

**MEETING HIGHLIGHTS
HEALTH OUTCOMES SUBCOMMITTEE**

Clackamas Community College, Wilsonville Training Center - Room 111

January 27, 2005

9:00 a.m. – 11:00 a.m.

Members Present: Daniel Mangum, DO, Chair; Somnath Saha, MD; Eric Walsh, MD; Andy Glass, MD

Members Absent: Bryan Sohl, MD

Staff Present: Darren Coffman; Alison Little, MD, MPH; Laura Lanssens.

Also Attending: Chris Barber, RN, OMAP; Marsha Becker-Mehr, OMAP; Tom Turek, MD, OMAP; Kelly Wright, AMGEN; Kristina Frank, AMGEN, Mark Rutstein, MD, AMGEN; Kevin Olson, MD

TOPIC	ACTION
Highlights of December 10, 2004 mtg	Reviewed, no changes recommended
NEW CPT CODES- FOLLOW UP:	
97605/97606 Negative pressure wound therapy: CMS does not reimburse for physician work component. 8 RCTs and a Cochrane review show weak evidence of effectiveness. OMAP currently covers with guidelines.	No change to guideline necessary, do not add these codes to list.
93745 Set-up/programming of wearable cardioverter-defibrillator: One study only of 289 patients (no mortality data), also coverage statement from Oregon Blue Cross (investigational but covered in many cases) and Wisconsin Blue Cross TEC assessment (investigational, not covered). Cost \$3200/month. Concern is safety, since there appears to be a high false discharge rate, and vast majority of time IACD is indicated and appropriate. May be appropriate in rare circumstances (bridge to transplant).	Add to non-OHP services list

TOPIC	ACTION
<p>66711 Ciliary body destruction, endoscopic cyclophotocoagulation: Few small studies, no RCTs, one with 90% success rate. Testimony from OHSU recommends coverage for most advanced cases. Eric concerned that there are no evidence based sources. Som points out that it is primarily used in very refractory glaucoma, which likely is fairly rare. Question need for guideline.</p>	<p>Keep code on List. OMAP to monitor frequency of use.</p>
<p>19296-8 Brachytherapy for breast cancer: Use of Brachytherapy for breast cancer well established as local boost therapy in addition to external beam radiation. Question is whether Brachytherapy alone is adequate, without external beam. TEC assessments do not establish efficacy of Brachytherapy only.</p>	<p>Add to breast cancer Line (228).</p>
<p>45391 colonoscopy with US 45392 colonoscopy with US and bx: Email from Dr. Faigel (VA) states this is well established for follow up of rectal cancer, but this would be sigmoidoscopy with U/S (separate code, 45341- currently only on Line 78). Literature referred to by him regarding colonoscopy not very convincing.</p>	<p>Add 45341 to Line 273, Cancer of colon and rectum. Add 45391/2 to non-OHP services list.</p>
<p>31620 endobronchial ultrasound: Descriptive article showing change of therapy in 45% of cases. Used primarily for cancer staging and aiding debridement. Dan concerned that nodes will be biopsied anyway, not sure what ultrasound adds. No outcomes given, but Som states can't really apply outcomes requirement to diagnostic test. Question is whether this is more accurate, and/or avoids another test or procedure.</p>	<p>Alison to get expert testimony regarding whether or not this is being used, recommendations.</p>

