conception and asked to hear from an ethics expert. Dr. Saha suggests this topic be revisited, asking Ms. Silvey to attend in person and to review the evidence the GAC used to make their recommendations. An ethicist will also be invited.

The recommendations were not accepted at this time.

## **IX. Mental Health Care & Chemical Dependency Subcommittee Report**

Due to time constraints, the ICD-10-CM conversion and Biennial Review discussion was tabled until March, 10, 2011.

The HSC agreed with MHCD's recommendation to add HCPCS code T1007 (Alcohol and/or substance abuse services, treatment plan development and/or modification), to Lines 5, Abuse or Dependence of Psychoactive Substance, and 67, Substance-Induced Delusional and Mood Disorders; Intoxication.

## **X. Guidelines for Submitted Materials and Topic Review**

Dr. Livingston began by stating, in the past, some materials and evidence submitted to the HOSC has lacked weight needed to make an informed decision. Staff has worked to develop a list of criteria, ranking types of evidence and when topics might be reviewed. There was a brief discussion around the phrase “community standard of care” which resulted in a single word change. Please see Attachment G for the accepted wording.

**MOTION: Make changes to the Prioritized List for the April 1, 2011 Interim Modification as recommended by the HOSC and MHCD: MOTION CARRIES. 10-0.**

## **XI. Other Business**

There was no other business at this time.

## **XII. Public Comment**

No public comment was offered at this time.

## **XII. Adjournment**

Dr. Saha adjourned the meeting of the Health Services Commission at 3:35 p.m.

## **Attachment A Revised Statement of Intent & New Guidelines**

### **STATEMENT OF INTENT 1: PALLIATIVE CARE**

It is the intent of the Commission that palliative care services be covered for patients with a life-threatening illness or severe advanced illness expected to progress toward dying, regardless of the goals for medical treatment and with services available according to the patient's expected length of life (see examples below).

Palliative care is comprehensive, specialized care ideally provided by an interdisciplinary team (which may include but is not limited to physicians, nurses, social workers, etc.) where care is particularly focused on alleviating suffering and promoting quality of life. Such interdisciplinary care should include assessment, care planning, and care coordination, emotional and psychosocial counseling for patients and families, assistance accessing services from other needed community resources, and should reflect the patient and family's values and goals.

Some examples of palliative care services that should be available to patients with a life-threatening/limiting illness,

1. without regard to a patient's expected length of life:
  - Inpatient palliative care consultation; and,
  - Outpatient palliative care consultation, office visits.
2. with an expected median survival of less than one year, as supported by the best available published evidence:
  - Home-based palliative care services (to be defined by DMAP), with the expectation that the patient will move to home hospice care.
3. with an expected median survival of six months or less, as supported by peer-reviewed literature:
  - Home hospice care, where the primary goal of care is quality of life (hospice services to be defined by DMAP).

It is the intent of the Commission that certain palliative care treatments be covered when these treatments carry the primary goal to alleviate symptoms and improve quality of life, without intending to alter the trajectory of the underlying disease.

Some examples of covered palliative care treatments include:

4. Radiation therapy for painful bone metastases with the intent to relieve pain and improve quality of life.
5. Surgical decompression for malignant bowel obstruction.
6. Medication therapy such as chemotherapy with low toxicity/low side effect agents with the goal to decrease pain from bulky disease or other identified complications. Cost of chemotherapy and alternative medication(s) should also be considered.
7. Medical equipment and supplies (such as non-motorized wheelchairs, walkers, bandages, and catheters) determined to be medically appropriate for completion of basic activities of daily living, for management of symptomatic complications or as required for symptom control.
8. Acupuncture with intent to relieve nausea.

Cancer treatment with intent to palliate is not a covered service when the same palliation can be achieved with pain medications or other non-chemotherapy agents.

It is NOT the intent of the Commission that coverage for palliative care encompasses those treatments that seek to prolong life despite substantial burdens of treatment and limited chance of benefit. [See Statement of Intent on Treatment of Cancer with Little or No Benefit Provided Near the End of Life](#) See [Guideline Note 12: TREATMENT OF CANCER WITH LITTLE OR NO BENEFIT PROVIDED NEAR THE END OF LIFE](#).

## **Attachment A Revised Statement of Intent & New Guidelines**

### **ANCILLARY GUIDELINE A1, NEGATIVE PRESSURE WOUND THERAPY**

- A) Negative pressure wound therapy (97605, 97606) is a covered benefit only for patients who:
- 1) Have wounds that are refractory to or have failed standard therapies;
  - 2) Are not suitable candidates for surgical wound closure; or,
  - 3) Are at high risk for delayed or non-healing wounds due to factors such as compromised blood flow, diabetic complications, wounds with high risk of fecal contamination, extremely exudative wounds, and similar situations.

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

*Line 413*

Tympanostomy tubes (69436) are only included on this line as treatment for 1) recurrent acute otitis media (three or more episodes in six months or four or more episodes in one year) that fail appropriate medical management, 2) for patients who fail medical treatment secondary to multiple drug allergies or who fail two or more consecutive courses of antibiotics, or 3) complicating conditions (immunocompromised host, meningitis by lumbar puncture, acute mastoiditis, sigmoid sinus/jugular vein thrombosis by CT/MRI/MRA, cranial nerve paralysis, sudden onset dizziness/vertigo, need for middle ear culture, labyrinthitis, or brain abscess). Patients with craniofacial anomalies, Down's syndrome, cleft palate, and patients with speech and language delay may be considered for tympanostomy with their first episode of acute otitis media.

### **GUIDELINE NOTE 69, SYNAGIS**

*Line 3*

CPT code 90378, Synagis (palivizumab), is covered for infants meeting one of the criteria given below (A-E), according to the treatment guidelines for each criterion:

- A) Infants younger than 24 months who have congenital heart disease (CHD) or chronic lung disease of prematurity (CLD, formerly called bronchopulmonary dysplasia) AND require medical therapy
  - 1) Therapy is initiated within 6 months before the start of the RSV season
  - 2) Maximum 5 doses
- B) Infants younger than 12 months with congenital abnormalities of the airway or neuromuscular disease
  - 1) Maximum 5 doses
- C) Had a gestation age of 28 weeks or less
  - 1) Initiated during the RSV season before the infant reaches 12 months
  - 2) Maximum 5 doses
- D) Had a gestation age of 29 weeks and 0 days to 31 weeks and 6 days
  - 1) Initiated during the RSV season before the infant reaches 6 months
  - 2) Maximum 5 doses
- E) Had a gestational age of 32 weeks 0 days to 34 weeks 6 days
  - 1) Born within 3 months before the start of RSV season or at any time throughout the RSV season
  - 2) Have at least 1 of these 2 risk factors
    - a) Infant attends child care; or
    - b) One or more siblings or other children younger than 5 years live permanently in the child's household.
  - 3) Should receive prophylaxis only until they reach 90 days of age or a maximum of 3 doses (whichever comes first).

## Attachment B Revised Guidelines

### GUIDELINE NOTE 6, REHABILITATIVE THERAPIES

Lines 12,50-52,63,73-75,77,79,84,88,89,93,94,97-100,108,109,115,116,122,129,139,141-143,145,146,158,161,165,179,184,185,189,190,192,194,195,201,202,208,217,227,237,239,270,271,273,274,279,287,288,292,296,301,303,306-308,317,334,340,347,348,362,366,368,372,373,375,379,381,382,384,397,403,404,428,434,436,440,448,460,469,480,497,508,539,551,569,587,610,627

Physical, occupational and speech therapy, and cardiac and vascular rehabilitation, are covered for diagnoses paired with the respective CPT codes, depending on medical necessity, for up to 3 months immediately following stabilization from an acute event. Thereafter, the following number of combined physical and occupational therapy visits are allowed per year, depending on medical necessity:

- Age < 8: 24
- Age 8-12: 12
- Age > 12: 2

Following 3 months of acute therapy, the following number of speech therapy visits are allowed per year, depending on medical necessity (with the exception of swallowing disorders, for which limits do not apply):

- Age < 8: 24
- Age 8-12: 12
- Age > 12: 2

An additional 6 visits of speech, and/or an additional 6 visits of physical or occupational therapy are allowed, regardless of age, whenever there is a change in status, such as surgery, botox injection, rapid growth, an acute exacerbation or for evaluation/training for an assistive communication device.

No limits apply while in a skilled nursing facility for the primary purpose of rehabilitation, an inpatient hospital or an inpatient rehabilitation unit.

If the admission/encounter is for rehabilitation, a V code from V57.1-V57.3,V57.8 should be listed as the principle/first diagnosis. The underlying diagnosis for which rehab is needed should be listed as an additional diagnosis and this diagnosis must appear in the funded region of the Prioritized List for the admission/encounter to be covered.

### GUIDELINE NOTE 7, ERYTHROPOIETIN GUIDELINESERYTHROPOIESIS-STIMULATING AGENT (ESA) GUIDELINE

Lines 33,65,78,101,102,105,123-125,131,138,144,159,166-168,170,181,197,198,206-208,219,221,222,229,230,232,236,243,249,252,275-278,280,286,291,309-311,313,319,337-339,350,354,365,452,612

- F) Indicated for anemia (Hgb < 10gm/dl or Hct < 30%) induced by cancer chemotherapy, in given within the previous 8 weeks or in the setting of myelodysplasia or in chronic renal failure, with or without dialysis.
- 1) Reassessment should be made after 8 weeks of treatment. If no response, treatment should be discontinued. If response is demonstrated, EPO should be titrated to maintain a level between 10 and 12 ESAs should be discontinued once the hemoglobin level reaches 10, unless a lower hemoglobin level is sufficient to avoid the need for blood transfusion.
- G) Indicated for anemia (Hgb < 10gm/dl or HCT < 30%) associated with HIV/AIDS.
- 1) An endogenous erythropoietin level < 500 IU/L is required for treatment, and patient may not be receiving zidovudine (AZT) > 4200 mg/week.
  - 2) Reassessment should be made after 8 weeks. If no response, treatment should be discontinued. If response is demonstrated, EPOESAs should be titrated to maintain a level between 10 and 12.

## Attachment B Revised Guidelines

H) Indicated for anemia (Hgb < 10 gm/dl or HCT <30%) associated with chronic renal failure, with or without dialysis.

3)1) Reassessment should be made after 8 weeks. If no response, treatment should be discontinued. If response is demonstrated, ESAs should be titrated to maintain a level between 11 and 12.

### **GUIDELINE NOTE 8, BARIATRIC SURGERY**

*Lines 33,607*

Bariatric surgery for obesity is included on Line 33 TYPE II DIABETES MELLITUS, and Line 607 OBESITY under the following criteria:

- A) Age ≥ 18
- B) For inclusion on Line 33: BMI ≥ 35 with co-morbid type II diabetes. For inclusion on Line 607: BMI ≥ 35 with at least one significant co-morbidity other than type II diabetes (e.g., obstructive sleep apnea, hyperlipidemia, hypertension) or BMI ≥ 40 without a significant co-morbidity.

C) No prior history of Roux-en-Y gastric bypass or laparoscopic adjustable gastric banding, unless they resulted in failure due to complications of the original surgery.

D) Participate in the following four evaluations and meet criteria as described.

