

**MEETING HIGHLIGHTS  
HEALTH OUTCOMES SUBCOMMITTEE**

Meridian Park Hospital  
Tualatin, Oregon  
January 15, 2009  
10:00-1:00

**Members Present:** Lisa Dodson, MD, Chair; Kevin Olson, MD; K. Dean Gubler, MD MPH; Somnath Saha, MD, MPH

**Member Absent:** Carla McKelvey, MD

**Staff Present:** Darren Coffman; Ariel Smits, MD MPH; Brandon Repp

**Also Attending:** Wally Shaffer MD, DMAP; Caroline Price RN, DMAP; Chris Kirk, MD OHP Medical Directors; David Pass, MD, HRC Director; Jan Spence, Samaritan Health Systems; Judith Van Osdol, RN DMAP

*Note: Next HOSC meeting is scheduled for June 11, 2009.*

<b>Topic</b>	<b>Action</b>
<p><b>General</b> Highlights from December 2008 HOSC meeting reviewed. No changes or corrections were noted.</p>	<p>Highlights approved without change.</p>
<p><b>New HCPCS Codes</b></p> <p>Smits introduced an Excel spreadsheet outlining recommendations for placement of new HCPCS codes. The recommendations were accepted as outlined in the meeting materials, with minimal discussion.</p> <p>Smits introduced a summary document regarding hip resurfacing. The group felt that the evidence supported coverage of hip resurfacing. Discussion centered around the guideline proposed to specify when hip resurfacing should be a covered benefit. The statement referring to the FDA contraindications was considered to not be specific enough. The actual contraindications were added to the guideline.</p>	<p>Final recommendations are as listed in Appendix A. These recommendations are as presented in the meeting materials, with the guideline listed in Appendix B.</p>
<p><b>Intrathecal pumps for chronic non-cancer pain control</b> Smits reviewed a document regarding coverage of intrathecal pumps for chronic non-cancer pain. Washington state has done as extensive review of the topic and elected not to cover this service.</p> <p>In general, the Subcommittee felt that the evidence supported</p>	<p>1) Delete 62350-62355 and 62360-62362 from Lines 397 (DISORDERS OF SPINE WITH NEUROLOGIC IMPAIRMENT), 552 (ACUTE AND CHRONIC DISORDERS OF SPINE WITHOUT NEUROLOGIC IMPAIRMENT) and 624 (DISORDERS OF SOFT TISSUE).</p>

<p>not covering intrathecal pumps for non-cancer pain indications. Discussion centered around how to allow patients who currently have a pump in place have these pumps maintained or removed if indicated. 62355 (Removal of previously implanted intrathecal or epidural catheter) and 62365 (Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion) were <u>not</u> removed from lines 397, 552, and 624, as recommended. The group felt that these codes should be maintained on the list to allow existing pumps to be removed. There was some concern that patients who had pumps placed while on insurance other than OHP would not be able to have pumps maintained or removed without these codes.</p> <p>The group also decided to not remove 62367-62368 from the back pain lines. Patients with pumps in place would need these codes for maintenance. The following coding guideline was added to lines 397, 552, and 624: “Coding guideline: 62367-62368 is covered only if pump was implanted prior to April 2009.”</p> <p>There was discussion that trial non-implanted pumps should not be covered. However, these pumps are placed using CPT codes for implanted pumps and no further changes were found to be needed to not cover these devices.</p>	<ol style="list-style-type: none"> <li>2) Maintain these codes on cancer and dysfunction lines.</li> <li>3) Add the following coding guideline to lines 397, 552, and 624: “Coding guideline: 62367-62368 is covered only if pump was implanted prior to April 2009.”</li> </ol>
<p><b>Heart kidney transplants</b>  Smits reviewed a summary statement regarding coverage for dual heart kidney transplants. The group agreed that dual transplants had evidence for coverage. The group briefly discussed the situations for transplant. The evidence was felt to support kidney transplants when added to cardiac transplantation (i.e. heart transplant candidate who subsequently had renal failure would be a candidate for a dual transplant). However, renal transplant candidates who subsequently had cardiac failure would not have the option of a dual transplant as the evidence for that situation is not as strong. Similarly, heart-lung-kidney transplants were not found to have evidence supporting their coverage.</p> <p>A guideline was adopted specifying that candidates for the dual transplant need to qualify for each transplant individually, with the exception of heart and/or kidney disease.</p> <p>Note: Dr. Gubler abstained from voting on this topic due to conflicts of interest.</p>	<ol style="list-style-type: none"> <li>1) Add renal transplant codes (50300-50370,50547,76776) to Line 279 CONGESTIVE HEART FAILURE, CARDIOMYOPATHY, TRANSPOSITION OF GREAT VESSELS, HYPOPLASTIC LEFT HEART SYNDROME</li> <li>2) Change name of line to “Cardiac transplant, heart/kidney transplant”</li> <li>3) Renal transplant codes not added to heart-lung transplant lines.</li> <li>4) Guideline added to Line 279 as listed in Appendix B.</li> </ol>
<p><b>Chondromalacia patella</b></p>	<ol style="list-style-type: none"> <li>1) Remove 717.7 (Chondromalacia</li> </ol>

<p>Smits introduced a summary document regarding chondromalacia patella. The subcommittee agreed with the recommendations in this document with minimal discussion.</p>	<p>patella) from Line 449 (internal derangement of the knee) 2) Maintain 717.7 on Line 628 (minor sprains/strains)</p>
<p><b>Intestinal malabsorption</b> Smits introduced a summary document specifying issues with 579.8 (Other specified intestinal malabsorption). This diagnosis includes serious and minor conditions. Also 579.9 (Unspecified intestinal malabsorption) is a covered diagnosis, which is not consistent with the HSC policy of not covered unspecified codes. Discussion centered around whether to cover 579.8 at all. Gubler argued that this code should not be on the list. Saha felt that doctors' visits should be covered for these diagnoses and only physician visit CPT codes pair with these diagnoses. Others expressed concern that taking the entire code off the list would lead to more diagnostic tests to see if the condition could be found to be a covered diagnosis. Saha argued that the more serious diagnoses included by this code, such as protein-losing enteropathy, are reasonable to include on line 241. The group concluded that the guideline listed in Appendix B specified which diagnoses under 579.8 should be covered (chronic steatorrhea, exudative enteropathy, and protein-losing enteropathy).</p>	<p>1) Remove 579.9 (Unspecified intestinal malabsorption) from Line 241 (Intestinal malabsorption) and place on Never Covered List 2) Add a guideline for 579.8 (Other specified intestinal malabsorption) to line 241 as listed in Appendix B.</p>
<p><b>Anesthetic injection codes</b> Smits introduced a document highlighting issues around anesthetic injections and suggested changes to the Prioritized List. Discussion centered around whether the proposed Statement of Intent should cover "anesthetic procedures" or "nerve blocks." Nerve blocks were thought to better represent the types of procedures to be covered by the SOI. Kirk also recommended specifying the CPT codes covered (CPT 64400-64530), but the Subcommittee did not feel this was necessary. Shaffer asked whether "nerve blocks" specifically included infusions? Gubler and Pass felt that continuous types of nerve blocks could be very useful perioperatively. Kirk asked whether infusional control for a joint should be covered. The group decided to cover both single and continuous nerve blocks.</p>	<p>1) 64400-64450 are Ancillary 2) 64470-64480 are Never Covered 3) 64483-64484 are on Line 165 4) 64505-64530 are Ancillary 5) Statement of Intent adopted as listed in Appendix B.</p>
<p><b>Guidelines</b> 1) <u>Essure</u> Smits introduced a document with recommendations regarding Essure (permanent bilateral fallopian tube occlusion device). The Subcommittee agreed with the recommendation that Essure should only be covered as an outpatient procedure. The</p>	<p><u>Essure:</u> Guideline for Essure adopted as listed in Appendix B.  <u>Breast Reconstruction:</u> 1) V16.3 (Family history of breast cancer), V16.41 (Family history of</p>

group suggested that the proposed guideline be strengthened, specifying that this procedure is not covered in the hospital or ambulatory care setting.

2) Breast reconstruction following prophylactic mastectomy

Smits introduced a summary document regarding coverage of breast reconstruction following prophylactic mastectomy. Gubler raised concerns regarding authorizing coverage for reconstruction. He felt that prophylactic mastectomy is done for prevention of breast cancer and subsequent reconstruction hinders the ability to screen the patient for breast cancer. Patients are still at some risk for breast cancer because mastectomy does not remove 100% of breast tissue. He felt that covering reconstruction would remove some of the benefit gained by covered prophylactic mastectomy. Olson felt that the incidence of cancer very low after bilateral prophylactic mastectomy and that the issue of subsequent screening would not be a major issue. Dodson felt that the psychological benefits in reconstruction outweighed the risks of impaired screening. Olson raised a concern that women at high risk for breast cancer may not elect a prophylactic mastectomy if reconstruction would not be covered. Saha agreed that the HSC did not want to create barriers to patients getting prophylactic mastectomies when doing them can reduce costs (MRIs, cancer, etc.). The group affirmed their December decision to cover prophylactic mastectomy and agreed to the guideline listed in Appendix B regarding when reconstruction is covered.

3) Lymphedema

Smits introduced a document outlining concerns from the PT community regarding limitations on coverage for lymphedema. The Subcommittee heard testimony from Jan Spence, a representative from Samaritan Health Systems. The group also heard testimony from Dr. David Pass, HRC Director and expert on lymphedema.

Spence agreed with the commission that LANA certification is the best qualification for therapists who perform lymphedema therapy. However, she argued that it is difficult to become certified in rural and outlying areas. Only 1 therapist in her system was LANA certified, and would be allowed to provide services for all the patients on OHP in that area. She had concerns for travel time for patients, increased expense for DMAP to provide transportation for patients, and increased

ovarian cancer), and V45.71 (Acquired Absence of Breast) added to Line 4 (Preventive Services)

2) The coding guideline removed from Line 198

3) Guideline adopted as listed in Appendix B.

Lymphedema

1) Guideline adopted as listed in Appendix B.

workload for the limited number of therapists. She felt that there should be more time for therapist to become qualified before this requirement was enforced, due to the difficulty of getting therapists to training programs.

Saha argued that the HSC required LANA certification because there is a very narrow therapeutic margin for lymphedema therapy, and unqualified therapists could cause harm. Why should we cover treatment that may not be effective until you get effective training?

Spence responded that non treatment can have horrible outcomes, worse than treatment with non certified providers.

Saha asked “What is the evidence that the non-certified therapists are actually providing beneficial treatments? Without certification, how do we know who is doing this? I could do this?” He argued that the HSC need to have some type of evidence that therapists providing this service are qualified, and LANA certification is the best available evidence of qualification.

Olson added that when the HSC discussed this before, they found that when lymphedema therapy is done right, it is effective, and we want to pay for effective service. However, LANA certification does put burdens on rural areas. The time commitment to do the training/certification is substantial. He felt that if a therapist was in training, it showed a level of serious commitment, and that therapists in training should be allowed to provide lymphedema therapy for OHP patients. Smits stated that the guideline change adopted in December already allowed for therapists in training to provide services, as long as they are within a 2 year period from coursework.

Spence stated that this requirement will force the hospital system to get their PTs trained, which would be a positive development.

Saha suggested that the HSC consider allowing therapists who are practicing under a qualified person to provide services. Smits asked how the HSC should define “supervised by.”

Pass then provided testimony, and summarized materials given out at meeting/in packet. LANA certified therapists had better outcomes than non-certified (WA state Medicaid review). Requirement is 135 hours of training, 1 year of practice

afterwards. Needs 2 weeks for the course, has come costs associated with it. There are 9-12 LANA certified therapists in Oregon, most in Portland area. WA has seen a significant increase in numbers of certified therapists as they put in this requirement. What is best for the patient is a highly qualified provider.

Saha stated that for 13 ½ yrs, the HSC did not cover this. We need to ensure that what we pay for is effective. We have opened the door to therapy to a reasonable extent. If you really want to do this, do it effectively. Let the HSC motivate people to get the right training to do this effectively. Gubler agreed, stating that this is a quality of care issue.

Dodson stated that “I am an advocate for rural health and I think we should stick with a standard.”

Shaffer stated that DMAP must assure access to covered services. We are obligated to provide these services. The problem is that only 9 or 12 providers are not enough to ensure access. Saha replied that the HSC does not have perview over the delivery system.

Price suggested that it would be appropriate to review in a few years and see if enough providers are out there.

Olson proposed rejecting the new changes proposed for January. He had concern that the non specific wording leaves us open to some vague training program. The decision was made reject red changes (new changes for January). December changes were affirmed.

**Repair of blood vessels of the head and neck**  
Smits reviewed proposed changes for placement of repair codes for injuries to blood vessels of the head and neck. Saha suggested that the HSC keep injuries on the injuries line. He proposed moving the repair CPT codes to line 143 to pair rather than moving 900.XX to line 302.

1) Add 35201 (Repair blood vessel, direct, neck), 35231 (Repair blood vessel with vein graft, neck), and 35261 (Repair blood vessel with graft other than vein; neck) to Line 143 (Crush injuries)

2) Remove 35201, 35231, and 35261 from Line 302 (BUDD-CHIARI SYNDROME, AND OTHER VENOUS EMBOLISM AND THROMBOSIS)

2) Keep 900.XX on Line 302

**Straightforward Issues**

Smits reviewed the straightforward issues document in the meeting materials. The Subcommittee agreed with the suggested changes.

Add 35632 (Harvest of ilio-celiac vein) to:

**270** ARTERIAL  
EMBOLISM/THROMBOSIS:  
ABDOMINAL AORTA, THORACIC  
AORTA

**306** DISSECTING OR RUPTURED  
AORTIC ANEURYSM  
330 DISORDERS OF ARTERIES,  
OTHER THAN CAROTID OR  
CORONARY

**347** NON-DISSECTING  
ANEURYSM WITHOUT RUPTURE

**465** ATHEROSCLEROSIS, AORTIC  
AND RENAL

**Appendix A: 2009 HCPCS Code Placement**

**See attached Excel Spreadsheet**

## Appendix B

# Guideline and Statement of Intent Changes from December 2008 HOSC Meeting

## New Guidelines

### **GUIDELINE XXX HIP RESURFACING**

*Line 381*

Hip resurfacing is a covered service for patients who are likely to outlive a traditional prosthesis, who would otherwise require a total hip replacement, and should only be done by surgeons with specific training in this technique.

Patients who are candidates for hip resurfacing must not be:

- i. Patients with infection or sepsis
- ii. Patients who are skeletally immature
- iii. Patients with any vascular insufficiency, muscular atrophy, or neuromuscular disease severe enough to compromise implant stability or postoperative recovery
- iv. Patients with bone stock inadequate to support the device, including severe osteopenia or a family history of severe osteoporosis or osteopenia
- v. Patients with osteonecrosis or avascular necrosis with >50% involvement of the femoral head
- vi. Patients with multiple cysts of the femoral head
- vii. Females of childbearing age
- viii. Patients with known moderate-to-severe renal insufficiency
- ix. Patients who are immunosuppressed with diseases such as AIDS or persons receiving high doses of corticosteroids
- x. Patients who are severely overweight
- xi. Patients with known or suspected metal sensitivity

### **GUIDELINE NOTE XXX HEART-KIDNEY TRANSPLANTS**

*Line 279*

Patients under consideration for heart/kidney transplant must qualify for each individual type of transplant under current DMAP administrative rules and transplant center criteria with the exception of any exclusions due to heart and/or kidney disease.

## **GUIDELINE XXX 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.

## **Guideline XXX 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.

## **GUIDELINE NOTE XXX: BREAST RECONSTRUCTION**

*Lines 4, 198*

Breast reconstruction is only covered after mastectomy as a treatment for breast cancer or as prophylactic treatment for the prevention of breast cancer in a woman who qualifies under Guideline Note 3, and must be completed within 5 years of initial mastectomy.