TOPIC	ACTION
<p>92620/92621 Evaluation of central auditory function: Has been covered for years, but response from expert regarding why/when it is used, states they are no longer doing this test. No response from person question referred to. Per Marsha Becker-Meier, old code rarely used.</p>	<p>Will discuss with speech therapists later in meeting.</p>
<p>92625 Assessment of tinnitus: Tinnitus diagnosis currently on Line 511. Cochrane review and another systematic review of 69 trials found no evidence of effective therapy except possibly TCAs.</p>	<p>Move diagnosis of tinnitus, 388.3, to Line 721. Keep 92625 on non-OHP services list.</p>
<p>63295 osteoplastic reconstruction of dorsal spine elements. Very scant literature suggests may prevent kyphosis later in children who undergo laminectomy for spinal cord tumors. Unlikely to have RCT on this, rare condition.</p>	<p>Add to Lines 217, 280, 327, 611.</p>
<p>Technical corrections: Report titled “Proposed Interim Modification of Prioritized List of Health Services Reviewed on January 27, 2005 for Implementation April 1, 2005”</p>	<p>Recommend approval by full commission of all changes except as follows:</p> <ul style="list-style-type: none"> • Do not add Umbilical and ventral hernia to Line 6 (keep only on lower hernia line) • Add 733.13 to Line 113 also (in addition to 485)
<p>Dental testimony: Retreatment of root canals. D3430 Retrograde filling is also done in combination with apicoectomy, hence should be added to Line 507(apicoectomy added to 507 at last meeting), as well as maintaining on Line 560. Also, D7511 and D7521, I&D of abscesses, complicated, currently are not on the list, should be added to Line 359 where other abscess codes are.</p>	<p>Add D3430, retrograde filling to Line 507. Add D7511 and D7521 to Line 359.</p>
<p>Viral Hepatitis: Hepatitis with coma has always been below the funding line, despite supportive treatment being required (likely being covered as “hepatic coma” on Line 447). “Proposed Changes to the Viral Hepatitis Lines” report reviewed.</p>	<p>Recommend changes in report be adopted by full Commission for implementation October 2005.</p>

TOPIC	ACTION
<p>Revision of EPO guideline:</p> <ul style="list-style-type: none"> • Delete requirement for EPO levels in chronic renal failure • Change monitoring so criteria are the same for HIV, CRF and oncology <p>Testimony from Kevin Olson: disagrees with ASCO guidelines regarding at what Hgb level EPO should be initiated. He states that if it is not begun until 10 while it is dropping, the Hgb drops farther than if starting at 11 (per 2 abstracts), and higher incidence of needing transfusion. Also, QOL is improved. Patients who drop to 10 have a lower likelihood of reaching 12, and take longer to do so (up to 4 weeks longer). Graph shown of % requiring transfusion, 22% (EPO start at 10) vs 14% (EPO start at 11), but not significant. Som asks if there was a comparison between groups of total EPO dose used: mean dose per week=95 micrograms in early intervention group vs. 109 micrograms in late intervention group (sig difference). Eric asked if cost data exists.</p> <p>Mark Rutstein, MD, Amgen, testimony: incremental change in Hgb from 11 to 12 was associated with the largest incremental increase in QOL (based on abstract). Al Collins has retrospective cost data regarding cost effectiveness; he will get it to us. Mortality data available as well. Alison notes Cochrane review does not support benefit of starting EPO at 11 compared with 10. Eric: Suggests HSC reconsider guideline when ASCO does.</p> <p>Kelly Wright, AMGEN, questions why EPO levels required for oncology patients. Alison quotes from article supplied by AMGEN supporting use of EPO levels. Rutstien disagrees, states response is variable and not well predicted by EPO level. Andy says we will reconsider when other data is submitted.</p>	<p>Recommendation to accept the guideline as revised and presented in packet.</p>

TOPIC	ACTION
<p>Neurostimulators: Central nervous system: used for Parkinson's, reasonable data, experimental for epilepsy except for vagal nerve. Spinal cord devices used for chronic pain or incontinence (sacral nerve). Cochrane review of chronic pain (failed back syndrome, CRPS) showed some evidence of effectiveness. Tom getting few requests which are above the line. Spinal cord devices are not on list at all. Little interest from Commissioners in spending time on this.</p>	<p><i>Alison to ask Medical Directors if this topic is problematic for them, if they get many requests and if they want changes made.</i></p>
<p>Cochlear Implant: No response to letter sent from Alison to head of cochlear implant department at OHSU. Criteria posted on OSHU website are the same as Medicare's, with the exception that for adults, the criteria is for test scores of 40% or less on open set sentence recognition. Current Medicare criteria is for test scores of 30% or less, though there is proposal to expand coverage to 40% or less, and 60% or less if the patient is enrolled in a clinical trial.</p>	<p>Adopt OHSU guidelines for cochlear implants.</p>

MEETING HIGHLIGHTS
HEALTH OUTCOMES SUBCOMMITTEE

*Meridian Park Hospital Health Education Center, Room 117-A
Tualatin, OR
April 28, 2005
9:00 a.m. – 12:00 p.m.*

Members Present: Daniel Mangum, DO, Chair; Bryan Sohl, MD; Andy Glass, MD; Eric Walsh, MD.

Members Absent: Somnath Saha, MD.

Staff Present: Darren Coffman; Alison Little, MD, MPH; Laura Lanssens.