- 1) Psychosocial evaluation: (Conducted by a licensed mental health professional)
  - a) Evaluation to assess compliance with post-operative requirements.
  - b) Must remain free of abuse of or dependence on alcohol during the six-month period immediately preceding surgery. No current use of nicotine or illicit drugs and must remain abstinent from their use during the six-month observation period. Testing will, at a minimum, be conducted within one month of the surgery to confirm abstinence from nicotine and illicit drugs.
  - c) No mental or behavioral disorder that may interfere with postoperative outcomes<sup>1</sup>.
  - d) Patient with previous psychiatric illness must be stable for at least 6 months.
- 2) Medical evaluation: (Conducted by OHP primary care provider)
  - a) Pre-operative physical condition and mortality risk assessed with patient found to be an appropriate candidate.
  - b) Optimize medical control of diabetes, hypertension, or other co-morbid conditions.
  - c) Female patient not currently pregnant with no plans for pregnancy for at least 2 years post-surgery. Contraception methods reviewed with patient agreement to use effective contraception through 2nd year post-surgery.
- 3) Surgical evaluation: (Conducted by a licensed bariatric surgeon associated with program<sup>2</sup>)
  - a) Patient found to be an appropriate candidate for surgery at initial evaluation and throughout period leading to surgery while continuously enrolled on OHP.
  - b) Received counseling by a credentialed expert on the team regarding the risks and benefits of the procedure<sup>3</sup> and understands the many potential complications of the surgery (including death) and the realistic expectations of post-surgical outcomes.
- 4) Dietician evaluation: (Conducted by licensed dietician)
  - a) Evaluation of adequacy of prior dietary efforts to lose weight. If no or inadequate prior dietary effort to lose weight, must undergo six-month medically supervised weight reduction program.
  - b) Counseling in dietary lifestyle changes

E) Participate in additional evaluations:

- 1) Post-surgical attention to lifestyle, an exercise program and dietary changes and understands the need for post-surgical follow-up with all applicable professionals (e.g. nutritionist, psychologist/psychiatrist, exercise physiologist or physical therapist, support group participation, regularly scheduled physician follow-up visits).

<sup>1</sup> Many patients (>50%) have depression as a co-morbid diagnosis that, if treated, would not preclude their participation in the bariatric surgery program.

<sup>2</sup> ~~All surgical services including evaluation are to be performed at a center of excellence for bariatric surgery as recognized by Medicare.~~

## Attachment B Revised Guidelines

- <sup>2</sup> [All surgical services must be provided by a program with current certification by the American College of Surgeons \(ACS\) or the Surgical Review Corporation \(SCR\), or in active pursuit of such certification with all of the following: a dedicated, comprehensive, multidisciplinary, pathway-directed bariatric program in place; hospital to have performed bariatrics > 1 year and > 25 cases the previous 12 months; trained and credentialed bariatric surgeon performing at least 50 cases in past 24 months; qualified bariatric call coverage 24/7/365; appropriate bariatric-grade equipment in outpatient and inpatient facilities; appropriate medical specialty services to complement surgeons' care for patients; and quality improvement program with prospective documentation of surgical outcomes. If the program is still pursuing ACS or SRC certification, it must also restrict care to lower-risk OHP patients including: age < 65 years; BMI < 70; no major elective revisional surgery; and, no extreme medical comorbidities \(such as wheel-chair bound, severe cardiopulmonary compromise, or other excessive risk\). All programs must agree to yearly submission of outcomes data to Division of Medicaid Assistance Programs \(DMAP\).](#)
- <sup>3</sup> Only Roux-en-Y gastric bypass, laparoscopic adjustable gastric banding and sleeve gastrectomy are approved for inclusion.
- <sup>4</sup> The patient must meet criteria #1, [#2](#), and [#23](#), and be referred by the OHP primary care provider as a medically appropriate candidate, to be approved for evaluation at a qualified bariatric surgery program.

### **GUIDELINE NOTE 12, TREATMENT OF CANCER WITH LITTLE OR NO BENEFIT PROVIDED NEAR THE END OF LIFE**

*Lines 101,102,123-125,144,159,166,167,170,181,197,198,207,208,219,221,222,229,230,232,243,249,252,275-278,280,286,291,309-311,319,337-339,354,452,574,612*

[This guideline only applies to patients with advanced cancer who have less than 24 months median survival with treatment.](#)

All patients receiving end of life care, either with the intent to prolong survival or with the intent to palliate symptoms, should have/be engaged with palliative care providers (for example, have a palliative care consult or be enrolled in a palliative care program).

Treatment with intent to prolong survival is not a covered service for patients with any of the following:

- Median survival of less than 6 months with or without treatment, as supported by the best available published evidence
- Median survival with treatment of 6-12 months when the treatment is expected to improve median survival by less than 50%, as supported by the best available published evidence
- Median survival with treatment of more than 12 months when the treatment is expected to improve median survival by less than 30%, as supported by the best available published evidence
- ~~Eastern Co-operative Oncology Group (ECOG) performance score of 3 or higher.~~
- [Poor prognosis with treatment, due to limited physical reserve or the ability to withstand treatment regimen, as indicated by low performance status.](#)

[Unpublished evidence may be taken into consideration in the case of rare cancers which are universally fatal within six months without treatment.](#)

The Health Services Commission is reluctant to place a strict \$/QALY (quality adjusted life-year) or \$/LYS (life-year saved) requirement on end-of-life treatments, as such measurements are only approximations and cannot take into account all of the merits of an individual case. However, cost must be taken into consideration when considering treatment options near the end of life. For example, in no instance can it be justified to spend \$100,000 in public resources to increase an individual's expected survival by three months when hundreds of thousands of Oregonians are without any form of health insurance.

Treatment with the goal to palliate is addressed in Statement of Intent 1, Palliative Care.

## Attachment B Revised Guidelines

### **GUIDELINE NOTE 24, COMPLICATED HERNIAS**

*Line 175*

Complicated hernias are included on this line if they are incarcerated (defined as non-reducible by physical manipulation) or have symptoms of obstruction and/or strangulation.

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

*Line 492*

Antibiotic and other medication therapy are not indicated for children with ~~bilateral~~-chronic ~~nonsuppurative otitis media- with effusion (OME)~~. Children with ~~bilateral~~-chronic ~~nonsuppurative otitis media~~~~OME~~ present for 3 months or longer or with language delay, learning problems, or significant hearing loss at any time should have hearing testing. Children with ~~bilateral~~-chronic ~~nonsuppurative otitis media~~~~OME~~ who are not at risk should be reexamined at 3- to 6-month intervals until the effusion is no longer present, significant hearing loss is identified, or structural abnormalities of the eardrum or middle ear are suspected.

For the child who has had ~~bilateral~~-chronic ~~nonsuppurative otitis media~~~~OME~~ and who has a ~~bilateral~~ hearing deficiency ~~diagnosed by formal audiometry testing, bilateral~~in the better-hearing ear of 25 dB or greater, myringotomy with tube insertion recommended after a total of 4 to 6 months of ~~bilateral~~-effusion with a documented ~~bilateral~~-hearing deficit.

Adenoidectomy is an appropriate surgical treatment for ~~bilateral~~-chronic ~~nonsuppurative otitis media~~~~OME~~ in children over 3 years with their second set of tubes. First time tubes are not an indication for an adenoidectomy.

### **GUIDELINE NOTE 68, HYSTEROSCOPIC BILATERAL FALLOPIAN TUBE OCCLUSION**

*Line 7*

Placement of permanent implants in the fallopian tubes to induce bilateral occlusion (CPT code 58565) is covered only if the procedure is done in the office setting, not in the ambulatory surgical center or hospital setting.

Hysterosalpingography (58340, ~~58345~~, 74740) is covered only for the follow-up testing after placement of permanent implants in the fallopian tubes to induce bilateral occlusion.

### **GUIDELINE NOTE 74, GROWTH HORMONE TREATMENT**

*Lines 411, 485*

Treatment with growth hormone is included only for children with: pituitary dwarfism, Turner's syndrome, Prader-Willi-syndrome, Noonan's syndrome, ~~and~~-short stature homeobox-containing gene (SHOX)-, chronic kidney disease (stages 3, 4, 5 or 6) and those with renal transplant. Treatment with growth hormone should continue only until adult height as determined by bone age is achieved. Treatment is not included for isolated deficiency of human growth hormone or other conditions in adults.

**Attachment C  
Placement of 2011 CPT Codes**

Code	Description	Line placement/recommendations for DMAP files
11045	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	<p>63 BURN FULL THICKNESS GREATER THAN 10% OF BODY SURFACE            79 BURN, PARTIAL THICKNESS GREATER THAN 30% OF BODY SURFACE OR WITH VITAL SITE; FULL THICKNESS WITH VITAL SITE, LESS THAN 10% OF BODY SURFACE            86 PHLEBITIS AND THROMBOPHLEBITIS, DEEP            165 TRAUMATIC AMPUTATION OF ARM(S), HAND(S), THUMB(S), AND FINGER(S) (COMPLETE)(PARTIAL) WITH AND WITHOUT COMPLICATION            202 BURN, PARTIAL THICKNESS WITHOUT VITAL SITE, 10-30% OF BODY SURFACE            215 SUPERFICIAL ABSCESSSES AND CELLULITIS            217 DEEP OPEN WOUND, WITH OR WITHOUT TENDON OR NERVE INVOLVEMENT            250 PERIPHERAL VASCULAR DISEASE, LIMB THREATENING INFECTIONS, AND VASCULAR COMPLICATIONS            271 CHRONIC OSTEOMYELITIS            291 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA            307 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT            407 CHRONIC ULCER OF SKIN            440 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT            480 OSTEOARTHRITIS AND ALLIED DISORDERS            541 DEFORMITIES OF UPPER BODY AND ALL LIMBS            563 XEROSIS            567 KERATODERMA, ACANTHOSIS NIGRICANS, STRIAE ATROPHICAE, AND OTHER HYPERTROPHIC OR ATROPHIC CONDITIONS OF SKIN            623 DISORDERS OF SOFT TISSUE            624 MINOR BURNS            641 SEBORRHEIC KERATOSIS, DYSCHROMIA, AND VASCULAR DISORDERS, SCAR CONDITIONS, AND FIBROSIS OF SKIN</p>
11046	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	<p>165 TRAUMATIC AMPUTATION OF ARM(S), HAND(S), THUMB(S), AND FINGER(S) (COMPLETE)(PARTIAL) WITH AND WITHOUT COMPLICATION            215 SUPERFICIAL ABSCESSSES AND CELLULITIS            217 DEEP OPEN WOUND, WITH OR WITHOUT TENDON OR NERVE INVOLVEMENT            250 PERIPHERAL VASCULAR DISEASE, LIMB THREATENING INFECTIONS, AND VASCULAR COMPLICATIONS            271 CHRONIC OSTEOMYELITIS            291 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA            307 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT            407 CHRONIC ULCER OF SKIN            440 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT            563 XEROSIS            567 KERATODERMA, ACANTHOSIS NIGRICANS, STRIAE ATROPHICAE, AND OTHER HYPERTROPHIC OR ATROPHIC CONDITIONS OF SKIN            624 MINOR BURNS</p>