## **New Statement of Intent**

### **STATEMENT OF INTENT FOR NERVE BLOCKS**

The Health Services Commission intends that single injection and continuous nerve blocks should be covered services if they are required for successful completion of, perioperative pain control for, or post-operative recovery from a covered operative procedure when the diagnosis requiring the operative procedure is also covered. Additionally, nerve blocks, are covered services for patients hospitalized with trauma, cancer, or intractable pain conditions, if the underlying condition is a covered diagnosis.

## **Revised Guideline**

### **GUIDELINE NOTE 43, LYMPHEDEMA**

*Lines 441,589*

Lymphedema treatments are included on these lines when medically appropriate. These services are to be provided by a licensed practitioner who is certified by one of the accepted lymphedema training certifying organizations or a graduate of one of the National Lymphedema Network accepted training courses within the last 2 years. The only accepted certifying organization at this time is LANA (Lymphology Association of North America; <http://www.clt-lana.org>). Treatments for lymphedema are not subject to the visit number restrictions found in Guideline Note 6, Rehabilitative Therapies.

<b>HCPCS Code</b>	<b>Code Description</b>	<b>List</b>	<b>Line(s)</b>
G0406	FOLLOW-UP INPATIENT TELEHEALTH CONSULTATION, LIMITED, PHYSICIANS TYPICALLY SPEND 15 MINUTES COMMUNICATING WITH THE PATIENT VIA TELEHEALTH	List	Lines with telephone consultation codes
G0407	FOLLOW-UP INPATIENT TELEHEALTH CONSULTATION, INTERMEDIATE, PHYSICIANS TYPICALLY SPEND 25 MINUTES COMMUNICATING WITH THE PATIENT VIA TELEHEALTH	List	Lines with telephone consultation codes
G0408	FOLLOW-UP INPATIENT TELEHEALTH CONSULTATION, COMPLEX, PHYSICIANS TYPICALLY SPEND 35 MINUTES COMMUNICATING WITH THE PATIENT VIA TELEHEALTH	List	Lines with telephone consultation codes
G0409	SOCIAL WORK AND PSYCHOLOGICAL SERVICES, DIRECTLY RELATING TO AND/OR FURTHERING THE PATIENT'S REHABILITATION GOALS, EACH 15 MINUTES, FACE-TO-FACE; INDIVIDUAL (SERVICES PROVIDED BY A CORF-QUALIFIED SOCIAL WORKER OR PSYCHOLOGIST IN A CORF)	List	Any line with PT codes: 12,50,51,52,63,74,75,76,78,80,85,89,90, 94,95,98,99,100,101,109,110,116,117, 123,130,140,142,143,144,146,147,159, 162,166,180,185,186,190,191,193,195, 196,202,203,209,217,227,237,239,270, 271,273,274,279,287,288,292,296,301, 303,306,307,308,317,334,340,347,348, 362,366,368,372,373,375,379,381,382, 384,397,403,404,429,435,437,441,449, 461,481,498,509,540,552,570,588,611, 628
G0410	GROUP PSYCHOTHERAPY OTHER THAN OF A MULTIPLE-FAMILY GROUP, IN A PARTIAL HOSPITALIZATION SETTING, APPROXIMATELY 45 TO 50 MINUTES	List	Mental health lines containing inpatient and partial inpatient services
G0411	INTERACTIVE GROUP PSYCHOTHERAPY, IN A PARTIAL HOSPITALIZATION SETTING, APPROXIMATELY 45 TO 50 MINUTE	List	Mental health lines containing inpatient and partial inpatient services
G0412	OPEN TREATMENT OF ILIAC SPINE(S), TUBEROSITY AVULSION, OR ILIAC WING FRACTURE(S), UNILATERAL OR BILATERAL FOR PELVIC BONE FRACTURE PATTERNS WHICH DO NOT DISRUPT THE PELVIC RING	List	<b>190</b> FRACTURE OF PELVIS, OPEN AND CLOSED
G0413	PERCUTANEOUS SKELETAL FIXATION OF POSTERIOR PELVIC BONE FRACTURE AND/OR DISLOCATION, FOR FRACTURE PATTERNS WHICH DISRUPT THE PELVIC RING, UNILATERAL OR BILATERAL, (INCLUDES ILIUM,	List	<b>190</b> FRACTURE OF PELVIS, OPEN AND CLOSED
G0414	OPEN TREATMENT OF ANTERIOR PELVIC BONE FRACTURE AND/OR DISLOCATION FOR FRACTURE PATTERNS WHICH DISRUPT THE PELVIC RING, UNILATERAL OR BILATERAL,	List	<b>190</b> FRACTURE OF PELVIS, OPEN AND CLOSED

Appendix A: 2009 HCPCS Code Placement

G0415	OPEN TREATMENT OF POSTERIOR PELVIC BONE FRACTURE AND/OR DISLOCATION, FOR FRACTURE PATTERNS WHICH DISRUPT THE PELVIC RING, UNILATERAL OR BILATERAL, INCLUDES INTERNAL FIXATION, WHEN	List	<b>190</b> FRACTURE OF PELVIS, OPEN AND CLOSED
S2118	METAL-ON-METAL TOTAL HIP RESURFACING, INCLUDING ACETABULAR AND FEMORAL COMPONENTS	List	<b>381</b> RHEUMATOID ARTHRITIS, OSTEOARTHRITIS, OSTEOCHONDRITIS DISSECANS, AND ASEPTIC NECROSIS OF BONE
S2270	INSERTION OF VAGINAL CYLINDER FOR APPLICATION OF RADIATION SOURCE OR CLINICAL BRACHYTHERAPY	List	<b>145</b> CANCER OF CERVIX <b>219</b> CANCER OF UTERUS <b>252</b> CANCER OF OVARY, <b>310</b> CANCER OF VAGINA, VULVA AND OTHER FEMALE GENITAL ORGANS

**MEETING HIGHLIGHTS  
HEALTH OUTCOMES SUBCOMMITTEE**

Meridian Park Hospital

Tualatin, Oregon

June 11, 2009

8:30-12:00

**Members Present:** Lisa Dodson, MD, Chair; Kevin Olson, MD; Somnath Saha, MD, MPH

**Members Absent:** Carla McKelvey, MD; K. Dean Gubler, MD, MPH

**Staff Present:** Darren Coffman; Ariel Smits, MD, MPH; Brandon Repp, Dorothy Allen

**Also Attending:** Wally Shaffer MD, DMAP; Caroline Price RN, DMAP; Isabel Bickle, DMAP; Chris Kirk, MD OHP Medical Directors

*Note: The meeting adjourned at 11:30 AM. The next HOSC meeting is scheduled for August 6, 2009.*

<b>Topic</b>	<b>Action</b>
<p><b>General</b> Highlights from January 2009 HOSC meeting reviewed. No changes or corrections were noted.</p>	<p>Highlights approved without change.</p>
<p><b>Autism spectrum disorders</b></p> <p>Smits reviewed the recommendations from the MHCD subcommittee review of the new autism line. It was noted that the CPT and HCPCS codes from the January MHCD meeting were not included. Smits will review those minutes and add those recommendations to the suggested List changes and return these recommendations for the August meeting.</p> <p>The new guideline for autism was reviewed and the HOSC felt that the wording should be worked on for clarity and brevity. Dodson and Smits will work on an edited version before the next MHCD meeting next week and bring the new guideline with MHCD input back to the August meeting.</p>	<p>Smits to bring back full CPT and HCPCS recommendations for the August meeting.</p> <p>Smits and Dodson will review the autism guideline and suggest wording changes for the next MHCD meeting on June 17.</p>
<p><b>Watch List</b></p> <p>Coffman reviewed the “Watch List” of procedures which the HSC has asked DMAP to monitor for utilization. DMAP is in the process of developing a system to better monitor these procedure codes. The HOSC members present did not have a particular procedure they were concerned about at this meeting. HSC staff and DMAP will continue to monitor these codes.</p>	<p>HSC and DMAP staff will continue to monitor “Watch List” codes.</p>

<p><b>Scrotoplasty and penile anomalies</b>  Smits reviewed the codes in the 752.6 series, penile anomalies, and the suggested changes to the list regarding coverage of these conditions. No changes were made to the suggestions in the meeting document.</p>	<ol style="list-style-type: none"> <li>1) Move 752.63-752.65 to Line 678 (GENITOURINARY CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY), delete from line 452 (HYPOSPADIAS AND EPISPADIAS)</li> <li>2) Add 55180 (Scrotoplasty, complicated) and 55175 (Scrotoplasty, simple) to Line 452</li> </ol>
<p><b>Growth hormone</b>  Smits introduced the evidence regarding treatment with growth hormone for adult conditions, particularly isolated idiopathic growth hormone deficiency.</p> <p>Saha wanted to ensure that kids could be treated to prevent dwarfism. Kirk indicated that the MCOs did not consider treatment of kids to be an issue. Shaffer indicated that DUR board guidelines exist for treatment in kids which are effective for DMAP. Shaffer suggested a change to the suggested guideline to limit it to adults. Kirk indicated that the major problem for the MCOs was request for growth hormone in diabetics to increase glucose levels and for “I just don’t feel good.” Saha noted that the evidence reviewed related to adults and that there was no evidence presented on treatment for kids. He supported changes to the proposed guideline which limited the guideline to adults. Smits indicated that if medical directors find problems, then HSC staff can bring issue back to the HOSC.</p>	<ol style="list-style-type: none"> <li>1) No change to the location of codes for growth hormone treatment on the List.</li> <li>2) Add a coding guideline to line 411 (Pituitary Dwarfism) <ol style="list-style-type: none"> <li>a. “Treatment with growth hormone is included on this line only for pituitary dwarfism; treatment is not included for isolated deficiency of human growth hormone in adults.”</li> </ol> </li> </ol>
<p><b>Small bowel transplant</b>  Smits presented a summary document on small bowel transplants. Currently, DMAP is authorizing cadaveric donor transplants (approximately 2-3 in the last few years), but cannot authorize living related transplants due to the experimental nature of this treatment. Smits reviewed that the literature does indicate that this procedure is experimental. The HOSC agreed that it should not be covered, as long as patients have access to the standard cadaveric transplant.</p>	<ol style="list-style-type: none"> <li>1) Remove 44133 (Donor enterectomy from living donor) and 44136 (Intestinal allotransplantation, from living donor) from Line 253 (<b>SHORT BOWEL SYNDROME - AGE 5 OR UNDER Treatment: INTESTINE AND INTESTINE/LIVER TRANSPLANT</b>).</li> </ol>
<p><b>Esophagoscopy</b>  Smits introduced a document highlighting suggested changes to clean up the codes for esophagoscopy on the List. No changes were made to the suggestions on the summary document.</p>	<ol style="list-style-type: none"> <li>1) Delete 43201 from Line 60; add 43201 to Lines 337, 406, 408, 416</li> <li>2) Delete 43204 and 43205 from Line 60</li> </ol>

	<p>3) Delete 43216 from the Ancillary list; add 43216 to Lines 337, 613, 656</p> <p>4) Delete 43217 from the Ancillary list; add 43217 to Lines 337, 613, 656</p> <p>5) Delete 42319 from Line 339; add 42319 to Lines 613 and 656</p> <p>6) Add 43220 and 43226 to Lines 613, 656</p> <p>7) Add 43220 and 43226 to Lines 408, 613, 656</p> <p>8) Add 43228 to Lines 61 and 408</p>
<p><b>Varicose veins</b> Smits reviewed a suggestion to change the treatment codes associated with varicose vein diagnoses, as well as previous deliberations on these treatments from HOSC minutes. The HOSC did not change any treatments associated with varicose veins.</p>	<p>No changes made</p>
<p><b>Guidelines</b></p> <p>1) <u>Lymphedema.</u> DMAP has requested clarifying wording changes to the lymphedema guideline. There was brief discussion over wording choices.</p> <p>2) <u>PET scan guideline</u> Smits introduced recommended changes to the PET scan guideline, which serve to clarify previous HOSC/HSC intent. Specifically, the HSC did not intend to cover restaging of cervical cancer. Additionally, CPT codes for PET scans were suggested for addition to several lines which contain diagnoses covered in the new guideline. There was some editing of the new guideline to improve clarity.</p> <p>3) <u>Palliative care guideline</u> Smits introduced a document outlining recommendations from the Palliative Care Taskforce regarding the palliative care guidelines. These guidelines have been sent to the OHP Medical Directors for comment and their suggestions were presented as well.</p> <p>Coverage of DME, such as motorized wheelchairs and expensive hospital beds, was discussed. The OHP medical directors have raised concerns about DME cost for patients with limited life expectancy who would not benefit from such expensive care for any reasonable length of time. The old</p>	<p><u>Lymphedema:</u> See appendix A for adopted wording changes to guideline.</p> <p><u>PET scan:</u></p> <ol style="list-style-type: none"> <li>1. Add 78811-78816 (PET scan CPT codes) to lines 171, 208, 209, 221, 276, 291, 311, 337</li> <li>2. Guideline amended as seen in Appendix A</li> </ol> <p><u>Palliative Care</u></p> <ol style="list-style-type: none"> <li>1) Statements of Intent adopted as seen in Appendix B.</li> </ol> <p><u>Pickwickian Syndrome.</u></p> <ol style="list-style-type: none"> <li>1) Pickwickian Syndrome (278.8) was added to lines 8, 211, and 608.</li> <li>2) A guideline was adopted as shown in Appendix A.</li> </ol> <p><u>Bariatric Surgery</u></p> <ol style="list-style-type: none"> <li>1) Line 608 (Obesity) was deleted</li> <li>2) Guideline 61 <b>MEDICAL AND SURGICAL MANAGEMENT OF OBESITY NOT MEETING CRITERIA SPECIFIED IN</b></li> </ol>

guideline had a clause limiting DME supplies to patients who would benefit for a reasonable length of time. Smits suggested adding this phrase to the 4<sup>th</sup> example of the palliative care statement of intent. Kirk thought that this change would result in lots of issues in hearings. Saha was concerned about the meaning of “reasonable.” Was it 24 hours of life or another period? Olson asked about what types of DME is this concerning. The concern from DMAP and the medical directors was specifically about motorized wheelchairs. Dodson suggested that the guideline should specify electric wheelchairs, and Olson further clarified that this specifically should refer to motorized wheelchair. Saha suggested taking this issue back to the palliative care taskforce to give us specific wording for this issue. However, Kirk suggested that the issue would be resolved with specifying specify “standard” wheelchairs in the wording, and this change was adopted.

Discussion then centered around the criteria for the evidence to be used in decisions regarding palliative care and end of life care. The Medical Directors had suggested “as supported by the best available peer reviewed literature” as the standard. However, Saha and Smits pointed out that some data (for example SEER or CDC data) does not go through the peer review process, but is still good evidence. Olson stated that having data this is published in some form would be a good requirement to prevent decisions based on word of mouth, or other unreliable sources. Kirk stressed the importance of having some control of the evidence presented by having it be published. Saha noted however that at times the best available evidence is expert opinion and that in other HSC guidelines evidence is not required to be published. What if there is no published evidence? Kirk noted that that is currently a problem, that currently for many conditions there is not any data available and therefore no grounds to deny coverage for a treatment which is ineffective. Saha noted that requiring published data could be a problem if what is published is limited and not actually the best evidence out there. Coffman stated that the problem is that the OHP medical directors and plans are the ones making these determinations and need to have decisions that can hold up in hearings. Shaffer stated that published is an important word for hearings. Saha agreed that it was okay to include wording about publication if it was necessary for the plans/DMAP. It was agreed to use the wording “the best available published evidence.”

Other changes which either clarified meaning or were

**OTHER OBESITY-RELATED GUIDELINES** was deleted.

Obesity:

Guideline 5 changed as shown in Appendix A.

suggested by Taskforce members were accepted with minimal discussion.