Also Attending: Chris Barber, RN, and Kathy Kirk, RN, Office of Medical Assistance Programs (OMAP); Kelly Wright, AMGEN; Alexander Roubanis, Tina Rodriguez, EyeTech; Michelle Plotner, Ortho BioTech.

Note: Adjourned 11:29 a.m. Next HOSC meeting is scheduled for Thursday, July 7, 2005, 9:00 a.m. in Room 117A, Meridian Park Hospital, Community Health Education Center, 19300 SW 65th Avenue, Tualatin, Oregon.

TOPIC	ACTION
Highlights of January 27, 2005 mtg	Reviewed, no changes recommended
Technical corrections: Report titled "Proposed Interim Modification of Prioritized List of Health Services Reviewed on April 28, 2005 for Implementation October 1, 2005"	Recommend approval by full commission of all changes
Mastocytosis: Reviewed current line placements for all mast cell diagnoses; considered moving 238.5, mast cell tumor to Line 714, or add coding specification that Line 714 includes all forms of cutaneous mastocytosis.	Take no action; have OMAP determine prevalence of claims for this diagnosis, and review again when Kevin Olson joins the commission.
Artificial Discs: No cost comparison between artificial discs and fusion; Charite lacks long-term efficacy studies. If added to List, would be on non-funded line.	Obtain cost information comparing the artificial disc and fusion. Review full NICE guidance.

TOPIC	ACTION
<p>Revision of EPO guideline: Testimony from Kelly Wright, AMGEN. Discussion of the requirement for EPO levels before administration.</p> <p>Andy: in practice, this is rarely done.</p> <p>Alison: Cochrane review reports data was inadequate to test for different predictive factors such as low baseline serum EPO level.</p> <p>OMAP is not implementing this on FFS, but plans are.</p> <p>Wright: regarding Hg level for initiation, dialysis centers are under a lot of pressure to meet CMS guidelines, which are Hg levels between 11 and 12.</p> <p>Eric: asked about conflict of interest; all except 3 of the articles were supported by AMGEN. Does AMGEN own the results?</p> <p>Wright: she didn't know, but will provide follow up. Newer studies (than Cochrane) would be oriented more toward the most appropriate hemoglobin level.</p> <p>Dan: disappointed that the large volume of information provided by AMGEN did not address the question of whether it was better to begin treatment at Hgb 10 or 11, despite the Commission specifically asking for it. His review of the CMS website did not address the need to begin treatment at Hgb at 11.</p> <p>Eric: what would be the cost of the requested change, and what services should be eliminated in order to cover the increased cost?</p> <p>Wright: savings could be achieved by better management of hyporesponders</p> <p>Andy: too much an issue of implementation.</p> <p>Dan: very narrow range of Hgb between 11 and 12 is problematic, and 10 to 12 would be easier to manage.</p> <p>Eric: Commission philosophy is to wait to add new medical services until there is a preponderance of evidence from a trusted</p>	<p>Recommend revision of guideline to eliminate the requirement for EPO level < 200 for oncology patients, as follows:</p> <p style="text-align: center;">GUIDELINE FOR USE OF ERYTHROPOIETIN AND DARBEPOETIN</p> <p>1. Indicated for anemia (Hgb < 10 gm/dl or HCT <30%) induced by cancer chemotherapy, in the setting of myelodysplasia, or chronic renal failure, with or without dialysis.</p> <p style="padding-left: 20px;">a. Endogenous erythropoietin levels of < 200 IU/L are required for treatment, except in chronic renal failure.</p> <p style="padding-left: 20px;">b.a. Reassessment should be made after 8 weeks of treatment. If no response, treatment should be discontinued. If response is demonstrated, EPO should be titrated to maintain a level between 10 and 12.</p> <p>1. Indicated for anemia (Hgb < 10 gm/dl or HCT <30%) associated with HIV/AIDS.</p> <p style="padding-left: 20px;">a. An endogenous erythropoietin < 500 IU/L is required for treatment, and patient may not be receiving zidovudine (AZT) > 4200mg/week.</p> <p style="padding-left: 20px;">b. Reassessment should be made after 8 weeks of treatment. If no response, treatment should be discontinued. If response is demonstrated, EPO should be titrated to maintain a level between 10 and 12.</p>