**Attachment C  
Placement of 2011 CPT Codes**

Code	Description	Line placement/recommendations for DMAP files
11047	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	165 TRAUMATIC AMPUTATION OF ARM(S), HAND(S), THUMB(S), AND FINGER(S) (COMPLETE)(PARTIAL) WITH AND WITHOUT COMPLICATION 215 SUPERFICIAL ABSCESSSES AND CELLULITIS 217 DEEP OPEN WOUND, WITH OR WITHOUT TENDON OR NERVE INVOLVEMENT 250 PERIPHERAL VASCULAR DISEASE, LIMB THREATENING INFECTIONS, AND VASCULAR COMPLICATIONS 271 CHRONIC OSTEOMYELITIS 291 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA 307 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT 407 CHRONIC ULCER OF SKIN 440 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT 563 XEROSIS 567 KERATODERMA, ACANTHOSIS NIGRICANS, STRIAE ATROPHICAE, AND OTHER HYPERTROPHIC OR ATROPHIC CONDITIONS OF SKIN 624 MINOR BURNS
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2	83 DEEP ABSCESSSES, INCLUDING APPENDICITIS AND PERIORBITAL ABSCESS 158 CERVICAL VERTEBRAL DISLOCATIONS/FRACTURES, OPEN OR CLOSED; OTHER VERTEBRAL DISLOCATIONS/FRACTURES, OPEN; SPINAL CORD INJURIES WITH OR WITHOUT EVIDENCE OF VERTEBRAL INJURY 208 CANCER OF BONES 271 CHRONIC OSTEOMYELITIS 397 DISORDERS OF SPINE WITH NEUROLOGIC IMPAIRMENT 428 SPINAL DEFORMITY, CLINICALLY SIGNIFICANT 497 CLOSED DISLOCATIONS/FRACTURES OF NON-CERVICAL VERTEBRAL COLUMN WITHOUT SPINAL CORD INJURY 539 BENIGN NEOPLASM BONE AND ARTICULAR CARTILAGE INCLUDING OSTEOID OSTEOMAS; BENIGN NEOPLASM OF CONNECTIVE AND OTHER SOFT TISSUE 596 SPINAL DEFORMITY, NOT CLINICALLY SIGNIFICANT
22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for separate procedure)	83 DEEP ABSCESSSES, INCLUDING APPENDICITIS AND PERIORBITAL ABSCESS 158 CERVICAL VERTEBRAL DISLOCATIONS/FRACTURES, OPEN OR CLOSED; OTHER VERTEBRAL DISLOCATIONS/FRACTURES, OPEN; SPINAL CORD INJURIES WITH OR WITHOUT EVIDENCE OF VERTEBRAL INJURY 208 CANCER OF BONES 271 CHRONIC OSTEOMYELITIS 397 DISORDERS OF SPINE WITH NEUROLOGIC IMPAIRMENT 428 SPINAL DEFORMITY, CLINICALLY SIGNIFICANT 497 CLOSED DISLOCATIONS/FRACTURES OF NON-CERVICAL VERTEBRAL COLUMN WITHOUT SPINAL CORD INJURY 539 BENIGN NEOPLASM BONE AND ARTICULAR CARTILAGE INCLUDING OSTEOID OSTEOMAS; BENIGN NEOPLASM OF CONNECTIVE AND OTHER SOFT TISSUE 596 SPINAL DEFORMITY, NOT CLINICALLY SIGNIFICANT
29914	Arthroscopy, hip, surgical; with femoroplasty (ie, treatment of cam lesion)	DMAP Excluded File
29915	Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)	DMAP Excluded File

**Attachment C  
Placement of 2011 CPT Codes**

Code	Description	Line placement/recommendations for DMAP files
29916	Arthroscopy, hip, surgical; with labral repair	DMAP Excluded File
31295	Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa	388 ACUTE SINUSITIS 488 CHRONIC SINUSITIS 523 NASAL POLYPS, OTHER DISORDERS OF NASAL CAVITY AND SINUSES
31296	Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)	388 ACUTE SINUSITIS 488 CHRONIC SINUSITIS 523 NASAL POLYPS, OTHER DISORDERS OF NASAL CAVITY AND SINUSES
31297	Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (eg, balloon dilation)	388 ACUTE SINUSITIS 488 CHRONIC SINUSITIS 523 NASAL POLYPS, OTHER DISORDERS OF NASAL CAVITY AND SINUSES
31634	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, with assessment of air leak, with administration of occlusive substance (eg, fibrin glue), if performed	153 PNEUMOTHORAX AND HEMOTHORAX
33620	Application of right and left pulmonary artery bands (eg, hybrid approach stage 1)	73 VENTRICULAR SEPTAL DEFECT 76 CONGENITAL PULMONARY VALVE STENOSIS 93 ENDOCARDIAL CUSHION DEFECTS 94 CONGENITAL PULMONARY VALVE ATRESIA 97 TRANSPOSITION OF GREAT VESSELS 98 CONGENITAL MITRAL VALVE STENOSIS/INSUFFICIENCY 115 TETRALOGY OF FALLOT (TOF) 116 CONGENITAL STENOSIS AND INSUFFICIENCY OF AORTIC VALVE 122 CONGENITAL HEART BLOCK; OTHER OBSTRUCTIVE ANOMALIES OF HEART 139 COMMON TRUNCUS 141 TOTAL ANOMALOUS PULMONARY VENOUS CONNECTION 148 EBSTEIN'S ANOMALY 184 COMMON VENTRICLE 192 MULTIPLE VALVULAR DISEASE 194 CONGENITAL TRICUSPID ATRESIA AND STENOSIS 237 DISEASES AND DISORDERS OF AORTIC VALVE 247 HYPOPLASTIC LEFT HEART SYNDROME 274 DISEASES OF MITRAL AND TRICUSPID VALVES 279 CONGESTIVE HEART FAILURE, CARDIOMYOPATHY, TRANSPOSITION OF GREAT VESSELS, HYPOPLASTIC LEFT HEART SYNDROME 672 CARDIOVASCULAR CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY

**Attachment C  
Placement of 2011 CPT Codes**

Code	Description	Line placement/recommendations for DMAP files
33621	Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg, hybrid approach stage 1)	73 VENTRICULAR SEPTAL DEFECT 76 CONGENITAL PULMONARY VALVE STENOSIS 93 ENDOCARDIAL CUSHION DEFECTS 94 CONGENITAL PULMONARY VALVE ATRESIA 97 TRANSPOSITION OF GREAT VESSELS 98 CONGENITAL MITRAL VALVE STENOSIS/INSUFFICIENCY 115 TETRALOGY OF FALLOT (TOF) 116 CONGENITAL STENOSIS AND INSUFFICIENCY OF AORTIC VALVE 122 CONGENITAL HEART BLOCK; OTHER OBSTRUCTIVE ANOMALIES OF HEART 139 COMMON TRUNCUS 141 TOTAL ANOMALOUS PULMONARY VENOUS CONNECTION 148 EBSTEIN'S ANOMALY 184 COMMON VENTRICLE 192 MULTIPLE VALVULAR DISEASE 194 CONGENITAL TRICUSPID ATRESIA AND STENOSIS 237 DISEASES AND DISORDERS OF AORTIC VALVE 247 HYPOPLASTIC LEFT HEART SYNDROME 274 DISEASES OF MITRAL AND TRICUSPID VALVES 279 CONGESTIVE HEART FAILURE, CARDIOMYOPATHY, TRANSPOSITION OF GREAT VESSELS, HYPOPLASTIC LEFT HEART SYNDROME 672 CARDIOVASCULAR CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY
33622	Reconstruction of complex cardiac anomaly (eg, single ventricle or hypoplastic left heart) with palliation of single ventricle with aortic outflow obstruction and aortic arch hypoplasia, creation of cavopulmonary anastomosis, and removal of right and left pulmonary bands (eg, hybrid approach stage 2, Norwood, bidirectional Glenn, pulmonary artery debanding)	184 COMMON VENTRICLE 247 HYPOPLASTIC LEFT HEART SYNDROME
37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	375 ATHEROSCLEROSIS, PERIPHERAL
37221	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	375 ATHEROSCLEROSIS, PERIPHERAL
37222	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)	375 ATHEROSCLEROSIS, PERIPHERAL
37223	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	375 ATHEROSCLEROSIS, PERIPHERAL
37224	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty	375 ATHEROSCLEROSIS, PERIPHERAL
37225	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	375 ATHEROSCLEROSIS, PERIPHERAL

**Attachment C  
Placement of 2011 CPT Codes**

Code	Description	Line placement/recommendations for DMAP files
37226	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	375 ATHEROSCLEROSIS, PERIPHERAL
37227	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	375 ATHEROSCLEROSIS, PERIPHERAL
37228	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty	375 ATHEROSCLEROSIS, PERIPHERAL
37229	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	375 ATHEROSCLEROSIS, PERIPHERAL
37230	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	375 ATHEROSCLEROSIS, PERIPHERAL
37231	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	375 ATHEROSCLEROSIS, PERIPHERAL
37232	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)	375 ATHEROSCLEROSIS, PERIPHERAL
37233	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	375 ATHEROSCLEROSIS, PERIPHERAL
37234	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	375 ATHEROSCLEROSIS, PERIPHERAL
37235	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	375 ATHEROSCLEROSIS, PERIPHERAL
38900	Intraoperative identification (eg, mapping) of sentinel lymph node(s) includes injection of non-radioactive dye, when performed (List separately in addition to code for primary procedure)	DMAP Diagnostic File
43283	Laparoscopy, surgical, esophageal lengthening procedure (eg, Collis gastroplasty or wedge gastroplasty) (List separately in addition to code for primary procedure)	70 CONGENITAL ANOMALIES OF UPPER ALIMENTARY TRACT, EXCLUDING TONGUE
43327	Esophagogastric fundoplasty partial or complete; laparotomy	61 ULCERS, GASTRITIS, DUODENITIS, AND GI HEMORRHAGE 70 CONGENITAL ANOMALIES OF UPPER ALIMENTARY TRACT, EXCLUDING TONGUE 408 ESOPHAGITIS; ESOPHAGEAL AND INTRAESOPHAGEAL HERNIAS 416 ACHALASIA, NON-NEONATAL

**Attachment C  
Placement of 2011 CPT Codes**

Code	Description	Line placement/recommendations for DMAP files
43328	Esophagogastric fundoplasty partial or complete; thoracotomy	61 ULCERS, GASTRITIS, DUODENITIS, AND GI HEMORRHAGE 70 CONGENITAL ANOMALIES OF UPPER ALIMENTARY TRACT, EXCLUDING TONGUE 408 ESOPHAGITIS; ESOPHAGEAL AND INTRAESOPHAGEAL HERNIAS 416 ACHALASIA, NON-NEONATAL
43332	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis	408 ESOPHAGITIS; ESOPHAGEAL AND INTRAESOPHAGEAL HERNIAS
43333	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; with implantation of mesh or other prosthesis	408 ESOPHAGITIS; ESOPHAGEAL AND INTRAESOPHAGEAL HERNIAS
43334	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; without implantation of mesh or other prosthesis	408 ESOPHAGITIS; ESOPHAGEAL AND INTRAESOPHAGEAL HERNIAS
43335	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; with implantation of mesh or other prosthesis	408 ESOPHAGITIS; ESOPHAGEAL AND INTRAESOPHAGEAL HERNIAS
43336	Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; without implantation of mesh or other prosthesis	408 ESOPHAGITIS; ESOPHAGEAL AND INTRAESOPHAGEAL HERNIAS
43337	Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; with implantation of mesh or other prosthesis	408 ESOPHAGITIS; ESOPHAGEAL AND INTRAESOPHAGEAL HERNIAS
43338	Esophageal lengthening procedure (eg, Collis gastroplasty or wedge gastroplasty) (List separately in addition to code for primary procedure)	70 CONGENITAL ANOMALIES OF UPPER ALIMENTARY TRACT, EXCLUDING TONGUE
43753	Gastric intubation and aspiration(s) therapeutic, necessitating physician's skill (eg, for gastrointestinal hemorrhage), including lavage if performed	DMAP Exempt File
43754	Gastric intubation and aspiration, diagnostic; single specimen (eg, acid analysis)	DMAP Diagnostic File
43755	Gastric intubation and aspiration, diagnostic; collection of multiple fractional specimens with gastric stimulation, single or double lumen tube (gastric secretory study) (eg, histamine, insulin, pentagastrin, calcium, secretin), includes drug administration	DMAP Diagnostic File
43756	Duodenal intubation and aspiration, diagnostic, includes image guidance; single specimen (eg, bile study for crystals or afferent loop culture)	DMAP Diagnostic File
43757	Duodenal intubation and aspiration, diagnostic, includes image guidance; collection of multiple fractional specimens with pancreatic or gallbladder stimulation, single or double lumen tube, includes drug administration	DMAP Diagnostic File

