

**MEETING HIGHLIGHTS
HEALTH OUTCOMES SUBCOMMITTEE
Clackamas Community College
Wilsonville Training Center, Room 112
Wilsonville, Oregon
December 9, 2010
8:30 AM – 2:30 PM**

Members Present: Lisa Dodson, MD, Chair; K. Dean Gubler, DO, MPH; Kevin Olson, MD; Carla McKelvey, MD; James Tyack, DMD.

Members Absent: Somnath Saha, MD, MPH

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

Also Attending: Carol Camfield, Shawna Jones, Sharon Boren, Cora Elder, Caroline Price and Wally Shaffer, MD, DMAP; David Rohrer, DHS Actuarial Services; Howard Song, OHSU; Diann Matthews and Fred Sego, Centocor Ortho Biotech; Sean Coster and Jim Chesnutt, MD, OHSU Sports Medicine.

Note: The meeting adjourned at 2:30 pm. The next HOSC meeting is scheduled for January 13, 2011.

Topic	Action
<p>General Highlights from the October, 2010 HOSC meeting reviewed. No changes or corrections were made.</p>	<p>Highlights from the October, 2010 meeting were approved without change.</p>
<p>LVADs as destination therapy Smits introduced the summary document reviewing the possible expansion of left ventricular assist devices (LVADs) for use as destination therapy. Dr. Howard Song from OHSU provided testimony.</p> <p>Dr. Song noted that not covering LVADs for destination therapy created problems when patients are unable to receive a heart transplant due to donor shortages or when patients decide to simply keep the LVAD rather than pursue transplant.</p> <p>There was discussion about whether LVADs as destination therapy was new technology. Coffman noted that CMS has covered LVADs for this indication since 2003, which included older LVAD technology which was less effective.</p> <p>Concern was expressed on the part of the OHP health plans and DMAP that expanding the indications for LVAD use to destination therapy would greatly increase</p>	<p>Dr. Song and DMAP will try to obtain better cost figures for coverage of LVADs for destination therapy as well as medical care of patients who would qualify but do not receive LVADs. The HOSC will reconsider LVADs as destination therapy at their August, 2011 meeting.</p>

Topic	Action
<p>the number of patients receiving this expensive technology and therefore increase costs considerably. Song stated that including Joint Commission certification as a qualification in the guideline would restrict the number of centers that would be available to place LVADs in the future. He did not think that this would lead to a “growth industry.” Concern was raised that such restricted access could be problematic for rural patients. Song replied that the OHSU program (currently the only accredited program in Oregon) tries to ensure outreach to rural areas to train local providers/make sure support is there to allow access. Olson wondered which patients would not qualify for LVAD. Song replied that patients with right ventricular failure or other major organ failure or lack of social support would not qualify. Olson also wondered how many patients would access LVAD technology through Medicaid, given that many would end up on disability (Medicare). Song noted that many younger patients with LVADs are not disabled, and in fact are able to return to work. McKelvey stated that she felt that LVAD use would not increase much with allowing destination therapy, as OHP already covers LVADs for bridge to transplant, which frequently turns into destination therapy. She noted that the population that qualifies for LVADs given the proposed guideline would be quite small. Olson pointed out that the patients who would become eligible for LVADs as destination therapy are already costing the health plans a considerable amount of money in other health care costs.</p> <p>Song was asked whether his program has any projected numbers for OHP patients who would receive LVADs if destination therapy was allowed. Song would anticipate possibly a 50% increase (7-8 total patients per year).</p> <p>Price reported that 5 OHP patients a year have received LVADs as bridge to transplant in the past 2 years. Of the 5 patients given LVADs in 2010, 1 has elected to not be transplanted, 2 have not been listed for transplant yet, 1 is listed for transplant, and 1 died before transplant. In 2009, 5 patients received LVADs, and all were transplanted.</p> <p>Shaffer expressed DMAPs concern with how much expansion there would be with destination therapy, the cost associated with this technology, and the limited evidence of effectiveness in current published literature for destination therapy. Dodson also indicated concern</p>	

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<p>about lack of cost effectiveness data.</p> <p>DMAP indicated that adding LVADs as destination therapy would lead to cost increases in the current contracts with the health plans. These rate increase estimates would not be ready until January, 2012. Therefore, DMAP could not implement coverage of LVADs as destination therapy until that time.</p> <p>In terms of current knowledge of costs, Song indicated that after the initial hospitalization and procedure, the patient has costs for dressing changes (\$100/mo out of pocket), medications, and Coumadin monitoring. Price indicated that DMAP has paid for LVAD placement/hospital stay, as well as \$11,000 to set up at home. She did not have information on ongoing costs.</p> <p>The group felt that there was not enough data on cost-effectiveness, possible cost increases for OHP and anticipated numbers of patients who would use this technology. The group felt that waiting until the August meeting to readdress this issue would not affect the implementation date of this technology if the decision was for coverage, given that DMAP cannot cover until January, 2012. Song will try to obtain cost data on patients who would qualify who do not receive LVADs (hospital costs, medications, etc.) to help the HSC look at overall cost. He will also try to obtain overall health care costs after LVAD placement.</p>	
<p>Growth Hormone Treatment for CF Smits introduced a summary document discussing coverage of growth hormone treatment for children with cystic fibrosis (CF). Currently, CF experts in Oregon are not using growth hormone in this population.</p>	<p>Cystic fibrosis was not added as an indication for growth hormone treatment.</p>
<p>New CPT/HCPCS codes Smits reviewed placement recommendations for the new CPT and HCPCS codes for 2011, as included in the packet information. All placements were accepted as described in the packet except:</p> <ol style="list-style-type: none"> 1) It was recommended that DMAP place 83861 (Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolarity) on the Excluded File 2) The placement of 49327 and 49412 was tabled until January. HSC staff will work with Dr. Olson to find a more limited number of lines which are more appropriate for these procedures 3) 92227 (Remote imaging for detection of retinal 	<p>See Appendix A for code placement recommendations</p> <p>49327 and 49412 placement will be discussed further at the January, 2011 meeting</p>

Topic	Action
<p>disease) was added to Line 106, DIABETIC AND OTHER RETINOPATHY, in addition to lines 10 and 33.</p> <p>4) G0429 (Dermal fillers as treatment for facial lipodystrophy syndrome (LDS)) was determined to be cosmetic. It was placed on Line 675, DERMATOLOGICAL CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY, with no guideline required. If a patient suffered depression from HIV treatment related LDS which could not be adequately treated by any other means, then the patient could argue the co-morbidity rule to allow treatment.</p> <p>5) 272.6 (Lipodystrophy syndrome) was moved from Line 66, METABOLIC DISORDERS INCLUDING HYPERLIPIDEMIA, to Line 675.</p> <p>6) ICD-9 codes 250.51 and 250.53 (Type I Diabetes with ophthalmic manifestations) were added to line 10, TYPE I DIABETES MELLITUS.</p> <p>7) 64553, 61885 and 61888 added to line 459. TRIGEMINAL AND OTHER NERVE DISORDERS.</p> <p>8) 64553 to line 182 GENERALIZED CONVULSIVE OR PARTIAL EPILEPSY WITHOUT MENTION OF IMPAIRMENT OF CONSCIOUSNESS</p>	
<p>Concussion Dr. Jim Chesnutt from the statewide Oregon Concussion Awareness and Management program gave a presentation on the current evidence of the seriousness of concussions without loss of consciousness. When the Prioritized List was created, concussions were graded based on loss of consciousness. Today, concussions are graded on continued symptoms, such as headache, cognitive difficulties, etc. TBI (traumatic brain injury) is classified under the concussion ICD-9 codes.</p> <p>There was some discussion about whether care of concussions is a medical issue or a school/work issue. The group felt that this was a medical issue. Lack of coverage of concussion follow up was felt to be an access to care issue. The general feeling was that care of concussion was secondary prevention, to prevent worsening medical issues. The group felt that concussions should be treated, by specialists if needed. The patients should not need to be seen for “headache” or other symptom codes. The treatments used for post-concussion issues are IMPACT testing, medication, PT/gait training, restrictions from school/activities, and</p>	<p>1) Rename Line 100 SEVERE/MODERATE HEAD INJURY: HEMATOMA/EDEMA WITH LOSS OF CONSCIOUSNESS PERSISTENT SYMPTOMS; COMPOUND/DEPRESSED FRACTURES OF SKULL.</p> <p>2) Rename Line 631 MINOR HEAD INJURY: HEMATOMA/EDEMA WITH LOSS OF CONSCIOUSNESS NO PERSISTENT SYMPTOMS</p> <p>3) Add 850.0 (Concussion with no loss of consciousness) to Line 100. Keep 850.0 on Line 631.</p> <p>4) Add 310.2 (Postconcussion syndrome) to Line 100, keep on current lines</p> <p>5) Add 96118 (Neuropsychological testing, per hour or psychologist or physician time) to line 100</p>

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<p>visual therapy.</p> <p>The group wanted the current list to reflect that the more serious concussions are those with continued symptoms. Line 100 will be renamed SEVERE/MODERATE HEAD INJURY: HEMATOMA/EDEMA WITH LOSS OF CONSCIOUSNESS PERSISTENT SYMPTOMS; COMPOUND/DEPRESSED FRACTURES OF SKULL. Line 631 will be renamed MINOR HEAD INJURY: HEMATOMA/EDEMA WITH LOSS OF CONSCIOUSNESS NO PERSISTENT SYMPTOMS.</p> <p>The group wanted to add concussion ICD-9 codes without loss of consciousness (850.0) to a covered line. The location of the diagnosis (line 100 or line 631) will be dependent on whether the patient has continued symptoms. 850.9 (Concussion unspecified) will not be moved to the higher line.</p> <p>Post concussive syndrome (310.2) was discussed briefly. Chesnutt thought that it was not necessary to add, but the group felt that it should be added to Line 100 to allow for evaluation and treatment of patients with multiple head hits, patients who are not getting better after 3 months (post-concussive syndrome by definition is diagnosed 3 months or more after the injury).</p> <p>Smits asked if a guideline was needed to differentiate when the diagnoses (850.0 and 310.2) were covered on Line 100. The group felt that this was not needed. The line titles would determine which cases are covered on which of the two lines.</p> <p>The group requested that 96118 (Neuropsychological testing, per hour or psychologist or physician time) be added to line 100 to allow for IMPACT testing to be done.</p> <p>The issue of which diagnoses are on which head injury line and their relative prioritization will be further addressed during the next biennial review.</p>	<p>6) The head injury lines will be reviewed during the next biennial review</p>
<p>Extracorporeal circulation Smits introduced a summary document discussing extracorporeal circulation. There was minimal discussion. Gubler excused himself from the discussion because of a conflict of interest (he does this type of therapy).</p>	<p>1) Advise DMAP to place 33960 and 33961 on the Exempt File 2) Remove 33960 and 33961 from current lines on the Prioritized List</p>
<p>Cholesteatoma removal Smits introduced a summary document discussing cholesteatoma removal. There was no discussion.</p>	<p>No change in current coverage</p>

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<p>Guidelines</p> <p><u>Prevention Tables</u></p> <p>Livingston introduced a document regarding proposed changes to the prevention tables. The group decided to eliminate all of the current Prevention tables. The current prevention lines (lines 3 and 4) will be collapsed into one line. This prevention line will contain the CPT codes for highly recommended tests. A lower prevention line with CPT codes will be added to this line with tests with lower levels of recommendation. The usual line placement methodology will be used to determine the location of this lower line.</p> <p>The group discussed what should constitute a high level of recommendation for a preventive service. The USPSTF A and B recommendations should be considered highly recommended. Additionally, other services which are recommended by other similarly evidence based groups will be considered, particularly if the USPSTF has not reviewed that particular service.</p> <p>The group was concerned about non-specific CPT codes like counseling codes. These codes can be used for both highly recommended types of screening as well as non-recommended services. There was discussion about possibly needing a guideline to specify which type of service is included with that code on each prevention line. Alternatively, Livingston thought that the intent could be indicated by placing the appropriate ICD-9 codes on lines.</p> <p>Coffman and Gingerich brought up that USPSTF A and B recommendations need to be covered without cost-sharing with federal health reform. Coffman recommended placing all of these services in the Value Based Services list.</p> <p>The decision was to have HSC staff devise two new prevention lines, with appropriate ICD-9 and CPT codes for the January, 2011 meeting. A list of Value Based Services codes will also be created for review at the January meeting.</p> <p><u>Synagis</u></p> <p>Livingston introduced a summary document regarding a guideline for Synagis use. Shaffer noted that DMAP already has administrative rules restricting Synagis use which are very similar to the proposed HSC guideline.</p>	<p><u>Prevention Tables</u></p> <p>HSC staff to bring a proposal to the January 2011 meeting creating two new prevention lines, one containing highly recommended preventive services CPT codes and appropriate ICD-9 codes. The other line will contain preventive services with lower levels of recommendation.</p> <p>The current Prevention Tables will be deleted.</p> <p>If adopted, these changes would go into effect no sooner than 1/1/11.</p> <p><u>Synagis</u></p> <p>A guideline restricting Synagis use was adopted. See Appendix B for wording. This guideline will initially be</p>

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<p>McKelvey thought that it would be useful to include this guideline on the List.</p> <p>Currently, Synagis is included on line 3, Prevention under age 10. However, with the new prevention lines (see discussion above), this service may be on either the upper or lower prevention lines. HSC staff will examine and recommend the best placement.</p> <p>There was no discussion regarding the wording of the guideline.</p> <p><u>MRI of Spine</u> Livingston introduced a document summarizing suggested changes to the MRI of the spine guideline. There was minimal discussion.</p> <p><u>Hernia guideline</u> Smits introduced a summary document with recommendations for changes to the current hernia guideline. Gubler felt that there should be no differentiation between inguinal and femoral hernias. He moved to strike the first clause in the proposed new guideline. The group debated the definition of "incarcerated." Gubler felt that symptomatic fat incarceration should be included, as well as incarceration of other organs such as gut, ovaries, etc. The group decided that the proposed new guideline was not workable. The decision was made to simply add a clause defining incarcerated as non-reducible by physical manipulation to the current guideline. This guideline will be reviewed by the OHP Medical Directors at their next meeting for comments.</p> <p><u>ESA guideline</u> Smits introduced a summary document with recommendations for changes to the current ESA guideline. The group felt that a separate clause requiring iron studies and replacement if indicated for all ESA use indications should be added to the current guideline. Restrictions on ESA use in cancer based on current CMS restrictions were added to the cancer clause. Perioperative use was approved as suggested in the meeting materials, with a hemoglobin level of <10 required to qualify for use.</p> <p>The wording of how ESAs should be titrated in cancer patients was debated. The package insert states that ESA dosage should be titrated to the lowest possible</p>	<p>on Line 3 but HSC staff may recommend that it be placed on the higher or lower prevention line for the January 2012.</p> <p><u>MRI of spine</u> Recommend modifications to the current guideline as shown in Appendix B.</p> <p><u>Hernia</u> Recommend modifications to the current guideline as shown in Appendix B.</p> <p><u>ESA</u> The guideline will be brought back for further discussion at the January 2011 meeting.</p>

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<p>hemoglobin level sufficient to avoid blood transfusion. Other thoughts were to put in a requirement to discontinue use once the hemoglobin level reaches 10. The decision was to have HSC staff continue to work on this wording and bring back to the January 2011 HOSC meeting.</p>	
<p>Negative Pressure Wound Therapy (NPWT) Dr. Pass from the Health Resources Commission (HRC) presented the HRC report on NPWT. Discussion centered around the lack of high quality evidence, and the fact that much of the evidence was industry sponsored. Gubler noted that most surgical interventions are not rigorously studied. He doubted new, well designed studies on the efficacy of NPWT will be done in the future, as NPWT is now the standard of care. Pass noted that NPWT has been in use for many years, and is not a new technology. Smits noted that moderate evidence of effectiveness was found in the HRC report, which is similar to many procedures included on the Prioritized List. Coffman and Shaffer pointed out that NPWT is actually currently covered on the List (the DME portion, not the physician service portion). There has traditionally been a lower standard of evidence to keep a service on the List than to add a service. Kirk was concerned about costs.</p> <p>The group felt that the evidence was sufficient to keep NPWT on the list. There was concern that having these codes only on the deep open wound line would be limiting. It was decided to recommend placing the NPWT codes on the Ancillary File with the proposed guideline.</p>	<p>Recommend to DMAP that the physician fee CPT codes for NPWT (97605 and 97606) be placed on the Ancillary File and removed from the Excluded File. Adopt the ancillary guideline as shown in Appendix B.</p>
<p>Straightforward Issues Smits reviewed a summary document outlining the straightforward issues from the October as well as the December meetings. There was minimal discussion.</p>	<p>Adopt changes outlined in the straightforward issues tables in the packet.</p>
<p>Line 209 name change The MHCD Subcommittee recommends the name of Line 209 be changed to CHRONIC ORGANIC MENTAL DISORDERS INCLUDING DEMENTIAS. There was no discussion</p>	<p>Change Line 209 name to CHRONIC ORGANIC MENTAL DISORDERS INCLUDING DEMENTIAS.</p>
<p>Public Comment None received</p>	