<p>evidence based site. Wright: more literature exists regarding the use of EPO in oncology, but because of a legal agreement with Ortho-Biotec, she cannot provide it to us. Eric: is her salary linked to the volume of sales in this region? Wright: no. Bryan: how was Hgb level of 10 initially chosen? Alison: ASCO guidelines, and supported by the recent Cochrane and AHRQ reviews. There is very little data looking at the difference between Hgb 10 and 11.</p>	
<p>Photodynamic therapy and Macugen for age-related macular degeneration (AMD): Testimony from Alex Roubanis (his bonus is tied to sales in the region): both Macugen and photodynamic therapy (PDT) are indicated only for the wet form of the disease, which accounts for less than 20% of AMD. Wet form is further divided into 3 subtypes, predominantly classic (most severe, approx 25% of all wet AMD), minimally classic (35%), and occult (40%). Visudyne (drug used in PDT) is only indicated for the predominantly classic form. There are no prospective studies showing efficacy of PDT for minimally classic or occult lesions. <5% of AMD patients are Medicaid. Bryan: is this being used in diabetic retinopathy? Roubanis: currently enrolling patients in a trial for both this and retinal vein occlusion, but results will be several years out. Concern was noted about off-label use. Bryan: is Macugen being used first or second line? Roubanis: both, depending on the physician. PDT is being used off-label in minimally classic and occult disease. Noted in the NEJM article, patients in both arms also received PDT, slightly more in the sham group than the Macugen group.</p>	<p><i>Add PDT to Line 409. Add guideline to Line 409 stating pegaptanib is covered only for mimimally classic and occult lesions.</i></p>

No head-to-head trial between PDT and Macugen, but the 2 have similar response rates. No data to suggest that non-responders to PDT will respond to Macugen, though one can make a theoretical case for this.

Alison: currently, neither therapy is on the macular degeneration line (PDT is currently on the diabetic retinopathy line only). A health technology assessment from the NHS included a CEA showing cost utility between \$100,000 and \$200,000.

Questioned whether either therapy should be on the List. Noted that utilization will be very low.

Rodriguez: decreased visual acuity results in increased medical expenses due to things like hip fracture. 50% increased risk of development in contralateral eye.

Bryan: data on 2 or 3 year outcomes?

Rodriguez: yes, 2 year outcomes showed continued choice of Macugen therapy by patients, resulted in 45% decreased relative risk of loss of visual acuity (equivalent to 1.5 to 2 lines). 1/3 of patients did not lose any, or gained, visual acuity.

Dan: more efficacious in one subtype or the other?

Roubanis: no, equally effective in all 3.

Current procedures on List: ophthalmic endoscopy, epiretinal membrane stripping, photocoagulation.

Eric: which QALY should be used?

Because outcome is blindness, use lowest QALY (£47,000 = \$89,000), therefore meets algorithm.

Bryan: allow both treatments, if PDT fails?

Will be at discretion of plans.

Ventricular Assist Devices: Discussed ~ 1 year ago, decision to only cover as bridge to transplant, not as destination therapy, but not documented except in minutes.

Remove CPT codes 33979 and 33980 from Line 264 (ACUTE AND SUBACUTE ISCHEMIC HEART DISEASE, MYOCARDIAL INFARCTION) and add to Line 172 (HEART FAILURE). Add guideline to Line 172 stating the following: “Ventricular Assist Devices are only included on this line as a bridge to cardiac transplantation.”

MEETING HIGHLIGHTS
HEALTH OUTCOMES SUBCOMMITTEE

*Meridian Park Hospital Health Education Center, Room 117-A
Tualatin, OR
July 7, 2005
9:00 a.m. – 11:05 p.m.*

Members Present: Daniel Mangum, DO, Chair; Eric Walsh, MD, Somnath Saha, MD (arrived at 9:15); Kevin Olson, MD; Bryan Sohl, MD (by phone).

Members Absent: none.

Staff Present: Darren Coffman; Alison Little, MD, MPH; Dorothy Allen.

Also Attending: Chris Barber, RN, and Thomas Turek, MD, Office of Medical Assistance Programs (OMAP); Chris Kirk, MD, Oregon Health Plan Medical Directors liaison, Steve Duffin, DDS, DCO Dental Director

Note: Adjourned 11:05 a.m. Next HOSC meeting is scheduled for Thursday, September 21, 2005, 9:00 a.m. in Room 117A, Meridian Park Hospital, Community Health Education Center, 19300 SW 65th Avenue, Tualatin, Oregon.