**Attachment C**  
**Placement of 2011 CPT Codes**

Code	Description	Line placement/recommendations for DMAP files
49327	Laparoscopy, surgical; with placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), intra-abdominal, intrapelvic, and/or retroperitoneum, including imaging guidance, if performed, single or multiple (List separately in addition to code for primary procedure)	123 CANCER OF TESTIS 144 CANCER OF CERVIX 159 CHORIOCARCINOMA 219 CANCER OF UTERUS 230 CANCER OF STOMACH 252 CANCER OF OVARY 275 CANCER OF PENIS AND OTHER MALE GENITAL ORGANS 277 CANCER OF RETROPERITONEUM, PERITONEUM, OMENTUM AND MESENTERY 286 CANCER OF BLADDER AND URETER 310 CANCER OF VAGINA, VULVA AND OTHER FEMALE GENITAL ORGANS 339 CANCER OF PANCREAS 354 CANCER OF PROSTATE GLAND 452 CANCER OF GALLBLADDER AND OTHER BILIARY
49412	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), open, intra-abdominal, intrapelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure)	123 CANCER OF TESTIS 144 CANCER OF CERVIX 159 CHORIOCARCINOMA 219 CANCER OF UTERUS 230 CANCER OF STOMACH 252 CANCER OF OVARY 275 CANCER OF PENIS AND OTHER MALE GENITAL ORGANS 277 CANCER OF RETROPERITONEUM, PERITONEUM, OMENTUM AND MESENTERY 286 CANCER OF BLADDER AND URETER 310 CANCER OF VAGINA, VULVA AND OTHER FEMALE GENITAL ORGANS 339 CANCER OF PANCREAS 354 CANCER OF PROSTATE GLAND 452 CANCER OF GALLBLADDER AND OTHER BILIARY
49418	Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous	DMAP Ancillary Codes File
53860	Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence	DMAP Excluded File
57156	Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy	144 CANCER OF CERVIX 167 CANCER OF COLON, RECTUM, SMALL INTESTINE AND ANUS 219 CANCER OF UTERUS 252 CANCER OF OVARY 286 CANCER OF BLADDER AND URETER 310 CANCER OF VAGINA, VULVA AND OTHER FEMALE GENITAL ORGANS
61781	Stereotactic computer-assisted (navigational) procedure; cranial, intradural (List separately in addition to code for primary procedure)	137 BENIGN NEOPLASM OF THE BRAIN 162 BENIGN NEOPLASM OF PITUITARY GLAND 201 SUBARACHNOID AND INTRACEREBRAL HEMORRHAGE/HEMATOMA; COMPRESSION OF BRAIN 266 PARKINSON'S DISEASE 319 CANCER OF BRAIN AND NERVOUS SYSTEM 340 STROKE 358 BENIGN CEREBRAL CYSTS
61782	Stereotactic computer-assisted (navigational) procedure; cranial, extradural (List separately in addition to code for primary procedure)	137 BENIGN NEOPLASM OF THE BRAIN 162 BENIGN NEOPLASM OF PITUITARY GLAND 201 SUBARACHNOID AND INTRACEREBRAL HEMORRHAGE/HEMATOMA; COMPRESSION OF BRAIN 266 PARKINSON'S DISEASE 319 CANCER OF BRAIN AND NERVOUS SYSTEM 340 STROKE 358 BENIGN CEREBRAL CYSTS

**Attachment C  
Placement of 2011 CPT Codes**

Code	Description	Line placement/recommendations for DMAP files
61783	Stereotactic computer-assisted (navigational) procedure; spinal (List separately in addition to code for primary procedure)	201 SUBARACHNOID AND INTRACEREBRAL HEMORRHAGE/HEMATOMA; COMPRESSION OF BRAIN 319 CANCER OF BRAIN AND NERVOUS SYSTEM
64566	Ferior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming	DMAP Excluded File
64568	Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	182 GENERALIZED CONVULSIVE OR PARTIAL EPILEPSY WITHOUT MENTION OF IMPAIRMENT OF CONSCIOUSNESS 459 TRIGEMINAL AND OTHER NERVE DISORDERS
64569	Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator	182 GENERALIZED CONVULSIVE OR PARTIAL EPILEPSY WITHOUT MENTION OF IMPAIRMENT OF CONSCIOUSNESS 307 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT 459 TRIGEMINAL AND OTHER NERVE DISORDERS
64570	Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	182 GENERALIZED CONVULSIVE OR PARTIAL EPILEPSY WITHOUT MENTION OF IMPAIRMENT OF CONSCIOUSNESS 307 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT 459 TRIGEMINAL AND OTHER NERVE DISORDERS
64611	Chemodenervation of parotid and submandibular salivary glands, bilateral	518 SIALOLITHIASIS, MUOCOCELE, DISTURBANCE OF SALIVARY SECRETION, OTHER AND UNSPECIFIED DISEASES OF SALIVARY GLANDS
65778	Placement of amniotic membrane on the ocular surface for wound healing; self-retaining	63 BURN FULL THICKNESS GREATER THAN 10% OF BODY SURFACE 224 BULLOUS DERMATOSES OF THE SKIN 226 TOXIC EPIDERMAL NECROLYSIS AND STAPHYLOCOCCAL SCALDED SKIN SYNDROME; STEVENS-JOHNSON SYNDROME; ERYTHEMA MULTIFORME MAJOR; ECZEMA HERPETICUM 259 CORNEAL ULCER; SUPERFICIAL INJURY OF EYE AND ADNEXA 335 CORNEAL OPACITY AND OTHER DISORDERS OF CORNEA 394 AMBLYOPIA 445 STRABISMUS WITHOUT AMBLYOPIA AND OTHER DISORDERS OF BINOCULAR EYE MOVEMENTS; CONGENITAL ANOMALIES OF EYE 593 ERYTHEMA MULTIFORME MINOR
65779	Placement of amniotic membrane on the ocular surface for wound healing; single layer, sutured	63 BURN FULL THICKNESS GREATER THAN 10% OF BODY SURFACE 224 BULLOUS DERMATOSES OF THE SKIN 226 TOXIC EPIDERMAL NECROLYSIS AND STAPHYLOCOCCAL SCALDED SKIN SYNDROME; STEVENS-JOHNSON SYNDROME; ERYTHEMA MULTIFORME MAJOR; ECZEMA HERPETICUM 259 CORNEAL ULCER; SUPERFICIAL INJURY OF EYE AND ADNEXA 335 CORNEAL OPACITY AND OTHER DISORDERS OF CORNEA 394 AMBLYOPIA 445 STRABISMUS WITHOUT AMBLYOPIA AND OTHER DISORDERS OF BINOCULAR EYE MOVEMENTS; CONGENITAL ANOMALIES OF EYE 593 ERYTHEMA MULTIFORME MINOR
66174	Transluminal dilation of aqueous outflow canal; without retention of device or stent	DMAP Excluded File
66175	Transluminal dilation of aqueous outflow canal; with retention of device or stent	DMAP Excluded File
74176	Computed tomography, abdomen and pelvis; without contrast material	DMAP Diagnostic File

**Attachment C  
Placement of 2011 CPT Codes**

Code	Description	Line placement/recommendations for DMAP files
74177	Computed tomography, abdomen and pelvis; with contrast material(s)	DMAP Diagnostic File
74178	Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions	DMAP Diagnostic File
76881	Ultrasound, extremity, nonvascular, real-time with image documentation; complete	DMAP Diagnostic File
76882	Ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific	DMAP Diagnostic File
80104	Drug screen, qualitative; multiple drug classes other than chromatographic method, each procedure	DMAP Diagnostic File
82930	Gastric acid analysis, includes pH if performed, each specimen	DMAP Diagnostic File
83861	Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolarity	DMAP Excluded File
84112	Placental alpha microglobulin-1 (PAMG-1), cervicovaginal secretion, qualitative	DMAP Diagnostic File
85598	Phospholipid neutralization; hexagonal phospholipid	DMAP Diagnostic File
86481	Tuberculosis test, cell mediated immunity antigen response measurement; enumeration of gamma interferon-producing T-cells in cell suspension	DMAP Diagnostic File
86902	Blood typing; antigen testing of donor blood using reagent serum, each antigen test	DMAP Diagnostic File
87501	Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, reverse transcription and amplified probe technique, each type or subtype	DMAP Diagnostic File
87502	Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, for multiple types or subtypes, reverse transcription and amplified probe technique, first 2 types or sub-types	DMAP Diagnostic File
87503	Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, for multiple types or subtypes, multiplex reverse transcription and amplified probe technique, each additional influenza virus type or sub-type beyond 2 (List separately in addition to code for primary procedure)	DMAP Diagnostic File
87906	Infectious agent genotype analysis by nucleic acid (DNA or RNA); HIV-1, other region (eg, integrase, fusion)	DMAP Diagnostic File
88120	Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual	286 CANCER OF BLADDER AND URETER
88121	Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology	286 CANCER OF BLADDER AND URETER
88177	Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, each separate additional evaluation episode, same site (List separately in addition to code for primary procedure)	DMAP Diagnostic File
88363	Examination and selection of retrieved archival (ie, previously diagnosed) tissue(s) for molecular analysis (eg, KRAS mutational analysis)	DMAP Diagnostic File
88749	Unlisted in vivo (eg, transcutaneous) laboratory service	DMAP Excluded File