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Appendix A**

CPT Codes

Code	Code Description	Line(s) April List
11045	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	63, 79, 86, 165, 202, 215, 217, 250, 271, 291, 307, 407, 440, 480, 541, 563, 567, 623, 624, 641
11046	Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	165, 215, 217, 250, 271, 291, 307, 407, 440, 563, 567, 624
11047	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)	165, 215, 217, 250, 271, 291, 307, 407, 440, 563, 567, 624
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophyctectomy and decompression of spinal cord and/or nerve roots; cervical below C2	83, 158, 208, 271, 397, 428, 497, 539, 596
22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophyctectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for separate procedure)	83, 158, 208, 271, 397, 428, 497, 539, 596
29914	Arthroscopy, hip, surgical; with femoroplasty (ie, treatment of cam lesion)	Excluded
29915	Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)	Excluded
29916	Arthroscopy, hip, surgical; with labral repair	Excluded
31295	Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa	388, 488, 523
31296	Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (eg, balloon dilation)	388, 488, 523
31297	Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (eg, balloon dilation)	388, 488, 523
31634	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, with assessment of air leak, with administration of occlusive substance (eg, fibrin glue), if performed	153 PNEUMOTHORAX AND HEMOTHORAX.
33620	Application of right and left pulmonary artery bands (eg, hybrid approach stage 1)	Congenital heart lines: 73, 76, 93, 94, 97, 98, 115, 116, 122, 139, 141, 148, 184, 192, 194, 237, 247, 274, 279, 672
33621	Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg, hybrid approach stage 1)	Congenital heart lines: 73, 76, 93, 94, 97, 98, 115, 116, 122, 139, 141, 148, 184, 192, 194, 237, 247, 274, 279, 672

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Code	Code Description	Line(s) April List
33622	Reconstruction of complex cardiac anomaly (eg, single ventricle or hypoplastic left heart) with palliation of single ventricle with aortic outflow obstruction and aortic arch hypoplasia, creation of cavopulmonary anastomosis, and removal of right and left	184, 247
37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	375 ATHEROSCLEROSIS, PERIPHERAL
37221	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	375 ATHEROSCLEROSIS, PERIPHERAL
37222	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty	375 ATHEROSCLEROSIS, PERIPHERAL
37223	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	375 ATHEROSCLEROSIS, PERIPHERAL
37224	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty	375 ATHEROSCLEROSIS, PERIPHERAL
37225	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	375 ATHEROSCLEROSIS, PERIPHERAL
37226	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	375 ATHEROSCLEROSIS, PERIPHERAL
37227	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	375 ATHEROSCLEROSIS, PERIPHERAL
37228	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty	375 ATHEROSCLEROSIS, PERIPHERAL
37229	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	375 ATHEROSCLEROSIS, PERIPHERAL
37230	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	375 ATHEROSCLEROSIS, PERIPHERAL

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Code	Code Description	Line(s) April List
37231	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	375 ATHEROSCLEROSIS, PERIPHERAL
37232	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)	375 ATHEROSCLEROSIS, PERIPHERAL
37233	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	375 ATHEROSCLEROSIS, PERIPHERAL
37234	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for p	375 ATHEROSCLEROSIS, PERIPHERAL
37235	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (List separately in additi	375 ATHEROSCLEROSIS, PERIPHERAL
38900	Intraoperative identification (eg, mapping) of sentinel lymph node(s) includes injection of non-radioactive dye, when performed (List separately in addition to code for primary procedure)	Diagnostic
43283	Laparoscopy, surgical, esophageal lengthening procedure (eg, Collis gastroplasty or wedge gastroplasty) (List separately in addition to code for primary procedure)	70 CONGENITAL ANOMALIES OF UPPER ALIMENTARY TRACT
43327	Esophagogastric fundoplasty partial or complete; laparotomy	61, 70, 408, 416
43328	Esophagogastric fundoplasty partial or complete; thoracotomy	61, 70, 408, 416
43332	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis	408 ESOPHAGITIS; ESOPHAGEAL AND INTRAESOPHAGEAL HERNIA
43333	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; with implantation of mesh or other prosthesis	408 ESOPHAGITIS; ESOPHAGEAL AND INTRAESOPHAGEAL HERNIA
43334	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; without implantation of mesh or other prosthesis	408 ESOPHAGITIS; ESOPHAGEAL AND INTRAESOPHAGEAL HERNIA
43335	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; with implantation of mesh or other prosthesis	408 ESOPHAGITIS; ESOPHAGEAL AND INTRAESOPHAGEAL HERNIA

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Code	Code Description	Line(s) April List
43336	Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; without implantation of mesh or other prosthesis	408 ESOPHAGITIS; ESOPHAGEAL AND INTRAESOPHAGEAL HERNIA
43337	Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; with implantation of mesh or other prosthesis	408 ESOPHAGITIS; ESOPHAGEAL AND INTRAESOPHAGEAL HERNIA
43338	Esophageal lengthening procedure (eg, Collis gastroplasty or wedge gastroplasty)	70 CONGENITAL ANOMALIES OF UPPER ALIMENTARY TRACT
43753	Gastric intubation and aspiration(s) therapeutic, necessitating physician's skill (eg, for gastrointestinal hemorrhage), including lavage if performed	Exempt
43754	Gastric intubation and aspiration, diagnostic; single specimen (eg, acid analysis)	Diagnostic
43755	Gastric intubation and aspiration, diagnostic; collection of multiple fractional specimens with gastric stimulation, single or double lumen tube (gastric secretory study) (eg, histamine, insulin, pentagastrin, calcium, secretin), includes drug administration	Diagnostic
43756	Duodenal intubation and aspiration, diagnostic, includes image guidance; single specimen (eg, bile study for crystals or afferent loop culture)	Diagnostic
43757	Duodenal intubation and aspiration, diagnostic, includes image guidance; collection of multiple fractional specimens with pancreatic or gallbladder stimulation, single or double lumen tube, includes drug administration	Diagnostic
49327	Laparoscopy, surgical; with placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), intra-abdominal, intrapelvic, and/or retroperitoneum, including imaging guidance, if performed, single or multiple	Pending January, 2011 meeting
49412	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), open, intra-abdominal, intrapelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple	Pending January, 2011 meeting
49418	Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological superv	Ancillary
53860	Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence	Excluded
57156	Insertion of a vaginal radiation afterloading apparatus for clinical	144, 167, 219, 252, 286, 310

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Code	Code Description	Line(s) April List
61781+ A56	Stereotactic computer-assisted (navigational) procedure; cranial, intradural	137, 162, 201, 266, 319, 340, 358
61782	Stereotactic computer-assisted (navigational) procedure; cranial, extradural	137, 162, 201, 266, 319, 340, 358
61783	Stereotactic computer-assisted (navigational) procedure; spinal	201, 319
64566	Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming	Excluded
64568	Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	182,459
64569	Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator	182, 307, 459
64570	Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	182, 307, 459
64611	Chemodenervation of parotid and submandibular salivary glands, bilateral	518 SIALOLITHIASIS, MUCOCELE, DISTURBANCE OF SALIVARY
65778	Placement of amniotic membrane on the ocular surface for wound healing; self-retaining	63, 224, 226, 259, 335, 394, 445, 593
65779	Placement of amniotic membrane on the ocular surface for wound healing; single layer, sutured	63, 224, 226, 259, 335, 394, 445, 593
66174	Transluminal dilation of aqueous outflow canal; without retention of device or stent	Excluded
66175	Transluminal dilation of aqueous outflow canal; with retention of device or stent	Excluded
74176	Computed tomography, abdomen and pelvis; without contrast material	Diagnostic
74177	Computed tomography, abdomen and pelvis; with contrast material(s)	Diagnostic
74178	Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions	Diagnostic
76881	Ultrasound, extremity, nonvascular, real-time with image documentation; complete	Diagnostic
76882	Ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific	Diagnostic
80104	Drug screen, qualitative; multiple drug classes other than chromatographic method, each procedure	Diagnostic
82930	Gastric acid analysis, includes pH if performed, each specimen	Diagnostic

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Code	Code Description	Line(s) April List
84112	Placental alpha microglobulin-1 (PAMG-1), cervicovaginal secretion, qualitative	Diagnostic
85598	Phospholipid neutralization; hexagonal phospholipid	Diagnostic
86481	Tuberculosis test, cell mediated immunity antigen response measurement; enumeration of gamma interferon-producing T-cells in cell suspension	Diagnostic
86902	Blood typing; antigen testing of donor blood using reagent serum, each antigen test	Diagnostic
87501	Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, reverse transcription and amplified probe technique, each type or subtype	Diagnostic
87502	Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, for multiple types or sub-types, reverse transcription and amplified probe technique, first 2 types or sub-types	Diagnostic
87503	Infectious agent detection by nucleic acid (DNA or RNA); influenza virus, for multiple types or sub-types, multiplex reverse transcription and amplified probe technique, each additional influenza virus type or sub-type beyond 2 (List separately in additio	Diagnostic
87906	Infectious agent genotype analysis by nucleic acid (DNA or RNA); HIV-1, other region (eg, integrase, fusion)	Diagnostic
88120	Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual	286 CANCER OF BLADDER AND URETER
88121	Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology	286 CANCER OF BLADDER AND URETER
88177	Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy for diagnosis, each separate additional evaluation episode, same site (List separately in addition to code for primary procedure)	Diagnostic
88363	Examination and selection of retrieved archival (ie, previously diagnosed) tissue(s) for molecular analysis (eg, KRAS mutational analysis)	Diagnostic
88749	Unlisted in vivo (eg, transcutaneous) laboratory service	Excluded
90460	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component	3,4

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Code	Code Description	Line(s) April List
90461	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine/toxoid component (List separately in addition to code for primary proced	3,4
90470	H1N1 immunization administration (intramuscular, intranasal), including counseling when performed	3,4
90644	Meningococcal conjugate vaccine, serogroups C & Y and Hemophilus influenza B vaccine, tetanus toxoid conjugate (Hib-MenCY-TT), 4 dose schedule, when administered to children 2-15 months of age, for intramuscular use	3 PREVENTIVE SERVICES, BIRTH TO 10 YEARS OF AGE
90664	Influenza virus vaccine, pandemic formulation, live, for intranasal use	3,4
90666	Influenza virus vaccine, pandemic formulation, split virus, preservative free, for intramuscular use	3,4
90667	Influenza virus vaccine, pandemic formulation, split virus, adjuvanted, for intramuscular use	3,4
90668	Influenza virus vaccine, pandemic formulation, split virus, for intramuscular use	3,4
90867	Therapeutic repetitive transcranial magnetic stimulation treatment; planning	Excluded
90868	Therapeutic repetitive transcranial magnetic stimulation treatment; delivery and management, per session	Excluded
91117	Colon motility (manometric) study, minimum 6 hours continuous recording (including provocation tests, eg, meal, intracolonic balloon distension, pharmacologic agents, if performed), with interpretation and report	Excluded
92132	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral	106,124,130,149,164,174, 258,259,263,282,285,298, 320,321,323,333,335,342, 343,360,361,363,371,378, 389,390,394,401,423,445, 454,458,465,467,468,476, 487,489,506,515,519,573, 578,585,614,638,643,644, 650
92133	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve	See 92132 above
92134	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina	See 92132 above
92227	Remote imaging for detection of retinal disease (eg, retinopathy in a patient with diabetes) with analysis and report under physician supervision, unilateral or bilateral	10, 33, 106

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Code	Code Description	Line(s) April List
92228	Remote imaging for monitoring and management of active retinal disease (eg, diabetic retinopathy) with physician review, interpretation and report, unilateral or bilateral	106 DIABETIC AND OTHER RETINOPATHY
93451	Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed	Diagnostic
93452	Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed	Diagnostic
93453	Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed	Diagnostic
93454	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation;	Diagnostic
93455	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial veno	Diagnostic
93456	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization	Diagnostic
93457	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, ven	Diagnostic

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Code	Code Description	Line(s) April List
93458	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ven	Diagnostic
93459	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ven	Diagnostic
93460	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) fo	Diagnostic
93461	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) fo	Diagnostic
93462	Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure)	Diagnostic
93463	Pharmacologic agent administration (eg, inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) including assessing hemodynamic measurements before, during, after and repeat pharmacologic agent administration, w	Diagnostic
93464	Physiologic exercise study (eg, bicycle or arm ergometry) including assessing hemodynamic measurements before and after	Diagnostic
93563	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization	Diagnostic
93564	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective opacification of aortocoronary venous or arterial bypass graft(s) (eg, aortocoronary saphenous vein, free radial artery, or free ma	Diagnostic
93565	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective left ventricular or left atrial angiography	Diagnostic

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Code	Code Description	Line(s) April List
93566	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective right ventricular or right atrial angiography	Diagnostic
93567	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for supra-avalvular aortography	Diagnostic
93568	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for pulmonary angiography (List separately in addition to code for primary procedure)	Diagnostic
95800	Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time	Diagnostic
95801	Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (eg, by airflow or peripheral arterial tone)	Diagnostic
96446	Chemotherapy administration into the peritoneal cavity via indwelling port or catheter	Chemotherapy lines: 101, 123, 144, 159, 166, 167, 181, 197, 207, 208, 219, 221, 222, 229, 230, 243, 249, 252, 275, 276, 277, 278, 286, 291, 309, 310, 311, 319, 337, 338, 339, 354, 452, 612
99224	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: Problem focused interval history; Problem focused examination; Medical decision making that is straightforward or of	Lines with E&M codes
99225	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of mo	Lines with E&M codes
99226	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or c	Lines with E&M codes

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Code	Code Description	Line(s) April List
HCPCS Codes		
G0157	SERVICES PERFORMED BY A QUALIFIED PHYSICAL THERAPIST ASSISTANT IN THE HOME HEALTH OR HOSPICE SETTING, EACH 15 MINUTES	PT lines: 12,50-52,63,73-75,77,79,84,88,89,93,94,97-100, 108,109,115,116,122,129,139,141-143,145,146,158,161,165, 179,184,185,189,190,192,194,195, 201, 202,208,217,227,237, 239,270,271,273,274,279,287,288,292,296,301,303,306-308,317, 334,340,347,348,362, 366, 368, 372,373,375,379, 381, 382, 384,3 97,403,404,428,434, 436,440,448, 460,480,497,508,539,551,569, 587,610,627
G0158	SERVICES PERFORMED BY A QUALIFIED OCCUPATIONAL THERAPIST ASSISTANT IN THE HOME HEALTH OR HOSPICE SETTING, EACH 15 MINUTES	See G0157
G0159	SERVICES PERFORMED BY A QUALIFIED PHYSICAL THERAPIST, IN THE HOME HEALTH SETTING, IN THE ESTABLISHMENT OR DELIVERY OF A SAFE AND EFFECTIVE PHYSICAL THERAPY MAINTENANCE PROGRAM, EACH 15 MINUTES	See G0157
G0160	SERVICES PERFORMED BY A QUALIFIED OCCUPATIONAL THERAPIST, IN THE HOME HEALTH SETTING, IN THE ESTABLISHMENT OR DELIVERY OF A SAFE AND EFFECTIVE OCCUPATIONAL THERAPY MAINTENANCE PROGRAM, EACH 15 MINUTES	See G0157
G0161	SERVICES PERFORMED BY A QUALIFIED SPEECH-LANGUAGE PATHOLOGIST, IN THE HOME HEALTH SETTING, IN THE ESTABLISHMENT OR DELIVERY OF A SAFE AND EFFECTIVE SPEECH-LANGUAGE PATHOLOGY MAINTENANCE PROGRAM, EACH 15 MINUTES	See G0157
G0162	SKILLED SERVICES BY A REGISTERED NURSE (RN) IN THE DELIVERY OF MANAGEMENT & EVALUATION OF THE PLAN OF CARE; EACH 15 MINUTES (THE PATIENT'S UNDERLYING CONDITION OR COMPLICATION REQUIRES AN RN TO ENSURE THAT ESSENTIAL NON-SKILLED CARE ACHIEVE ITS PURPOSE IN	Ancillary

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Code	Code Description	Line(s) April List
G0163	SKILLED SERVICES BY A LICENSED NURSE (LPN OR RN) FOR THE OBSERVATION AND ASSESSMENT OF THE PATIENT'S CONDITION, EACH 15 MINUTES (THE CHANGE IN THE PATIENT'S CONDITION REQUIRES SKILLED NURSING PERSONNEL TO IDENTIFY AND EVALUATE THE PATIENT'S NEED FOR POSSIBLE MODIFICATION OF TREATMENT IN THE HOME HEALTH OR HOSPICE SETTING)	Ancillary
G0164	SKILLED SERVICES OF A LICENSED NURSE (LPN OR RN), IN THE TRAINING AND/OR EDUCATION OF A PATIENT OR FAMILY MEMBER, IN THE HOME HEALTH OR HOSPICE SETTING, EACH 15 MINUTES	Ancillary
G0428	COLLAGEN MENISCUS IMPLANT PROCEDURE FOR FILLING MENISCAL DEFECTS (E.G., CMI, COLLAGEN SCAFFOLD, MENAFLEX)	Excluded
G0429	DERMAL FILLER INJECTION(S) FOR THE TREATMENT OF FACIAL LIPODYSTROPHY SYNDROME (LDS) (E.G., AS A RESULT OF HIGHLY ACTIVE ANTIRETROVIRAL THERAPY)	675 DERMATOLOGICAL CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY
G0432	INFECTIOUS AGENT ANTIBODY DETECTION BY ENZYME IMMUNOASSAY (EIA) TECHNIQUE, HIV-1 AND/OR HIV-2, SCREENING	Diagnostic
G0433	INFECTIOUS AGENT ANTIBODY DETECTION BY ENZYME-LINKED IMMUNOSORBENT ASSAY (ELISA) TECHNIQUE, HIV-1 AND/OR HIV-2, SCREENING	Diagnostic
G0434	DRUG SCREEN, OTHER THAN CHROMATOGRAPHIC; ANY NUMBER OF DRUG CLASSES, BY CLIA WAIVED TEST OR MODERATE COMPLEXITY TEST, PER PATIENT ENCOUNTER	Diagnostic
G0435	INFECTIOUS AGENT ANTIBODY DETECTION BY RAPID ANTIBODY TEST, HIV-1 AND/OR HIV-2, SCREENING	Diagnostic
G0436	SMOKING AND TOBACCO CESSATION COUNSELING VISIT FOR THE ASYMPTOMATIC PATIENT; INTERMEDIATE, GREATER THAN 3 MINUTES, UP TO 10 MINUTES	6 TOBACCO DEPENDENCE
G0437	SMOKING AND TOBACCO CESSATION COUNSELING VISIT FOR THE ASYMPTOMATIC PATIENT; INTENSIVE, GREATER THAN 10 MINUTES	6 TOBACCO DEPENDENCE