TOPIC	ACTION
Highlights of April 28, 2005 meeting	Reviewed, no changes recommended
<p>Technical corrections: Report titled "Recommended Interim Modifications for Review on 7/7/05".</p> <ul style="list-style-type: none"> • Edentulism (525.40-.44, 525.50-.54): Previously coded 525.10-.19, new codes created to describe the degree of edentulism (Class I-IV), which are to be the primary codes, with 525.10-.19 becoming secondary. Dental director in audience concurs. • Retinal telescreening (S0625): Alison distributed an Aetna coverage decision stating that it is as effective as exam by an optometrist for identifying disease, but is not very good for following established disease. One CEA showed that costs of digital vs. film-based procedure would be recouped after 	Recommend approval by full commission of all changes, except as noted below.

<p>2-3 years. Eric noted this could increase screening in rural areas.</p> <ul style="list-style-type: none"> • 995.2 is very non-specific, discussion concerning need for such a code. Darren noted that dermatitis due to ingestion or injection of drug, correct substance properly administered 693.0 is currently on Line 596. Som suggested that severe skin reactions such as red man syndrome may not have another appropriate code. Agreed to keep 995.2 on Line 249. • Discussion about the title of Line 606, since it also includes some hernias in children (femoral, ventral umbilical and unspecified). Umbilical hernia repair over age 5, CPT code 49585, currently resides on both Lines 6 and 606 • Discussion concerning physical therapy for torticollis. Eric recalled prior discussion about the utility of treatment of torticollis. • Error on report; 259.5 should be added to Line 485, Gonadal Dysgenesis, not Line 163. • Drug and alcohol induced sleep disorders (291.82/292.85) are fairly benign problems, should not be prioritized this high. • Kevin stated erythromelalgia (443.82) is often secondary to malignant disease, in which case the disease would be coded first. In cases where no etiology is identified, it is most similar to Raynauds. • Som asked if there was another line for retroperitoneal diseases, and none was found. • Discussion about genetic testing. Bryan noted that it is a moving target, and Eric noted some of this testing is very expensive. Dr. Kirk pointed out that OARs state that to be covered, a service must be 	<ul style="list-style-type: none"> • Change title of Line 606 to “Uncomplicated Hernia” • Remove CPT code 49580 (repair of reducible umbilical hernia, under age 5 years) and 49585 from Line 6 • Alison to check prior minutes for action concerning torticollis • Add to Line 610, Disorders of sleep without sleep apnea • Change line title to “Peritonitis and retroperitoneal infections” • Alison to research which tests are currently offered with their associated costs, in the areas of pregnancy population screening, pregnancy individual screening
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<p>expected to improve the health status of the member. Since testing for a carrier state doesn't, the plans generally don't cover it. Som noted that would not be true for BRCA. It was noted that there is a difference between disease status and carrier status, and between population based screening and familial based family history screening. Bryan stated 655.23 (hereditary disease in family) is currently on the pregnancy line and is covered. Tom noted that just because a test is offered, doesn't meet it has to be covered by the health plan. Som did not believe all these tests can be placed on one line, but will need to be placed on individual lines. Bryan noted that he is not aware of any denials for CF screening, and that many OBs do not feel it is a good use of state \$. Tom stated he wasn't aware that this was covered.</p>	<p>and well-person screening.</p> <ul style="list-style-type: none"> Do not add V26.31-.33 to any Line pending above research. In addition, remove V26.3 from Line 53.
<p>Benign Essential Tremor: Currently on Line 344, Dystonia (Uncontrollable); medical director recommended consideration of re-prioritization. Som felt this can be quite disabling, and is very inexpensive to treat, didn't feel it should be moved down.</p>	<p>Do not move.</p>
<p>Cracked Nipple: Medical director felt this was prioritized too high on the pregnancy line. Bryan disagrees; feels most will need a lactation consultant, and if treatment not covered, will stop breastfeeding.</p>	<p>Do not move.</p>
<p>Congenital Hydrocele: Closest term to describe communicating hydrocele, which urologist believes is a hernia and hence should be placed on the hernia line. Alison could not find outcomes for non-repair in the literature. Textbooks state repair needed if still present by age 1, as do consultant surgeon and urologist from OHSU, but no consequences of non-repair stated. Som asked what the rationale for</p>	<p>Do not move. Alison will communicate the decision to Dr. Wheeler.</p>