Saha expressed a desire to move the Death with Dignity SOI away from the palliative care and the end of life SOI, to stress that they were not related due to a lot of negative attention. Olson thought that separating them out as separate SOIs shows the HSC's intent that they are not connected.

#### 4) Pickwickian Syndrome

Smits introduced a summary document outlining the issues around Pickwickian Syndrome, a diagnosis which does not currently appear on the Prioritized List. Because this syndrome is mainly just obesity with sleep apnea, the diagnosis will be added to the obesity and sleep apnea lines. A guideline specifying the 278.8 is included on these lines only for coverage of Pickwickian Syndrome.

Kirk asked the commission if the DSM-IV criteria for this syndrome had been considered. In his view, this syndrome is an eating disorder. Saha replied that the commission's intent was to treat the complications of this condition with sleep apnea and obesity. After staff looked up the other diagnoses under 278.8, Saha state that he felt that other hyperalimantation has several other conditions including hypervitaminosis, and cardiopulmonary obesity, and thus necessitated a guideline.

#### 5) Bariatric surgery/Guideline 61

DMAP has expressed concern with the location of bariatric surgery CPT codes on lines both above (Line 8) and below (Line 608) the funding line. This duplication is causing non-diabetic obese patients to argue that they require payment for bariatric surgery under the co-morbidity rule. Several solutions to this issue were discussed. The commission decided that the cleanest solution was to delete Line 608 (Obesity), as without bariatric surgery codes it had very little other treatment CPT code differences from Line 8 (Obesity). Guideline 61, which refers to Line 608 also needed to be deleted.

#### 6) Guideline 5, Obesity

Smits introduced a summary document regarding issues with the Obesity guideline. Specifically, the Medical Directors and DMAP are having issues with coverage of DME for obesity, and its lack of reference in this guideline.

Smits read an email from Tina Kitchen, from Aging and Disability Services regarding her concerns about changing the guideline to exclude DME.

- First and most importantly, it is inhumane to not provide a wheelchair to someone who can't walk (even if it is because of obesity - are people going to not treat gun shot wounds because of their life style choices?).
- Two, keeping people mobile, even in a chair, is a preventative step. It keeps them engaged in their life and not stuck in a bed, making hygiene easier, and decreasing the chances of decubiti, pneumonia, etc.
- Third, I am surprised that MPCHP has gotten away with this decision in the past. I think this is a violation of the ADA. If you are going to provide a wheel chair to one person who can't walk because of one type of disability and you can't refuse to provide it because of a different diagnosis. I don't think it would stand up to a law suit. This decision has nothing to do with efficacy of the treatment.
- Finally, it will just be a cost shift to SPD and in fact, end up costing the state more. We have folks already in NHs who are there solely because of their size. Not only will we have to provide the DME but some will be in a higher cost setting.

Shaffer argued that it would be very unusual to pick a single diagnosis like obesity and not cover ancillary services. He stated that such a change would still let patients with co-morbidities get these services, but would discriminate against obese patients. However, obese pt might need equipment Saha wondered if the HSC could put obesity on the dysfunction line(s) rather than include DME on the obesity line. Smits replied that DME is on every line because they are ancillary services. Olson thought the real question is whether we want to provide DME for obesity, and the best way to specify this. Saha asked about pairing of diagnoses with DME. Shaffer replied that DME is limited by administrative guidelines. Olson stated that obesity was below the line and this was not previously an issue until we moved the obesity line. Moving obesity appears to have unintended consequences. Coffman wondered if most people with obesity would still receive DME through co-morbid condition diagnoses. Kirk replied that it was rare to have obesity and nothing else. However, his MCO plan has interpreted the current guideline as the intent of the commission was just to

offer intensive counseling. Olson wondered whether the risks outlined by Dr. Kitchen worth the benefits of pulling these services out from this line. Kirk stated that his MCO has authorization criteria which limit these services. Saha stated that he thought it would be discrimination to call out obesity. Kirk replied that the OHP waiver would allow such discrimination. Saha replied that it might be legal under the waiver, but it would not be right. He was worried about other conditions below the line that would not have DME which would improve the quality of their life. We prioritized based on the fact that there are no treatments for the conditions themselves, not that there are some things that could improve their quality of life. Our palliative care SOI might apply here.

Olson asked what evidence is there that DME would achieve the goals of improving health (prevent bedsore, etc). He also stated that he thought that the number of patients affected by the DME issue who had only obesity without comorbid conditions would be small enough that no change should be made. Saha stated that hopefully clinicians will use their discretion and plans will have restrictions in place. Kirk argued that it was difficult to have physician input with DME vendors. Coffman asked if we could make a SOI about DME for non covered diagnoses. Shaffer stated that OHP/DMAP are denying DME for below the line diagnoses, and not having any issues with this. Kirk returned to his argument that the HSC intent was to cover only counseling issues for obesity. Coffman argued that changing the coverage of DME for obesity will just move these services to other lines though comorbid conditions. Saha suggested changing guideline 5 to read “DME is included on this line only to improve physical activity.” Olson wondered whether this was mainly about motorized wheelchairs; Shaffer noted other expensive DME items such as bariatric beds were also issues. Saha stated that the HSC’s goal with this line was to help with the public health problem of obesity and promote better nutrition and physical activity. We have evidence that drugs do not help, that bariatric surgery helps in some cases. We did not consider DME when we created this line. Tina Kitchen’s argument applies to lots of things below the line. Olson agreed that Saha’s suggestion about covering DME to allow physical activity would follow intent of the line to cover exercise, but added that the HSC needed to limit this wording to normal physical activity (not any activity), not covering treadmills, etc. Kirk stated that the issue was that Line 8 is titled “obesity” not “morbid obesity.” Suggests specifying the DME

<p>is only included for morbid obesity. This suggestion was accepted. The modified guideline shown in Appendix A was adopted.</p>	
<p><b>Complex wound closure, trunk</b> Smits reviewed a summary document regarding placement of wound closure codes for trunk wounds. There was no discussion.</p>	<ol style="list-style-type: none"> <li>1) Delete 13101 from Line 91</li> <li>2) Delete 13101 from Line 198</li> </ol>
<p><b>Syringomyelia and syringobulbia</b> Smits introduced a summary document about syringomyelia and syringobulbia coverage. The suggested changes were accepted, except that the ICD-9 codes for these conditions were only added to line 397 to simplify the changes to the List.</p>	<ol style="list-style-type: none"> <li>1) Delete 63172 and 63173 from Line 429</li> <li>2) Add 336.0 (Syringomyelia and syringobulbia) to Line 397: <b>DISORDERS OF SPINE WITH NEUROLOGIC IMPAIRMENT</b>.</li> </ol>
<p><b>Bone flaps and cranioplasty</b> Smits introduced a summary document outlining suggested changes to the placement of coverage for bone flaps and cranioplasty. There was no discussion.</p>	<ol style="list-style-type: none"> <li>1) Add 62142-62145 to lines 101, 138, and 273.</li> <li>2) Add 62146-62148 to Line 138</li> </ol>
<p><b>Straightforward Issues</b> Smits reviewed the straightforward issues document in the meeting materials. The Subcommittee agreed with the suggested changes with the exception of 92081-92083 (Visual field testing). Saha stated that there was no support in the USPSTF recommendations for this service to be included on the prevention lines. Dodson echoed this opinion, stating that it could easily lead to abuse to add these codes to the prevention lines. These codes were not added to Lines 3 and 4. All changes accepted as stated in the meeting materials, except 92081-92083 was not added to Lines 3 and 4.</p>	<ol style="list-style-type: none"> <li>1) Change name of Line 512 to “Closed fractures of ribs, sternum, and coccyx”</li> <li>2) Delete 27202 from Line 512</li> <li>3) Delete 62270 from Line 22. Add 62270 to the Diagnostic List.</li> <li>4) Delete 196.0 from Line 198. Add 196.0 to Line 613</li> <li>5) Add 90828 and 90829 to lines 181, 315, 395, 414, 421</li> <li>6) Add H0023 to all mental health lines.</li> <li>7) Delete 99468-99480 from Lines 7, 43, 68</li> <li>8) Delete V57.0, V57.4, and V57.9 from the Prioritized List and place on the Never Covered List.</li> <li>9) Delete 96150-96154 from Lines 210 and 456.</li> <li>10) Add 611.0 to Line 84. Delete 611.0 from Line 501.</li> <li>11) Add 10061 to Line 84</li> <li>12) Add 19020 to Line 84. Delete 19020 from Line 501.</li> <li>13) Add 50542 and 50543 to Lines 84, 96, 229 and 286.</li> <li>14) Add 50545 and 50546 to Line 539</li> <li>15) Add 511.9 to Line 154. Delete 511.9 from Line 582.</li> </ol>

	<p>16) Remove all C codes from all lines on which they appear on the list</p> <p>17) Invalid CPT codes will be removed as they are identified from all lines on the List</p>
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## Appendix A: Guidelines

### **GUIDELINE NOTE 43, LYMPHEDEMA**

*Lines 441,589*

Lymphedema treatments are included on these lines when medically appropriate. These services are to be provided by a licensed practitioner who is certified by one of the accepted lymphedema training certifying organizations or a graduate of one of the National Lymphedema Network accepted training courses ~~and certified within the past 2 years of such a course~~. The only accepted certifying organization at this time is LANA (Lymphology Association of North America; <http://www.clt-lana.org>). Treatments for lymphedema are not subject to the visit number restrictions found in Guideline Note 6, Rehabilitative Therapies.

### **GUIDELINE NOTE 19, PET SCAN GUIDELINES**

*Lines 126,171,183,208,209, 221,222,243,276,278, 291, 311, 337*

PET Scans are covered ~~indicated only~~ for the 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, 2) evaluation of cervical lymph node metastases when CT or MRI do not demonstrate an obvious primary tumor, and 3) 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.

For staging, PET is covered in the following situations:

Clinical management of the patient will differ depending on the stage of the cancer identified and either: 1) the stage of the cancer remains in doubt after standard diagnostic work up OR 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 cancer. Restaging is not covered for cervical cancer. 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.

### **Guideline XXX Pickwickian Syndrome**

*Lines 8, 211, 608*

278.8 (Other hyperalimantation) is included on these lines only for coverage of Pickwickian Syndrome/ Obesity Hypoventilation Syndrome.

### **GUIDELINE NOTE 5, OBESITY**

*Line 8*

Medical treatment of obesity is limited to accepted intensive counseling on nutrition and exercise, provided by health care professionals. Intensive counseling is defined as face to face contact more than monthly. Visits are not to exceed more than once per week. Intensive counseling visits (once every 1-2 weeks) are covered for 6 months. Intensive counseling visits may continue for longer than 6 months as long as there is evidence of continued weight loss. Maintenance visits are covered no more than monthly after this intensive counseling period. Pharmacological treatments are not intended to be included as a treatment services on this line. Durable medical equipment, prosthetics/orthotics and supplies are included on this line only for patients with morbid obesity and only for promoting normal physical activity. See also Guideline Note 61.

## Appendix B Statements of Intent

### PALLIATIVE CARE STATEMENT OF INTENT

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 ~~patient's expected length of life, or~~ 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 for those patients with a life-threatening/limiting illness, without regard to life expectancy, and/or who have the primary goal of prolonging life (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 the best available published evidence:
  - ~~Home hospice care for those patients with a life-threatening illness and a life expectancy of 6 months or less, 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:

1. Radiation therapy for painful bone metastases with the intent to relieve pain and improve quality of life;
2. Surgical decompression for malignant bowel obstruction; and,
3. 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.

4. 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.
5. 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.

### **STATEMENT OF INTENT ON TREATMENT OF CANCER WITH LITTLE OR NO BENEFIT PROVIDED NEAR THE END OF LIFE**

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 peer-reviewed literature
- 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 peer-reviewed literature
- Median survival with treatment of more than 12 months when the treatment is ~~not~~ expected to improve median survival by less than 30%, as supported by the best available published evidence peer-reviewed literature
- Eastern Co-operative Oncology Group (ECOG) performance score of 3 or higher

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 measurement 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 ~~from six to nine~~ 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 the Palliative Care Statement of Intent.

## **DEATH WITH DIGNITY STATEMENT OF INTENT**

It is the intent of the Commission that services under ORS 127.800-127.897 (Oregon Death with Dignity Act) be covered for those that wish to avail themselves to those services. Such services include but are not limited to attending physician visits, consulting physician confirmation, mental health evaluation and counseling, and prescription medications.

**MEETING HIGHLIGHTS  
HEALTH OUTCOMES SUBCOMMITTEE**

Clackamas Community College

Wilsonville, Oregon

August 6, 2009

8:00-11:30

**Members Present:** Lisa Dodson, MD, Chair; Somnath Saha, MD, MPH, Carla McKelvey, MD; K. Dean Gubler, MD, MPH

**Members Absent:** Kevin Olson, MD

**Staff Present:** Darren Coffman; Ariel Smits, MD, MPH; Brandon Repp; Dorothy Allen

**Also Attending:** Wally Shaffer MD, DMAP; Caroline Price RN, DMAP; Isabel Bickle, DMAP; Chris Barber, DMAP; Chris Kirk, MD OHP Medical Directors; Kathryn Weit, MHCD Subcommittee

*Note: The meeting adjourned at 11:40 AM. The next HOSC meeting is scheduled for October 15, 2009.*

<b>Topic</b>	<b>Action</b>
<p><b>General</b> Highlights from June 2009 HOSC meeting reviewed. No changes or corrections were made.</p>	<p>Highlights from June 09 meeting approved</p>
<p><b>2010 ICD-9 codes</b></p> <p>Smits reviewed a spreadsheet with recommended changes for the 2010 ICD-9 codes. The suggested code placements were accepted as presented without discussion in the meeting document with the following exceptions:</p> <ol style="list-style-type: none"> <li>1) V26.42 Encounter for fertility preservation counseling and V26.82 Encounter for fertility preservation procedure. Question was raised about what type of counseling V26.42 represented. Smits indicated that the majority of literature with this phrase dealt with treating cancer patients and counseling for preserving future fertility with chemotherapy or other cancer treatments. It was question whether this type of counseling should be covered if the HSC does not intend to cover the actual fertility preservation procedure (V26.82). The discussion centered around whether it was fair to cover counseling but not treatment. Treatment would fall under infertility and should not be covered. The decision was that counseling on options should be covered, but not the procedure.</li> </ol>	<p>ICD-9 codes placed on the Prioritized List as noted in the meeting materials except:</p> <ol style="list-style-type: none"> <li>1) V53.51 Fitting and adjustment of gastric lap band placed on Line 33 <b>TYPE II DIABETES MELLITUS</b> <b>Treatment: MEDICAL THERAPY, BARIATRIC SURGERY WITH BMI ≥ 35</b></li> <li>2) 569.87 Vomiting of fecal matter was placed on the Signs and Symptoms list</li> <li>3) All pregnancy related codes were added to Line 1 <b>Pregnancy</b></li> </ol> <p>The following additional List changes were made:</p> <ol style="list-style-type: none"> <li>1) 779.3 (Feeding problems in the newborn) was placed on the Signs and Symptoms list</li> <li>2) 285.2 (Anemia of chronic disease) deleted from Line 170 (Biliary atresia)</li> <li>3) 995.91 (Sepsis) added to Line 189 (SEPTICEMIA).</li> </ol>