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Code	Code Description	Line(s) April List
G0438	ANNUAL WELLNESS VISIT; INCLUDES A PERSONALIZED PREVENTION PLAN OF SERVICE (PPS), INITIAL VISIT	3 PREVENTIVE SERVICES, BIRTH TO 10 YEARS OF AGE 4 PREVENTIVE SERVICES, OVER AGE OF 10
G0439	ANNUAL WELLNESS VISIT, INCLUDES A PERSONALIZED PREVENTION PLAN OF SERVICE (PPS), SUBSEQUENT VISIT	3 PREVENTIVE SERVICES, BIRTH TO 10 YEARS OF AGE 4 PREVENTIVE SERVICES, OVER AGE OF 10
G0440	APPLICATION OF TISSUE CULTURED ALLOGENEIC SKIN SUBSTITUTE OR DERMAL SUBSTITUTE FOR USE ON LOWER LIMB, INCLUDES THE SITE PREPARATION AND DEBRIDEMENT IF PERFORMED; FIRST 25 SQ CM OR LESS	63, 79, 95, 142, 187, 202, 207, 217, 243, 291, 407, 424, 440
G0441	APPLICATION OF TISSUE CULTURED ALLOGENEIC SKIN SUBSTITUTE OR DERMAL SUBSTITUTE; FOR USE ON LOWER LIMB, INCLUDES THE SITE PREPARATION AND DEBRIDEMENT IF PERFORMED; EACH ADDITIONAL 25 SQ CM	63, 79, 95, 142, 187, 202, 207, 217, 243, 291, 407, 424, 440
G9147	OUTPATIENT INTRAVENOUS INSULIN TREATMENT (OIVIT) EITHER PULSATILE OR CONTINUOUS, BY ANY MEANS, GUIDED BY THE RESULTS OF MEASUREMENTS FOR:RESPIRATORY QUOTIENT; AND/OR, URINE UREA NITROGEN (UUN); AND/OR, ARTERIAL,VENOUS OR CAPILLARY GLUCOSE; AND/OR POTASSIUM CONCENTRATION	Excluded

APPENDIX B GUIDELINES

New guidelines

GUIDELINE NOTE XXX, SYNAGIS (palivizumab)

Line 3

90378 Synagis (palivizumab) is covered for infants who:

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

ANCILLARY GUIDELINE A1, NEGATIVE PRESSURE WOUND THERAPY

Negative pressure wound therapy (97605, 97606) is a covered benefit only for patients who

- 1) have wounds that are refractory to or have failed standard therapies, or
- 2) who are not suitable candidates for surgical wound closure, or
- 3) are at high risk for delayed or non-healing wounds due to factors such as compromised blood flow, diabetic complications, wounds with high risk of fecal contamination, extremely exudative wounds, and similar situations

Revised guidelines

DIAGNOSTIC GUIDELINE D4, MRI OF THE SPINE

MRI of the spine is covered in the following situations:

- 1) Recent onset of 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), or suspected central spinal canal stenosis neurogenic claudication in patients who are potential candidates for surgery
- 2) Clinical or radiological suspicion of neoplasm
- 3) Clinical or radiological suspicion of infection

GUIDELINE NOTE 24, COMPLICATED HERNIAS

Line 175

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

**MEETING HIGHLIGHTS
HEALTH OUTCOMES SUBCOMMITTEE
Clackamas Community College
Wilsonville, Oregon
October 14, 2010
8 AM – 11:30 AM**

Members Present: Lisa Dodson, MD, Chair; K. Dean Gubler, DO, MPH; Kevin Olson, MD; Somnath Saha, MD, MPH; Carla McKelvey, MD; James Tyack, DMD.

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

Also Attending: Caroline Price, Wally Shaffer, MD, Isabel Bickel, Chris Barber, Shauna Jones, Barbara Ries, Alex Blau, DMAP; Chris Kirk, MD, OHP Medical Directors. Howard Song, MD, Pamela Grumbles, OHSU VAD program; Jean Knospe, Gary Knospe.

Note: The meeting adjourned at 12:10 pm. The next HOSC meeting is scheduled for December 9, 2010.

Topic	Action
General Highlights from the August, 2010 HOSC meeting reviewed. No changes or corrections were made.	Highlights from the August, 2010 meeting were approved without change.
Wrist and elbow arthrotomy Smits introduced a summary of suggested changes for coverage for arthrotomy procedures of the upper extremity. There was no discussion; changes were accepted as presented in the meeting document.	1) Add 24006, 25105 and 25107 to Lines 161, 217, 296, 381, and 541 2) Add 24000 to lines 217, 296, 381, and 541. 3) Add 24101 to lines 161, 217, and 381; remove 24101 from Diagnostic List 4) Add 24102 to lines 161, 217, 296, and 541 5) Add 25101 to Lines 296, 381, and 541; remove 25101 from Diagnostic List 6) Add 25109 to Lines 161, 217, 296, and 381; keep on Lines 296, 307, 434, and 522
Growth Hormone Treatment Smits introduced a summary document discussing coverage of growth hormone treatment for children with	Chronic renal insufficiency was added to the guideline for covered conditions for growth

Topic	Action
<p>chronic renal insufficiency (CRI) and with cystic fibrosis (CF). CRI as an indication for growth hormone treatment was added to the guideline without discussion.</p> <p>McKelvey requested that HSC staff contact pediatric pulmonologists who care for CF kids to determine if growth hormone is being routinely given to these children and/or is standard of care for CF kids. If treatment for CF is standard, the group was in favor of adding coverage, due to the evidence of reduced hospitalizations.</p>	<p>hormone treatment (see Appendix A for amended guideline). HSC staff was asked to consult pediatric pulmonologists who treat CF patients to determine if growth hormone is a standard treatment for CF and bring this information back to the December HOSC meeting.</p>
<p>Hamartoses Livingston introduced a summary document with recommendations for coverage of hamartoses. Saha noted that the recommended pairings for this diagnosis code were procedures that were all screening and/or diagnostic in nature. The primary issues that would need treatment for the syndromes included under this diagnosis (cancer, glaucoma, etc.) would all be treatable under their appropriate lines. Barber stated that to date DMAP has treated the diagnoses included under this code as diagnostic. McKelvey pointed out that PT should be covered as well. Barber stated that to date DMAP has treated the diagnoses included under this code as diagnostic. Saha recommended that PT would be covered on the dysfunction in posture and movement line (Line 317). The decision was to include this ICD-9 code only on the dysfunction in posture and movement line. The screening and diagnostic tests for these types of conditions would be covered under the diagnostic list. Treatment of cancers, glaucoma, and other complications would be done under the respective diagnosis lines.</p> <p>Smits suggested putting this diagnosis on the list of items to consider for a new line during the next biennial review.</p>	<p>Add 759.6 (other hamartoses) to Line 317</p> <p>Advise DMAP to remove 759.6 from the Never Covered List</p> <p>Consider 759.6 for creation of a new line with the next biennial review.</p>
<p>LVAD as destination therapy Dr. Howard Song from OHSU Heart Transplantation Program gave a presentation on left ventricular assist devices (LVAD) as destination therapy. A patient, Jean Knospe from Salem, spoke on her experiences with long term LVAD therapy. The discussion centered around cost savings from the device. Saha was concerned about the newness of the technology. There is currently only 1 certified VAD program in Oregon (OHSU). Dodson was concerned about access for rural patients. Song and McKelvey reported that there are rural patients receiving VADs and that the rural</p>	<p>HSC staff to review CMS coverage criteria and the MED report and any additional information found on cost information/possible cost savings. Staff to develop criteria/guideline for LVAD as destination therapy to discuss at the December meeting</p>

Topic	Action
<p>physicians are able to care for this device. The device costs the same as a heart transplant. Olson pointed out that our current coverage is twice as expensive (payment for VAD and transplant).</p> <p>Olson suggested having only CMS certified centers provide this treatment for OHP patients. Song stated that CMS has criteria for when patients should be given a VAD.</p> <p>Saha suggested having the HRC look at this technology and bring a report to the HSC. Shaffer reported that the MED project reviewed VADs recently. Only one study has been done to date on the new generation of VAD devices with 120 patients. No children or adolescents were included in that trial. No cost-effectiveness data was found. McKelvey felt that the HSC already pays for this technology and therefore further research does not need to be done. There is not a huge group of patients who will demand this therapy if it becomes covered. Song indicated that there will be some newer studies published soon.</p> <p>The decision was to have HSC staff review CMS criteria and the MED report and cost info and possible cost savings from rehospitalizations, etc. and come up with criteria/guideline to discuss in December.</p>	
<p>Stereotactic body radiation therapy Smits introduced a summary document discussing stereotactic body radiation therapy (SBRT).</p> <p>Olson corrected the meeting materials, stating the SBRT is not experimental. It's a different way to delivery radiation that is more focused. There is increased cost in the planning stage and in the increased imaging. The controversy is whether SBRT is better than conventional radiation therapy. The data is not there for whether this is better/has better long term outcomes. The HSC currently covers SBRT for the brain, which has much more experience/data. The radiation therapy community is divided on whether this should be used instead of conventional radiation therapy. Olson felt that it was reasonable to wait for long term follow up studies, which should be available in about 2 years. Olson also noted that commercial payers are currently denying coverage for SBRT for the reasons he outlined above.</p> <p>The decision was to wait until better data is available on</p>	<p>No change in current coverage for SBRT.</p>

Topic	Action
<p>improved outcomes/lower cost/improved safety before covering SBRT for non-brain indications.</p>	
<p>Guidelines vs. coding specifications Smits introduced a summary document discussing when a limitation of coverage should be a guideline and when it should be a coding specification included as part of the line.</p> <p>The group decided that coding specifications should be straightforward statements which apply to only one line. Examples of coding specifications include 1) definitions of which conditions included in one ICD-9 code are intended to be included on a line, 2) statements that a certain CPT code is included on a line only for pairing with a particular ICD-9 code.</p> <p>Guidelines should be statements which are more qualitative in nature which may apply to one or more lines. Examples of guidelines include 1) the degree of a condition with must be present for treatment to be covered, 2) associated conditions which must be present for treatment to be covered, 3) limitations of coverage.</p> <p>Most of the suggested changes from guidelines to coding specifications were rejected. Three current guidelines were changed to coding specifications.</p>	<p>Guideline Notes 29, 69, and 84 were changed to a coding specifications. See Appendix A for details.</p> <p>Guideline Note 48 will be deleted with the next biennial review.</p>
<p>Acute and chronic otitis media</p> <p><u>Acute otitis media</u> Smits introduced a summary document continuing the discussion about a new guideline for acute otitis media. McKelvey reported that she reviewed all of the documents in this section, and found the evidence quality to be low. She was concerned that kids under 1 year of age were not included in many of these studies, possibly due to ethical issues. She suggested changing newborn (which restricts to 1 to 30 days of age) to under 1 year of age. The group debated whether the age for complications should be changed from newborn to <1 year. Smits argued that most kids would qualify under other conditions, and would not broaden the coverage to widely. The decision was to remove newborn from the guideline, and not include the under 1 year group. If providers find that they are having problems with coverage for kids who truly need the tubes, then the HSC should reconsider this decision. McKelvey also suggested removing bulging tympanic membrane as a criteria, as this is part of the diagnosis of acute otitis media, not a complication. She was also</p>	<p>Acute otitis media: see adopted guideline in Appendix A</p> <p>Chronic otitis media: see updated guideline in Appendix A</p>

Topic	Action
<p>concerned about use of “episodes” because some children never clear the infection. The decision was made to keep episodes in the guideline, as no better wording was found. The group also decided to remove the second clause from the guideline, which referred to severe symptoms unresponsive to antibiotic therapy. Antibiotic failure was added to the new second clause instead. The group also rejected the proposed 4th clause about hospitalization. The complications included in the guideline were felt to represent the spectrum of things for which a child with otitis media would be hospitalized.</p> <p><u>Chronic otitis media</u> Smits introduced the summary of proposed changes to the chronic otitis media guideline. McKelvey made two wording change suggestions.</p> <p>There was some discussion regarding the ability to get formal decibel loss testing on small children. Shaffer stated that the problem with audiology specified decibel hearing loss was that rural kids need to be referred to specialized centers can do this. This is a barrier and additional expense. McKelvey replied that Eugene can do this testing. This is not a problem in her opinion. Smits suggested having DMAP keep track of costs and if they increase with the wording change, then the HSC can reconsider this specification. Shaffer replied that it is hard for DMAP to keep track of costs, as it would require separating out which cases are additional due to this guideline. The decision was to adopt the guideline changes as noted in Appendix A.</p>	
<p>Prevention tables Livingston introduced a summary document concerning changes to the Prevention Tables. The discussion began with screening for lead. McKelvey expressed concern with widespread coverage, because the incidence of lead poisoning is very low. However, Head Start programs require a yearly lead test. Currently, AAP guideline recommends screening all kids at 9 months, but children going to Head Start get screened once a year in her office. Saha reminded the group that the HSC determines coverage of procedures and tests, not population screening recommendations. Gingerich pointed out that the Prevention Tables have “recommendation” in the titles. Saha suggested changing the titles. McKelvey asked why the tables exist at all? Coffman replied that the tables function as a guideline clarifying what services are included on Lines 3 and 4 (Preventive services). Saha replied that if</p>	<p>HSC staff to develop a single table with guidelines for coverage of preventive services. HOSC members will assist staff via email prior to the December meeting. The revised prevention table will be discussed at the December meeting.</p>

Topic	Action
<p>that is the case, then “I” recommendations from the USPSTF should not be part of these guidelines, as the HSC should not prioritize services with “I” recommendations on such high lines. He felt that the HSC should cull out anything that is not an A or B level recommendation. The discussion then centered around how to handle items which are “I” recommendations. Some of these items are probably useful (screen for domestic violence etc). McKelvey pointed out that other group recommendations are frequently used rather than USPSTF recommendations. For example, pediatricians use AAP recommendations. She felt that the HSC should use appropriate guidelines, not just the USPSTF guidelines. Smits pointed out that many of these services are considered part of the routine preventive visit, and are not billed separately. Dodson recommended that only items billed separately, with a charge separate from the general preventive visit, be included in these tables. Smits suggested having a list of services that are covered in addition to the cost of the preventive care visit. Use only USPSTF A and B recommendations on this list, or other recommendations from expert groups with equivalent evidence standards.</p> <p>The group decided that HSC staff should develop a single table to replace the multiple existing Prevention Tables. This table would contain procedures with CPT codes that are A and B level recommendations. Anything that is “I” level or not reviewed will come back for discussion. McKelvey and Dodson volunteered to assist staff on recommendations for children, Saha and Dodson on adults, Tyack for dental issues. Staff with send suggestions to HOSC members prior to the next meeting for comments to help streamline the discussion prior to the Dec meeting</p>	
<p>Epo Guideline A summary document was presented with suggested changes for the guideline for erythropoiesis-stimulating agents. Olson suggested adding a clause to the cancer with chemotherapy section which would limit ESA treatment to patients undergoing chemotherapy treatment within past 8 weeks to mirror most current oncology guidelines. Because of the adverse outcomes associated with ESA treatment for cancer patients not undergoing chemotherapy, a separate clause stating this is not a covered treatment was added to the guideline.</p> <p>Discussion then turned to the initiation hemoglobin level</p>	<p>See updated ESA guideline in Appendix A</p>

Topic	Action
<p>for patients with renal disease. Gubler felt that patients with chronic renal insufficiency (CRI) are given too high a dose of ESAs. The group felt that a higher hemoglobin level for initiation of ESA therapy would result in much higher drug costs without significant improvement in health outcomes. Saha pointed out that the National Kidney Foundation guideline does not specify a starting hemoglobin. Smits reviewed the NICE evidence review behind their recommendations (not provided in packet due to length) which includes two studies on initial hemoglobin level, which show longer times to optimal hemoglobin level but no other outcomes. Saha stated that the evidence supported a higher maintenance hemoglobin level for patients with CRI, but not a higher initiation hemoglobin level.</p> <p>The subcommittee decided to maintain the initiation hemoglobin level for CRI, but increase the goal maintenance range.</p>	
<p>Synagis Deferred to December meeting</p>	
<p>Spine MRI guideline Deferred to December meeting</p>	
<p>Hospice concurrent treatment for children Coffman discussed an issue regarding hospice with concurrent curative care for children with cancer. New federal rules require concurrent treatment. DMAP is discussing with the federal agencies whether the current cancer care at the end of life guideline is in conflict with this new requirement.</p> <p>Saha felt that the CMS letter only specified that kids should be given palliative care while undergoing curative chemotherapy.</p> <p>Smits pointed out that this was informational only. If and when CMS issues a ruling that the end of life guideline needs to change, HSC staff will bring back at a later meeting.</p>	<p>Informational only. HSC staff will monitor and bring back this issue if CMS requires a guideline change</p>
<p>Criteria for topic review and for submitted evidence Smits reviewed a summary document outlining when the HSC will review topics and what types of evidence are considered acceptable. The subcommittee members felt that the two documents should be combined into one, longer document to better show how a topic will be reviewed only when a certain level of evidence is provided as proof that a change is required.</p> <p>Suggested changes included making a clearer</p>	<p>HSC staff to compile suggested changes to the criteria for topic review and submitted evidence and bring back to the December meeting.</p> <p>HSC staff to obtain a conflict of interest form and circulate it to HSC members to</p>