**Attachment C  
Placement of 2011 CPT Codes**

Code	Description	Line placement/recommendations for DMAP files
90460	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component	3 PREVENTIVE SERVICES, BIRTH TO 10 YEARS OF AGE 4 PREVENTIVE SERVICES, OVER AGE OF 10
90461	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine/toxoid component (List separately in addition to code for primary procedure)	3 PREVENTIVE SERVICES, BIRTH TO 10 YEARS OF AGE 4 PREVENTIVE SERVICES, OVER AGE OF 10
90470	H1N1 immunization administration (intramuscular, intranasal), including counseling when performed	3 PREVENTIVE SERVICES, BIRTH TO 10 YEARS OF AGE 4 PREVENTIVE SERVICES, OVER AGE OF 10
90644	Meningococcal conjugate vaccine, serogroups C & Y and Hemophilus influenza B vaccine, tetanus toxoid conjugate (Hib-MenCY-TT), 4 dose schedule, when administered to children 2-15 months of age, for intramuscular use	3 PREVENTIVE SERVICES, BIRTH TO 10 YEARS OF AGE
90664	Influenza virus vaccine, pandemic formulation, live, for intranasal use	3 PREVENTIVE SERVICES, BIRTH TO 10 YEARS OF AGE 4 PREVENTIVE SERVICES, OVER AGE OF 10
90666	Influenza virus vaccine, pandemic formulation, split virus, preservative free, for intramuscular use	3 PREVENTIVE SERVICES, BIRTH TO 10 YEARS OF AGE 4 PREVENTIVE SERVICES, OVER AGE OF 10
90667	Influenza virus vaccine, pandemic formulation, split virus, adjuvanted, for intramuscular use	3 PREVENTIVE SERVICES, BIRTH TO 10 YEARS OF AGE 4 PREVENTIVE SERVICES, OVER AGE OF 10
90668	Influenza virus vaccine, pandemic formulation, split virus, for intramuscular use	3 PREVENTIVE SERVICES, BIRTH TO 10 YEARS OF AGE 4 PREVENTIVE SERVICES, OVER AGE OF 10
90867	Therapeutic repetitive transcranial magnetic stimulation treatment; planning	DMAP Excluded File
90868	Therapeutic repetitive transcranial magnetic stimulation treatment; delivery and management, per session	DMAP Excluded File
91013	Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report; with stimulation or perfusion during 2-dimensional data study (eg, stimulant, acid or alkali perfusion) (List separately in addition to code for primary procedure)	DMAP Excluded File(A)
91117	Colon motility (manometric) study, minimum 6 hours continuous recording (including provocation tests, eg, meal, intracolonic balloon distension, pharmacologic agents, if performed), with interpretation and report	DMAP Excluded File
92132	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral	All vision lines: 106,124,130,149,164,174,258,259,263,282,285,298,320,321,323,333,335,342,343,360,361,363,371,378,389,390,394,401,423,445,454,458,465,467,468,476,487,489,506,515,519,573,578,585,614,638,643,644,650
92133	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve	All vision lines: 106,124,130,149,164,174,258,259,263,282,285,298,320,321,323,333,335,342,343,360,361,363,371,378,389,390,394,401,423,445,454,458,465,467,468,476,487,489,506,515,519,573,578,585,614,638,643,644,650
92134	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina	All vision lines: 106,124,130,149,164,174,258,259,263,282,285,298,320,321,323,333,335,342,343,360,361,363,371,378,389,390,394,401,423,445,454,458,465,467,468,476,487,489,506,515,519,573,578,585,614,638,643,644,650

**Attachment C  
Placement of 2011 CPT Codes**

Code	Description	Line placement/recommendations for DMAP files
92227	Remote imaging for detection of retinal disease (eg, retinopathy in a patient with diabetes) with analysis and report under physician supervision, unilateral or bilateral	10 TYPE I DIABETES MELLITUS 33 TYPE II DIABETES MELLITUS 106 DIABETIC AND OTHER RETINOPATHY
92228	Remote imaging for monitoring and management of active retinal disease (eg, diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral	106 DIABETIC AND OTHER RETINOPATHY
93451	Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed	DMAP Diagnostic File
93452	Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed	DMAP Diagnostic File
93453	Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed	DMAP Diagnostic File
93454	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation;	DMAP Diagnostic File
93455	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial venous grafts) including intraprocedural injection(s) for bypass graft angiography	DMAP Diagnostic File
93456	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization	DMAP Diagnostic File
93457	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization	DMAP Diagnostic File
93458	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	DMAP Diagnostic File
93459	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	DMAP Diagnostic File

**Attachment C  
Placement of 2011 CPT Codes**

Code	Description	Line placement/recommendations for DMAP files
93460	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	DMAP Diagnostic File
93461	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	DMAP Diagnostic File
93462	Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure)	DMAP Diagnostic File
93463	Pharmacologic agent administration (eg, inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) including assessing hemodynamic measurements before, during, after and repeat pharmacologic agent administration, when performed (List separately in addition to code for primary procedure)	DMAP Diagnostic File
93464	Physiologic exercise study (eg, bicycle or arm ergometry) including assessing hemodynamic measurements before and after (List separately in addition to code for primary procedure)	DMAP Diagnostic File
93563	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization (List separately in addition to code for primary procedure)	DMAP Diagnostic File
93564	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective opacification of aortocoronary venous or arterial bypass graft(s) (eg, aortocoronary saphenous vein, free radial artery, or free mammary artery graft) to one or more coronary arteries and in situ arterial conduits (eg, internal mammary), whether native or used for bypass to one or more coronary arteries during congenital heart catheterization, when performed (List separately in addition to code for primary procedure)	DMAP Diagnostic File
93565	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective left ventricular or left atrial angiography (List separately in addition to code for primary procedure)	DMAP Diagnostic File
93566	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective right ventricular or right atrial angiography (List separately in addition to code for primary procedure)	DMAP Diagnostic File
93567	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for supraaortic aortography (List separately in addition to code for primary procedure)	DMAP Diagnostic File

**Attachment C  
Placement of 2011 CPT Codes**

Code	Description	Line placement/recommendations for DMAP files
93568	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for pulmonary angiography (List separately in addition to code for primary procedure)	DMAP Diagnostic File
95800	Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time	DMAP Diagnostic File
95801	Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (eg, by airflow or peripheral arterial tone)	DMAP Diagnostic File
96446	Chemotherapy administration into the peritoneal cavity via indwelling port or catheter	All Cancer lines 101,123,144,159,166,167,181,197,207,208,219,221,222,229,230,243,249,252,275-278,286,291,309-311,319,337-339,354,452,612
99224	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: Problem focused interval history; Problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.	All Lines with hospital Evaluation and Management codes 1-5,7,9-21,23-49,52-58,60-84,86-90,92-101,106-109,111-124,126-130,132,134-168,171,174-176,178-181,183-195,197,199-205,207-209,211-222,224-231,233-246,248-252,256-268,271,273-279,281-296,298-312,314-320,322-331,333-343,345-347,349-355,359-366,368-370,372-376,378-386,388,391-394,397,399,401-407,409-411,413-437,439-448,451-454,456,458-460,462,464-470,472,475-477,480,481,483-489,491-497,500-503,506-509,511,514,517-521,523-529,531-537,539-547,549-558,560-564,566-569,571-573,575,577,578,580,581,584-596,598,599,601,602,604-615,617,618,620,623-628,631-642,644,645,647,648,650-658,661,662,664,666,667,669-679
99225	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.	All Lines with hospital Evaluation and Management codes 1-5,7,9-21,23-49,52-58,60-84,86-90,92-101,106-109,111-124,126-130,132,134-168,171,174-176,178-181,183-195,197,199-205,207-209,211-222,224-231,233-246,248-252,256-268,271,273-279,281-296,298-312,314-320,322-331,333-343,345-347,349-355,359-366,368-370,372-376,378-386,388,391-394,397,399,401-407,409-411,413-437,439-448,451-454,456,458-460,462,464-470,472,475-477,480,481,483-489,491-497,500-503,506-509,511,514,517-521,523-529,531-537,539-547,549-558,560-564,566-569,571-573,575,577,578,580,581,584-596,598,599,601,602,604-615,617,618,620,623-628,631-642,644,645,647,648,650-658,661,662,664,666,667,669-679
99226	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.	All Lines with hospital Evaluation and Management codes 1-5,7,9-21,23-49,52-58,60-84,86-90,92-101,106-109,111-124,126-130,132,134-168,171,174-176,178-181,183-195,197,199-205,207-209,211-222,224-231,233-246,248-252,256-268,271,273-279,281-296,298-312,314-320,322-331,333-343,345-347,349-355,359-366,368-370,372-376,378-386,388,391-394,397,399,401-407,409-411,413-437,439-448,451-454,456,458-460,462,464-470,472,475-477,480,481,483-489,491-497,500-503,506-509,511,514,517-521,523-529,531-537,539-547,549-558,560-564,566-569,571-573,575,577,578,580,581,584-596,598,599,601,602,604-615,617,618,620,623-628,631-642,644,645,647,648,650-658,661,662,664,666,667,669-679

**2011 HCPCS & CDT Codes  
Attachment D**

Code	Description	Line placement/recommendations for DMAP files
A6200	COMPOSITE DRESSING, PAD SIZE 16 SQ. IN. OR LESS, WITHOUT ADHESIVE BORDER, EACH DRESSING	DMAP Ancillary Codes File
A6201	COMPOSITE DRESSING, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING	DMAP Ancillary Codes File
A6202	COMPOSITE DRESSING, PAD SIZE MORE THAN 48 SQ. IN., WITHOUT ADHESIVE BORDER, EACH DRESSING	DMAP Ancillary Codes File
A6542	GRADIENT COMPRESSION STOCKING, CUSTOM MADE	DMAP Ancillary Codes File
A6543	GRADIENT COMPRESSION STOCKING, LYMPHEDEMA	DMAP Ancillary Codes File
A7020	INTERFACE FOR COUGH STIMULATING DEVICE, INCLUDES ALL COMPONENTS, REPLACEMENT ONLY	DMAP Ancillary Codes File
D1352	PREVENTIVE RESIN RESTORATION IN A MODERATE TO HIGH CARIES RISK PATIENT - PERMANENT TOOTH	DMAP Excluded File
D3354	PULPAL REGENERATION (COMPLETION OF REGENERATIVE TREATMENT IN AN IMMATURE PERMANENT TOOTH WITH A NECROTIC PULP); DOES NOT INCLUDE FINAL RESTORATION	498 DENTAL CONDITIONS (EG. SEVERE TOOTH DECAY)
D5992	ADJUST MAXILLOFACIAL PROSTHETIC APPLIANCE	77 NEUROLOGICAL DYSFUNCTION IN BREATHING, EATING, SWALLOWING, BOWEL, OR BLADDER CONTROL CAUSED BY CHRONIC CONDITIONS 208 CANCER OF BONES 273 DEFORMITIES OF HEAD 324 CLEFT PALATE AND/OR CLEFT LIP 506 ENOPHTHALMOS 621 CONGENITAL ANOMALIES OF THE EAR WITHOUT IMPAIRMENT OF HEARING; UNILATERAL ANOMALIES OF THE EAR
D5993	MAINTENANCE AND CLEANING OF A MAXILLOFACIAL PROSTHESIS (EXTRA OR INTRAORAL) OTHER THAN REQUIRED ADJUSTMENTS, BY REPORT	77 NEUROLOGICAL DYSFUNCTION IN BREATHING, EATING, SWALLOWING, BOWEL, OR BLADDER CONTROL CAUSED BY CHRONIC CONDITIONS 208 CANCER OF BONES 273 DEFORMITIES OF HEAD 324 CLEFT PALATE AND/OR CLEFT LIP 506 ENOPHTHALMOS 621 CONGENITAL ANOMALIES OF THE EAR WITHOUT IMPAIRMENT OF HEARING; UNILATERAL ANOMALIES OF THE EAR
D6254	INTERIM PONTIC	DMAP Excluded File
D6795	INTERIM RETAINER CROWN	DMAP Excluded File
D7251	CORONECTOMY - INTENTIONAL PARTIAL TOOTH REMOVAL	59 DENTAL CONDITIONS (EG. INFECTIONS)
D7295	HARVEST OF BONE FOR USE IN AUTOGENOUS GRAFTING PROCEDURE	DMAP Excluded File