- 2) V53.51 Fitting and adjustment of gastric lap band should not be placed on GI lines, but on the bariatric surgery line as this is the only location of lap band procedures on the List (Line 33)
- 3) V60.81 Foster care (status). Dr. McKelvey wanted to ensure that placing this code on the Never Covered List would not cause undesired effects such as preventing increased frequency of visits for this at-risk population. Smits explained that this code was a secondary code. It can be used as a secondary diagnosis to explain why a patient was seen, but cannot be used as a primary diagnosis.
- 4) 416.2 Chronic pulmonary embolism. Dr Gubler suggested that this diagnosis should be matched on a line for some type of risk factor, such as hypercoagulable state, which is Line 200. Saha thought it would be most appropriate paired with acute PE, which is Line 227. The decision was to place on the recommended line, 109, Heart Failure, due to treatments on that line.
- 5) 569.87 Vomiting of fecal matter should be on the Signs and Symptoms list, not the Diagnostic list, as it is a symptom
- 6) 779.34 Failure to thrive in newborn. McKelvey was concerned that this diagnosis does not belong in Signs and Symptoms. This is a frequent diagnosis for hospitalizing babies. Kirk noted that the lack of List placement of this code is a frequent complaint from pediatricians, who want to send a patient to feeding clinic. Smits noted that the HSC would need to pair this code with lots of diagnostic tests to cover the work up for all cases of failure to thrive, and this large array of tests doesn't fit on a current line. Coffman noted that feeding issues was below the line for a while, and that this movement was to help the situation. Kirk asked if there is there an effective treatment for ideopathic failure to thrive, and would treatments like tube feeding be authorized for these kids if failure to thrive is on the Signs and Symptoms List. Smits replied that the evaluation would be covered under Signs and Symptoms. In the large majority of cases, a

<p>diagnosis would be made and treatment done under that diagnosis. McKelvey felt that as long as the work up is covered, it was okay to leave on the Signs and Symptoms list.</p>	
<p><b>Pandemia/Seasonal Influenza</b>  Smits reviewed a handout on coverage for influenza. Saha wanted to know whether OHP covers prophylaxis? Shaffer replied that it was unclear with the current policy. Saha felt that the suggested changes to the viral illness statement of intent be expanded to include outbreaks as well as epidemic influenza, to cover local outbreaks, such as in a nursing home. Kirk felt that if the suggested changes covered prophylactic meds, then the plans would need to deal with treating a well person and coding may be an issue. Smits replied that there was no V code or other code for exposure to influenza. Shaffer noted that national recommendations should specify prophylactic treatment. The discussion turned to lab testing, which McKelvey argued was diagnostic. Shaffer replied that it may be problem for DMAP/OHP due to lack of coverage. McKelvey noted that the current recommendations are not to treat with antiviral without a documented influenza infection; however further recommendations are not to test unless sick enough to hospitalize. The recommendation was to change the SOI to state that “treatment” of influenza should be covered. Shaffer asked whether this implied post exposure prophylaxis. Saha suggested that the SOI be expanded to include post exposure prophylaxis. Kirk suggested bringing these guideline changes to medical directors for advice. Coffman suggested consideration of moving influenza above the current funding line with a guideline. This will be part of the biennial review Saha agreed, and thought that at the next biennial review, the HSC should break out flu from other viral illnesses.</p> <p>The final decision was to changing the last paragraph of the viral statement of intent to read “Treatment of viral pneumonia <u>and influenza</u> of significant severity that is associated with either respiratory failure or dehydration should be a covered service if the case fulfills the requirement of hospital admission guidelines using an index of severity of illness. <u>Treatment and post-exposure prophylaxis of influenza should comply with state and national public health recommendations.</u>”</p> <p>The Commission intends that testing, prophylaxis for, and treatment of influenza should be covered if that service is</p>	<p>See Appendix A for changes to the Statement of Intent for Hospitalizations for Viral Infections.</p> <p>Prioritization of treatment of influenza will be placed on the agenda for the next biennial review.</p>

<p>recommended by state and national health officials.</p> <p>The placement of influenza on the Prioritized List will be addressed at the next biennial review.</p>	
<p><b>Autism Spectrum Disorder</b> Smits reviewed the MHCD Subcommittee suggestions for code placement on the new autism line (Line 211). There was no discussion about these code placements.</p> <p>The new guideline for autism treatment was debated. McKelvey felt that the new guideline did not follow American Academy of Pediatrics recommendations for treatment. Kirk agreed, but stated that many of these treatments may fall under educational interventions. Saha noted that the HSC can't afford to follow everyone's recommendations for any condition. McKelvey felt that the definition of autism in the longer guideline was incorrect. She felt that the shorter version was more inclusive. She was concerned that the guideline simply referred to mental health treatments, but that the majority of care for persons with autism was in the primary care office. Dodson noted that there are no effective treatments for autism itself, but that the HSC wants to cover treatment of associated conditions, such as anxiety, that have evidence for effective treatment. McKelvey argued that the guideline should state that. It should say that treatments of autism itself are not covered, but that co-morbid conditions should be treated. Saha noted that by the rules of HSC, autism would be below the line. Current placement is a political statement.</p> <p>McKelvey wondered what behavior health services meant? Kirk replied that they are services provided by a mental health professional. Weit noted that this guideline addressed the ability to bill for a mental health professional to do the supervision of mental health care for these patients. We are not talking about the 20 hrs a week that the pediatric association recommends.</p> <p>The decision was made to continue the discussion in the full HSC. See HSC minutes</p>	<p>1) Included on the new Autism line:</p> <ul style="list-style-type: none"> <li>• ICD-9: 299.xx</li> <li>• CPT: 90801, 90804-90807, 90846-90847, 90849, 90862 (with a guideline), 90882,90887,96101, 96118, 98966-98969, 99051, 99060, 99201-99205, 99211-99215, 99241-99245, 99366, 99441-99444</li> <li>• HCPCS: G0176-G0177, H0002, H0031,H0034, H0038, H2010, H2011, H2014, H2027, H2032, S9484, T1013, T1016, T1023</li> </ul> <p>2) Deleted from the new autism line:</p> <ul style="list-style-type: none"> <li>• CPT: 90816-90819, 90823-90824, 90826-90827, 90848, 90850-90853, 96150-96154, 99217-99223, 99231-99236, 99238-99239, 99251-99255, 99304-99310, 99315, 99316, 99318, 99477, 99605-99607</li> <li>• HCPCS: H0004,H0017-H0019, H0032, H0033, H0035-H0037, H0039, H0045, H2012, H2013, H2021, H2022, H2023, S5151, T1005</li> </ul> <p>3) 96150-96154 deleted from Line 210 <b>CHRONIC ORGANIC MENTAL DISORDERS INCLUDING DEMENTIAS</b></p> <p>4) Autism guideline referred to the full HSC for discussion.</p>
<p><b>Growth hormone</b> Smits presented a summary document examining endpoints for treatment with growth hormone. In June, the HOSC adopted the following coding guideline for line 411 (Pituitary Dwarfism): "Treatment with growth hormone is included on this line only for pituitary dwarfism; treatment is not included</p>	<p>Guideline for growth hormone revised as shown in Appendix B.</p>

<p>for isolated deficiency of human growth hormone in adults.”</p> <p>After reviewing the evidence the HOSC recommended adopting the following as a guideline for Lines 411 and 486</p> <p>a. “Treatment with growth hormone should continue only until adult height as determined by bone age is achieved.”</p> <p>The HOSC combined the coding guideline adopted in June with this statement and created a new guideline. See Appendix B for wording.</p>	
<p><b>Mental Health and Chemical Dependency Subcommittee Code Change Recommendations</b></p> <p>Smits presented a summary document on several codes with the MHCD Subcommittee is recommending for either removal or addition to the Prioritized List. There was no discussion of these recommendations.</p> <p>At the meeting, the coding guideline was added to all the mental health lines; however the MHCD Subcommittee actually recommended adding this note to the extracted lines. This change was made by HSC staff.</p>	<p>1) T1023, H0031, H0002, 90801, 90802, H0001 were removed from the Prioritized List and added to the Diagnostic List</p> <p>2) A note be added to the extracted mental health document:</p> <p>a. Note: T1023, H0031, H0002, 90801, 90802, H0001 are on the Diagnostic List</p> <p>3) 99408 and 99409 added to Line 5 ABUSE OR DEPENDENCE OF PSYCHOACTIVE SUBSTANCE</p>
<p><b>Moyamoya syndrome</b></p> <p>Smits introduced a document regarding placement of Moyamoya syndrome on the Prioritized List. There was minimal discussion. The HOSC elected to move Moyamoya syndrome to Line 202.</p>	<p>1) 437.5 (Moyamoya syndrome) added to Line 202 SUBARACHNOID AND INTRACEREBRAL HEMORRHAGE/HEMATOMA; COMPRESSION OF BRAIN and deleted from Line 184 POLYARTERITIS NODOSA AND ALLIED CONDITIONS</p> <p>2) 61711 (Anastomosis, arterial, extracranial-intracranial arteries) added to line 202</p>
<p><b>Cholelithiasis with cholecystitis</b></p> <p>Smits reviewed a document outlining problems the health plans are having with list placement and line names for lines dealing with cholelithiasis. The HSC has always intended that asymptomatic gallstones should be placed on an uncovered line.</p> <p>The discussion first centered around whether symptomatic gallstones should be covered. Saha wondered if there could be an obstructing stone without some type of cholecystitis. Gubler stated that pain without other signs of cholecystitis is relatively rare. Pathology usually comes back chronic inflammation. Surgeons generally do not remove gallstones which are only found incidentally based on Interqual</p>	<p>No changes made to line titles.</p> <p>575.6 (Cholesterolosis of gallbladder) and 575.9 (Unspecified disorder of gallbladder) deleted from Line 60 CHOLELITHIASIS, CHOLECYSTITIS, COMMON BILIARY DUCT STONE; added to Line 659 GALLSTONES WITHOUT CHOLECYSTITIS</p>

<p>guidelines. Kirk responded that Interqual guidelines used to be “biliary colic and evidence of inflammation,” but the new version is “more than one incidence of biliary colic.” He did not feel that renaming the upper line “Clinically significant” would work. Saha stated that the HSC needs to make clear that we won’t pay for this unless there is active infection or active pain due to their gallstones. The discussion then centered around whether pain should be an indication. Kirk asked about the statistics for complications in people with colic. Gubler stated that the majority will develop cholecystitis without treatment. If there is no colic, only 10% will develop complications. Saha proposed attaching a guideline or SOI to the cholecystitis lines. Such a guideline would state “Asymptomatic cholelithiasis with or without pathologic diagnosis of cholelithiasis is not covered.” However, Gubler argued that surgeons don’t want to watch diabetics with stones, even if they don’t have pain or complications, due to higher complication rates when untreated. Dodson felt that the HSC should just leave it the way it is, that the HSC can’t mandate that a provider take a good history. The decision was to make no changes to the current lines other than the simple code changes proposed in the summary document.</p>	
<p><b>Gamekeeper’s Thumb</b> Smits introduced a summary document regarding treatment of gamekeeper’ thumb (MCP joint sprain). There was minimal discussion.</p>	<p>26530 (Arthroplasty, MCP point) added to Line 403 (DISRUPTIONS OF THE LIGAMENTS AND TENDONS OF THE ARMS AND LEGS, EXCLUDING THE KNEE, GRADE II AND III)</p>
<p><b>Reflex sympathetic dystrophy</b> Smits reviewed a summary document regarding reflex sympathetic dystrophy (also known as complex regional pain syndrome). The discussion centered around where other peripheral neuropathies were located on the List. Saha was surprised that peripheral neuropathies are appearing on an uncovered line. Bickle reported that office visits for these conditions are covered for FFS. Kirk stated that PCP office visits would be covered for managed care plans, but not pain specialist visits. Saha argued that if there is evidence of benefit for treatment of some of these conditions, such treatment should be covered. Kirk replied that medications are covered regardless of diagnosis, as long as the medication doesn’t require prior authorization. Coffman reported that peripheral neuropathies also appear on the dysfunction line and would therefore have all treatments on those lines available. Saha felt that RSD should be on the dysfunction lines as well if the other peripheral neuropathies were there. Coffman</p>	<p>Smits to 1) evaluate placement of various peripheral neuropathies on the List and 2) evaluate the impact of placing RSD on the dysfunction lines. This topic will be revisited at the October HOSC meeting.</p>

<p>wondered if RSD should then be taken off the medical line (526). Kirk was concerned about possibly pairing RSD with ineffective treatments on the dysfunction lines if it was placed there.</p> <p>Smits recommended having HSC staff locate the peripheral neuropathies on the List to see if they are in appropriate locations. Staff will also evaluate the impact of putting RSD on the dysfunction lines and ensure that there would be no inappropriate pairings, such as with nerve blocks.</p>	
<p><b>Second solid organ transplants</b></p> <p>Smits presented a summary document regarding coverage of a second transplant of the same solid organ outside of the initial hospitalization. The group wanted to know how many patients are requesting this type of transplant. Shaffer replied that DMAP is not getting any requests for this type of transplant at the moment, because the transplant programs know that they are not covered. However, DMAP estimates that about 30-40 patients a year might be eligible if this type of transplant was covered. Gubler noted that this is a very complex issue, with the efficacy of the transplant being very organ specific, different criteria for transplant in place at different centers, and different clinical situations having different outcomes. Saha noted that UNOS has an accepted process for rationing organs, and felt that the HSC should not get in the way of the UNOS system of organ allocation. Dodson felt that while UNOS takes evidence into account with their rationing, this process does not address the cost issue. Price noted that transplant committees decide who to list with UNOS, so this HSC guideline gets in the way not only of the UNOS process, but of the transplant committee process. She noted that two separate groups already make the decision about whether a client will receive an organ. Shaffer replied that this is a very high cost service, which needs restraints. Saha argued that there are already evidence based resource allocation in place, and Gubler noted that the transplant centers in this state are very conservative about listing patients. McKelvey wanted to know what unintended consequences might happen if this guideline was removed. For example, what about following UNOS guidelines for multiple organ transplants, which the HSC doesn't cover? Saha suggested referring the topic to the HRC for review of the evidence around outcomes. Coffman thought that this topic would not be very high on the HRC agenda. The final decision was to have HSC staff review second organ transplants on an organ by organ basis and bring back to the HSC as these reviews are completed.</p>	<p>HSC staff to review the outcomes of second organ transplant on an organ by organ basis and bring back to the HSC as these reviews are completed.</p>

<p><b>Hernia line names</b></p> <p>Smits introduced a summary of proposed changes to the names of the two hernia lines, to better reflect the coverage for various types of hernias in various age groups. There was minimal discussion.</p>	<p>Change the title of Line 176:          COMPLICATED HERNIA (OTHER THAN DIAPHRAGMATIC HERNIA);          UNCOMPLICATED INGUINAL HERNIA IN CHILDREN AGE 18 AND UNDER;          PERSISTENT HYDROCELE</p> <p>Change the title of Line 538:          UNCOMPLICATED HERNIA (OTHER THAN INGUINAL HERNIA IN CHILDREN AGE 18 AND UNDER OR DIAPHRAGMATIC HERNIA)</p>
<p><b>Guidelines</b></p> <p>1) <u>Early childhood mental health guidelines</u>          Smits presented the MHCD Subcommittee suggestions for changes in the childhood mental health guidelines. The suggestions were accepted with minimal discussion.</p> <p>2) <u>Cataract surgery</u>          Smits presented a summary regarding adding glare testing to the current cataract surgery guideline. The HOSC felt that there was inadequate evidence to expand to this type of testing and decided to leave the guideline as is.</p> <p>3) <u>PET scans</u>          Smits presented a summary document regarding possible changes to the current PET scan guideline. Saha felt that the proposed changes might be reasonable, as the HSC does not want to put restraints which would raise costs or put undue barriers for patients. Kirk replied that the current guideline does not put up undue barriers as the plans prior authorize all PET scans. The current guideline helps in the prior authorization process for both the plans and FFS. Saha replied that plans that want to liberalize when PET scans are allowed can do so if they want. The decision was to make no changes in the current guideline.</p> <p>4) <u>Bariatric surgery</u>          Smits presented a summary document regarding “re-do’s” of bariatric surgery. There was minimal discussion; the HOSC decided to keep the guideline as currently written.</p> <p>5) <u>Obesity</u>          Smits presented a summary document regarding issues over the wording on DME coverage for obesity that was added at the June HOSC meeting. There was significant discussion about what types of DME should be available to obese patients, what types of physical activity should be covered, and</p>	<p>1) See Appendix C for changes to the <u>Early childhood mental health guidelines</u>.</p> <p>2) <u>Cataract surgery</u>: no change made to current guideline</p> <p>3) <u>PET scans</u>: no change made to current guideline</p> <p>4) <u>Bariatric surgery</u>: no change made to current guideline</p> <p>5) <u>Obesity</u>: see Appendix B for wording changes</p> <p>6) <u>“Mini-transplants:”</u> no changes to the current mini-transplant guideline. HSC staff with request the HRC to review this topic with rest of bone marrow transplants.</p>

in what settings (rehab, SNF, homes, etc.) these should be covered. The group questioned whether DME could promote exercise, or weight loss, or other activity. Dodson noted that the guideline changes in June were done with the intention of controlling costs around motorized wheelchairs and other big ticket items. Bickle noted that DMAP already had cost controls for DME in place through their rule process. It was agreed that the best place for controlling DME use and cost was through DMAP's rule making. DMAP staff agreed to look at this issue. The group decided to remove the wording changes added to the guideline in June.