Topic	Action
<p>statement about expert opinion being accepted only when no other evidence is available. The group also wanted a statement about requiring conflict of interest statements from all presenters. This led to a discussion that HSC members should have conflict of interest statements on record yearly. The HRC has a conflict of interest form and currently requires members to complete this form yearly. HSC staff will obtain this form from HRC staff and circulate it to the HSC members.</p> <p>Suggested changes to the criteria for evidence were minimal.</p>	complete.
<p>Straightforward Issues The subcommittee deferred reviewing the straightforward table. The members decided that HSC staff should send out the table for review and comment prior to the December meeting. Additional straightforward issues will be reviewed prior to the December meeting and sent out at a later date. Any items on the straightforward table which a commission member feels needs discussion will be brought to the December meeting. The remaining items will be placed on a "consent agenda" for the December meeting and not discussed in any detail. The group will evaluate how this system works at the next meeting.</p>	HSC staff to send HOSC members the straightforward table with material from the October for review after the meeting. Additional topics for December should be sent to HOSC members prior to the December meeting for review.
<p>Line 209 name change Deferred to December meeting</p>	
<p>Public Comment None received</p>	

Appendix A Guidelines

Updated guidelines

GUIDELINE NOTE 74, GROWTH HORMONE TREATMENT

Lines 411,485

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

GUIDELINE NOTE 51, CHRONIC OTITIS MEDIA WITH EFFUSION

Line 492

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

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

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

GUIDELINE NOTE 7, ERYTHROPOIETIN ERYTHROPOIESIS-STIMULATING AGENT (ESA) GUIDELINE

Lines 33,65,78,101,102,105,123-125,131,138,144,159,166-168,170,181,197,198,206-208,219,221,222,229,230,232,236,243,249,252,275-278,280,286,291,309-311, 313, 319, 337-339,350,354,365,452,611

1. Indicated for anemia (Hgb < 10gm/dl or Hct < 30%) induced by cancer chemotherapy given within the previous 8 weeks or in the setting of myelodysplasia ~~or in chronic renal failure, with or without dialysis.~~

A. Reassessment should be made after 8 weeks of treatment. If no response, treatment should be discontinued. If response is demonstrated, ~~EPO~~ ESAs should be titrated to maintain a level between 10 and 12.

B. Not indicated for anemia in cancer patients not undergoing chemotherapy

2. Indicated for anemia (Hgb < 10gm/dl or HCT < 30%) associated with HIV/AIDS.

A. An endogenous erythropoietin level < 500 IU/L is required for treatment, and patient may not be receiving zidovudine (AZT) > 4200 mg/week.

B. Reassessment should be made after 8 weeks. If no response, treatment should be discontinued. If response is demonstrated, ~~EPO~~ ESAs should be titrated to maintain a level between 10 and 12.

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

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

New guideline

GUIDELINE NOTE XXX TYMPANOSTOMY TUBES IN ACUTE OTITIS MEDIA

Line 413

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

Guidelines deleted and made into coding specifications

~~GUIDELINE NOTE 29, MASTOCYTOSIS~~

~~Lines 222,674~~

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

Condition: NON-HODGKIN'S LYMPHOMAS (See Guideline Notes 1,7,11,12,19,29,64,65,76)

Treatment: MEDICAL THERAPY, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY

ICD-9: 200,202.0-202.3,202.6-202.9,238.5-238.7

CPT: 32553,49411,38100,38120,38720,49080-49081,77261-77295,77300-77321,77331-77370,77401-77427,77470,78811-78816,79005-79445,96150-96154,96405-96406,96420-96450,96542-96571,98966-98969,99024,99051,99060,99070,99078,99201-99360,99366,99374-99375,99379-99444,99468-99480,99605-99607

HCPCS:

G0235,G0406,G0407,G0408,G0425,G0426,G0427,S0270,S0271,S0272,S0273,S0274,S9355,S9537

Line: 222

Malignant and systemic mastocytosis (202.3) are included on line 222. Mastocytosis limited to the skin (757.3) resides on Line 674.

~~GUIDELINE NOTE 69, INTESTINAL MALABSORPTION~~

~~Line 241~~

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

Condition: INTESTINAL MALABSORPTION (See Guideline Notes 64,65,69)

Treatment: MEDICAL THERAPY

ICD-9: 040.2,579.0-579.8

CPT: 98966-98969,99024,99051,99060,99070,99078,99201-99360,99366,99374-99375,99379-99444,99468-99480,99605-99607

HCPCS: G0406,G0407,G0408,G0425,G0426,G0427,S0270,S0271,S0272,S0273,S0274

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 NOTE 84, PAROTID GLAND PLEOMORPHIC ADENOMA~~

~~Line 311~~

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

Line: 311

Condition: CANCER OF ORAL CAVITY, PHARYNX, NOSE AND LARYNX (See Guideline Notes 1,7,11,12,19,64,65,76,84)

Treatment: MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY

ICD-9: 140-149,160-161,196.3,210.2,231.0,231.8,235.0-235.1,235.6,235.9

CPT: 13132,13151,14040-14302,15570,15732,15734,15756-15760,21011-21014,21016,21552-21555,21557,21558,30117,30118,30520,31075-31230,31300,31360-31370,31380-31395,31540,31541,31600-31603,31611,31820,31825,32553,38724,40500-40530,40810-40816,40819,40845,41019,41110-41155,41820,41825-41827,41850,42104-42120,42280,42281,42410-42500,42826,42842,42845,43450,43496,49411,60220,69110,69150,69155,69502,77014,77261-77295,77300-77315,77326-77370,77401-77470,77750-77790,78811-78816,79005-79445,92506-92508,92526,92607-92609,92633,96150-96154,96405,

96406,96420-96450,96542-96571,98966-98969,99051,99060,99070,99078,99201-99360,99366,99374,
99375,99379-99444,99468-99480,99605-99607
HCPCS: D5983-D5985,D7440,D7441,D7920,D7981,G0235,G0406-G0408,G0425-G0427,S0270-
S0274,S9152,S9537

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

Guideline deleted with next biennial review

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

~~Line 473~~

~~By Report (D4240, D4260)~~

**MEETING HIGHLIGHTS
HEALTH OUTCOMES SUBCOMMITTEE
Clackamas Community College
Wilsonville Training Center, Room 112
Wilsonville, Oregon
December 9, 2010
8:30 AM – 2:30 PM**

Members Present: Lisa Dodson, MD, Chair; K. Dean Gubler, DO, MPH; Kevin Olson, MD; Carla McKelvey, MD; James Tyack, DMD.

Members Absent: Somnath Saha, MD, MPH

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

Also Attending: Carol Camfield, Shawna Jones, Sharon Boren, Cora Elder, Caroline Price and Wally Shaffer, MD, DMAP; David Rohrer, DHS Actuarial Services; Howard Song, OHSU; Diann Matthews and Fred Sego, Centocor Ortho Biotech; Sean Coster and Jim Chesnutt, MD, OHSU Sports Medicine.

Note: The meeting adjourned at 2:30 pm. The next HOSC meeting is scheduled for January 13, 2011.

Topic	Action
<p>General Highlights from the October, 2010 HOSC meeting reviewed. No changes or corrections were made.</p>	<p>Highlights from the October, 2010 meeting were approved without change.</p>
<p>LVADs as destination therapy Smits introduced the summary document reviewing the possible expansion of left ventricular assist devices (LVADs) for use as destination therapy. Dr. Howard Song from OHSU provided testimony.</p> <p>Dr. Song noted that not covering LVADs for destination therapy created problems when patients are unable to receive a heart transplant due to donor shortages or when patients decide to simply keep the LVAD rather than pursue transplant.</p> <p>There was discussion about whether LVADs as destination therapy was new technology. Coffman noted that CMS has covered LVADs for this indication since 2003, which included older LVAD technology which was less effective.</p> <p>Concern was expressed on the part of the OHP health plans and DMAP that expanding the indications for LVAD use to destination therapy would greatly increase</p>	<p>Dr. Song and DMAP will try to obtain better cost figures for coverage of LVADs for destination therapy as well as medical care of patients who would qualify but do not receive LVADs. The HOSC will reconsider LVADs as destination therapy at their August, 2011 meeting.</p>

**MEETING HIGHLIGHTS
HEALTH OUTCOMES SUBCOMMITTEE
Clackamas Community College
Wilsonville, Oregon
August 12, 2010
8 AM – 11:30 AM**

Members Present: Lisa Dodson, MD, Chair; K. Dean Gubler, DO, MPH; Kevin Olson, MD; Somnath Saha, MD, MPH; Carla McKelvey, MD; James Tyack, DMD.

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

Also Attending: Caroline Price, Wally Shaffer, MD, Isabel Bickel, Chris Barber, Mike Love, Karen Sunderland, DMAP; Chris Kirk, MD, OHP Medical Directors; Joe Hassett, MD, Ellen Lowe, Oregon Association of Hospitals and Health Systems; Jenifer Valley, Stoney Girl Gardens Foundation; Deborah Travis & Don McQueen, NW Resource Center; Claire Hartwel.

Note: The meeting adjourned at 11:40 am. Next HOSC meeting scheduled for October 14, 2010.

Topic	Action
<p>General Highlights from the May, 2010 HOSC meeting reviewed. No changes or corrections were made.</p>	<p>Highlights from the May, 2010 meeting were approved without change.</p>
<p>New ICD-9 Codes Smits introduced a spreadsheet with suggested placements for the 2011 ICD-9 codes. There was minimal discussion. Suggested placements were accepted as presented in the meeting materials.</p> <p>Additionally, several changes to the Prioritized List required to accommodate the new ICD-9 codes were accepted as presented. See items #2-5 at right.</p>	<p>1) ICD-9 placements accepted as proposed in the meeting materials shown in Attachment A.</p> <p>2) Remove 278.8 (Other hyperalimantation) from Lines 8 and 211 and place on the Never Covered List</p> <p>3) Delete Guideline Note 73</p> <p>4) Add 57800 (Dilation of cervical canal, instrumental) to Line 441</p> <p>5) Advise DMAP to move V62.81 (Interpersonal problems, NEC), V62.83 (Counseling for perpetrator of</p>

Topic	Action
	physical/ sexual abuse) and V62.89 (Other psychological or physical) from Ancillary List to Never Covered List; move V62.84 (Suicidal ideation) from Never Covered List to the Ancillary List.
<p>Chronic Sinusitis</p> <p>Joe Hassett, MD, allergist, testified to the importance of patients with chronic sinusitis receiving evaluation and treatments from allergists. He provided a written summary of his testimony to the Commission. He suggested that the HSC add coverage for allergist visits and immunotherapy for chronic sinusitis, with a guideline limiting this coverage to patients with “≥3 episodes of antibiotics/yr or ≥ 3 months of symptoms despite antibiotics in a year” who also have “evidence of atopy in the form of RAST positivity class 2 or higher to dust mite or an animal in the home or to all three categories of pollens (trees, grasses, weeds).”</p> <p>There was considerable discussion about adding allergist care for chronic sinusitis. Saha suggested using the exceptions process to allow such care, but Kirk indicated that this would be difficult for the OHP plans. Kirk also noted that his plan does not see requests for allergist treatment for this condition under the exceptions process. Smits reviewed the literature, which shows evidence for medical treatment (nasal steroids, etc.) and surgery, but not for immunotherapy.</p> <p>Hassett argued that it was a cost savings to cover allergist treatments for chronic sinusitis, due to decreased medication use. The cost savings paid for the allergy treatment after approximately 5 years. Saha countered that if such treatment was truly cost saving, then the health plans would already be covering it under an exception. Kirk replied that his plan does not allow allergist treatments for chronic sinusitis due to lack of cost savings having been found. In his experience, patients continue to need medication after immunotherapy, and most patients are not compliant with finishing immunotherapy.</p> <p>The proposed guideline was discussed. Saha suggested that if coverage of allergy treatment was adopted, then a guideline such as Dr. Hassett recommended should be adopted. He suggested that the guideline also state that medical therapy has been</p>	<p>No change made to current treatment coverage for chronic sinusitis.</p>

Topic	Action
<p>maximized.</p> <p>The discussion then turned to the evidence for the effectiveness of allergy treatments and immunotherapy for this condition. The consensus was that there was limited evidence for immunotherapy for chronic sinusitis. The condition is common and the treatment is common so evidence should be attainable. Lack of evidence is concerning because this should be studied and there may be a situation where there are negative studies which are not being published. McKelvey noted that guidelines do not mention immunotherapy as a treatment modality, even in the allergist specialty society guideline.</p> <p>Kirk suggested that Dr. Hassett present data on the cost-effectiveness of allergy treatment for chronic sinusitis to the OHP Medical Directors. Shaffer agreed that this topic would be brought up at the next Medical Directors meeting, and Dr. Hassett invited to present if the Medical Directors felt that it would be useful.</p>	
<p>Pain Not Elsewhere Classified</p> <p>Smits introduced a summary document with recommendations for placement for ICD-9 codes in the 338.x family based on expert recommendations. This was a follow up from the discussion in May, 2010. Kirk asked whether all the available treatments for chronic pain should be added to the lines with chronic pain due to trauma, etc. The group felt that no further changes needed to be made, unless there are concerns.</p>	<ol style="list-style-type: none"> 1) Recommend to DMAP that 338.11, 338.19, 338.21, 338.28, 338.29 and 338.4 be added to the Never Covered List. 2) 338.12 and 338.18 added to Line 307. 3) 338.22 added to Line 440. 4) Advise DMAP to keep 338.3 on Always Covered/ Exempt List
<p>Growth Hormone Treatment in Children</p> <p>Smits introduced a summary document about increasing the indications for growth hormone treatment in children. There was little discussion about adding Noonan's syndrome, or SHOX syndrome.</p> <p>The subcommittee discussed whether treating Prader-Willi syndrome had long term benefit. Treatment of this group is mainly to improve lean body mass. Kirk noted that in his experience, these patients end up with normal heights generally. He expressed concern about whether the benefit for improved lean body mass would wane in adulthood if treatment was stopped as the guideline states. The consensus was to allow coverage for this condition, based on other evidence-based guidelines recommending it, and the fact that there are few patients with this diagnosis in Oregon so it will not be subject to abuse.</p>	<p>Noonan's syndrome, Prader-Willi syndrome, and SHOX added as indications for growth hormone treatment for children in the growth hormone treatment guideline for the October 1st list. HSC staff will research coverage for treatment with growth hormone for CRI for children and bring a suggested modified guideline to the October HOSC meeting.</p> <p>See Attachment B for accepted October 1 growth hormone treatment guideline.</p>

Topic	Action
<p>Small for gestation age was considered a concerning indication for growth hormone treatment. McKelvey expressed concern that children with small parents might qualify for treatment who are otherwise healthy. There was general concern for the treatment of healthy kids (small for gestation age and idiopathic short stature) with growth hormone when there are no long term studies of its effects on such patients. Additionally, McKelvey pointed out that idiopathic short stature does not have a clear diagnosis. Kirk felt that covering short stature would greatly increase the number of children requesting treatment. Dodson also raised concern that treatment of these groups was mainly cosmetic; cosmetic treatments are not generally covered by the HSC. The group decided not to extend coverage to either small for gestational or idiopathic short stature children.</p> <p>Idiopathic growth hormone deficiency was clarified to be the same diagnosis as pituitary dwarfism (both are 253.3).</p> <p>Chronic renal insufficiency (CRI) was debated as an indication. Kirk felt that the HSC needed to include a definition of what constituted CRI. Olson indicated that there are accepted definitions currently. Shaffer suggested restricting treatment to children with Grade 5 CRI or higher, which is a severe, pre-dialysis level of CRI. Dodson suggested using the NICE criteria for CRI patients, which are very stringent.</p> <p>The decision was made to add Noonan's syndrome, Prader-Willi syndrome, and SHOX to the guideline for the October 1st list. HSC staff will research coverage for CRI and bring a suggested modified guideline to the October HOSC meeting. The guideline should follow the NICE guideline if possible.</p>	
<p>Amyloidosis Smits introduced a summary document recommending coverage of chemotherapy for amyloidosis. There was little discussion about adding coverage for medical treatment of amyloidosis. There was discussion about whether stem cell transplantation should be covered. Smits reviewed the discussion about stem cell transplantation for amyloidosis from May, 2008. Olson stated that stem cell transplantation was used on the 80's and 90's because effective chemotherapy did not exist. New therapies have been developed recently which are more effective than transplant—better outcomes and less toxic than transplant. Most patients</p>	<ol style="list-style-type: none"> 1) Add amyloidosis unspecified (277.30) and other amyloidosis (277.39) to line 249 Acute Lymphocytic Leukemias (Adult) and Multiple Myeloma. 2) Delete 277.3 from 670 Endocrine And Metabolic Conditions With no or Minimally Effective Treatments or no