**2011 HCPCS & CDT Codes  
Attachment D**

Code	Description	Line placement/recommendations for DMAP files
G0157	SERVICES PERFORMED BY A QUALIFIED PHYSICAL THERAPIST ASSISTANT IN THE HOME HEALTH OR HOSPICE SETTING, EACH 15 MINUTES	All lines containing therapy codes 12,50-52,63,73-75,77,79,84,88,89,93,94,97- 100,108,109,115,116,122,129,139,141- 143,145,146,158,161,165,179,184,185,189,190,192,194, 195,201,202,208,217,227,237,239,270,271,273,274,279, 287,288,292,296,301,303,306- 308,317,334,340,347,348,362,366,368,372,373,375,379, 381,382,384,397,403,404,428,434,436,440,448,460,480, 497,508,539,551,569,587,610,627
G0158	SERVICES PERFORMED BY A QUALIFIED OCCUPATIONAL THERAPIST ASSISTANT IN THE HOME HEALTH OR HOSPICE SETTING, EACH 15 MINUTES	All lines containing therapy codes 12,50-52,63,73-75,77,79,84,88,89,93,94,97- 100,108,109,115,116,122,129,139,141- 143,145,146,158,161,165,179,184,185,189,190,192,194, 195,201,202,208,217,227,237,239,270,271,273,274,279, 287,288,292,296,301,303,306- 308,317,334,340,347,348,362,366,368,372,373,375,379, 381,382,384,397,403,404,428,434,436,440,448,460,480, 497,508,539,551,569,587,610,627
G0159	SERVICES PERFORMED BY A QUALIFIED PHYSICAL THERAPIST, IN THE HOME HEALTH SETTING, IN THE ESTABLISHMENT OR DELIVERY OF A SAFE AND EFFECTIVE THERAPY MAINTENANCE PROGRAM, EACH 15 MINUTES	All lines containing therapy codes 12,50-52,63,73-75,77,79,84,88,89,93,94,97- 100,108,109,115,116,122,129,139,141- 143,145,146,158,161,165,179,184,185,189,190,192,194, 195,201,202,208,217,227,237,239,270,271,273,274,279, 287,288,292,296,301,303,306- 308,317,334,340,347,348,362,366,368,372,373,375,379, 381,382,384,397,403,404,428,434,436,440,448,460,480, 497,508,539,551,569,587,610,627
G0160	SERVICES PERFORMED BY A QUALIFIED OCCUPATIONAL THERAPIST, IN THE HOME HEALTH SETTING, IN THE ESTABLISHMENT OR DELIVERY OF A SAFE AND EFFECTIVE THERAPY MAINTENANCE PROGRAM, EACH 15 MINUTES	All lines containing therapy codes 12,50-52,63,73-75,77,79,84,88,89,93,94,97- 100,108,109,115,116,122,129,139,141- 143,145,146,158,161,165,179,184,185,189,190,192,194, 195,201,202,208,217,227,237,239,270,271,273,274,279, 287,288,292,296,301,303,306- 308,317,334,340,347,348,362,366,368,372,373,375,379, 381,382,384,397,403,404,428,434,436,440,448,460,480, 497,508,539,551,569,587,610,627
G0161	SERVICES PERFORMED BY A QUALIFIED SPEECH-LANGUAGE PATHOLOGIST, IN THE HOME HEALTH SETTING, IN THE ESTABLISHMENT OR DELIVERY OF A SAFE AND EFFECTIVE THERAPY MAINTENANCE PROGRAM, EACH 15 MINUTES	All lines containing therapy codes 12,50-52,63,73-75,77,79,84,88,89,93,94,97- 100,108,109,115,116,122,129,139,141- 143,145,146,158,161,165,179,184,185,189,190,192,194, 195,201,202,208,217,227,237,239,270,271,273,274,279, 287,288,292,296,301,303,306- 308,317,334,340,347,348,362,366,368,372,373,375,379, 381,382,384,397,403,404,428,434,436,440,448,460,480, 497,508,539,551,569,587,610,627
G0162	SKILLED SERVICES BY A REGISTERED NURSE (RN) IN THE DELIVERY OF MANAGEMENT & EVALUATION OF THE PLAN OF CARE; EACH 15 MINUTES (THE PATIENT'S UNDERLYING CONDITION OR COMPLICATION REQUIRES AN RN TO ENSURE THAT ESSENTIAL NON-SKILLED CARE ACHIEVE ITS PURPOSE IN	DMAP Ancillary Codes File
G0163	SKILLED SERVICES OF A LICENSED NURSE (LPN OR RN) IN THE DELIVERY OF OBSERVATION & ASSESSMENT OF THE PATIENT'S CONDITION, EACH 15 MINUTES (WHEN THE LIKELIHOOD OF CHANGE IN THE PATIENT'S CONDITION REQUIRES SKILLED NURSING PERSONNEL TO IDENTIFY AND EVALUATE	DMAP Ancillary Codes File
G0164	SKILLED SERVICES OF A LICENSED NURSE, IN THE TRAINING AND/OR EDUCATION OF A PATIENT OR FAMILY MEMBER, IN THE HOME HEALTH OR HOSPICE SETTING, EACH 15 MINUTES	DMAP Ancillary Codes File

**2011 HCPCS & CDT Codes  
Attachment D**

Code	Description	Line placement/recommendations for DMAP files
G0428	COLLAGEN MENISCUS IMPLANT PROCEDURE FOR FILLING MENISCAL DEFECTS (E.G., CMI, COLLAGEN SCAFFOLD, MENAFLEX)	DMAP Excluded File
G0429	DERMAL FILLER INJECTION(S) FOR THE TREATMENT OF FACIAL LIPODYSTROPHY SYNDROME (LDS) (E.G., AS A RESULT OF HIGHLY ACTIVE ANTIRETROVIRAL THERAPY)	675 DERMATOLOGICAL CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY
G0432	INFECTIOUS AGENT ANTIBODY DETECTION BY ENZYME IMMUNOASSAY (EIA) TECHNIQUE, HIV-1 AND/OR HIV-2, SCREENING	DMAP Diagnostic File
G0433	INFECTIOUS AGENT ANTIBODY DETECTION BY ENZYME-LINKED IMMUNOSORBENT ASSAY (ELISA) TECHNIQUE, HIV-1 AND/OR HIV-2, SCREENING	DMAP Diagnostic File
G0434	DRUG SCREEN, OTHER THAN CHROMATOGRAPHIC; ANY NUMBER OF DRUG CLASSES, BY CLIA WAIVED TEST OR MODERATE COMPLEXITY TEST, PER PATIENT ENCOUNTER	DMAP Diagnostic File
G0435	INFECTIOUS AGENT ANTIBODY DETECTION BY RAPID ANTIBODY TEST, HIV-1 AND/OR HIV-2, SCREENING	DMAP Diagnostic File
G0436	SMOKING AND TOBACCO CESSATION COUNSELING VISIT FOR THE ASYMPTOMATIC PATIENT; INTERMEDIATE, GREATER THAN 3 MINUTES, UP TO 10 MINUTES	6 TOBACCO DEPENDENCE
G0437	SMOKING AND TOBACCO CESSATION COUNSELING VISIT FOR THE ASYMPTOMATIC PATIENT; INTENSIVE, GREATER THAN 10 MINUTES	6 TOBACCO DEPENDENCE
G0438	ANNUAL WELLNESS VISIT; INCLUDES A PERSONALIZED PREVENTION PLAN OF SERVICE (PPS), INITIAL VISIT	3 PREVENTIVE SERVICES, BIRTH TO 10 YEARS OF AGE 4 PREVENTIVE SERVICES, OVER AGE OF 10
G0439	ANNUAL WELLNESS VISIT, INCLUDES A PERSONALIZED PREVENTION PLAN OF SERVICE (PPS), SUBSEQUENT VISIT	3 PREVENTIVE SERVICES, BIRTH TO 10 YEARS OF AGE 4 PREVENTIVE SERVICES, OVER AGE OF 10
G0440	APPLICATION OF TISSUE CULTURED ALLOGENEIC SKIN SUBSTITUTE OR DERMAL SUBSTITUTE; FOR USE ON LOWER LIMB, INCLUDES THE SITE PREPARATION AND DEBRIDEMENT IF PERFORMED; FIRST 25 SQ CM OR LESS	63 BURN FULL THICKNESS GREATER THAN 10% OF BODY SURFACE 79 BURN, PARTIAL THICKNESS GREATER THAN 30% OF BODY SURFACE OR WITH VITAL SITE; FULL THICKNESS WITH VITAL SITE, LESS THAN 10% OF BODY SURFACE 95 CONGENITAL ANOMALIES OF URINARY SYSTEM 142 CRUSH INJURIES OTHER THAN DIGITS; COMPARTMENT SYNDROME 187 CONDITIONS INVOLVING EXPOSURE TO NATURAL ELEMENTS (EG. LIGHTNING STRIKE, HEATSTROKE) 202 BURN, PARTIAL THICKNESS WITHOUT VITAL SITE, 10-30% OF BODY SURFACE 207 CANCER OF SOFT TISSUE 217 DEEP OPEN WOUND, WITH OR WITHOUT TENDON OR NERVE INVOLVEMENT 243 MALIGNANT MELANOMA OF SKIN 291 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA 407 CHRONIC ULCER OF SKIN 424 BILATERAL ANOMALIES OF EXTERNAL EAR WITH IMPAIRMENT OF HEARING 440 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT

**2011 HCPCS & CDT Codes  
Attachment D**

Code	Description	Line placement/recommendations for DMAP files
G0441	APPLICATION OF TISSUE CULTURED ALLOGENEIC SKIN SUBSTITUTE OR DERMAL SUBSTITUTE; FOR USE ON LOWER LIMB, INCLUDES THE SITE PREPARATION AND DEBRIDEMENT IF PERFORMED; EACH ADDITIONAL 25 SQ CM	63 BURN FULL THICKNESS GREATER THAN 10% OF BODY SURFACE 79 BURN, PARTIAL THICKNESS GREATER THAN 30% OF BODY SURFACE OR WITH VITAL SITE; FULL THICKNESS WITH VITAL SITE, LESS THAN 10% OF BODY SURFACE 95 CONGENITAL ANOMALIES OF URINARY SYSTEM 142 CRUSH INJURIES OTHER THAN DIGITS; COMPARTMENT SYNDROME 187 CONDITIONS INVOLVING EXPOSURE TO NATURAL ELEMENTS (EG. LIGHTNING STRIKE, HEATSTROKE) 202 BURN, PARTIAL THICKNESS WITHOUT VITAL SITE, 10-30% OF BODY SURFACE 207 CANCER OF SOFT TISSUE 217 DEEP OPEN WOUND, WITH OR WITHOUT TENDON OR NERVE INVOLVEMENT 243 MALIGNANT MELANOMA OF SKIN 291 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA 407 CHRONIC ULCER OF SKIN 424 BILATERAL ANOMALIES OF EXTERNAL EAR WITH IMPAIRMENT OF HEARING 440 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
G9147	OUTPATIENT INTRAVENOUS INSULIN TREATMENT (OIVIT) EITHER PULSATILE OR CONTINUOUS, BY ANY MEANS, GUIDED BY THE RESULTS OF MEASUREMENTS FOR: RESPIRATORY QUOTIENT; AND/OR, URINE UREA NITROGEN (UUN); AND/OR, ARTERIAL, VENOUS OR CAPILLARY GLUCOSE; AND/OR POTASS	DMAP Excluded File

**Attachment E**  
**Guidelines Deleted or Replaced by Coding Specifications**

**~~GUIDELINE NOTE 29, MASTOCYTOSIS~~**

*~~Lines 222,675~~*

~~Mastocytosis limited to the skin resides on Line 676.~~

**Line: 222**  
Condition: NON-HODGKIN'S LYMPHOMAS (See Coding Specification Below) (See Guideline Notes 1,7,11,12,19,64,65,76)  
Treatment: MEDICAL THERAPY, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY  
ICD-9: 200,202.0-202.3,202.6-202.9,238.5-238.7  
CPT: 32553,38100,38120,38720,49080,49081,49411,77261-77295,77300-77321,77331-77370,77401-77431,77470,78811-78816,79005-79445,96150-96154,96405,96406,96420-96450,96542-96571,98966-98969,99051,99060,99070,99078,99201-99360,99366,99374,99375,99379-99444,99468-99480,99605-99607  
HCPCS: G0235,G0406-G0408,G0425-G0427,S0270-S0274,S9355,S9537

Malignant and systemic mastocytosis (202.3) are included on Line 222. Mastocytosis limited to the skin (757.3) resides on Line 675.