6) Mini-transplants

Smits presented a summary regarding coverage of "mini-transplants." Such transplants are specifically prohibited under current guidelines. Saha noted that this type of transplant would be best evaluated by the HRC during their bone marrow transplant review. The decision was to make no changes to the current mini-transplant guideline and ask the HRC to review with rest of bone marrow transplants.

## Appendix A: Statements of Intent

### **HOSPITALIZATION FOR ACUTE VIRAL INFECTIONS**

Most acute viral infections are self-limited (e.g. colds, infectious mononucleosis, gastroenteritis). However, some viral infections such as viral pneumonia, aseptic meningitis, or severe gastroenteritis may require hospitalization to treat the complications of the primary disease.

Accepted coding practices insist that the underlying condition in these cases be the principle diagnosis. For example, complicated viral pneumonia requiring respiratory support with a ventilator would have a principle diagnosis of viral pneumonia and a secondary diagnosis of respiratory failure. Since the ICD-9-CM code for viral pneumonia has historically appeared only on a non-funded line, treatment has not been reimbursable regardless of the severity of the disease. In contrast, the code for viral gastroenteritis appears on line 296 and any necessary outpatient or inpatient services would be covered.

The Commission has added the following statements to indicate their intent that reimbursement for the treatment of certain conditions appearing low on the Prioritized List should be provided in severe cases of the disease.

Diagnosis: OTHER NONINFECTIOUS GASTROENTERITIS AND COLITIS

Treatment: MEDICAL THERAPY

Line: 541

Treatment of non-infectious gastroenteritis of significant severity that is associated with dehydration should be a covered service if the case fulfills the requirement of hospital admission guidelines using an index of severity of illness.

Diagnosis: VIRAL, SELF-LIMITING ENCEPHALITIS, MYELITIS AND ENCEPHALOMYELITIS

Treatment: MEDICAL THERAPY

Line: 548

Treatment of viral encephalitis, myelitis and encephalomyelitis of significant severity that is associated with either obtundation or dehydration should be a covered service if the case fulfills the requirement of hospital admission guidelines using an index of severity of illness.

Diagnosis: ASEPTIC MENINGITIS

Treatment: MEDICAL THERAPY

Line: 562

Treatment of aseptic meningitis of significant severity that is associated with either obtundation or dehydration should be a covered service if the case fulfills the requirement of hospital admission guidelines using an index of severity of illness.

Diagnosis: OTHER VIRAL INFECTIONS, EXCLUDING PNEUMONIA DUE TO RESPIRATORY SYNCYTIAL VIRUS IN PERSONS UNDER AGE 3

Treatment: MEDICAL THERAPY

Line: 635

Treatment of viral pneumonia and influenza of significant severity that is associated with either respiratory failure or dehydration should be a covered service if the case fulfills the requirement of hospital admission guidelines using an index of severity of illness. Treatment and post-exposure prophylaxis of influenza should comply with state and national public health recommendations.

## **Appendix B Guidelines**

### **GUIDELINE NOTE XXX GROWTH HORMONE TREATMENT**

*Lines 411, 486*

Treatment with growth hormone is included only for pituitary dwarfism and Turner's syndrome; treatment is not included for isolated deficiency of human growth hormone in adults. Treatment with growth hormone should continue only until adult height as determined by bone age is achieved.

### **GUIDELINE NOTE 5, OBESITY**

*Line 8*

Medical treatment of obesity is limited to intensive counseling on nutrition and exercise, provided by health care professionals. Intensive counseling is defined as face to face contact more than monthly. Visits are not to exceed more than once per week. Intensive counseling visits (once every 1-2 weeks) are covered for 6 months. Intensive counseling visits may continue for longer than 6 months as long as there is evidence of continued weight loss. Maintenance visits are covered no more than monthly after this intensive counseling period. Pharmacological treatments are not intended to be included as a treatment on this line. ~~Durable medical equipment, prosthetics/orthotics and supplies are included on this line only for patients with morbid obesity and only for promoting normal physical activity.~~

## Appendix C Early Childhood Mental Health Guidelines

### **GUIDELINE NOTE 20, ATTENTION DEFICIT AND HYPERACTIVITY DISORDERS IN ~~EARLY CHILDHOOD~~ CHILDREN AGE FIVE AND UNDER**

*Line 134*

When using 314.9, Unspecified Hyperkinetic Syndrome, in children age 5 and under, it is appropriate only when the following apply:

- Child does not meet the full criteria for the full diagnosis because of their age.
- For children age 3 and under, when the child exhibits functional impairment due to hyperactivity that is clearly in excess of the normal activity range for age (confirmed by the evaluating clinician's observation, not only the parent/caregiver report), and when the child is very limited in his/her ability to have the sustained periods of calm, focused activity which would be expected for the child's age.

For children age 3 and under, it is especially important that psychosocial interventions, including parent skills training and/or parent-child therapy, and environmental modifications, be tried prior to medication. For children over the age of 3, psychosocial interventions are important, whether the child is on medications or not.

Use of 314.9 for children age five and younger is limited to pairings with the following procedure codes:

- Assessment and Screening: 90801, 90802, H0002, H0031, H0032, T1023
- Family interventions and supports: 90846, 90847, 90849, 90887, H0038, H0045, H2021, H2022, H2027, S5151, S9125, T1005
- Group therapy: 90853, 90857, H2032
- Medication management: 90862
- Case Management: 90882, T1016
- Interpreter Service: T1013

### **GUIDELINE NOTE 25, MENTAL HEALTH PROBLEMS IN ~~EARLY CHILDHOOD~~ CHILDREN AGE FIVE AND UNDER RELATED TO NEGLECT OR ABUSE**

*Line 181*

995.52, Child Neglect (Nutritional), 995.53, Child Sexual Abuse, and 995.54, Child Physical Abuse, may be used in any ~~children age five and younger~~ when there is evidence or suspicion of abuse or neglect. These codes are to be used when the focus of treatment is on the alleged child victim. This can include findings by child welfare of abuse or neglect; or statements of abuse or neglect by the child, the perpetrator, or a caregiver or collateral report. Although these diagnoses can be used preventively, i.e. for children who are not yet showing symptoms, presence of symptoms should be demonstrated for interventions beyond evaluation or a short-term child or family intervention.

The codes 995.52-995.54 may be used in children age five and younger and, in these instances only, is limited to pairings with the following procedure codes:

- Assessment and Screening: 90801, 90802, H0002, H0031, H0032, T1023
- Family interventions and supports: 90846, 90847, 90849, 90887, H0038, H0045, H2021, H2022, H2027, S5151, S9125, T1005
- Individual counseling and therapy: 90810, 90812
- Group therapy: 90853, 90857, H2032
- Case Management: 90882, T1016
- Interpreter Service: T1013
- Medication management, 90862, is not indicated for these conditions in children age 5 and under.

**GUIDELINE NOTE 28, MOOD DISORDERS IN ~~EARLY CHILDHOOD~~ CHILDREN AGE EIGHTEEN AND UNDER**

*Line 213*

The use of 296.90, Unspecified Episodic Mood Disorder, is appropriate only when the following apply:

- For children ~~five~~ 18 years old and under.
- In the presence of significant difficulty with emotional regulation that causes functional impairment.

Use of 296.90 ~~for children five years old and under~~ is limited to pairings with the following procedure codes:

- Assessment and Screening: 90801, 90802, H0002, H0031, H0032, T1023
- Family interventions and supports: 90846, 90847, 90849, 90887, H0038, H0045, H2021, H2022, H2027, S5151, S9125, T1005
- Individual Counseling and Therapy: 90810, 90812, H0004
- Group therapy: 90853, 90857, H2032
- Medication management: 90862
- Case Management: 90882, T1016
- Interpreter Service: T1013

**GUIDELINE NOTE 42, DISRUPTIVE BEHAVIOR DISORDERS IN ~~EARLY CHILDHOOD~~ CHILDREN AGE FIVE AND UNDER**

*Line 439*

The use of 312.9, Unspecified Disturbance of Conduct, is appropriate only for children five years old and under who display sustained patterns of disruptive behavior beyond what is developmentally appropriate.

- Interventions should prioritize parent skills training in effective behavior management strategies or focus on other relational issues.

Use of 312.9 is limited to pairings with the following procedure codes:

- Assessment and Screening: 90801, 90802, H0002, H0031, H0032, T1023
- Family interventions and supports: 90846, 90847, 90849, 90887, H0038, H0045, H2021, H2022, H2027, S5151, S9125, T1005
- Individual Counseling and Therapy: 90810, 90812, H0004
- Group therapy: 90853, 90857, H2032
- Case Management: 90882, T1016
- Interpreter Service: T1013
- Medication management, 90862, is not indicated for these conditions in children age 5 and under.

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

*Line 462*

ICD-9-CM code 309.89 can be used for individuals of any age. However, when using it for children five years of age or younger, who have experienced abuse or neglect, the following must apply:

1. The child must demonstrate some symptoms of PTSD (such as disruption of his or her usual sleeping or eating patterns, or more increased irritability/lower frustration tolerance) but does not meet the full criteria for PTSD or any other disorder.
2. 309.89 is limited to pairings with the following procedure codes:
  - Assessment and Screening: 90801, 90802, H0002, H0031, H0032, T1023
  - Group Therapy: 90853, 90857, H2032
  - Family Interventions and Supports: 90846, 90847, 90849, 90887, H0038, H0045, H2021, H2022, H2027, S5151, S9125, T1005
  - Case Management: 90882, T1016
  - Interpreter Service: T1013
  - Individual Counseling and Therapy: 90810, 90812
  - Medication Management, 90862, is not indicated for this condition in children five years of age or younger.

Note: Cessation of the traumatic exposure must be the first priority. Infants and toddlers may benefit from parental guidance regarding management of the child's symptoms, parental guidance around enhancing safety and stability in the child's environment, and therapeutic support for the parents.

Two V-codes, V61.20 (Counseling for Parent-Child Problem, Unspecified) and V62.82 (Bereavement, Uncomplicated), may only be used as secondary diagnoses to the primary diagnosis of 309.89, and only for children five years of age or younger.

1. When using V61.20, the following must apply:
  - a. Service provision will have a clinically significant impact on the child.

- b. A rating of 40 or lower has been assessed on the PIR-GAS (Parent-Infant Relationship Global Assessment Scale).
  - c. The same limitations in pairings to CPT and HCPCS codes as given for ICD-9-CM code 309.89 apply, with the only exception being that 90810 and 90812 cannot be used.
2. When using V62.82, the following must apply:
- a. The child exhibits a change in functioning subsequent to the loss of a primary caregiver;
  - b. The child exhibits at least three of the following eight symptoms:
    - i. Crying, calling and/or searching for the absent primary caregiver,
    - ii. Refusing attempts of others to provide comfort,
    - iii. Emotional withdrawal manifesting in lethargy, sad facial expression, and lack of interest in age-appropriate activities that do not meet mood disorder criteria,
    - iv. Disruptions in eating and sleeping that do not meet criteria for feeding and eating disorders of infancy or early childhood,
    - v. Regression in or loss of previously achieved developmental milestones not attributable to other health or mental health conditions,
    - vi. Constricted range of affect not attributable to a mood disorder or PTSD,
    - vii. Detachment, seeming indifference toward, or selective “forgetting” of the lost caregiver and/or of reminders of the lost caregiver,
    - viii. Acute distress or extreme sensitivity in response to any reminder of the caregiver or to any change in a possession, activity, or place related to the lost caregiver;
  - c. The symptoms in 2(b) above are exhibited for most of the day and for more days than not, for at least 2 weeks.
  - d. The same limitations in pairings to CPT and HCPCS codes as given for ICD-9-CM code 309.89 apply.

Note: Intervention should include persons significantly involved in the child’s care and include psychoeducation and developmentally-specific guidance.

**MEETING HIGHLIGHTS**  
**HEALTH OUTCOMES SUBCOMMITTEE**

Clackamas Community College  
Wilsonville, Oregon  
October 15, 2009  
8:30-11:30

**Members Present:** Lisa Dodson, MD, Chair; Somnath Saha, MD, MPH, Carla McKelvey, MD; K. Dean Gubler, MD, MPH

**Members Absent:** Kevin Olson, MD

**Staff Present:** Darren Coffman; Ariel Smits, MD, MPH; Cat Livingston, MD, MPH; Brandon Repp; Dorothy Allen

**Also Attending:** Wally Shaffer MD, DMAP; Caroline Price RN, DMAP; Isabel Bickle, DMAP; Chris Kirk, MD OHP Medical Directors; George Anudrontis, Emanuel Children’s Hospital; David Whiteman, Jeff Bailey, Stephanie Kraxec and Kay Barry, Shire Human Genetic Therapies; Alex Kipr, OHSU medical student.