Topic	Action
<p>are diagnosed with amyloidosis due to work up of organ dysfunction, which is the group that transplant doesn't work well for anyway. Recommended adding amyloidosis only to chemotherapy line; transplant can be done as an exception process. Shaffer indicated that DMAP gets transplant requests for amyloidosis (Price stated that DMAP has authorized 3 patients with 2 or fewer organs involvement for stem cell transplant in the past year). Currently multiple myeloma (a very similar condition) is on Line 198 with transplant as a treatment. Shaffer stated that having an HSC guideline would help the exceptions process. Saha felt that if the best available evidence indicated that chemotherapy and transplant are equally effective, and chemo is less toxic, then reasonable to only cover chemotherapy.</p> <p>The HRC has been asked to do a global review of stem cell transplantation, and is awaiting the results of a national review. The group decided to wait for this report before making decisions to add stem cell treatment.</p>	<p>Treatment Necessary.</p>
<p>Overweight The discussion centered around the lack of evidence of effectiveness of treatment for overweight. The group decided to add overweight to the never covered list.</p>	<p>Advise DMAP to place 278.02 (overweight) on the Never Covered List.</p>
<p>Dyspraxia Smits introduced a summary document regarding dyspraxia. The discussion centered around whether there was effective treatments for dyspraxia syndrome (315.4), and the decision was there were not, and that the diagnosis was hard to define. However, the group felt that dyspraxia (781.3) should be kept on the Signs and Symptoms list to allow work up for a cause. There are no treatments included for diagnoses on the signs and symptoms list.</p>	<p>1) Advise DMAP to keep dyspraxia (781.3) on the Signs and Symptoms List.</p> <p>2) Remove dyspraxia syndrome (315.4) from line 317 Neurological Dysfunction In Posture And Movement Caused By Chronic Conditions. Advise DMAP to place dyspraxia syndrome (315.4) on the Never Covered List.</p>
<p>Epidural Nerve Blocks Smits introduced a summary document about epidural nerve blocks. Currently, nerve blocks are on the Ancillary List. There is a guideline about these blocks, but Shaffer indicated that DMAP has difficulty applying guidelines to ancillary procedures. Coffman indicated that when the PT guideline was written, the PT codes were taken from the Ancillary List and put on lines on the Prioritized List. It was proposed that HSC staff research putting nerve blocks on lines and remove from</p>	<p>HSC staff to request additional information from DMAP regarding the hearing which led to this topic being reviewed. HSC staff to bring back recommendations about either the diagnosis in this case or about placing nerve block diagnoses on lines on the Prioritized List and</p>

Topic	Action
<p>the Ancillary List. Coffman indicated that the lines in the current nerve block guideline were chosen because they had procedure codes, not because the diagnoses on that line could benefit from the blocks. HSC staff will need to review the lines for this guideline if the procedure codes are placed on lines. Coffman suggested that Line 307 would include most diagnoses in the guideline because of the chronic pain diagnosis codes added earlier in the meeting. The other conditions in the guideline could have appropriate lines identified. McKelvey requested that HSC staff get more information about the question that started this review from DMAP. It may be that the problem at the hearing was the diagnosis and not the procedure.</p>	<p>revising the accompanying guideline.</p>
<p>Tympanostomy/PE Tubes A summary document was presented regarding guidelines for tympanostomy. There was no discussion about the coding guideline suggested for addition to Line 380. The proposed new guideline for acute otitis media (AOM) was discussed. McKelvey was concerned about the vague term “moderate to severe symptoms” in the second clause of the guideline. She recommended putting in greater specificity—what symptoms? Does this mean complications? What is moderate or severe? She also recommended striking “or intolerance” from the 3rd clause. Kirk noted that Interqual has a guideline for PE tubes for AOM, which his plan currently follows. He offered to forward this guideline to HSC staff. The decision was to have HSC staff look at the Interqual guideline and discuss the guideline further with Dr. Milczuk.</p> <p>McKelvey raised concerns about the current guideline for chronic otitis media (Guideline Note 51). The second paragraph of the guideline restricts PE tube to kids with bilateral chronic otitis media. She feels that unilateral chronic otitis media should be covered as well, because it can lead to speech delays. Coffman stated that there is a non-covered line for unilateral hearing loss, and this guideline was an attempt to conform with the non-covered state of this condition. The decision was made to have HSC staff discuss the chronic otitis media guideline with Dr. Milczuk. Specifically, staff will discuss whether unilateral chronic otitis media causes speech delay. If this is the case, then the guideline may be modified to allow treatment of unilateral chronic otitis media if speech delay can be documented (or similar wording).</p>	<ol style="list-style-type: none"> 1) Add the following coding guideline to Line 380 Hearing Loss – Age 5 Or Under: “CPT code 69436 is included on this line only as treatment for conductive hearing loss (389.0, 389.2).” 2) HSC staff to review the proposed guideline for acute otitis media with experts and bring back to the October meeting. 3) HSC staff to review the chronic otitis media guideline with experts and bring back to the October meeting.

Topic	Action
<p>Parotid Gland Pleomorphic Adenoma Smits introduced a summary document regarding the resection of parotid gland pleomorphic adenoma. The group agreed this condition needed to be treated, due to locally aggressive behavior. Gubler indicated that this surgery has significant risks and will not be abused. The guideline for this condition was approved as written.</p>	<p>1) Add 210.2 (Benign neoplasm of major salivary glands) to Line 311. Delete from Line 644.</p> <p>2) Add the guideline in Attachment B to Line 311.</p>
<p>Sciatica Smits reviewed a summary document regarding sciatica. The group felt that sciatica can be a sign of some other condition. The MRI back guideline applies to conditions on the signs and symptoms list. Therefore, the group decided to leave sciatica on the Signs and Symptoms list, where the cause could be evaluated, with restrictions in the MRI back guideline, but treatments are not covered.</p>	<p>Advise DMAP to leave sciatica (724.3) on Signs and Symptoms List.</p>
<p>Superior Vena Cava Syndrome Smits reviewed a summary document on superior vena cava syndrome. Olson agreed that this change would be helpful for cancer patients. The proposed changes were accepted as included in the meeting materials.</p>	<p>1) Add 459.2 to Line 278 Cancer Of Lung, Bronchus, Pleura, Trachea, Mediastinum And Other Respiratory Organs.</p> <p>2) Add a coding guideline to Line 278: "ICD-9 code 459.2 is included on this line for superior vena cava syndrome only."</p> <p>3) Add 37205 (transcatheter placement of an intravascular stent) to Line 278.</p> <p>4) Keep 459.2 on Line 655 Varicose Veins Of Lower Extremities Without Ulcer Or Inflammation.</p>
<p>Congenital Chordee Smits reviewed a summary document on congenital chordee. The group agreed to add this diagnosis to Line 451; however, the proposed guideline was amended. The group was concerned about the second clause in the guideline allowing coverage when later sexual function might be compromised. The group felt that the first clause (greater than 35% curvature) should cover most of these cases, and this wording was open to abuse.</p>	<p>1) Add 752.63 to Line 451 (Hypospadias and epispadias)</p> <p>2) The guideline regarding congenital chordee shown in Attachment B was adopted.</p>
<p>Wrist and Elbow Arthroscopy Smits introduced a summary document regarding arthroscopies. Livingston raised concern about the evidence supporting the placement of arthroscopies on</p>	<p>HSC staff to review the effectiveness of arthroscopy for wrist and elbow conditions and bring back a revised</p>

Topic	Action
<p>the Prioritized List. Smits replied that many of these codes are already on the list; traditionally the HSC has had a lower standard of effectiveness for adding procedures already on the list to new lines. The group indicated that HSC staff should review the evidence of effectiveness for these procedures. Smits indicated that such a review would need to look at every possible indication/ diagnosis for these procedures. Gubler noted that there may not be much evidence available. This type of procedure (functional procedure) is hard to research. The decision was made to have HSC staff do an evidence review on the effectiveness of arthroscopy and bring back a proposal for coverage or non-coverage. Specialists should be consulted if no literature is found. The HSC may need to take certain CPT codes off the list if evidence shows the procedure is not effective.</p>	<p>coverage proposal to the October meeting.</p>
<p>Spinal MRI Guideline The Spinal MRI guideline was reviewed. The group agreed that evaluation of spinal stenosis should be added to the guideline. However, the proposed wording for this change was made more specific.</p>	<p>The MRI of the Spine guideline was modified as shown in Attachment B.</p>
<p>Prevention Tables The changes recommended in the summary document presented were accepted. McKelvey then raised concerns about the footnotes specifying ages for immunizations. The group decided that the tables should not specify ages, as they could keep children from getting appropriate catch up shots. McKelvey suggested referring to the CDC/ACIP guidelines. Coffman stated that the HSC must refer to a specific document, not guidelines subject to change. Smits noted that referring to specific CDC recommendations would not allow future changes in the immunization recommendations to be reflected in the Prevention Tables. The group decided to strike specific ages from the tables, unless the HSC varies from national recommendations or when such ages or other criteria are highly relevant.</p> <p>Coffman then brought up that the OHPR administrator has requested that the HSC look at how closely the Prevention Tables agree with the USPSTF A and B recommendations. It was agreed that HSC staff should review these recommendations, and ensure that the guidelines are up to date and note where they differ from USPSTF recommendations.</p>	<ol style="list-style-type: none"> 1) Changes in blue in the meeting materials approved 2) HSC staff to remove references to ages in the immunization section of the tables unless they vary from national guidelines or are highly relevant. 3) HSC staff to review how the Prevention Tables compare to current USPSTF A and B recommendations and make proposals, if needed, for the October meeting to bring the Prevention Tables in line with USPSTF recommendations (if indicated).

Topic	Action
<p>Reflex sympathetic dystrophy Smits reviewed a summary document regarding RSD. The suggested changes were accepted without discussion.</p>	<p>Add 337.2 (RSD) to Lines 317 and 404; remove 337.2 from Lines 525 and 548</p>
<p>Contralateral Breast Reconstruction Smits reviewed a summary document regarding breast reconstruction of the contralateral breast in breast cancer cases. The group debated whether contralateral reduction mammoplasty should be covered for breast cancer patients. The group felt that if the breast undergoing surgery for cancer could be augmented with reconstruction to allow symmetry, then patients who require the contralateral breast be reduced for symmetry should be allowed to have this surgery as it is not uncommon that the affected breast cannot be augmented sufficiently to achieve symmetry. The breast reconstruction guideline (approved in January 2009 but mistakenly never added to the Prioritized List) was modified to reflect that reduction mammoplasty is only covered for patients undergoing mastectomy for breast cancer or as prophylaxis.</p>	<p>1) Leave 19318 on Line 197. 2) Re-approve the breast reconstruction guideline with the change noted in Attachment B.</p>
<p>DMAP/HSC Code Clean Up Smits introduced an Excel spreadsheet with recommendations for placement of CPT codes which currently are duplicated on several lists or are otherwise in need of revision. The supplemental issues Word document was also reviewed. There was no discussion; the subcommittee accepted the recommendations as presented.</p>	<p>Please see <i>Attachment A of the 8/12/10 HSC minutes</i> for the DMAP/HSC code clean up suggestions as recommended by the HOSC.</p>
<p>Audiometry Smits introduced a summary document outlining where various audiometry testing codes should be placed. There was minimal discussion; recommendations were accepted as presented in the meeting materials, with the exception that the testing CPT codes were removed from the Diagnostic List for any code that was placed or left on lines on the Diagnostic List.</p>	<p>Audiometry codes were accepted as presented in the meeting materials table except that the correction was made to strike the CPT codes from the Diagnostic List for any code kept on the Prioritized List or added to the List. Please see table in <i>Attachment B of the 8/12/10 HSC minutes</i> for these changes.</p>
<p>Straightforward Issues Suggested changes were accepted without discussion.</p>	<p>The straightforward table suggested changes were accepted as shown in <i>Attachment C of the 8/12/10 HSC minutes</i>.</p>
<p>Public Comment Testimony was heard from Jenifer Valley of the Stoney</p>	<p>No action taken.</p>

Topic	Action
Girl Gardens Foundation regarding upcoming vote on the medical marijuana initiative.	

ATTACHMENT A

New ICD-9-CM Codes -- Straightforward -- Code Breakouts

ICD-9	Code description	List/line(s)	Additional Information
237.73	Schwannomatosis	319 CANCER OF BRAIN AND NERVOUS SYSTEM Dysfunction lines (77, 317, 372, 404)	
237.79	Other neurofibromatosis	319 CANCER OF BRAIN AND NERVOUS SYSTEM Dysfunction lines (77, 317, 372, 404)	
275.01	Hereditary hemochromatosis	160 DISORDERS OF MINERAL METABOLISM, OTHER THAN CALCIUM 255 ACUTE AND SUBACUTE NECROSIS OF LIVER; SPECIFIED INBORN ERRORS OF METABOLISM Treatment: LIVER TRANSPLANT	
275.02	Hemochromatosis due to repeated red blood cell transfusions	160 DISORDERS OF MINERAL METABOLISM, OTHER THAN CALCIUM 255 ACUTE AND SUBACUTE NECROSIS OF LIVER; SPECIFIED INBORN ERRORS OF METABOLISM Treatment: LIVER TRANSPLANT	
275.03	Other hemochromatosis	160 DISORDERS OF MINERAL METABOLISM, OTHER THAN CALCIUM 255 ACUTE AND SUBACUTE NECROSIS OF LIVER; SPECIFIED INBORN ERRORS OF METABOLISM Treatment: LIVER TRANSPLANT	
275.09	Other disorders of iron metabolism	160 DISORDERS OF MINERAL METABOLISM, OTHER THAN CALCIUM 255 ACUTE AND SUBACUTE NECROSIS OF LIVER; SPECIFIED INBORN ERRORS OF METABOLISM Treatment: LIVER TRANSPLANT	
276.61	Transfusion associated circulatory overload	236 DISORDERS OF FLUID, ELECTROLYTE, AND ACID-BASE BALANCE	

New ICD-9-CM Codes -- Straightforward -- Code Breakouts

ICD-9	Code description	List/line(s)	Additional Information
276.69	Other fluid overload	236 DISORDERS OF FLUID, ELECTROLYTE, AND ACID-BASE BALANCE	
278.03	Obesity hypoventilation syndrome	8 OBESITY 211 SLEEP APNEA	
287.41	Posttransfusion purpura	327 THROMBOCYTOPENIA	Post-transfusion purpura (PTP) is an adverse reaction to a blood transfusion involving alloantibody formation to the introduced platelets' antigens. These alloantibodies destroy the patient's platelets leading to thrombocytopenia
287.49	Other secondary thrombocytopenia	327 THROMBOCYTOPENIA	
315.35	Childhood onset fluency disorder	372 NEUROLOGICAL DYSFUNCTION IN COMMUNICATION CAUSED BY CHRONIC CONDITIONS	
447.70	Aortic ectasia, unspecified site	347 NON-DISSECTING ANEURYSM WITHOUT RUPTURE	Mild enlargement of the aorta with a diameter of less than 1.5 times the size of the normal aorta. 441 is on Line 306 DISSECTING OR RUPTURED AORTIC ANEURYSM. 447.70 is more appropriate for Line 347.
447.71	Thoracic aortic ectasia	347 NON-DISSECTING ANEURYSM WITHOUT RUPTURE	See above
447.72	Abdominal aortic ectasia	347 NON-DISSECTING ANEURYSM WITHOUT RUPTURE	See above
447.73	Thoracoabdominal aortic ectasia	347 NON-DISSECTING ANEURYSM WITHOUT RUPTURE	See above
488.01	Influenza due to identified avian influenza virus with pneumonia	Line 633 OTHER VIRAL INFECTIONS, EXCLUDING PNEUMONIA DUE TO RESPIRATORY SYNCYTIAL VIRUS IN PERSONS UNDER AGE 3	Will be moved with the other 488 codes to the new influenza line created in the 2010 Biennial Review for the January, 2012 List

New ICD-9-CM Codes -- Straightforward -- Code Breakouts

ICD-9	Code description	List/line(s)	Additional Information
488.02	Influenza due to identified avian influenza virus with other respiratory manifestations	Line 633 OTHER VIRAL INFECTIONS, EXCLUDING PNEUMONIA DUE TO RESPIRATORY SYNCYTIAL VIRUS IN PERSONS UNDER AGE 3	See above
488.09	Influenza due to identified avian influenza virus with other manifestations	Line 633 OTHER VIRAL INFECTIONS, EXCLUDING PNEUMONIA DUE TO RESPIRATORY SYNCYTIAL VIRUS IN PERSONS UNDER AGE 3	See above
488.11	Influenza due to identified novel H1N1 influenza virus with pneumonia	Line 633 OTHER VIRAL INFECTIONS, EXCLUDING PNEUMONIA DUE TO RESPIRATORY SYNCYTIAL VIRUS IN PERSONS UNDER AGE 3	See above
488.12	Influenza due to identified novel H1N1 influenza virus with other respiratory manifestations	Line 633 OTHER VIRAL INFECTIONS, EXCLUDING PNEUMONIA DUE TO RESPIRATORY SYNCYTIAL VIRUS IN PERSONS UNDER AGE 3	See above
488.19	Influenza due to identified novel H1N1 influenza virus with other manifestations	Line 633 OTHER VIRAL INFECTIONS, EXCLUDING PNEUMONIA DUE TO RESPIRATORY SYNCYTIAL VIRUS IN PERSONS UNDER AGE 3	See above
560.32	Fecal impaction	48 INTUSSUSCEPTION, VOLVULUS, INTESTINAL OBSTRUCTION, AND FOREIGN BODY IN STOMACH, INTESTINES, COLON, AND RECTUM	
724.03	Spinal stenosis, lumbar region, with neurogenic claudication	428 SPINAL DEFORMITY, CLINICALLY SIGNIFICANT	
752.31	Agenesis of uterus	595 CONGENITAL ANOMALIES OF FEMALE GENITAL ORGANS EXCLUDING VAGINA	The conditions represented by the new codes were all included as examples under parent code in coding manual
752.32	Hypoplasia of uterus	595 CONGENITAL ANOMALIES OF FEMALE GENITAL ORGANS EXCLUDING VAGINA	
752.33	Unicornuate uterus	595 CONGENITAL ANOMALIES OF FEMALE GENITAL ORGANS EXCLUDING VAGINA	