**~~GUIDELINE NOTE 69, INTESTINAL MALABSORPTION~~**

*~~Line 241~~*

~~ICD-9 code 579.8 (Other specified intestinal malabsorption) is included on this line only for chronic steatorrhea, exudative enteropathy, and protein-losing enteropathy.~~

**Line: 241**  
Condition: INTESTINAL MALABSORPTION (See Coding Specification Below) (See Guideline Notes 64,65)  
Treatment: MEDICAL THERAPY  
ICD-9: 040.2,579.0-579.8  
CPT: 97802-97804,98966-98969,99051,99060,99070,99078,99201-99360,99366,99374,99375,99379-99444,99468-99480,99605-99607  
HCPCS: G0406-G0408,G0425-G0427,S0270-S0274

ICD-9 code 579.8 (Other specified intestinal malabsorption) is included on this line only for chronic steatorrhea, exudative enteropathy, and protein-losing enteropathy.

**~~GUIDELINE NOTE 84, PAROTID GLAND PLEOMORPHIC ADENOMA~~**

*~~Line 311~~*

~~ICD-9 code 210.2 is only covered on this line for parotid gland pleomorphic adenomas.~~

**Line: 311**  
Condition: CANCER OF ORAL CAVITY, PHARYNX, NOSE AND LARYNX (See Coding Specification Below) (See Guideline Notes 1,7,11,12,19,64,65,76)  
Treatment: MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY  
ICD-9: 140-149,160-161,196.3,210.2,231.0,231.8,235.0-235.1,235.6,235.9  
CPT: 13132,13151,14040-14302,15570,15732,15734,15756-15760,21011-21014,21016,21552-21555,21557,21558,30117,30118,30520,31075-31230,31300,31360-31370,31380-31395,31540,31541,31600-31603,31611,31820,31825,32553,38720,38724,40500-40530,40810-40816,40819,40845,41019,41110-41155,41820,41825-41827,41850,42104-42120,42280,42281,42410-42500,42826,42842-42845,42890-42894,43450,43496,49411,60220,69110,69150,69155,69502,77014,77261-77295,77300-77370,77401-77470,77750-77790,78811-78816,79005-79445,92506-92508,92526,92607-92609,92633,96150-96154,96405,96406,96420-96450,96542-96571,98966-98969,99051,99060,99070,99078,99201-99360,99366,99374,99375,99379-99444,99468-99480,99605-99607  
HCPCS: D5983-D5985,D7440,D7441,D7920,D7981,G0235,G0406-G0408,G0425-G0427,S0270-S0274,S9152,S9537

ICD-9 code 210.2 is only covered on this line for parotid gland pleomorphic adenomas.

**Attachment E**  
**Guidelines Deleted or Replaced by Coding Specifications**

**Guideline deleted with Jan. 1, 2012 biennial review**

~~GUIDELINE NOTE 48, DENTAL SERVICES FOR SPACE MAINTENANCE AND PERIODONTAL MAINTENANCE~~

~~Line 473~~

~~By Report (D4240, D4260)~~

**Attachment F**  
**HSC January 13, 2011 Minutes**  
**Straightforward Issues**

**Straightforward Issues—October 2010**

<b>Code</b>	<b>Code Description</b>	<b>Line(s) Involved</b>	<b>Recommendation(s)</b>
784.52	Fluency disorder in conditions classified elsewhere (includes stuttering caused by conditions classified elsewhere).	372 NEUROLOGICAL DYSFUNCTION IN COMMUNICATION CAUSED BY CHRONIC CONDITIONS.	Remove 784.52 from Line 372  Recommend that DMAP place 784.52 on Excluded (Never Covered) File
T1007	Mental health service plan development by non-physician	5 Abuse Or Dependence Of Psychoactive Substance 67 Substance-Induced Delusional And Mood Disorders; Intoxication	Add T1007 to Lines 5 and 67
		469 URINARY INCONTINENCE	Line 469 contains CPT codes for PT services but is not included in Guideline Note 6, <b>REHABILITATIVE THERAPIES</b>  Add Line 469 to Guideline Note 6.
92610	Evaluation of oral and pharyngeal swallowing function		Advise DMAP to add 92610 and 92611 to the Diagnostic File and remove from the Ancillary File.
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording		
235.2	Neoplasm of uncertain behavior of stomach, intestines, and rectum	167 CANCER OF COLON, RECTUM, SMALL INTESTINE AND ANUS	Add 235.2 to Line 167
49203-49205	Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, various tumor sizes	167 CANCER OF COLON, RECTUM, SMALL INTESTINE AND ANUS	Add 49203-49205 to Line 167
43611	Excision, local; malignant tumor of stomach	230 CANCER OF STOMACH	Add 43611 to Line 230
44205	Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocolostomy	167 CANCER OF COLON, RECTUM, SMALL INTESTINE AND ANUS 654 BENIGN NEOPLASMS OF DIGESTIVE SYSTEM	Add 44205 to Lines 167 and 654
52354	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with biopsy and/or fulguration of ureteral or renal pelvic lesion	229 CANCER OF KIDNEY AND OTHER URINARY ORGANS	Add 52354 to Line 229  Recommend to DMAP to remove 52354 from the Diagnostic File.
61583	Craniofacial approach to anterior	208 CANCER OF BONES	Add 61583 to Line 319

**Attachment F**  
**HSC January 13, 2011 Minutes**  
**Straightforward Issues**

<b>Code</b>	<b>Code Description</b>	<b>Line(s) Involved</b>	<b>Recommendation(s)</b>
	cranial fossa; intradural, including unilateral or bifrontal craniotomy, elevation or resection of frontal lobe, osteotomy of base of anterior cranial fossa	319 CANCER OF BRAIN AND NERVOUS SYSTEM	
49203	Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas, 5 cm or less in diameter	111 CONGENITAL ANOMALIES OF DIGESTIVE SYSTEM AND ABDOMINAL WALL; CHRONIC INTESTINAL PSEUDO-OBSTRUCTION 166 HODGKIN'S DISEASE 207 CANCER OF SOFT TISSUE 219 CANCER OF UTERUS 252 CANCER OF OVARY 277 CANCER OF RETROPERITONEUM, PERITONEUM, OMENTUM AND MESENTERY 417 ENDOMETRIOSIS AND ADENOMYOSIS	Add 49203 to Lines 111, 166, 207, 219, 252, 277 and 417  Delete 49203 from Line 347
92235	Fluorescein angiography (includes multiframe imaging)	183 POLYARTERITIS NODOSA AND ALLIED CONDITIONS	Add 92235 to Line 183
42844	Radical resection of tonsil, tonsillar pillars, and/or retromolar trigone; with local flap (eg, tongue, buccal)	311 CANCER OF ORAL CAVITY, PHARYNX, NOSE AND LARYNX	Add 42844 to Line 311
49021	Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; percutaneous	83 DEEP ABSCESSSES, INCLUDING APPENDICITIS AND PERIORBITAL ABSCESS	Add 49021 to line 83
42890 42892 42894	Limited pharyngectomy 42892 Resection of lateral pharyngeal wall or PS, direct closure Resection of pharyngeal wall requiring closure with flap	83 DEEP ABSCESSSES, INCLUDING APPENDICITIS AND PERIORBITAL ABSCESS 311 CANCER OF ORAL CAVITY, PHARYNX, NOSE AND LARYNX	Add 42890-42894 to line 311
15620	Delay of flap or sectioning of flap, at forehead, cheeks, chin, neck, axillae, genitalia, hands or feet	165 TRAUMATIC AMPUTATION OF ARM(S), HAND(S), THUMB(S), AND FINGER(S) (COMPLETE)(PARTIAL) WITH AND WITHOUT COMPLICATION	Add 15620 to line 165
50780	Ureteroneocystostomy, anastomosis of single ureter to bladder	286 CANCER OF BLADDER AND URETER	Add 50780 to line 286
34203	Removal of leg artery clot	375 ATHEROSCLEROSIS,	Add 34203 to Line 375

**Attachment F**  
**HSC January 13, 2011 Minutes**  
**Straightforward Issues**

Code	Code Description	Line(s) Involved	Recommendation(s)
		PERIPHERAL	
58345	Transcervical introduction of fallopian tube catheter for diagnosis and/or re-establishing patency (any method), with or without hysterosalpingography	7 REPRODUCTIVE SERVICES	Remove 58345 from Line 7.  Keep 58345 on excluded (Never Covered) File  Remove reference to 58345 from Guideline Note 68 <b>HYSTEROSCOPIC BILATERAL FALLOPIAN TUBE OCCLUSION</b>
15220 15221	Full thickness skin graft, free, 20 sq cm or less Full thickness skin graft, free, each additional 20 sq cm	291 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA 407 CHRONIC ULCER OF SKIN	Add 15220 to Lines 291 and 407  Add 15221 to Line 407
14000	Adjacent tissue transfer or rearrangement, trunk, defect 10 sq cm or less	197 CANCER OF BREAST 217 DEEP OPEN WOUND, WITH OR WITHOUT TENDON OR NERVE INVOLVEMENT 307 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT 440 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT	Add 14000 to Lines 197, 217, 307 and 440.
77321	Special teletherapy port plan, particles, hemibody, total body	123 CANCER OF TESTIS 167 CANCER OF COLON, RECTUM, SMALL INTESTINE AND ANUS 197 CANCER OF BREAST 221 CANCER OF THYROID 230 CANCER OF STOMACH 275 CANCER OF PENIS AND OTHER MALE GENITAL ORGANS 278 CANCER OF LUNG, BRONCHUS, PLEURA, TRACHEA, MEDIASTINUM AND OTHER RESPIRATORY ORGANS 311 CANCER OF ORAL CAVITY, PHARYNX, NOSE AND LARYNX 319 CANCER OF BRAIN	Add 77321 to Lines 123, 167, 197, 221, 230, 275, 278, 311, 319, 337, 338, 339, 354, 452, and 611.