*Note: The meeting adjourned at 12:05 PM. The next HOSC meeting is scheduled for December 10, 2009.*

*Note: All line numbers are referenced from the October 1, 2009 Prioritized List. Line numbers in parentheses refer to line numbers from the January 1, 2010 Prioritized List.*

<b>Topic</b>	<b>Action</b>
<p><b>General</b>  Highlights from August 2009 HOSC meeting reviewed. No changes or corrections were made.</p>	<p>Highlights from August 09 meeting approved without change</p>
<p><b>Vertebroplasty</b>  Smits reviewed new studies which found no effectiveness to vertebroplasty based on sham controlled trials. Discussion centered around what level of evidence was needed to remove a procedure from the list. Saha felt that the previous inclusion of this procedure was based on moderate evidence, and now strong evidence of lack of effectiveness outweighed the moderate evidence of effectiveness. McKelvey asked what other procedure/treatments would be available if this was removed. Saha responded that there was little effective treatment for back pain/vertebral fractures, but that lack of effective alternative treatment was no reason for inclusion of an ineffective treatment. It was pointed out that patients with acute fracture could have PT or medication therapy.</p>	<p>Remove vertebroplasty (22520-22522) from Lines 159 (158)  CERVICAL VERTEBRAL DISLOCATIONS/FRACTURES, OPEN OR CLOSED; OTHER VERTEBRAL DISLOCATIONS/FRACTURES, OPEN; SPINAL CORD INJURIES WITH OR WITHOUT EVIDENCE OF VERTEBRAL INJURY and 498 (497) CLOSED DISLOCATIONS/FRACTURES OF NON-CERVICAL VERTEBRAL COLUMN WITHOUT SPINAL CORD INJURY</p> <p>Place vertebroplasty on the Never Covered list</p> <p>Delete vertebroplasty guideline (Guideline Note 22)</p>
<p><b>Peripheral neuropathy/RSD</b>  Smits reviewed a summary which examined the effects of adding reflex sympathetic dystrophy (RSD) to the dysfunction lines. The document also reviewed the placement of other types of peripheral neuropathies. Saha requested that RSD</p>	<p>Add RSD (337.20) to Lines 317 NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS and 404 DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE LEVEL OF INDEPENDENCE IN</p>

<p>only be added to the dysfunction lines which related to movement (317 NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS, 404 DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE LEVEL OF INDEPENDENCE IN SELF- DIRECTED CARE CAUSED BY CHRONIC CONDITIONS THAT CAUSE NEUROLOGICAL DYSFUNCTION). The coding guideline suggested for Line 317 was accepted. The subcommittee did not feel that any other peripheral neuropathy diagnosis needed to be moved.</p>	<p>SELF-DIRECTED CARE CAUSED BY CHRONIC CONDITIONS THAT CAUSE NEUROLOGICAL DYSFUNCTION.</p> <p>Place coding guideline on Line 317 stating that “337.20 is not to be paired with spinal cord stimulation (63655-63688)”</p>
<p><b>Second Solid Organ Transplants</b>  Smits and Livingston introduced a summary document with information about the effectiveness of second solid organ transplants. This document reviewed the generally good outcomes, except in the case of acute need for second transplant. Saha felt that the HSC should not dictate coverage in this area; rather national organ allocation groups and local transplant centers should allocate organs. McKelvey was concerned about not covering these transplants in acute cases, which might conflict with national organizations recommendations. Saha pointed out that currently, the HSC guideline conflicts with national recommendations.</p> <p>The subcommittee agreed that second solid organ transplants should be covered, with the exception of during the acute post transplant phase (3 months per OHSU transplant service).</p>	<p>Second solid organ transplants to be allowed, except in the 3 months post-transplant.</p> <p>Guideline Note 16 Second Solid Organ Transplants changed to read as shown in Appendix A</p> <p>Transplant algorithm first line changed to read “second solid organ within 3 months of first” from “second transplant of solid organ other than kidney”</p>
<p><b>Enzyme Replacement Therapy for Hunter’s Syndrome</b>  Shire Pharmaceuticals gave a 5 minute presentation. First, Dr. Anudrontis from Emanuel Children’s Hospital spoke about the dramatic effects on airway viability with Elaprase therapy, as well as the effects of this treatment on patient and family quality of life. Dr. Whiteman presented a packet of research articles to the Commission for their review.</p> <p>Saha began the discussion by noting that the HSC is charged with husbanding public money to provide cost effective care. All types of conditions—coverage will improve quality of life. Evidence needs to be reviewed. Main issue is cost of treatment.</p> <p>Whiteman agreed on the existence of a limited pool of money. However, he noted that the Subcommittee had just discussed second organ transplant, which is expensive. Oregon is the only public payer which will not cover this therapy. Public opinion is that this is an effective treatment and should be paid for. This is an approved treatment in UK, which uses evidence for coverage. He referred the Commission to NICE, for review of their guidelines. These guidelines are publically</p>	<p>The HOSC will continue the discussion on Elaprase treatment at the December meeting.</p> <p>HSC staff will confer with other state Medicaid agencies to verify that all other states are covering Elaprase treatment.</p>

available. He also stressed the importance of the HSC consulting with specialists in the Oregon area regarding Elaprase. He noted that no specialists had been consulted to date in the process for determination of coverage for Elaprase.

Saha noted that the Oregon process for determination of coverage for treatments such as Elaprase is very explicit about what can and cannot be afforded. Whiteman replied that Oregon needed to spread cost over the entire population. Saha replied that the HSC makes decisions about coverage and deliberations about cost in a very explicit, public manner. Oregon is willing to spend money when the results/benefit is there, such as second organ transplant. It is not cost, it is cost-effectiveness which is the primary determinant in Oregon.

Dodson requested that HSC staff check that Oregon is the only state to not cover for Medicaid. Smits and DMAP staff thought that this was true.

Whiteman specifically brought up the problematic nature of using QALY for evaluation of coverage for treatments for rare diseases, as they are not very reliable in these cases.

McKelvey asked how many cases of Hunter's syndrome were in Oregon. Anudrontis replied that there were three that he was aware of. Whiteman thought there may be 4 to 5 patients in Oregon based on incidence data. McKelvey asked at what age children are treated, what their life span was expected to be, and how long they would be expected to be on this treatment. Anudrontis replied that children are treated as soon after diagnosis as possible, and expected length of treatment is for life. He stated that expected life expectancy was in the teens for untreated children, and that no data on treated children's life spans was known to date. Whiteman concurred. McKelvey thought that conservatively patients would be expected to be on enzyme for 15 yrs? Anudrontis and Whiteman thought yes.

McKelvey asked how patients in Oregon were currently getting Elaprase. Anudrontis replied that one was receiving it through Shire patient assistance, one through OHP, and one through Washington Medicaid.

Gubler asked the presenter what should be prioritized below Hunter's syndrome enzyme treatment. Whiteman replied that prioritization was unique to Oregon and would not give a

<p>priority to the treatment. Whiteman stated that treatment reduces other medical expenses and improves quality of life. He noted treatment was very beneficial to airway issues (tongue, tonsils, etc shrink). Gubler asked for data to support claims of improving quality of life. Whiteman replied that these studies had not been done.</p> <p>Saha asked about the very high QALY reported in the Welsh government report. Whiteman replied that this study is being challenged in the British courts. He again stated that it was difficult or impossible to calculate QALY well for such rare diseases.</p> <p>The Subcommittee decision was to review the literature provided by the speakers and continue the discussion at the December HOSC meeting.</p>	
<p><b>Ophthalmologic issues</b></p> <p>1) <u>Central serous retinopathy</u> Smits introduced a document summarizing the issue on coverage of central serous retinopathy, as well as input from two ophthalmologists. The recommendation was for no change, with further evaluation during the next biennial review. The subcommittee had no discussion.</p> <p>2) <u>Pars planitis</u> Coverage of pars planitis was discussed. Saha disagreed with the recommended change (adding pars planitis to the uveitis line). He felt that the HSC “shouldn’t just “tuck” this diagnosis into a place to cover it because the expert says to.” He stressed that the HSC has criteria for prioritization. He recommended having the experts score this condition for number requiring medical care, burden of suffering, etc. and see where it falls out compared to the rest of the list. He stressed that the HSC does not necessarily need to follow expert recommendations, which may be biased toward treatment. The HSC should make coverage decisions based on evidence and the need to improve the overall health of the population.</p> <p>The discussion then discussed the reasons for covering this diagnosis: 1) making caring for OHP patients more difficult for providers, 2) covering similar conditions in a similar fashion—if pars planitis is a form of uveitis with the complications of uveitis, then it should be treated like uveitis, 3) treatment of this condition is low cost.</p> <p>Dodson thought that it might be appropriate to move pars</p>	<p>1) <u>Central serous retinopathy</u> a) No changes made to current list b) Will readdress at next biennial review</p> <p>2) <u>Pars planitis</u> a) No change in list placement made for pars planitis. b) 363.31 (solar retinopathy) removed from Line 107 (106) <b>DIABETIC AND OTHER RETINOPATHY and added to Line 674 (672) SENSORY ORGAN CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY</b></p> <p>3) <u>Hypotony</u> a) Keep Hypotony of eye (360.3) on Line 674 (672) SENSORY ORGAN CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY b) Add Hypotony of eye (360.3) to Line 307 <b>COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT</b> with the following coding guideline: “360.3 is only covered on this line when resulting from a complication of a procedure. Non-procedure related cases are covered on line 674 (672) SENSORY ORGAN CONDITIONS WITH NO OR MINIMALLY EFFECTIVE</p>

<p>planitis to be with uveitis, but that the HSC needed to see how this diagnosis would be treated if prioritized by itself. Smits offered to ask Drs. Baer and Lauer, the consulting ophthalmologists, to prioritize the condition based on HSC prioritization criteria. McKelvey thought that the HSC should cover pars planitis if it a complication of a covered condition, but otherwise no changes should be made to the list. Kirk noted that pars planitis would not be covered if it was coded under MS or other underlying condition.</p> <p>Discussion then centered around the lack of evidence that coverage is needed for pars planitis. The majority agreed that the evidence for coverage was weak. Saha pointed out that there is no strong evidence for coverage of certain conditions, necessitating the reliance on expert opinion for their treatment. McKelvey raised concerns that there may be harms of treatment, based on Dr. Baer’s statements.</p> <p>Based on the weak evidence that treatment was required, and the concerns for possible complications of this treatment; the subcommittee decided to not move pars planitis from its current uncovered line.</p> <p>3) <u>Hypotony</u> Smits introduced a summary document outlining suggested changes to the coverage for hypotony. The subcommittee agreed that hypotony resulting from a procedure should be covered under the complications of a procedure line.</p> <p>4) <u>Macular edema</u> Smits reviewed the evidence surrounding treatment for macular edema. Treatment of diabetic macular edema is already covered. Saha felt that if non-diabetic macular edema has the same pathophysiology and complications of diabetic macular edema, then treatment should be covered. However, it was pointed out that no evidence was found for vitrectomy for this condition. The subcommittee elected to cover treatment for this condition, except vitrectomy.</p>	<p>TREATMENTS OR NO TREATMENT NECESSARY.”</p> <p>c) Add the following CPT codes to Line 307 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT: 67005-67027, 67036-67043 (Vitrectomy), 67028 (Intravitreal administration of medication)</p> <p>d) Move 360.32 (ocular fistula causing hypotony) from Line 285 SYMPATHETIC UVEITIS AND DEGENERATIVE DISORDERS AND CONDITIONS OF GLOBE to Line 674 (672) SENSORY ORGAN CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY</p> <p>4) <u>Macular edema</u></p> <p>a) Add periocular injection (67515) to Line 107 (106) DIABETIC AND OTHER RETINOPATHY</p> <p>b) Add retinal edema (362.83) to Line 466 (465) DEGENERATION OF MACULA AND POSTERIOR POLE</p> <p>c) Add laser photocoagulation (67210) and periocular injection (67515) to Line 466 (465) DEGENERATION OF MACULA AND POSTERIOR POLE</p> <p>d) Delete 362.83 from Line 674 (672) SENSORY ORGAN CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY</p>
<p><b>Pulmonary Arterial Hypertension</b> Smits introduced the summary document on pulmonary hypertension. The recommendation was no change to the procedures on the list for this condition. Saha asked why the drugs for this condition were not open for discussion. Smits clarified that the HSC does not discuss medications unless they are an infusion or some other type of treatment with a CPT code. Shaffer also clarified that medications are discussed</p>	<p>No changes to List made</p>

<p>when the effectiveness of these medications as a treatment may affect a line placement. The HOSC agreed with the recommendation to not change current procedures for PAH.</p>	
<p><b>Anesthesia catheters</b>  Smits introduced a summary document about ON-Q and similar catheters used after surgery for pain control. Kirk indicated that these types of devices are covered. They are considered surgical supplies, like dressings or drains, and paid under DRG for inpatient surgery. However, outpatient surgical centers want to change an additional fee in addition to the surgical DRG. Medicare guidelines are clear that these are part of the surgical DRG. Main question is whether this would allow a surgery to happen in the outpatient setting rather than the inpatient. No data is available on this question, however. Shaffer indicated that the real question is whether professional fee for placement should be covered (rather than the cost of the device itself). The question is whether this professional service is part of anesthesia/ancillary services? Gubler noted that he has conflict of interest, as he uses this device. However, he noted that this device/placement can be gamed—placed when not indicated. However, he also has found significant benefit with these devices for patients for pain control, mobility, etc. He also noted that there are times when the devices are placed when there is no surgical procedure done, such as placement for rib fractures. Saha stressed that the HSC should only pay for devices that have good evidence of effectiveness.</p> <p>Mckelvey suggested covering the professional fee and not the cost of the device itself. The group concurred. Smits asked if this decision was advisory for DMAP, as it involves no change to the List or current guidelines. Shaffer indicated that this was possible.</p>	<p>No change to the List or guidelines. DMAP advised to pay for the professional fee for placement, but not for the device itself as it should be considered part of the surgical supplies.</p>
<p><b>Hepatic metastases</b>  Livingston introduced the summary document on liver metastases. The recommendation was to move 197.7 (Secondary malignant neoplasm of the liver) from Line 613 SECONDARY AND ILL-DEFINED MALIGNANT NEOPLASMS to Line 338 CANCER OF LIVER, to pair with 47120-47130 (Hepatectomy, resection of liver), with a coding specification to avoid inappropriate pairings: “Hepatic metastases (ICD-9 code 197.7) are covered in this line only when paired with CPT code 47120-47130 and only when no other extrahepatic metastases are present.”</p> <p>Saha asked whether this diagnosis could have the cancer care</p>	<p>HSC staff to develop a guideline restricting treatment of solitary hepatic metastases to evidence based situations, and to determine whether placement should be on the colorectal or liver cancer lines. Staff will forward this guideline/ recommendation to Saha and return to the December meeting for further discussion.</p>

statement of intent criteria applied to it. Livingston reported that the 5 year survival is not reported. Historically, survival is 3-25 month survival without treatment and 14-17 months with treatment. Mckelvey asked whether survival was affected by type of primary cancer; Livingston replied that all studies reviewed were on colorectal cancer. Saha noted that based on the 5 year survival data, it appears that treatment of solitary liver metastases meets the criteria in the SOI of improvement of 30%. Historically, best survival 2 yrs, this data shows 3 years, which is 50% increase in survival.

The suggestion was made that solitary liver metastases be moved to the colon cancer line, as this was where the evidence for treatment was strongest. Smits noted that CPT treatment codes would also need to be added to this line. Coffman cautioned that moving CPT codes would allow them to pair with other types of cancer as the ICD-9 code for liver metastases is generic/not specific for metastatic colorectal cancer. Saha asked whether the HSC could make a guideline restricting use of this code for metastatic colon/rectal cancer if this diagnosis was added to the liver cancer line; the answer from HSC staff was yes. Suggested wording for a guideline was: “Hepatic metastases (ICD-9 code 197.7) are covered in this line only for 1) a covered primary cancer treatment of which meets our statement of intent for cancer treatment, 2) when paired with CPT code 47120-47130 and 3) when no other extrahepatic metastases are present.”

Gubler disagreed, that thought that the solitary liver metastases diagnosis should be left under the liver cancer line, with treatment left to clinical judgment. Saha noted that in this situation, rare cases of other diagnoses could be treated under the exceptions process. Shaffer stated that DMAP don't grant exceptions when the HSC has a clear guideline stating limitations to coverage. Kirk objected as well, noting that the hearings/exceptions process for such exceptions are a strain to the plans. A patient with a terminal cancer below the line who has a hepatic met above the line will get an argument that the lower diagnoses (the terminal cancer) should be covered to help benefit the covered diagnosis (the liver metastases), as counterintuitive as that may be. Saha noted that some cases may involve an unknown primary cancer. He noted that in this case, there is no evidence that you would prolong life by treating the solitary metastasis.