New ICD-9-CM Codes -- Straightforward -- Code Breakouts

ICD-9	Code description	List/line(s)	Additional Information
752.34	Bicornuate uterus	595 CONGENITAL ANOMALIES OF FEMALE GENITAL ORGANS EXCLUDING VAGINA	
752.35	Septate uterus	595 CONGENITAL ANOMALIES OF FEMALE GENITAL ORGANS EXCLUDING VAGINA	
752.36	Arcuate uterus	595 CONGENITAL ANOMALIES OF FEMALE GENITAL ORGANS EXCLUDING VAGINA	
752.39	Other anomalies of uterus	595 CONGENITAL ANOMALIES OF FEMALE GENITAL ORGANS EXCLUDING VAGINA	
752.43	Cervical agenesis	441 MENSTRUAL BLEEDING DISORDERS	
752.44	Cervical duplication	400 IMPERFORATE HYMEN; ABNORMALITIES OF VAGINAL SEPTUM	Frequently occurs with vaginal septum and may be treated with resection of the septum
752.45	Vaginal agenesis	377 CONGENITAL ABSENCE OF VAGINA	
752.46	Transverse vaginal septum	400 IMPERFORATE HYMEN; ABNORMALITIES OF VAGINAL SEPTUM	
752.47	Longitudinal vaginal septum	400 IMPERFORATE HYMEN; ABNORMALITIES OF VAGINAL SEPTUM	
780.33	Post traumatic seizures	36 EPILEPSY AND FEBRILE CONVULSIONS	
780.66	Febrile nonhemolytic transfusion reaction	307 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT	780.62 (Post-procedural fever) is on the Signs and Symptoms List
784.52	Fluency disorder in conditions classified elsewhere	372 NEUROLOGICAL DYSFUNCTION IN COMMUNICATION CAUSED BY CHRONIC CONDITIONS	
784.92	Jaw pain	Signs and Symptoms	
786.30	Hemoptysis, unspecified	Signs and Symptoms	

New ICD-9-CM Codes -- Straightforward -- Code Breakouts

ICD-9	Code description	List/line(s)	Additional Information
786.31	Acute idiopathic pulmonary hemorrhage in infants [AIPHI]	14 OTHER RESPIRATORY CONDITIONS OF FETUS AND NEWBORN	
786.39	Other hemoptysis	Signs and Symptoms	
787.60	Full incontinence of feces	437 INCONTINENCE OF FECES	
787.61	Incomplete defecation	437 INCONTINENCE OF FECES	
787.62	Fecal smearing	Sign and Symptoms	
787.63	Fecal urgency	437 INCONTINENCE OF FECES	
799.51	Attention or concentration deficit	Signs and Symptoms	New code family
799.52	Cognitive communication deficit	Signs and Symptoms	New code family
799.53	Visuospatial deficit	Signs and Symptoms	New code family
799.54	Psychomotor deficit	Signs and Symptoms	New code family
799.55	Frontal lobe and executive function deficit	Signs and Symptoms	New code family
799.59	Other signs and symptoms involving cognition	Signs and Symptoms	New code family
970.81	Poisoning by cocaine	113 POISONING BY INGESTION, INJECTION, AND NON-MEDICINAL AGENTS Dysfunction lines (77, 317, 372, 404)	
970.89	Poisoning by other central nervous system stimulants	113 POISONING BY INGESTION, INJECTION, AND NON-MEDICINAL AGENTS Dysfunction lines (77, 317, 372, 404)	
999.60	ABO incompatibility reaction, unspecified	440 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT	
999.61	ABO incompatibility with hemolytic transfusion reaction not specified as acute or delayed	440 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT	

New ICD-9-CM Codes -- Straightforward -- Code Breakouts

ICD-9	Code description	List/line(s)	Additional Information
999.62	ABO incompatibility with acute hemolytic transfusion reaction	440 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT	
999.63	ABO incompatibility with delayed hemolytic transfusion reaction	440 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT	
999.69	Other ABO incompatibility reaction	440 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT	
999.70	Rh incompatibility reaction, unspecified	440 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT	
999.71	Rh incompatibility with hemolytic transfusion reaction not specified as acute or delayed	440 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT	
999.72	Rh incompatibility with acute hemolytic transfusion reaction	440 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT	
999.73	Rh incompatibility with delayed hemolytic transfusion reaction	440 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT	
999.74	Other Rh incompatibility reaction	440 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT	
999.75	Non-ABO incompatibility reaction, unspecified	440 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT	
999.76	Non-ABO incompatibility with hemolytic transfusion reaction not specified as acute or delayed	440 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT	
999.77	Non-ABO incompatibility with acute hemolytic transfusion reaction	440 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT	

New ICD-9-CM Codes -- Straightforward -- Code Breakouts

ICD-9	Code description	List/line(s)	Additional Information
999.78	Non-ABO incompatibility with delayed hemolytic transfusion reaction	440 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT	
999.79	Other non-ABO incompatibility reaction	440 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT	
999.80	Transfusion reaction, unspecified	307 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT	
999.83	Hemolytic transfusion reaction, incompatibility unspecified	307 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT	
999.84	Acute hemolytic transfusion reaction, incompatibility unspecified	307 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT	
999.85	Delayed hemolytic transfusion reaction, incompatibility unspecified	307 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT	
V11.4	Personal history of combat and operational stress reaction	Never covered	Secondary code only
V13.23	Personal history of vaginal dysplasia	Never covered	Secondary code only
V13.24	Personal history of vulvar dysplasia	Never covered	Secondary code only
V13.62	Personal history of other (corrected) congenital malformations of genitourinary system	Never covered	Secondary code only
V13.63	Personal history of (corrected) congenital malformations of nervous system	Never covered	Secondary code only

New ICD-9-CM Codes -- Straightforward -- Code Breakouts

ICD-9	Code description	List/line(s)	Additional Information
V13.64	Personal history of (corrected) congenital malformations of eye, ear, face and neck	Never covered	Secondary code only
V13.65	Personal history of (corrected) congenital malformations of heart and circulatory system	Never covered	Secondary code only
V13.66	Personal history of (corrected) congenital malformations of respiratory system	Never covered	Secondary code only
V13.67	Personal history of (corrected) congenital malformations of digestive system	Never covered	Secondary code only
V13.68	Personal history of (corrected) congenital malformations of integument, limbs, and musculoskeletal system	Never covered	Secondary code only
V15.53	Personal history of retained foreign body fully removed	Never covered	Secondary code only
V25.11	Encounter for insertion of intrauterine contraceptive device	7 REPRODUCTIVE SERVICES	
V25.12	Encounter for removal of intrauterine contraceptive device	7 REPRODUCTIVE SERVICES	
V25.13	Encounter for removal and reinsertion of intrauterine contraceptive device	7 REPRODUCTIVE SERVICES	
V49.86	Do not resuscitate status	Never covered	Secondary code only
V49.87	Physical restraints status	Never covered	Secondary code only

New ICD-9-CM Codes -- Straightforward -- Code Breakouts

ICD-9	Code description	List/line(s)	Additional Information
V62.85	Homicidal ideation	Sign and Symptoms	
V85.41	Body Mass Index 40.0-44.9, adult	Never covered	Secondary code only
V85.42	Body Mass Index 45.0-49.9, adult	Never covered	Secondary code only
V85.43	Body Mass Index 50.0-59.9, adult	Never covered	Secondary code only
V85.44	Body Mass Index 60.0-69.9, adult	Never covered	Secondary code only
V85.45	Body Mass Index 70 and over, adult	Never covered	Secondary code only
V88.11	Acquired total absence of pancreas	Never covered	Secondary code only
V88.12	Acquired partial absence of pancreas	Never covered	Secondary code only
V90.01	Retained depleted uranium fragments	Never covered	New code family Added at the request of the military for determination of objects left in wounds. From ICD-9 Committee minutes: <u>"These codes would be used as secondary status codes for cases such as injury codes"</u>
V90.09	Other retained radioactive fragments	Never covered	See above
V90.10	Retained metal fragments, unspecified	Never covered	See above
V90.11	Retained magnetic metal fragments	Never covered	See above
V90.12	Retained nonmagnetic metal fragments	Never covered	See above
V90.2	Retained plastic fragments	Never covered	See above
V90.31	Retained animal quills or spines	Never covered	See above
V90.32	Retained tooth	Never covered	See above
V90.33	Retained wood fragments	Never covered	See above

New ICD-9-CM Codes -- Straightforward -- Code Breakouts

ICD-9	Code description	List/line(s)	Additional Information
V90.39	Other retained organic fragments	Never covered	See above
V90.81	Retained glass fragments	Never covered	See above
V90.83	Retained stone or crystalline fragments	Never covered	See above
V90.89	Other specified retained foreign body	Never covered	See above
V90.9	Retained foreign body, unspecified material	Never covered	See above
V91.00	Twin gestation, unspecified number of placenta, unspecified number of amniotic sacs	1 Maternity Care	New code family Added at the request of the Society of Maternal Fetal Medicine. 651 (Multiple gestation) has no additional 5th digit codes available.
V91.01	Twin gestation, monochorionic/monoamniotic (one placenta, one amniotic sac)	1 Maternity Care	See above
V91.02	Twin gestation, monochorionic/diamniotic (one placenta, two amniotic sacs)	1 Maternity Care	See above
V91.03	Twin gestation, dichorionic/diamniotic (two placentae, two amniotic sacs)	1 Maternity Care	See above
V91.09	Twin gestation, unable to determine number of placenta and number of amniotic sacs	1 Maternity Care	See above
V91.10	Triplet gestation, unspecified number of placenta and unspecified number of amniotic sacs	1 Maternity Care	See above
V91.11	Triplet gestation, with two or more monochorionic fetuses	1 Maternity Care	See above

New ICD-9-CM Codes -- Straightforward -- Code Breakouts

ICD-9	Code description	List/line(s)	Additional Information
V91.12	Triplet gestation, with two or more monoamniotic fetuses	1 Maternity Care	See above
V91.19	Triplet gestation, unable to determine number of placenta and number of amniotic sacs	1 Maternity Care	See above
V91.20	Quadruplet gestation, unspecified number of placenta and unspecified number of amniotic sacs	1 Maternity Care	See above
V91.21	Quadruplet gestation, with two or more monochorionic fetuses	1 Maternity Care	See above
V91.22	Quadruplet gestation, with two or more monoamniotic fetuses	1 Maternity Care	See above
V91.29	Quadruplet gestation, unable to determine number of placenta and number of amniotic sacs	1 Maternity Care	See above
V91.90	Other specified multiple gestation, unspecified number of placenta and unspecified number of amniotic sacs	1 Maternity Care	See above
V91.91	Other specified multiple gestation, with two or more monochorionic fetuses	1 Maternity Care	See above
V91.92	Other specified multiple gestation, with two or more monoamniotic fetuses	1 Maternity Care	See above

New ICD-9-CM Codes -- Straightforward -- Code Breakouts

ICD-9	Code description	List/line(s)	Additional Information
V91.99	Other specified multiple gestation, unable to determine number of placenta and number of amniotic sacs	1 Maternity Care	See above

ATTACHMENT B

Guidelines

New Guidelines

GUIDELINE NOTE 84, PAROTID GLAND PLEOMORPHIC ADENOMA

Line 311

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

GUIDELINE NOTE 85, CONGENITAL CHORDEE

Lines 451, 678

Congenital chordee is included on Line 452 only for severe cases (35 degrees of curvature or greater) and for all cases associated with hypospadias.

Modified Guidelines

GUIDELINE NOTE 74, GROWTH HORMONE TREATMENT

Lines 411,485

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

DIAGNOSTIC GUIDELINE D05, MRI OF THE SPINE

Lines 397, 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), or suspected central spinal canal stenosis in patients who are potential candidates for surgery
- 2) Clinical or radiological suspicion of neoplasm
- 3) Clinical or radiological suspicion of infection

GUIDELINE NOTE 79, BREAST RECONSTRUCTION

Lines 4, 197

Breast reconstruction (which may include contralateral reduction mammoplasty) 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

MEETING HIGHLIGHTS
HEALTH OUTCOMES SUBCOMMITTEE

Clackamas Community College
Wilsonville, Oregon
May 13, 2010
8 AM – 1:00 PM

Members Present: Lisa Dodson, MD, Chair; K. Dean Gubler, DO, MPH; Kevin Olson, MD; Somnath Saha, MD, MPH; Carla McKelvey, MD; James Tyack, DMD.

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

Also Attending: Dave Pass, MD, HRC Director; Brittany Jones, OHSU Medical Student; Cora Elder, Denise Taray, Alexandria Blair, Shauna Jones, Caroline Price, Isabel Bickle, Carol Camfield, Lynnette Gregory, DMAP; Chris Kirk, MD, OHP Medical Directors; Paul Cieslak, Oregon Public Health Division.

Topic	Action
<p>General Highlights from the February, 2010 HOSC meeting reviewed. No changes or corrections were made.</p>	<p>Highlights from the February, 2010 meeting were approved without change.</p>
<p>Biennial Review</p> <p>1) <u>Influenza</u> The proposal for a new line for influenza was discussed. Two additional ICD-9 codes for influenza (488.0 [Avian influenza] and 488.1 [H1N1 influenza]) were added to the line, in addition to 487 (Influenza). There was discussion about how patients with viral illness who did not have actual testing for influenza would be treated on the List. It was pointed out that the diagnostic visit would be covered regardless of the actual cause of the flu like illness. The new line would allow treatment with anti-viral medications, hospitalizations, etc. for patients with influenza.</p> <p>A new influenza line was created as shown in Appendix A with an associated guideline shown in Appendix B. The new line was scored, and was placed at about Line 424.</p> <p>2) <u>Central Serous Retinopathy</u> A proposal for a new ophthalmology line to be entitled “Ophthalmologic conditions generally not requiring treatment” was discussed. The HOSC generally agreed that this line should be created; however, the decided to keep the previous line “Central Serous Retinopathy” and add the other diagnoses</p>	<p>1) Influenza. New influenza line created (see Appendix A). -Guideline 61 modified and new guideline created (see Appendix B) -New line scored with standard prioritization methodology (See Appendix C)</p> <p>2) Minor eye diagnoses. The line entitled “Central Serous Retinopathy” had additional CPT and ICD-9 codes added to it and was rescored. The new line appears in Appendix A with a guideline as shown in Appendix B. -360.30 and 363.21 were removed from Line 672. -New line scored with standard prioritization methodology (See Appendix C)</p> <p>3) Osteoid osteoma: no changes were made in the previous scoring of</p>

which had been proposed to this existing line. The proposed CPT codes were also all added. The line was rescored

3) Osteoid Osteoma

A proposal to move osteoid osteoma and similar diagnoses higher on the List was discussed. The group felt that most cases do not require treatment and generally thought that the current line scoring was correct. The cases which do require treatment can be taken care of through the exceptions process.

4) Spasmodic dysphonia

The line “Spasmodic Dysphonia” was proposed for rescoring to move higher on the list. There was some discussion about treatment increasing a person’s likelihood to return to work; however, Kirk pointed out that OAR states that services related to employment are not covered under OHP. The decision was made to rescore the line, which did not result in a significant line movement.

5) Inflammatory bowel disease

The line OTHER NONINFECTIOUS GASTROENTERITIS AND COLITIS was rescored after minimal debate. There was not a significant line movement.

6) Value Based Services

a) line review: The HOSC reviewed the lines from which the VBS were removed and did not feel that any line would have its prioritization scoring changed significantly. The decision was no make no changes in these line placements.

b) VBS content discussion:

Various changes were suggested for consideration by the full HSC. Changes to Value Based Services were agreed on for HSC consideration as presented in the meeting materials except:

i. Alcohol and drug treatment: methadone treatment was changed to methadone maintenance treatment to reflect that this service was for opioid addicted patients, not for treatment of pain or other indications. Medication management was added with “and case management” (“medication management and case management”) to reflect the importance of case management.

ii. Asthma: 99477-99480 of this line (NICU codes) were removed from Line 11. It was proposed to re-title Line 11 “Acute Asthma” due to the chronic management pieces being pulled out as VBS; however, it was pointed out that the

the line. It was acknowledged that some cases do require treatment, but that such treatment could be taken care of through the exceptions process.

-ICD-9 code changes accepted as proposed in the meeting materials

4) Spasmodic dysphonia:

-Line scored with standard prioritization methodology (See Appendix C)

5) Inflammatory bowel disease:

-Line scored with standard prioritization methodology (See Appendix C)

6) Value based services

-no change made in line placement
-99477-99480 removed from Line 11 Asthma

- Changes to Value Based Services were forwarded to the HSC for consideration as presented in the meeting materials except:

a) No CPT codes were deleted from lines containing VBS

b) For alcohol and drug treatment: methadone treatment was changed to methadone maintenance treatment and medication management was changed to “medication management and case management”).

c) Depression, major, in adults: tricyclic antidepressants were not added.