**Attachment F**  
**HSC January 13, 2011 Minutes**  
**Straightforward Issues**

Code	Code Description	Line(s) Involved	Recommendation(s)
		AND NERVOUS SYSTEM 337 CANCER OF ESOPHAGUS 338 CANCER OF LIVER 339 CANCER OF PANCREAS 354 CANCER OF PROSTATE GLAND 452 CANCER OF GALLBLADDER AND OTHER BILIARY 611 SECONDARY AND ILL-DEFINED MALIGNANT NEOPLASMS	
77418	Intensity modulated treatment delivery, single or multiple fields, arcs, via narrow spatially and temporally modulated beams, binary, dynamic	230 CANCER OF STOMACH 354 CANCER OF PROSTATE GLAND	Add 77418 to Lines 230 and 354 and remove recommend that DMAP remove this code from the diagnostic file.
77421	Stereoscopic X-ray guidance for localization of target volume for delivery of radiation therapy	354 CANCER OF PROSTATE GLAND	Add 77421 to Line 354
77431	Radiation therapy management with complete course of therapy consisting of 1 or 2 fractions only	222 NON-HODGKIN'S LYMPHOMAS	Add 77431 to Line 222
<b>Straightforward Issues, December 2010</b>			
603.9	Hydrocele, unspecified	175 COMPLICATED HERNIAS (OTHER THAN DIAPHRAGMATIC HERNIA); UNCOMPLICATED INGUINAL HERNIA IN CHILDREN AGE 18 AND UNDER; PERSISTENT HYDROCELE 176 NON-DIABETIC HYPOGLYCEMIC COMA	Add 603.9 to Line 175 Delete 603.9 from Line 176 Recommend to DMAP to remove 603.9 from the Exempt (Always Covered) File.
33010 33011	Pericardiocentesis, initial Pericardiocentesis, subsequent	89 MYOCARDITIS (NONVIRAL), PERICARDITIS (NONVIRAL) AND ENDOCARDITIS	Add 33010 to line 89
38720 38724	Radical cervical lymphadenectomy, (complete) Cervical lymphadenectomy, (modified radical neck dissection)	311 CANCER OF ORAL CAVITY, PHARYNX, NOSE AND LARYNX	Add 38720 to Line 311
15220	Full thickness graft	291 CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA	Add 15220 to Line 291
31528	Laryngoscopy, with dilation, initial	385 DYSTONIA (UNCONTROLLABLE); LARYNGEAL SPASM	Add 31528 to line 385

**Attachment F**  
**HSC January 13, 2011 Minutes**  
**Straightforward Issues**

Code	Code Description	Line(s) Involved	Recommendation(s)
		AND STENOSIS	
77421	Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy	144 CANCER OF CERVIX Treatment: MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY	Add 77421 to Line 144
77301	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specification	144 CANCER OF CERVIX 167 CANCER OF COLON, RECTUM, SMALL INTESTINE AND ANUS 286 CANCER OF BLADDER AND URETER	Add 77301 to Lines 144, 167, and 286
61210	Burr hole[s]; for implanting ventricular catheter, reservoir, EEG electrode[s] or pressure recording device [separate procedure	100 SEVERE/MODERATE HEAD INJURY: HEMATOMA/EDEMA WITH LOSS OF CONSCIOUSNESS, COMPOUND/DEPRESSED FRACTURES OF SKULL	Add 61210 to Line 100
92081	Visual field examination, unilateral or bilateral, with interpretation and report	82 ADDISON'S DISEASE	Add 92081-92083 to Lines 82 and 268
92082	Intermediate visual field examination	268 MULTIPLE SCLEROSIS AND OTHER	
92083	Extended visual field examination	DEMIELINATING DISEASES OF CENTRAL NERVOUS SYSTEM	
99231	Subsequent hospital care - 15 minutes at bedside	22 HYDROCEPHALUS AND BENIGN	Add 99201-99360, 99366, 99374, 99375,
99232	Subsequent hospital care - 25 minutes at bedside	INTRACRANIAL	99379-99444, 99468-
99238	Hospital discharge day management - 30 minutes or less	HYPERTENSION	99480 to Line 22
61108	Twist drill hole(s) for subdural, intracerebral, or ventricular puncture; for evacuation and/or drainage of subdural hematoma	201 SUBARACHNOID AND INTRACEREBRAL HEMORRHAGE/HEMATOMA; COMPRESSION OF BRAIN	Add 61108 to Line 201
28001	Incision and drainage, bursa, foot	215 SUPERFICIAL	Add 28001 and 28002 to Line 215
28002	Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space	ABSCESSES AND CELLULITIS	
46750	Sphincteroplasty, anal, for incontinence or prolapse; adult	493 RECTAL PROLAPSE	Add 46750 and 46751 to Line 493
46751	Sphincteroplasty, anal, for incontinence or prolapse; child		
46700	Anoplasty, plastic operation for stricture; adult.	493 RECTAL PROLAPSE	Add 46700 and 46705 to Line 493

**Attachment F**  
**HSC January 13, 2011 Minutes**  
**Straightforward Issues**

<b>Code</b>	<b>Code Description</b>	<b>Line(s) Involved</b>	<b>Recommendation(s)</b>
46705	Anoplasty, plastic operation for stricture; infant		
43840	Gastrorrhaphy, suture of perforated duodenal or gastric ulcer, wound, or injury	87 INJURY TO INTERNAL ORGANS	Add 43840 to Line 87
44143	Colectomy, partial; with end colostomy and closure of distal segment (Hartmann type procedure)	83 DEEP ABSCESSSES, INCLUDING APPENDICITIS AND PERIORBITAL	Add 44139 – 44146 to Line 83
44603 44604 44605 43840	Suture of small intestine (enterorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture; multiple perforations Suture of large intestine (colorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture without colostomy Suture of large intestine (colorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture with colostomy Gastrorrhaphy, suture of perforated duodenal or gastric ulcer, wound, or injury	83 DEEP ABSCESSSES, INCLUDING APPENDICITIS AND PERIORBITAL	Add 44603, 44604, and 44605 to Line 83  Add 43840 to Line 83
44602 44603 43840	Suture of small intestine (enterorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture; single perforation Suture of small intestine (enterorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture; multiple perforations Gastrorrhaphy, suture of perforated duodenal or gastric ulcer, wound, or injury	87 INJURY TO INTERNAL ORGANS	Add 44602, 44603 to Line 87  Add 43840 to Line 87
44312 44340	Revision of ileostomy; simple (release of superficial scar) Revision of colostomy; simple (release of superficial scar)	307 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT	Add 44312 and 44340 to Line 307
43845	Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)	607 OBESITY	Recommend DMAP add it to the Excluded (Never Covered) File.
90816-90819, 90823-90827, 90847	Various individual psychotherapy codes, and Family psychotherapy, except 90846 Family psychotherapy (without the patient present)	577 RUMINATION DISORDER OF INFANCY	Remove 90816-90819, 90823-90827, 90847 from line 577.
<b>Straightforward Issues, January, 2011</b>			
72285 72295	Discography, cervical or thoracic disc Discography, lumbar disc	Diagnostic File	Advise DMAP to remove 72285 and 72295 from the Diagnostic File and

**Attachment F  
HSC January 13, 2011 Minutes  
Straightforward Issues**

Code	Code Description	Line(s) Involved	Recommendation(s)
			place on the Excluded (Never Covered) File.
36002	Injection procedures (eg, thrombin) for percutaneous treatment of extremity pseudoaneurysm	344 OTHER ANEURYSM OF PERIPHERAL ARTERY 347 NON-DISSECTING ANEURYSM WITHOUT RUPTURE	Add 36002 to Lines 344 and 347
37206	Transcatheter placement of an intravascular stent(s) [except coronary, carotid, and vertebral vessel], percutaneous; each additional vessel	35 REGIONAL ENTERITIS, IDIOPATHIC PROCTOCOLITIS, ULCERATION OF INTESTINE 270 ARTERIAL EMBOLISM/THROMBOSIS: ABDOMINAL AORTA, THORACIC AORTA 278 CANCER OF LUNG, BRONCHUS, PLEURA, TRACHEA, MEDIASTINUM AND OTHER RESPIRATORY ORGANS	Add 37206 to Lines 35, 270, and 278
35256	Repair blood vessel with vein graft; lower extremity	330 DISORDERS OF ARTERIES, OTHER THAN CAROTID OR CORONARY 375 ATHEROSCLEROSIS, PERIPHERAL	Add 35256 to Lines 330 and 375
35621 35623 35650 35654 35656 35661 35665 35666 35671	Bypass graft, axillary-femoral Axillary-popliteal of –tibeal Axillary-axillary Axillary-femoral-femoral Femoral-popliteal Femoral-femoral Iliofemoral Femoral-anterior tibial Popliteal-tibeal or –peroneal	347 NON-DISSECTING ANEURYSM WITHOUT RUPTURE	Add 35621, 35623, 35650-35661, 35665-35671 to Line 347
75561	<i>Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences</i>	347 NON-DISSECTING ANEURYSM WITHOUT RUPTURE	<i>No action taken. Bring back with evidence review to next meeting.</i>
37201	Transcatheter therapy, infusion for thrombolysis other than coronary	307 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT	Add 37201 to Line 307

## **Guidelines for Submitted Materials to the Health Services Commission Attachment G**

The Health Services 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 are in need of updating.

Situations where topics may be reviewed include:

- A new treatment that has become available, with acceptable evidence of its clinical effectiveness and/or cost-effectiveness
- A change in current practice, best supported by high quality systematic reviews and/or evidence based guidelines
- When acceptable evidence is unavailable, expert opinion alone indicating that a more effective or cost-effective treatment exists and ~~or~~ that community standard of care differs from the current pairing will be considered

Please note that review of a topic does not necessarily lead to a change in the Prioritized List. All presenters to the Commission must provide disclosure of potential conflicts of interest.

The HSC relies heavily on high quality evidence and evidence-based guidelines in making its prioritization decisions. Lower quality evidence may be considered in situations where higher quality evidence is difficult to obtain (e.g., rare clinical conditions). Clinical judgment will still need to be used by the Commission to determine whether the available evidence is sufficient and compelling enough to affect prioritization decisions.

**The following types of evidence are considered high quality:**

- Systematic reviews of randomized controlled trials
- Systematic reviews of prospective cohort studies
- Evidence-based guidelines from trusted sources

**Examples of Sources of high-quality evidence**

- Agency for Healthcare Research and Quality (AHRQ) <http://www.ahrq.gov/clinic/>
- Blue Cross Blue Shield Technology Evaluation Center (TEC) <http://www.bcbs.com/blueresources/tec/>
- British Medical Journal (BMJ) Clinical Evidence <http://www.clinicalevidence.com>
- Canadian Coordinating Office for Health Technology Assessment (CCOHTA) <http://www.cadth.ca/index.php/en/hta>
- Cochrane Database of Systematic Reviews <http://www2.cochrane.org/reviews/>
- Evidence-Based Practice Centers (EPC) [www.ahcpr.gov/clinic/epc](http://www.ahcpr.gov/clinic/epc)

**Examples of Sources of high-quality evidence (cont'd)**

- Health Technology Assessment Programme - United Kingdom <http://www.hta.nhsweb.nhs.uk/ProjectData>
- National Institute for Clinical Excellence (NICE) - United Kingdom <http://guidance.nice.org.uk/>
- Scottish Intercollegiate Guidelines Network (SIGN) <http://www.sign.ac.uk/guidelines/index.html>
- University of York <http://www.york.ac.uk/inst/crd/>

**The following sources are considered medium quality and are often examined by the HSC.**

- Guidelines issued by professional societies and advocacy organizations (e.g. American Heart Association)
- Coverage decisions by private health plans (e.g. Aetna)
- Well-conducted, peer-reviewed individual studies (experimental or observational)

**The following types of evidence are considered low quality and are rarely reviewed by the HSC**

- Case reports, case series
- Unpublished studies (posters, abstracts, presentations, non-peer reviewed articles)
- Individual studies that are poorly conducted, do not appear in peer-reviewed journals, are inferior in design or quality to other relevant literature, or duplicate information in other materials under review by the Commission

## **Guidelines for Submitted Materials to the Health Services Commission Attachment G**

The HSC Medical Director will include a summary of high quality evidence in the meeting packets, along with the documents themselves, for the Commissioners to review. Discretion will be used, with the HSC Medical Director consulting with the Health Outcomes Subcommittee Chair, to determine if medium or low quality sources will be included for Commissioner review. A listing of other materials submitted but not included for Commissioner review will also be included in the packets to acknowledge their receipt, along with the reason for their omission.