The decision was to consider placing on either the colorectal or

<p>the liver cancer line, with a guideline to be developed by HSC staff and sent to Saha for comment. This topic will be revisited at the December meeting.</p>	
<p><b>Structural List Issues</b>  Smits opened the discussion by outlining issues the plans and DMAP are having with the Statements of Intent, specifically that the Legislature did not authorize the SOIs and therefore they do not have the same force as the List or the guidelines. Suggestions were that the statements of intent be made into OAR through DMAP rule making process or that the HSC approach the Legislature to receive authorization for the SOIs. Dodson suggested that the legislative approach was problematic, and recommended pursuing OAR approach at the agency level. Coffman reassured the group that there was a lot of legislation going forward from the Health Authority, and that this change could be easily put into one of these bills. Dodson recommended pursuing both approaches. Shaffer objected, stating that there will be issues for DMAP with going through OAR. No DMAP legal review has been done to date. Administrative law judges found no legislative authority for the SOIs. Shaffer was not sure if DMAP has the authority through OAR to give authority to the SOI. Coffman noted that some SOI are attached to lines as footnotes and therefore should have authority. Shaffer asked what the difference was between guideline and SOI. Saha asked whether the SOIs could simply be made into guidelines. Coffman replied that some would be easy to make into guidelines, such as the cancer statement of intent with is already referenced on the cancer lines. Others, such as the viral illness statement of intent would be more difficult to apply to specific lines. The consensus was to change SOI to guidelines and directly reference these guidelines on appropriate lines.</p>	<p>Statements of Intent will be redone into guidelines and directly applied to appropriate lines on the Prioritized List. Staff will only bring back to the HOSC if there are specific questions or issues that arise during this process.</p>
<p><b>Guidelines</b>  1) Spinal MRI  Smits introduced a suggested guideline for spinal MRI tests. The group felt the guideline was well done. Shaffer suggested adding a clause about “objective evidence” of neurological changes.   2) Cesarean Delivery on Maternal Request  Smits introduced a suggested guideline limiting cesarean deliveries to situations in which there was medical or obstetrical indications. Gubler noted that cesarean delivery on maternal request was an elective procedure, like cosmetic surgery, and should not be covered. It is a personal choice, not a societal need. The guideline was adopted as suggested.</p>	<p>1) Spinal MRI: guideline wording in Appendix A   2) Cesarean Delivery on Maternal Request: guideline wording in Appendix A</p>

<p><b>Codes on the Diagnostic List and the Prioritized List</b> Smits introduced a document outlining certain codes which currently appear on both the Prioritized and the Diagnostic List, which are suggested to be removed from the Prioritized List and left only on the Diagnostic List.</p> <p>Saha disagreed with the suggestions, stating that a code should be covered on diagnostic list only if needs to be done to make a diagnosis. Those things done to evaluate a particular diagnosis (extent of spread, level of severity, subtype, etc.) should be on lines of the Prioritized List. If a code can be placed on limited number of lines, put it on those lines. He stressed the need to tie codes to the List whenever possible and keep Line Zero small.</p> <p>The decision was to have HSC staff re-examine these codes and bring revised suggestions to the December HOSC meeting.</p>	<p>HSC staff to re-examine possible Prioritized List placement for these codes and bring to the December meeting.</p>
<p><b>Sigmoidoscopy and colonoscopy</b> Smits introduced a document outlining placement decisions for various GI endoscopy codes. The Subcommittee agreed to the suggestions.</p>	<p>All changes suggested in summary document approved.</p>
<p><b>Straightforward Issues</b> There was minimal discussion of the recommendations. Saha suggested that 87338 (H Pylori stool testing) be added to the peptic ulcer line instead of the Diagnostic List.</p>	<p>Changes approved as suggested in the summary document except:</p> <p>1) 87338 added to Line 61 <b>ULCERS, GASTRITIS, DUODENITIS, AND GI HEMORRHAGE</b></p>

## Appendix A: Guidelines

### **GUIDELINE NOTE 16, SECOND SOLID ORGAN TRANSPLANTS**

*Lines 92 (91),170 (169),253 ,254,255,256,279,332,575(574)*

~~Second solid organ transplants of the same type of organ are not covered except for acute graft failure that occurs during the original hospitalization for transplantation.~~ Second solid organ transplants of the same type of organ(s) are covered, except for within 3 months of original transplantation.

### **DIAGNOSTIC GUIDELINE DXX MRI OF THE SPINE**

*Lines 397, 552(551)*

MRI of the spine is covered in the following situations:

- 1) Major or progressive neurologic deficit (objective evidence of reflex loss, dermatomal muscle weakness, dermatomal sensory loss, EMG or NCV evidence of nerve root impingement) or suspected cauda equine syndrome (loss of bowel or bladder control or saddle anesthesia) in patients who are potential candidates for surgery
- 2) Clinical or radiological suspicion of neoplasm
- 3) Clinical or radiological suspicion of infection

### **GUIDELINE NOTE XXX CESAREAN DELIVERY ON MATERNAL REQUEST**

*Line 1*

Cesarean delivery on maternal request without medical or obstetrical indication is not a covered service

### **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.

**MEETING HIGHLIGHTS  
HEALTH OUTCOMES SUBCOMMITTEE**

Clackamas Community College

Wilsonville, Oregon

December 10, 2009

8:00 AM-3:00 PM

**Members Present:** Lisa Dodson, MD, Chair; Carla McKelvey, MD; Kevin Olson, MD

**Members Absent:** Somnath Saha, MD, MPH, K. Dean Gubler, MD, MPH

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

**Also Attending:** Wally Shaffer MD, DMAP; Caroline Price RN, DMAP; Isabel Bickle, DMAP;

Chris Barber, DMAP; Chris Kirk, MD, OHP Medical Directors; Becky Child, Mental Health

America of Oregon; Kelly Harms, OHPR

*Note: The next HOSC meeting is scheduled for January 14, 2010.*

*Note: All line numbers are referenced from the January 1, 2010 Prioritized List.*

<b>Topic</b>	<b>Action</b>
<p><b>General</b> Highlights from October 2009 HOSC meeting reviewed. No changes or corrections were made.</p>	<p>Highlights from October 09 meeting approved without change</p>
<p><b>2010 CPT/HCPCS codes</b> Smits reviewed an Excel spreadsheet with the 2010 CPT and HCPCS codes. The suggestions for code placement were generally accepted as outlined in the meeting materials. Codes which were discussed and suggestions changed included:</p> <ol style="list-style-type: none"> <li>1) 32550 and 32552 (insertion and removal of tunneled pleural catheter). Olson requested that these codes be placed on the lung cancer line for removal of malignant effusion in addition to the other suggested lines.</li> <li>2) 32553. There was discussion about why this code and similar codes were on lines 77 and 88. It was decided that the code may be on line 77 to pair with some other type of procedure series, and was on 88 for heterotopic bone formation. HSC staff was directed to look at old minutes to determine way this code is on Line 88 and whether it should remain there.</li> <li>3) 94011-94013. McKelvey was skeptical that these codes represent testing that can actually be done, given that young children are generally unable to co-operate with this type of testing. These codes should be seldom used. The consensus was to place these codes on the Watch List.</li> <li>4) S0280-S0281 (medical home care co-ordination). The suggested placement was on all lines with E&amp;M codes. Bickle expressed concern who what type of provider could bill for this service. McKelvey noted that this type of service been used heavily in pediatrics, but that</li> </ol>	<p>Code placements were approved as outlined in the Excel spreadsheet in the meeting materials with the following additions or changes:</p> <ol style="list-style-type: none"> <li>1) 32550 and 32552 added to Line 278</li> <li>2) S0280-S0281 were pended until the report on the Medical Home Taskforce is available.</li> </ol>

<p>the definition of medical home is vague and it would be hard to administer this type of code. Coffman noted that there was a taskforce at the state level meeting to define a medical home. The suggestion was made to hold on a decision regarding these codes until the taskforce report was complete and available for discussion. The HOSC members agreed. Decision was to not act on these codes until the statewide medical home taskforce report was available. Once a state policy on medical home is available, then the HSC will discuss these codes and determine the best List placement, need for guideline, or other action.</p> <p>5) 90670 (pneumococcal vaccine). Discussion centered around whether this code should simply be added to the List, with the assumption that FDA approval will occur. Bickle pointed out that DMAP needs to cover this vaccine if its approved for VFC. The decision was to wait for FDA approval and CDC/ACIP recommendations, and allow HSC to act on this code without further HSC action once these federal bodies make decisions.</p>	
<p><b>Codes appearing on both the Diagnostic and Prioritized Lists</b></p> <p>Smits reviewed a summary indicating that the majority of these codes need to be on the Diagnostic List. The recommendations were accepted as outlined in the meeting materials, with the following exceptions:</p> <ol style="list-style-type: none"> <li>1) 57500 (Biopsy of cervix): Coffman pointed out that all biopsies are on the Diagnostic list, and argued that for consistency sake, this should be Diagnostic as well. The decision was to remove from the Prioritized List and place on the Diagnostic List.</li> <li>2) 57505 (Endocervical curettage). This was felt to be the equivalent of a biopsy, and was also added to the Diagnostic List alone.</li> </ol>	<p>All recommendations in the meeting materials were accepted except:</p> <ol style="list-style-type: none"> <li>1) 57500 and 57505 were removed from the Prioritized List and kept on the Diagnostic List</li> </ol>
<p><b>Health and Behavior Assessment Codes</b></p> <p>Smits introduced a summary document with outlining issues with the type of provider who can bill for health and behavior assessments. Discussion centered around how OMHPs are licensed/certified by DMAP and the licensing boards. Bickle noted that these types of providers are not trained to deal with the physical health issues which these codes require. Also, DMAP does not pay these types of providers directly; they pay the larger organization. This makes quality control difficult. Shaffer pointed out that these types of providers are certified through Mental Health, which has different criteria for certification than DMAP. Also, these providers are getting paid from the physical health budget, although they are mental health professionals. The discussion then centered around the administrative issues with adopting these Health and Behavior</p>	<p>Continue the discussion at the MHCD Subcommittee meeting, and revisit at the January HSC meeting.</p>

<p>codes. There are also issues with access to this type of care, as well as quality issues. The role these types of codes/types of care play in the medical home was discussed. Also, the issues with OMHPs using these codes paired with mental health diagnoses, which is not correct. In general, the HOSC felt that only CMS approved providers for these codes should be allowed to bill; however, the group felt that further discussion should be help at the Mental Health and Chemical Dependency Subcommittee meeting in December, and then the issue discussed with the full HSC in January.</p>	
<p><b>Spasmodic Dysphonia</b>  Dr. James Thomas, Portland area ENT, gave a presentation on botox injection for treatment of dysphonia. There was extensive discussion about the accuracy of the diagnosis, the evidence base for this type of treatment, the cost of the procedure, other treatments available (no medical treatments), how patients are selected for treatment, and the effects of treatment. The evidence base supporting this treatment is limited. Olson pointed out that this is a rare condition, studies are small, but generally positive, showing benefit, for spasmodic dysphonia. The group felt that there was evidence to support treatment of spasmodic dysphonia; however, it is on a line by itself and cannot be moved until a biennial review. The suggestion was made to add spasmodic dysphonia to the list of diagnoses for review during the next biennial review. Dr. Thomas agreed to find and forward evidence from the literature to support coverage/treatment of vocal cord paralysis.</p>	<p>Spasmodic dysphonia will be considered for movement higher on the list during the next Biennial Review</p> <p>Dr. Thomas will find and forward literature to support treatment of vocal cord paralysis. Staff will review and put on a future agenda if there is evidence to support treatment.</p>
<p><b>Non specific arthropathies</b>  Smits introduced a summary document. There was minimal discussion, the outlined changes were accepted.</p>	<p>716.4-716.8 were removed from Lines 52 and 480 and added to Line 677.</p>
<p><b>Large ventral hernias</b>  Livingston introduced the summary document for this topic. The discussion centered around how the HSC developed the current hernia guidelines (years of trial and error) and the definition of “complicated”. There was general agreement that mesh had little evidence for use. The probability of successful repair of the large ventral hernia case in the summary document was felt to be low. Changing the guidelines based on a single case was felt to be undesirable. The decision was to make no changes to the current hernia guidelines.</p>	<p>No changes to List made</p>
<p><b>Negative Pressure Wound Therapy</b>  Livingston introduced a summary document about this topic. Anecdotal cases of success were brought up; however, the studies reviewed found no evidence of benefit. Subset analysis of specific types of wounds which may response to this treatment better than others was not identified. Shaffer and Barber reported that DMAP uses CMS criteria for payment at this point, but that they are getting many requests for use at the time of surgery. The code in question is only for doctor’s fees,</p>	<p>Negative pressure wound therapy physician codes remain on the Never Covered List.</p> <p>DMAP to provide HSC staff with equipment codes for consideration for removal from the List for the January meeting.</p>

<p>not for the equipment used. DMAP pointed out that if the HSC does not want these devices used, then changes will need to be made in the equipment codes. Dodson raised concerns about the evidence of harms found in studies. The decision was made to not move the current physician codes for negative pressure wound care from the Never Covered List. DMAP will give equipment codes to HSC staff for consideration for removal from the List.</p>	
<p><b>Sacroiliitis</b> Smits introduced a summary about the List placement of sacroiliitis. There was minimal discussion.</p>	<p>720.0 (Sacroiliitis) deleted from Line 511 and added to Line 52</p>
<p><b>TIPS</b> Smits introduced a summary document outlining suggested changes to the List for TIPS procedures. There was no discussion; the suggested changes were accepted as stated in the document.</p>	<p>TIPS (37182) was added to Lines 225 and 359</p> <p>37183 (Revision of transvenous intrahepatic portosystemic shunt) removed from the Ancillary list and placed on Lines 225, 231, 302, 359</p> <p>Guideline adopted as outlined in Appendix A</p>
<p><b>Lab test codes on the List</b> Smits introduced a document which outlined issues with placement of lab codes on the Prioritized List. The HOSC agreed that lab codes should be either Diagnostic or Never Covered (depending on the evidence of effectiveness and utility) unless there is a compelling reason to place them on a Prioritized List Line. Reasons would include 1) the test is abused or code be abused, 2) the test has very limited use, such as only for transplants, or 3) the test is only used for a diagnosis on lines below the funding line.</p>	<p>Lab CPT/HCPCS codes will be generally placed on the Never Covered or Diagnostic List, unless there is a compelling reason for placement on the Prioritized List.</p>
<p><b>Tobacco Cessation</b> Becky Child testified about the effectiveness and utility of peer delivered services. Coffman clarified that the HOSC is being asked to consider adding peer counseling for tobacco cessation to the alcohol and chemical dependency line. Coffman further clarified that the HOSC is being approached to allow peer services for several mental health issues. The majority of the codes needed for the requested services are already on the Prioritized List, with the exception of this tobacco code on the alcohol/chemical dependency line.</p> <p>The group felt that this topic was best sent to the MHCD meeting for December for further discussion. The HSC will further discuss this topic in January.</p>	<p>Referred to the MHCD Subcommittee, will be readdressed at the January HSC meeting.</p>
<p><b>Guidelines</b> <u>1) Solitary liver metastases</u> Livingston introduced a summary regarding solitary liver metastases. There was minimal discussion.</p>	<p>1) Move 197.7 (Secondary malignant neoplasm of the liver) from Line 612 to Line 338. Guideline adopted as shown in Appendix A.</p>

<p><u>2) Mammography/Pap smears</u>  Smits introduced suggested changes to the Prevention Tables based on new guidelines for mammograms and pap smears. Olson raised concerns about the clinical impact of these recommendations, and the evidence used for making the recommendation changes at the USPSTF. Other concerns were raised about higher risk younger women not getting screened, which was not the intent of the USPSTF changes. Coffman noted that the prevention tables are for the general population; wording about high risk women and mammograms could be added to the high risk tables if desired.</p> <p>McKelvey raised concerns about waiting for pap smears for certain high risk teens; Bickle stated that there are no controls on age in the DMAP payment system, so these patients could continue to get screening.</p> <p>McKelvey also suggested changing the entries regarding Td to TDaP to agree with current CDC recommendations.</p> <p>The decision was to modify the suggested changes to not call out the 40-49 age group for women for mammograms in the table itself, only in the footnote. See the suggested changes in Appendix B.</p> <p><u>3. Second solid organ transplants</u>  Smits introduced a summary document outlining a request to eliminate the second solid organ transplant guideline. Debate centered around the lack of desire to add a later of administrative complexity on top of UNOS. The decision was made to eliminate the guideline.</p> <p><u>4. Cystic fibrosis carrier testing</u>  Livingston introduced a summary document regarding CF testing in pregnancy. The discussion centered around usual care, and whether testing would result in pregnancy termination. Non pregnant patients would fall under the existing genetic testing algorithm. Changes were suggested which simplified the guideline and reflected the fact that non-pregnant patients should follow the genetic testing algorithm. The adopted guideline is shown in Appendix A.</p>	<p>2) Changes to the Prevention Tables adopted as shown in Appendix B.</p> <p>3) Second solid organ transplant guideline was eliminated.</p> <p>4) Add V77.6 (CF carrier testing) to Line 1. Add a guideline to Lines 1, 3 and 4 as shown in Appendix A</p>
<p><b>Indwelling catheters and cannulas</b>  Smits introduced a document outlining suggested changes to the current catheter and cannula code placement. 49422 was suggested for addition to line 252.</p>	<p>Changes adopted as outlined in the meeting materials. Additionally, 49422 was added to Line 252.</p>
<p><b>Straightforward Issues</b>  There was minimal discussion of the recommendations.</p>	<p>Changes approved as suggested in the summary document</p>
<p><b>Value based services</b>  Smits, Coffman and Livingston introduced documents related to Value Based Services. Discussion centered around what</p>	<p>Topic will be re-visited at January HSC meeting.</p>

types of services should be considered VBS, for example, should office visits be considered? Diagnoses up for review for VBS were reviewed. Olson suggested that rather than calling these services “value based services,” they should be called “extremely high value services” to reflect that most services have some value. Also, the group felt that VBS should have a low likelihood of abuse. Discussion centered around ways to simplify the VBS, for example by simply having certain medications or tests available regardless of diagnosis when they are shown to be VBS for one diagnosis. This was felt to be implementation issues, however.