7) Autism, depression, and dental lines deferred to the HSC

<p>primary care visits for management of asthma were still on this line. Therefore, it was decided to not change the line name or prioritization.</p> <p>iii. Depression, major, adults. Tricyclic antidepressants were not added due to concerns for harms.</p> <p>iv. Depression, major, in children. There was lively debate about adding SSRI treatment to this line. The decision was made to not add due to current controversies about treatment in this group, with a strong minority in favor of this addition.</p> <p>v. No CPT codes were removed from lines with VBS</p> <p>7) Autism Deferred to the HSC</p> <p>8) Depression Deferred to the HSC</p> <p>9) Dental lines Deferred to the HSC</p>	
<p>Non-myeloablative transplants Dave Pass, MD, the Director of the Health Resources Commission, gave a presentation on the new HRC report on non-myeloablative transplants. The HOSC generally agreed that the evidence was in favor of such transplants and the decision was to allow them. Guideline note 14 was changed to reflect this decision.</p>	<p>Guideline Note 14 modified as in Appendix B to allow non-myeloablative transplants</p>
<p>Pain not elsewhere classified Smits introduced a summary document with recommendations for placement for ICD-9 codes in the 338.x family. The group debated adding 338.3 Neoplasm related pain (acute) (chronic) to all the cancer lines. However, this was thought to be too cumbersome. The HSC intends that cancer pain be treated, even if it arises from a non-covered cancer. The decision was made to place 338.3 on the Exempt list (Always Covered).</p> <p>The codes referring to acute post-operative pain were discussed. Bickle and Gubler pointed out that these codes were used by a pain consult service, if the patient required pain control other than what could be provided by the provider who did the surgery/procedure. Coffman pointed out that the line regarding complications of a procedure usually requiring treatment would be a logical place for 338.12 (Acute post-thoracotomy pain) and 338.18 (Other acute postoperative pain). Smits suggested adding 338.11 (Acute pain due to trauma) to the Exempt List, but Saha felt that this was too open to abuse. The final decision was to add 338.3 to the Exempt</p>	<p>1) 338.3 Neoplasm related pain (acute) (chronic) recommended to DMAP to be placed on the Exempt list.</p> <p>2) Smits will consult with a Pain Management specialist regarding the placement of the other codes in the 338.x family.</p>

list and get consultation from a pain management specialist regarding the other codes in this family.	
Bladder cancer No discussion	Add 38780, 50605, and 55840 to Line 286 CANCER OF BLADDER AND URETER
Attendance at birth Smits introduced a summary document with suggested additional lines for placement of 99464 (attendance at delivery and initial stabilization of the newborn). Two suggestions were brought forward: adding to acute newborn lines or adding to the Ancillary List. The decision was to add to the Ancillary List. The HOSC felt that this code should be covered regardless of the reason the physician was called to attend the delivery.	Recommend to DMAP to add 99464 to the Ancillary List
Celiac Artery Compression Syndrome No discussion	Add 35761 to Line 330
Hip Core Decompression Minimal discussion	1) Add hip core decompression (S2325) on Line 381 RHEUMATOID ARTHRITIS, OSTEOARTHRITIS, OSTEOCHONDRITIS DISSECANS, AND ASEPTIC NECROSIS OF BONE 2) Guideline adopted as in Appendix B.
Vaccination Tables, HPV vaccines for males The HOSC heard a presentation from Paul Cieslak, MD from the Immunizations Division regarding the cost effectiveness of HPV vaccination for males. The decision based on the presented data was to not cover this immunization for males. The other suggested changes to the Prevention Tables were accepted.	Changes to the Prevention Tables were accepted as presented in the meeting materials except the footnote reading “Discussion with provider regarding HPV4 for males aged 9 through 18” was not accepted wherever it appeared in the document.
Early intervention for psychosis A summary document was presented outlining early intervention for psychosis. There was minimal discussion.	Early intervention in psychosis should continue to be covered as part of services for acute psychosis. Add a guideline to lines 27, 32, and 294 as in Appendix A:
Tongue deformities Smits introduced a summary document outlining issues around a case of unusual congenital problems involving the mandible and tongue. Based on information from the provider and her coder, the suggestion was to add a single code to allow this particular case to be billed. The larger issue of unusual cases needing some type of exceptions process was discussed. Some cases cannot be described in current ICD-9 terminology. The decision of the group was to have DMAP and possibly the	Add 14040 to Line 273 DEFORMITIES OF HEAD

<p>Medical Directors address how such unusual cases should be moved forward.</p>	
<p>Benign spinal cord tumors Smits introduced a summary document outlining issues around a case of unusual fatty tumor in a child’s spine. Review with the surgeon and his coder found some coding changes that should be made to the list. A guideline was proposed to specify when benign lipomas should be removed. This guideline was not adopted due to concerns about abuse.</p> <p>Discussion followed about whether this type of diagnosis should be added to the line with benign tumor of the spine. Currently, this code is on an unfunded line. Gubler stated that the code for benign neoplasm of the spine (225.3) should be moved to a higher line. Coffman replied that this code is on line 137 and the dysfunction lines, but noo spinal surgery codes are on those lines. The proposal was to add 225.3 to Line 397. However, this line has a guideline that requires neurologic component which might not be workable with this type of diagnose. Gubler proposed moving 225.3 to line 319 (cancer of brain and nervous system).</p> <p>The decision was for staff to look into the best placement of these codes and bring back a suggestion for the August meeting.</p>	<p>HSC staff to research further and bring back to the August meeting.</p>
<p>Lip and mouth vestibule tumors Smits introduced a summary document outlining changes needed for treatment of carcinoma in situ for lip and mouth vestibule tumors. There was no discussion.</p>	<p>Add to Line 171: 40500, 40510, 40520, 40525, 40527, 40530, 40810, 40812, 40814, 40816, 40319, 40820</p> <p>Add to Line 591: 40814, 40816</p> <p>Add to Line 644: 40500, 40510, 40520, 40525, 40527, 40530, 40810, 40812, 40816, 40820</p>
<p>Pyeloplasty Smits introduced a summary document proposing adding laparoscopic versions of pyeloplasty to all areas where open versions exist on the List. This is consistent with previous HSC intent to cover laparoscopic versions of covered open procedures unless they are contraindicated, less effective or have another reason to not be added to the List. There was no discussion.</p>	<p>Add 50400 to Lines 83, 95, 286, 307</p> <p>Add 50405 to lines 83, 95, 186 and 286</p> <p>Add 50544 to Lines 54, 186, 307</p>
<p>Straightforward Issues Changes were accepted without discussion except 37201 and 37202. Olson requested that HSC look into these codes and</p>	<p>Changes accepted as outlined in the meeting materials except:</p>

make sure the DVT is covered/paired in this placement.	37201 and 37202 will be re-examined by HSC staff and brought back to the August meeting
Guidelines Panniculectomy: deferred to August meeting Treatment of Cancer with Little or No Benefit Near the End of Life	1) Panniculectomy deferred to August 2) Treatment of Cancer Near the End of Life guideline was referred back to HSC staff and the Palliative Care Workgroup to work on wording and bring back to the August HOSC meeting
Public Comment No comment was heard	

Note: The meeting adjourned at 1:30 PM. The next HOSC meeting is scheduled for August, 2010.

Appendix A: Biennial Review Line Changes

New Lines

Condition: INFLUENZA (See Guideline Notes 64, 65, 79)

Treatment: Medical Therapy

ICD-9: 487, **488**

CPT: 98966-98969,99024,99051,99060,99070,99078,99201-99360,99366,99374-99375,99379-99444,99468-99480,99605-99607

HCPCS: G0406,G0407,G0408, G0425-G0427, S0270,S0271,S0272,S0273,S0274

Line TBD

Modified Lines

Condition: **CENTRAL SEROUS RETINOPATHY (See Guideline Notes 64,65,XXX)**

Treatment: Medical and surgical therapy

ICD-9: 360.3, 362.40-362.41, 362.6-362.7, 363.21

CPT: 67005-67028, 67036-67043, 67210, 67515, 68200, 92002-92060,92070-92313, 92325-92353,92358-92371,98966-98969,99024,99051,99060,99070, 99078, 99201-99360,99366,99374-99375,99379-99444,99468-99480,99605-99607

HCPCS: G0406,G0407,G0408, G0425-G0427, S0270,S0271,S0272,S0273,S0274

Line: TBD

Appendix B: Guidelines

New Guidelines

GUIDELINE NOTE 79 INFLUENZA

Line: TBD

Treatment and post-exposure prophylaxis of influenza should comply with state and national public health recommendations

GUIDELINE NOTE XXX CENTRAL SEROUS RETINOPATHY

Line: TBD

Central serous retinopathy (362.41) is included on this line only for treatment when the condition has been present for 3 months or longer. Pars planitis (363.21) should only be treated in patients with 20/40 or worse vision.

GUIDELINE NOTE XXX HIP CORE DECOMPRESSION

Line 381

Hip Core Decompression (S2325) is covered only for early/pre-collapse (stage I or II; before X-ray changes are evident) avascular necrosis of the hip (femoral head and/or neck).

GUIDELINE NOTE XXX EARLY INTERVENTION FOR PSYCHOSIS

Lines 27, 32, 294

These lines include “early intervention for psychosis,” a multidisciplinary specialty team-based intervention that includes

- a) Psychiatric medication management
- b) Individual counseling
- c) Family group therapy
- d) Family individual therapy

The goal of the early intervention is to minimize harms of a first outbreak of psychosis and improve long-term functioning.

Modified Guidelines

Guideline Note 61 (Excerpt)

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.~~

GUIDELINE NOTE 14, SECOND BONE MARROW TRANSPLANTS, ~~NON-MYELOABLATIVE STEM CELL TRANSPLANTS~~

Lines 79,103,106,126,132,167,171,199,207,232,280,313

Second bone marrow transplants are not covered except for tandem autologous transplants for multiple myeloma. ~~Non-myeloablative transplants (mini-transplants) are not covered.~~ Appendix

C: Biennial Review Rankings

TimeStamp	Old Line	Condition	Treatment	Score	NetCost	Subranking	Category	HLY	Suffering	PopEffcts	VulnerablePop	TertiaryPrev	Effectiveness	NeedForServices
Influenza														
13-May-10		INFLUENZA	MEDICAL THERAPY	440	4	0	6	6	1	2	0	2	2	0.5

Eye conditions

TimeStamp	Line	Condition	Treatment	Score	NetCost	Subranking	Category	HLY	Suffering	PopEff	Vulnera	Tertiar	Effecti	orServ
							ory		ng	ects	blePop	yPrev	veness	ices
Previous		OPHTHALMOLOGIC CONDITIONS GENERALLY NOT REQUIRING TREATMENT	MEDICAL AND SURGICAL TREATMENT	2100	4	0	7	8	4	2	2	5	5	1
13-May-10		CENTRAL SEROUS RETINOPATHY	MEDICAL AND SURGICAL TREATMENT	512	3	0	7	3	1	0	0	4	4	0.8

Osteoid osteomas

TimeStamp	Line	Condition	Treatment	Score	NetCost	Subranking	Category	HLY	Suffering	PopEff	Vulnera	Tertiar	Effecti	orServ
							ory		ng	ects	blePop	yPrev	veness	ices
13-May-10	539	BENIGN NEOPLASM BONE AND ARTICULAR CARTILAGE INCLUDING OSTEOID OSTEOMAS; BENIGN NEOPLASM OF CONNECTIVE AND OTHER SOFT TISSUE	MEDICAL AND SURGICAL TREATMENT, RADIATION THERAPY	120	3	4	7	2	1	0	0	0	4	0.5

Spasmodic dysphonia

TimeStamp	Line	Condition	Treatment	Score	NetCost	Subranking	Category	HLY	Suffering	PopEff	Vulnera	Tertiar	Effecti	orServ
							ory		ng	ects	blePop	yPrev	veness	ices
13-May-10	598	SPASTIC DYSPHONIA	MEDICAL THERAPY	48	2	0	7	1	1	0	0	0	3	0.4

Other unspecified noninfectious Gastroenteritis and colitis

TimeStamp	Line	Condition	Treatment	Score	NetCost	Subranking	Category	HLY	Suffering	PopEff	Vulnera	Tertiar	Effecti	NeedF
										ects	blePop	yPrev	veness	orServ
13-May-10	540	OTHER NONINFECTIOUS GASTROENTERITIS AND COLITIS	MEDICAL THERAPY	72	3	5	7	4	2	0	0	0	3	0.2

VBS

No changes made to prioritization of lines. VBS codes/services will be left in these lines

MEETING HIGHLIGHTS
HEALTH OUTCOMES SUBCOMMITTEE

Clackamas Community College
Wilsonville, Oregon
February 11, 2010
11:30 AM – 1:30 PM

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

Members Absent: Carla McKelvey, MD

Staff Present: Darren Coffman; Ariel Smits, MD, MPH; Cat Livingston, MD, MPH; Dorothy Allen (by teleconference)

Also Attending: Caroline Price RN, Barbara Ries, Shauna Jones, Sharon Boren, Isabel Bickle, Carol Camfield, and Chris Barber, DHS-Division of Medical Assistance Programs (DMAP); Chris Kirk, MD, OHP Medical Directors; Alison Little, MD, MPH, OHSU/MED Project; David Fischer, DHS-AMH; Venus Holder, Lilly USA; Mike Willett, Pfizer

Note: The meeting adjourned at 1:30 PM. The next HOSC meeting is scheduled for May, 2010.

Topic	Action
<p>General Highlights from the January, 2010 HOSC meeting reviewed. No changes or corrections were made.</p>	<p>Highlights from the January, 2010 meeting were approved without change.</p>
<p>Hyperbaric oxygen for osteoradionecrosis Smits introduced the summary document on osteoradionecrosis treatment. There was minimal discussion. The HOSC members felt that this treatment was not liable for abuse and had some evidence of effectiveness and coverage should be continued</p>	<p>No change to current coverage of hyperbaric oxygen for osteoradionecrosis of the jaw.</p>
<p>Home testing for obstructive sleep apnea (OSA) Smits introduced a summary document outlining evidence for the use of home sleep testing for diagnosis of OSA. The HOSC members had questions about relative cost. Kirk reported that it cost his plan approximately \$1000 for sleep lab studies compared to \$200-300 for home. Kirk also reported that CMS did a review recently and approved the home testing. Olson wanted to ensure that the test was still interpreted by a sleep medicine specialist, which it is. The decision was to allow coverage of home testing for diagnosis of OSA.</p>	<p>G0399 (Home sleep test respiratory movement/airflow/heart rate/O2 sat) recommended to be added to the Diagnostic List</p>
<p>Note: the HSC does not have authority over the Diagnostic</p>	

<p>List. This decision is advisory to DMAP.</p>	
<p>TENS Smits introduced a summary document reviewing the evidence for the effectiveness for TENS treatment for chronic and acute pain conditions. The HOSC found lack of evidence of effectiveness. Saha reported on a review of back pain treatments by Chou et al in the 2007 Annals of Internal Medicine, which found no benefit for TENS for acute or chronic back pain. The HOSC members agreed that this service should not be covered due to lack of effectiveness. Smits reported that there were additional CPT/HCPCS codes which were not included in the handout that needed to be added to the Never Covered List if TENS is not to be covered.</p> <p>Note: the HSC does not have authority over the Never Covered List. This decision is advisory to DMAP.</p>	<p>1) Delete 64550 (Application of surface (transcutaneous) neurostimulator) from Lines 522, 551 and 622. Recommend adding 64550 (Application of surface (transcutaneous) neurostimulator) to Never Covered List. 2) Delete 97032 from all 57 lines on Prioritized List. Recommend adding 97032 to Never Covered List 3) Recommend adding HCPCS codes A4556-A4558, A4595, A4630, E0720, E0730, E0731 to Never Covered List</p>
<p>Nutritional counseling Smits introduced a summary document outlining issues with coverage of nutritional counseling. There was discussion around the cost of this service. The cost was not seen to be very large, and such counseling can be provided in a group setting. Barber reported that DMAP currently covered nutrition counseling for diabetics as part of diabetes education. Saha urged coverage of services which promote self-management of chronic diseases, and though that nutritional counseling made sense as part of a self-management program. Smits suggested adding a guideline specifying that nutritional counseling be part of more intensive behavioral change counseling. Such a guideline was suggested by the Medical Directors. Dodson was against such a guideline, feeling that some conditions needed intensive counseling, like anorexia, while others, like PKU, did not. Saha agreed, saying that a guideline should only be added if the service is overused. Olson agreed, saying that this was not a new technology, and likely not open to abuse. Kirk felt that coverage was reasonable. Barber thought that DMAP and the plans might need to implement PA criteria for this service. Smits thought such criteria would be part of implementation, and did not need HSC input. Dodson thought nutrition counseling should be covered as part of the medical home movement. Gubler felt that it was not politically feasible to not cover nutrition counseling. Coffman felt that adding these services would reflect the public values of Oregonians. Dodson wanted to ensure that diagnoses such as AIDS wasting and cancer malnutrition were covered. Smits reported that such would be covered under malnutrition. Kirk wanted to ensure that</p>	<p>Add nutrition counseling (97802-97804) to the list of conditions in the summary materials. These lines are 1, 10, 12, 13, 17, 33, 35, 65, 66, 75, 89, 108, 109, 127, 160, 195, 238, 241, 255, 304, 328, 359, 365, 369, 409, 420. This service will continue to be on Line 8.</p>

<p>dietitians would not be the primary treatment provider for patients with eating disorders.</p> <p>The decision was made to cover nutrition counseling. The HSC will revisit the need for a guideline if DMAP or the plans have issues with overuse in the future.</p> <p>Barbur noted that adding this service may change rates. Coffman reported that implementation may be delayed if the rates would change.</p>	
<p>Nasal surgery guidelines Smits introduced a summary document outlining guidelines developed with help from Dr. Anna Kuang. The first guideline, which specified when the code for nose tip repair in cleft palate cases could be used, was accepted without discussion.</p> <p>The second guideline outlined restrictions of cleft palate/lip repair to Centers of Excellence. Members had questions regarding who designates Centers of Excellence and what criteria are used. Gubler did a brief web search during the meeting and reported that the designation appeared to be self-designated. The decision was to consult with Dr. Kuang about what body designates COE and on what criteria and to bring the guideline back to a later meeting.</p> <p>The third guideline outlined conditions for the repair of major nasal anomalies. Kirk wanted to know if the guideline allowed prostheses for nose replacement. Saha thought not, as the repair needed to improve physical function. Gubler argued that the cosmetic/psychosocial aspects of a major deformity such as lack of the nose was a reason to cover this type of repair. Saha thought that examining the psychosocial impact of disease reflect coverage set a broad precedent. The decision was that the guideline was fine as written.</p>	<p>Guidelines regarding nose tip repair in cleft lip/palate repair and for major nasal anomalies were adopted as shown in Appendix A. The guideline regarding restriction of cleft repair to centers of excellence was referred back to staff for clarification.</p>
<p>Straightforward Issues</p> <p>1) Foreign body in uterus No discussion</p> <p>2) Stereotactic navigation for pituitary surgery No discussion</p> <p>3) Canthopexy with synostosis repair The members wanted to ensure that the change would not allow cosmetic uses. The line this code is being added to has only ICD-9 codes for major skull anomalies, making cosmetic</p>	<ol style="list-style-type: none"> 1) Delete 939.1 from Line 349 2) Add 939.1 to Line 456 3) Add 61795 to Line 162 4) Add 21282 to Line 273

uses unlikely.	
<p>Biennial Review Smits reviewed topics which are being considered for the biennial review which will occur in May. The topics are</p> <ol style="list-style-type: none"> 1) Moving influenza off the viral illness line to its own line 2) Considering moving lines with minor eye conditions 3) Considering moving the spasmodic dysphonia line 4) Considering moving the line containing benign bone lesions such as osteoid ostoma 5) Moving/changing the dental lines 6) Examining the dysfunction lines (may wait for the ICD-10 conversion review) 	<p>The HOSC approved these topics. Any additional topics may be submitted to HSC staff by mid-April for review.</p>
<p>Value based services Smits, Coffman and Livingston introduced documents related to Value Based Services. This discussion was continued at the full HSC meeting. Please see HSC minutes for the expert testimony given and the Commission discussion.</p>	<p>.See HSC minutes for discussion.</p>

Appendix A: Guidelines

GUIDELINE NOTE XXX REPAIR OF NOSE TIP

Line 324

“Nose tip repair is included on this line only to be used in conjunction with codes 40700, 40701, 40702, or 40720 or subsequent correction of physical functioning.”

GUIDELINE NOTE XXX RECONSTRUCTION OF THE NOSE

Line 273

ICD-9 code 748.1 is on this line only for reconstruction of absence of the nose and other severe nasal anomalies which significantly impair physical functioning.

MEETING HIGHLIGHTS
HEALTH OUTCOMES SUBCOMMITTEE

Clackamas Community College
Wilsonville, Oregon
January 14, 2010
8:00 AM-11:30 AM

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

Members Absent: K. Dean Gubler, MD, MPH

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

Also Attending: Wally Shaffer MD, Caroline Price RN, Isabel Bickle, Chris Barber, Michael Love, Karen Sunderland, Shauna Jones and Chris Barber, DHS-Division of Medical Assistance Programs (DMAP); Chris Kirk, MD, OHP Medical Directors; Anna Kuang MD, OHSU Craniofacial Clinic; Michael Shapiro, MD, OHSU Cardiology

Note: The meeting adjourned at 11:55AM. The next HOSC meeting is scheduled for February 11, 2010.

Topic	Action
<p>General Highlights from the December 2009 HOSC meeting reviewed. No changes or corrections were made.</p>	<p>Highlights from the December 09 meeting were approved without change.</p>
<p>Tip of the Nose Reconstruction/Absence of the Nose</p> <p><u>Tip of the Nose</u> Dr. Anna Kuang from OHSU Craniofacial Clinic gave a presentation on repair of cleft lip and palate, focusing on the repair of the nose. Smits reviewed the summary document on issues regarding nasal reconstruction which the HOSC needed to consider.</p> <p>Kuang reviewed that repair of the nose tip, stressing that it was not cosmetic, but part of a larger reconstruction framework. Currently, she repairs the nose tip as the right thing to do, but does not get reimbursed for it. The repair of the nose has functional aspects, for improved breathing, etc. The CPT code under consideration for coverage is specific for cleft palate cases. This code can't be used to do a "nose job" on a child without a cleft.</p> <p>Discussion centered around whether there should be a guideline restricting repair of cleft lip/palate to high volume centers, based on evidence of significantly improved outcomes for centers doing >40 cases per year. Poor repairs result in</p>	<p>1) Add 30460 to Line 324</p> <p>2) HSC staff to consult with Dr. Kuang regarding a guideline to restrict the use of 30460 to be used "only to be use in conjunction with larger repair or subsequent correction of physical functioning." If Kuang has no concerns with this guideline, it will take effect April 1; if not, it will be brought back to the next HOSC meeting for further discussion</p> <p>3) HSC staff to consult with Dr. Kuang regarding about which cleft palate ICD-9 codes (i.e. which severity of cleft palate) should be repaired at a center of excellence vs. community care. This information will be used for possible creation of a guideline restricting repair to these</p>

more surgery and costs down the line. The group decided that such a guideline was not needed, given that Kuang reports taking care of most of the expected cases in the state and the group did not want to restrict follow up care among community providers.

Shaffer asked for clarification on whether the HSC intends to cover “touch up” procedures as teenagers. McKelvey reported her experience that teenagers with cleft palates repaired as children need further repair as their faces grow, and they have ear issues, swallowing issues, or other physical issues. Dodson proposed covering 30460 only as part of other procedure and questioned whether a guideline should be added to this effect. McKelvey felt that this was micromanagement. Saha thought it would be sufficient to have DMAP bring it to us again if overuse in teenagers becomes a problem. Kirk requested clarified that is the intent of the commission for “tune up” of the nose only for physical issues? The group replied “Yes.” After further discussion, the group requested that HSC staff consult with Kuang about whether guideline such as “only to be use in conjunction with larger repair or subsequent correction of physical functioning” would be workable. Also, staff will consult with Kuang about which cleft palate ICD-9 codes (i.e. which severity of cleft palate) should be repaired at a center of excellence, for possible future guideline around repair of cleft lip/palate restricted to such centers.

Absence of the Nose

Smits reviewed the current lack of coverage for absence of the nose. The proposal was to move this diagnosis to a covered line, with a guideline. The group did not want coverage for nasal deformities with only social impacts. The deformity must have significant physical impacts. Shaffer asked whether inability to breath through one side of the nose was considered a significant physical problem. Kirk reported that his health plan had some requests for nose prosthesis when the nose was completely removed. This would be completely cosmetic-no breathing or smell issue or humidification of inhaled air. Smits suggested that this diagnosis could be taken care of through the exceptions process. Kirk reported that currently, these cases are denied in exceptions. It was noted that absence of the nose would come up approximately twice a year and would not cost much. The group decided that the code should be moved to a covered line, with a guideline which specified that the nasal deformity would need to be absence of the nose or a “severe” nasal anomalies. The group asked HSC staff to

types of cleft to centers of excellence.

4) HSC staff with consult with Dr. Kuang about the nasal deformities issue. Specifically, staff will consult about the proposed guideline and which CPT codes to pair with ICD-9 748.1 if moved to line 273. Staff will bring this topic back to the next HOSC meeting.

<p>consult with Dr. Kuang regarding which procedures needed to be paired with this diagnosis, as well as this guideline.</p> <p>The guideline proposed by the HSC reads: GUIDELINE NOTE XXX RECONSTRUCTION OF THE NOSE <i>Line 273</i> <u>ICD-9 code 748.1 (Other anomalies of the nose)</u> is on Line 273 only for reconstruction <u>of absence of the nose and other severe nasal anomalies</u> which significantly impair physical or social functioning.</p> <p>After consulting with Dr. Kuang, staff is to bring 1) this guideline and 2) proposed CPT codes to pair with 748.1 back to the HOSC for review. This guideline was not adopted at this point.</p>	
<p>2010 CPT/HCPCS codes Cardiac CT Dr. Michael Shapiro from OHSU Cardiology gave a presentation on the uses and evidence for cardiac CT. He focused on CT angiograms. He stressed that CT angiograms are not to be used for screening asymptomatic patients for coronary artery disease. He presented data on the high negative predictive value of the test to rule about CAD in patients with low to moderate probability of disease. Stress tests require 70% obstruction of coronary artery dx to be detected as “true positive” CT angiogram finds all levels of occlusion. If stress test is suspected to be false pos, CT can be useful to avoid cardiac catheterization. CT angiogram is more cost effective than cardiac catheterization up to pretest likelihood of CAD of 80%. The other major use of this technology is to rule out coronary causes of chest pain in the ED. CT angiogram has a high negative predictive value in this circumstance. It allows the triage of patients out of the ER without going through the rule out MI protocol.</p> <p>Discussion centered around whether CT angiogram was feasible in the community hospital, given the needed equipment and expertise in reading the test. There was concern for inexperienced readers overreading the CT, leading to additional testing. The use of this test vs. others, such as stress tests, for low risk patients, was debated. Saha was concerned that this test would be ordered instead of nuclear imaging/stress test which might be more appropriate for these types of patients, and provides additional information on cardiac function. An additional concern was the lack of 64</p>	<p>No changes made to the December 09 recommendations for cardiac CT</p>

slice CT scanners in many communities. According to Dr. Shapiro, this is the minimum equipment to get reliable images for the CT angiogram. It was suggested that a guideline could be written restricting CT angiogram to 64 slice CT scanners; Shapiro did not think this was necessary due to lack of payment by Medicare for this.

When asked about outcomes data on this test, Shapiro reported that several studies look at what the outcomes are at 2 year; negative CT angiogram appears to give you a 4 year “warranty” against cardiac events.

Cost for CT angiogram was reported to be \$1500 vs. \$2600 for SPECT and more for cardiac catheterization.

CT for evaluation of coronary calcium was not specifically discussed. Shapiro stressed that coronary calcium scoring is an entirely different test than the CT angiogram discussed today.

Creating a guideline for the use of CT angiogram, like the guideline for PET scans, was suggested by Saha. Kirk noted that any guideline would need to define low and intermediate risk patients. McKelvey added that such a guideline would need to specify the appropriate level of training for the readers of this test. Saha asked Shapiro to write an appropriate guideline, which he agreed to do.

Discussion of use of CT angiogram to avoid long ED stays was discussed. Shapiro noted that no ED in the state is currently doing this test. The test is currently being used solely for evaluation of stable outpatients. Based on this information, members felt that the technology, while promising, was too new for HSC adoption.

The final decision was to not cover CT angiogram, as was decided at the December HOSC meeting. HSC staff will work with Dr. Shapiro to make an appropriate guideline, and will reopen discussion when guideline available.

Negative pressure wound therapy
 Smits reviewed the prior HOSC decision to not cover physician services for negative pressure wound therapy (CPT codes 97605 and 97606). The HOSC heard evidence at the December meeting that this type of therapy is not effective and might be harmful. However, DMAP is still covering the pump itself, under E2402. DMAP has brought forward multiple

All coverage decisions regarding negative pressure wound therapy are on hold until HSC staff can review data and consult with experts. This topic will be readdressed at a future HOSC meeting.

<p>concerns about stopping this coverage to HSC staff. The physician service code has been on the Never Covered List for some time and the decision in December was to leave it there. HSC staff will review further data on the pumps and consult with experts and bring back this topic for discussion at a future HOSC meeting.</p>	<p>Physician services (CPT codes 97605 and 97606) remain on the Never Covered List and the pump (E2402) on the Ancillary List.</p>
<p>Polydactyly of the foot Smits introduced a summary document outlining issues with coverage of polydactyly of the foot. The suggestion was to not change the current lack of coverage for extra toes. McKelvey agreed, noting that surgery on infants for such a minor condition does not justify the anesthetic risk. Dodson stated that prevention of possible future pain does not seem to be a very major issue. She suggested that providers could use other codes (trouble with gait, etc.) for extra toes that were truly interfering with function.</p>	<p>No change in the current coverage of polydactyly of the foot.</p>
<p>Line 447 and Gyn Surgery codes Smits introduced a summary document with suggested changes to Line 447 NONINFLAMMATORY DISORDERS AND BENIGN NEOPLASMS OF OVARY, FALLOPIAN TUBES AND UTERUS; OVARIAN CYSTS; STREAK OVARIES. The Commission agreed with HSC staff and expert Gynecologist suggestions regarding diagnoses and treatments belonging on this line. There was no discussion.</p>	<p>1) Remove 58120, 58140-58146, 58150-58152, 58180, 58260-58263, 58290-58292, 58541-58542, 58543-58544, 58545-58546, 58548, 58550-58552, 58553-58554, 58560, 58263, 58570-58573 from Line 447</p> <p>2) Move 256.0, 620.8, and 620.9 to Line 676 GENITOURINARY CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY</p> <p>3) No change to the placement of 625.9 (Unspecified female genital symptom) on Line 544 PELVIC PAIN SYNDROME, DYSPAREUNIA</p>
<p>Nasal Fracture Smits introduced a summary document. Saha wanted to ensure coverage for nasal septal hematoma. 920 nasal hematoma is on line 651 (facial contusion) while 30000 drainage of nasal septal is on line 488. The group agreed that it was the intent of the Commission to cover treatment of nasal septal hematoma, but that the current ICD-9 and CPT codes did not allow specification narrow enough to allow only this diagnosis to be treated. The suggested change was accepted.</p>	<p>802.0 (Closed fracture of the nasal bones) deleted from Line 242 and added to Line 591 DEVIATED NASAL SEPTUM, ACQUIRED DEFORMITY OF NOSE, OTHER DISEASES OF UPPER RESPIRATORY TRACT</p>
<p>Guidelines <u>Prenatal CF testing</u> Smits introduced a summary document which brings back issues raised by the OHP Medical Directors around CF prenatal carrier testing. The Medical Directors wished to</p>	<p>See Appendix A</p> <p><u>Prenatal cystic fibrosis screening</u> Guideline adopted:</p>

specify that the mother should be tested first, and if negative, the father should not be tested. There was discussion about whether the father could be tested at all if he was not an OHP patient. McKelvey also asked about situations in which the father is unknown or may be one of several people.

HSC staff raised other concerns about defining a patient as Caucasian. A patient may have Caucasian ancestry which puts him or her at risk for carrying the CF gene, but may not look Caucasian.

Kirk emphasized the importance of a workable guideline for this type of testing, noting that this type of screening test will be highly used. McKelvey noted that CF testing is now part of the routine newborn screening process, so carrier testing is solely for couples who would consider termination of pregnancy for a positive fetus. It was suggested that openness to pregnancy termination be a clause in the guideline. This was thought to be too controversial for adoption.

The group debated about whether prenatal genetic screening should be added to the current genetic screening guideline. Coffman noted that the Genetics Taskforce had specifically left out pregnant women from this guideline, with the thought that this was not a population that would abuse these tests. Dodson suggested reconvening the Genetics taskforce when able and have them work on this.

The group discussed wording changes to the guideline and adopted the following:

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

Growth Hormone

Smits introduced a summary document outlining issues with the current growth hormone guideline. The group debated whether adults should be mentioned in the guideline at all, given that the only conditions the HSC wants to treat occur in children. Shaffer noted that such wording would be useful to DMAP and Kirk agreed this would be helpful for the medical directors and plans. Shaffer noted that the guideline

“Cystic fibrosis carrier testing is covered for 1) non pregnant adults if indicated in the genetic testing algorithm or 2) pregnant women.”

Growth Hormone

The following wording was adopted:

“Treatment with growth hormone is included only for pituitary dwarfism and Turner’s syndrome in children.

Treatment with growth hormone should continue only until adult height as determined by bone age is achieved. Treatment is not included for isolated deficiency of human growth hormone or other conditions in adults. ~~Treatment with growth hormone should continue only until adult height as determined by bone age is achieved.~~”

<p>contradicts the DUR board recommendations (cover panhypopituitarism and AIDS wasting). He stated that DMAP would need to work with DUR board on this issue.</p>	
<p>Straightforward Issues There was minimal discussion of the recommendations.</p>	<p>Changes approved as suggested in the summary document</p>
<p>Value based services Smits, Coffman and Livingston introduced documents related to Value Based Services. This discussion was continued at the full HSC meeting. Please see HSC minutes.</p>	<p>.See HSC minutes for discussion.</p>

Appendix A: Guidelines

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) pregnant women.

GUIDELINE NOTE 74, GROWTH HORMONE TREATMENT

Lines 411, 486

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