The group decided to have HSC finish the review of the top 25 diagnoses identified at the October meeting, complete the summary table, and make suggestions about certain procedures, medications, etc. being always available as VB regardless of diagnosis.

## Appendix A: Guidelines

### **GUIDELINE NOTE XXX TIPS PROCEDURE**

*Lines 225, 231, 302, 359*

TIPS procedure (CPT code 37182, 37183) is included on these lines for patients who

- 1) Have failed sclerotherapy and have acute bleeding from varices; *or*
- 2) Have failed sclerotherapy and have had 2 or more episodes of re-bleeding requiring a transfusion during a 2-week period; *or*
- 3) Requires bleeding control from varices and surgery is contraindicated; *or*
- 4) Are liver transplant candidates who require bleeding control from varices; *or*
- 5) Have severe debilitating ascites or hepatic hydrothorax refractory to medical management (e.g., oral diuretics and repeated large-volume paracentesis).

### **GUIDELINE NOTE XXX, HEPATIC METASTASES**

*Line 338*

Hepatic metastases (ICD-9 code 197.7) are covered in this line only when:

- 1) Treatment of the primary tumor is covered on a funded line in accordance with the criteria in guideline note XX Treatment of Cancer With Little or No Benefit Provided Near the End of Life;
- 2) There are no other extrahepatic metastases; and,
- 3) The only treatment covered is hepatectomy/resection of liver (CPT codes 47120, 47122, 47125 or 47130)

### **Guideline Note XXX Cystic Fibrosis Carrier Screening**

*Lines 1, 3 and 4*

Cystic fibrosis carrier testing is covered for 1) non pregnant adults if indicated in the genetic testing algorithm or 2) couples who are seeking prenatal care in whom one or both are Caucasian (including Ashkenazi Jewish) or has a family history of cystic fibrosis.

# Appendix B

## Ages 11-24 Years

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### Interventions Considered and Recommended for the Periodic Health Examination

### Leading Causes of Death

**Motor vehicle/other unintentional injuries**  
**Homicide**  
**Suicide**  
**Malignant neoplasms**  
**Heart diseases**

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### Interventions for the General Population

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#### SCREENING

Height and weight  
Blood pressure<sup>1</sup>  
High-density lipoprotein cholesterol (HDL-C) and total blood cholesterol (age 20-24 if high-risk)<sup>2</sup>  
Papanicolaou (Pap) test<sup>3</sup>  
Chlamydia screen<sup>4</sup> (females <25 yr)  
Rubella serology or vaccination hx<sup>5</sup> (females >12 yr)  
Learning and attention disorders<sup>6</sup>  
Signs of child abuse, neglect, family violence  
Alcohol, inhalant, illicit drug use<sup>7</sup>  
Eating disorders<sup>8</sup>  
Anxiety and mood disorders<sup>9</sup>  
Suicide risk factors<sup>10</sup>

#### COUNSELING

##### Injury Prevention

Lap/shoulder belts  
Bicycle/motorcycle/ATV helmet\*  
Smoke detector\*  
Safe storage/removal of firearms\*  
Smoking near bedding or upholstery

##### Substance Use

Avoid tobacco use  
Avoid underage drinking & illicit drug use\*  
Avoid alcohol/drug use while driving, swimming, boating, etc.\*

#### Sexual Behavior

STD prevention: abstinence\*; avoid high-risk behavior\*; condoms/female barrier with spermicide\*  
Unintended pregnancy: contraception

#### Diet and Exercise

Limit fat & cholesterol; maintain caloric balance; emphasize grains, fruits, vegetables  
Adequate calcium intake (females)  
Regular physical activity\*

#### Dental Health

Regular visits to dental care provider\*  
Floss, brush with fluoride toothpaste daily\*

#### Mental Health/Chemical Dependency

Parent education regarding:

- Adolescent development
- Behavior management
- Effects of excess TV watching
- Special needs of child and family due to:
  - Family stress or disruption
  - Health problems
  - Temperamental incongruence with parent
  - Environmental stressors such as community violence or disaster, immigration, minority status, homelessness
- Referral for MHCD and other family support services as indicated

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<sup>1</sup>Periodic BP for persons aged > 21 yr. <sup>2</sup>High risk defined as having diabetes, family history of premature coronary disease or familial hyperlipidemia, or multiple cardiac risk factors. <sup>3</sup>Screening to start at age 21 ~~or 3 years after onset of sexual activity (whichever comes first); screening should occur at least every 3 years~~ <sup>4</sup>If sexually active. <sup>5</sup>Serologic testing, documented vaccination history, and routine vaccination against rubella (preferably with MMR) are equally acceptable alternatives. <sup>6</sup>Consider screening with full DSM-IV criteria for attention deficit disorder, inattentive or hyperactive types, in children with significant overall academic or behavioral difficulty including academic failure and/or learning difficulty, especially in reading, math or handwriting. <sup>7</sup>Persons using alcohol and/or drugs. Physical and behavioral indicators: liver disease, pancreatitis, hypertension, gastritis, esophagitis, hematological disorders, poor nutritional status, cardiac arrhythmias, alcoholic myopathy, ketoacidosis, neurological disorders: smell of alcohol on breath, mood swings, memory lapses or losses, difficulty concentrating, blackouts, inappropriateness, irritability or agitation, depression, slurry speech, staggering gait, bizarre behavior, suicidal indicators, sexual dysfunction, interpersonal conflicts, domestic violence, child abuse and neglect, automobile accidents or citation arrests, scholastic or behavior problems, secretiveness or vagueness about personal or medical history. <sup>8</sup>Persons with a weight >10% below ideal body weight, parotid gland hypertrophy or erosion of tooth enamel. Females with a chemical dependency. <sup>9</sup>In women who are at increased risk, diagnostic evaluation should include an assessment of history of sexual and physical violence, interpersonal difficulties, prescription drug utilization, medical and reproductive history. <sup>10</sup>Recent divorce, separation, unemployment, depression, alcohol or other drug abuse, serious medical illness, living alone, homelessness, or recent bereavement.

\*The ability of clinical counseling to influence this behavior is unproven.

## Ages 25-64 Years

### Interventions Considered and Recommended for the Periodic Health Examination

### Leading Causes of Death

**Malignant neoplasms**

**Heart diseases**

**Motor vehicle/other unintentional injuries**

**Human immunodeficiency virus infection**

**Suicide and homicide**

### Interventions for the General Population

#### SCREENING

Blood pressure [Ch 3]

Height and weight [Ch 21]

High-density lipoprotein cholesterol (HDL-C) and total blood cholesterol (men age 35-64, women age 45-64)

Papanicolaou (Pap) test<sub>1</sub> [Ch 9]

Fecal occult blood test<sub>2</sub> and/or sigmoidoscopy (>50 yr) [Ch 8]

[Mammogram<sup>5</sup> \(women 40-74 yrs\)](#)

Rubella serology or vaccination hxs (women of childbearing age) [Ch 32]

Learning and attention disorders<sub>6</sub>

Signs of child abuse, neglect, family violence

Eating disorders<sub>8</sub>

Anxiety and mood disorders<sub>9</sub>

Suicide risk factors<sub>10</sub>

Somatiform disorders<sub>11</sub>

Environmental stressors<sub>12</sub>

#### COUNSELING

##### Substance Use

Tobacco cessation [Ch 54]

Avoid alcohol/drug use while driving, swimming, boating, etc.\* [Ch 57, 58]

Limit fat & cholesterol; maintain caloric balance; emphasize grains, fruits, vegetables [Ch 56]

Adequate calcium intake (women) [Ch 56]

Regular physical activity\* [Ch 55]

#### Injury Prevention [Ch 57,58]

Lap/shoulder belts

Bicycle/motorcycle/ATV helmet\*

Smoke detector\*

Safe storage/removal of firearms\* [Ch 50, 59]

Smoking near bedding or upholstery

#### Sexual Behavior [Ch 62, 63]

STD prevention: abstinence\*; avoid high-risk

behavior\*; condoms/female barrier with spermicide\*

Unintended pregnancy: contraception

#### Dental Health [Ch 61]

Regular visits to dental care provider\*

Floss, brush with fluoride toothpaste daily\*

#### IMMUNIZATIONS [Ch 32, 66]

[Tetanus diphtheria \(Td\)-Tdap](#) boosters

Rubellas (women of childbearing age)

#### CHEMOPROPHYLAXIS

Multivitamin with folic acid (females planning or capable of pregnancy) [Ch 42]

Discuss hormone prophylaxis (peri- and postmenopausal women) [Ch 68]

#### Diet and Exercise

Revised 2-25-08

1 High-risk defined as having diabetes, family history of premature coronary disease or familial hyperlipidemia, or multiple cardiac risk factors. 2 Women who are or have been sexually active and who have a cervix: q < 3 yr. 3 FOBT: annually; flexible sigmoidoscopy: every 5 years; colonoscopy: every 10 years. <sup>4</sup> ~~Screening mammography should be performed every 1-2 years.~~ The screening decision for women 40-49 should be a mutual decision between a woman and her clinician. If a decision to proceed with mammography is made, it should be done every 2 years. <sup>5</sup> Between the ages of 50-74, screening mammography should be performed every 2 years. 5 Serologic testing, documented vaccination history, and routine vaccination (preferably with MMR) are equally acceptable. 6 High-risk defined as weight <70kg, not on estrogen replacement. 7 Consider screening with full DSM-IV criteria for attention deficit disorder, inattentive or hyperactive types, in children with significant overall academic or behavioral difficulty including academic failure and/or learning difficulty, especially in reading, math or handwriting. 8 Persons using alcohol and/or drugs. Physical and behavioral indicators: liver disease, pancreatitis, hypertension, gastritis, esophagitis, hematological disorders, poor nutritional status, cardiac arrhythmias, alcoholic myopathy, ketoacidosis, neurological disorders: smell of alcohol on breath, mood swings, memory lapses or losses, difficulty concentrating, blackouts, inappropriateness, irritability or agitation, depression, slurry speech, staggering gait, bizarre behavior, suicidal indicators, sexual dysfunction, interpersonal conflicts, domestic violence, child abuse and neglect, automobile accidents or citation arrests, scholastic or behavior problems, secretiveness or vagueness about personal or medical history. 9 Persons with a weight >10% below ideal body weight, parotid gland hypertrophy or erosion of tooth enamel. Females with a chemical dependency. 10 In women who are at increased risk, diagnostic evaluation should include an assessment of history of sexual and physical violence, interpersonal difficulties, prescription drug utilization, medical and reproductive history. 11 Recent divorce, separation, unemployment, depression, alcohol or other drug abuse, serious medical illness, living alone, homelessness, or recent bereavement. 12 Multiple unexplained somatic complaints. 13 Community violence or disaster, immigration, homelessness, family medical problems.

\*The ability of clinical counseling to influence this behavior is unproven.

## Age 65 and Older

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### Interventions Considered and Recommended for the Periodic Health Examination

### Leading Causes of Death

**Heart diseases**  
**Malignant neoplasms (lung, colorectal, breast)**  
**Cerebrovascular disease**  
**Chronic obstructive pulmonary disease**  
**Pneumonia and influenza**

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### Interventions for the General Population

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#### SCREENING

Blood pressure  
Height and weight  
Fecal occult blood test and/or sigmoidoscopy or colonoscopy  
Mammogram + ~~clinical breast exam~~ (women ages 65-74)<sup>2</sup>  
Bone density measurement (women)  
Fasting plasma glucose for patients with hypertension or hyperlipidemia  
Vision screening  
Assess for hearing impairment  
Signs of elder abuse, neglect, family violence  
Alcohol, inhalant, illicit drug use<sup>3</sup>  
Anxiety and mood disorders<sup>4</sup>  
Somatoform disorders<sup>5</sup>  
Environmental stressors<sup>6</sup>  
Abdominal aortic aneurysm (AAA) (men aged 65 to 75 who have ever smoked)<sup>7</sup>

#### COUNSELING

##### Substance Use

Tobacco cessation  
Avoid alcohol/drug use while driving, swimming, boating, etc.\*

##### Diet and Exercise

Limit fat & cholesterol; maintain caloric balance; emphasize grains, fruits, vegetables  
Adequate calcium intake (women)

Regular physical activity\*  
Assess eating environment

#### Injury Prevention

Lap/shoulder belts  
Motorcycle and bicycle helmets\*  
Fall prevention\*  
Safe storage/removal of firearms\*  
Smoke detector\*  
Set hot water heater to <120-130°F  
CPR training for household members  
Smoking near bedding or upholstery

#### Dental Health

Regular visits to dental care provider\*  
Floss, brush with fluoride toothpaste daily\*

#### Sexual Behavior

STD prevention: avoid high-risk sexual behavior\*;  
use condoms

#### IMMUNIZATIONS

Pneumococcal vaccine  
Influenza<sup>1</sup>  
~~Tetanus diphtheria (Td)-Tdap~~ boosters

#### CHEMOPROPHYLAXIS

Discuss aspirin prophylaxis for those at high-risk for coronary heart disease

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<sup>1</sup>FOBT: annually; flexible sigmoidoscopy: every 5 years; colonoscopy: every 10 years through age 75.  
<sup>2</sup>Screening mammography should be performed every ~~1-2 years in combination with an annual clinical breast examination~~.  
<sup>3</sup>Persons using alcohol and/or drugs. Physical and behavioral indicators: liver disease, pancreatitis, hypertension, gastritis, esophagitis, hematological disorders, poor nutritional status, cardiac arrhythmias, alcoholic myopathy, ketoacidosis, neurological disorders: smell of alcohol on breath, mood swings, memory lapses or losses, difficulty concentrating, blackouts, inappropriateness, irritability or agitation, depression, slurry speech, staggering gait, bizarre behavior, suicidal indicators, sexual dysfunction, interpersonal conflicts, domestic violence, child abuse and neglect, automobile accidents or citation arrests, scholastic or behavior problems, secretiveness or vagueness about personal or medical history.  
<sup>4</sup>In women who are at increased risk, diagnostic evaluation should include an assessment of history of sexual and physical violence, interpersonal difficulties, prescription drug utilization, medical and reproductive history.  
<sup>5</sup>Multiple unexplained somatic complaints.  
<sup>6</sup>Community violence or disaster, immigration, homelessness, family medical problems.  
<sup>7</sup>One-time ultrasound

\*The ability of clinical counseling to influence this behavior is unproven.