<p>covering hernias under 18 was. Darren responded that there was a higher percentage of incarceration in children, compared to adults. Eric recommended not adding coverage, since evidence of adverse outcome was not apparent. Som pointed out that if congenital hydrocele is added, ALL congenital hydroceles would be covered, including the 90% that resorb by the age of 1 year.</p>	
<p>Artificial Disks: Alison noted that contraindications to use include lumbar stenosis and isolated radicular compression syndromes, thus excluding this technology from a currently covered line. The NICE guidance was reviewed. Eric noted questionable safety data (re-op rate of 3-24%, 16-45% complication rate) lack of long-term outcomes.</p>	<p>Do not add to List.</p>
<p>Mast cell proliferative disorders: Costs associated with each diagnosis reviewed. Kevin described the spectrum of disease, noting that the more severe the disease, the less likely treatment will be effective, with mast cell leukemia being the most severe. The natural distinction is between mast cell disease of the skin, and mast cell disease of everything else. The coding does not reflect the scientific understanding of the disease. Sometimes no treatment is necessary, other times it is treated similar to lymphoma, though results are often not as effective.</p>	<p>Add guideline as follows: "mastocytosis limited to the skin resides on Line 695"</p>
<p>Acupuncture: Alison asked what information the commission would like when the topic is discussed at the next meeting.</p>	<p>Alison to identify those diagnoses for which evidence of acupuncture's effectiveness or lack of effectiveness exists.</p>

MEETING HIGHLIGHTS
HEALTH OUTCOMES SUBCOMMITTEE
Meridian Park Hospital Health Education Center, Room 117-A
Tualatin, OR
September 22, 2005
9:00 a.m. – 12:00 p.m.

Members Present: Daniel Mangum, DO, Chair; Eric Walsh, MD; Somnath Saha, MD; Kevin Olson, MD.

Members Absent: Bryan Sohl, MD.

Staff Present: Darren Coffman; Alison Little, MD, MPH; Dorothy Allen.

Also Attending: Kipp Bajaj, Central City Concern; Chris Barber, Kathy Kirk, and Thomas Turek, MD, Office of Medical Assistance Program; Chris Kirk, MD, OPCHP; Gary Hosstetter, OPCA; Kassie Clarke.

Note: Adjourned 12:04 p.m. Next HOSC meeting is scheduled for Thursday, December 8, 2005, 8:00 a.m. in Room 218, Clackamas Community College, Wilsonville Training Center, 29353 Town Center Loop East, Wilsonville, Oregon.

TOPIC	ACTION
Highlights of July 7, 2005 meeting	Not available; will be sent out by email tomorrow.
<p>Technical corrections: Report titled "Recommended Interim Modifications for Review on 9/22/05" was reviewed.</p> <ul style="list-style-type: none"> • Palatopharyngoplasty (42145): Provider letter reviewed, discussed significance and degree of impairment. Turek noted that this request occurs more often than might be expected, and at times request is for relatively minor impairment; however, this can be handled on a case by case basis, and he doesn't think a guideline is necessary. Kirk noted that speech therapy guidelines are being developed which require speech performance to be at least 2 standard deviations below the mean. 	Recommend approval by full commission of all changes, except as noted below.

TOPIC	ACTION
<p>Technical corrections (cont'd):</p> <ul style="list-style-type: none"> • Complication of transplanted organ (996.87): Intestine transplant does not reside on Line 435. • Prophylactic fluoride administration (V07.31): Treatment code is not on Line 141, so nothing to pair with. Moving code to preventive dental line, 298, to pair with appropriate CDT code. • Addition of donor codes to transplant lines: OMAP has requested these be added again, to automate process. Turek explained that organ harvesting is paid for by OMAP if recipient is OMAP member. • Anal Fissure: Email from medical director reviewed questioning rationale for covering chronic but not acute. Code for acute and chronic is the same, distinguished only by line title and guideline attached to Line 529. Noted that acute is being treated anyway, since diagnostic visit is covered, and medications are not preauthorized. 	<p>Do not add ICD-9 code 996.87 to Line 435, Diabetes Mellitus with end stage renal disease. Only add to Line 127.</p> <p>Eliminate Line 607 at the time of the next biennial review. Change Line 529 title to “Anal Fissure; Anal Fistula”, and change first sentence of guideline to read, “Surgery for chronic anal fissure is covered when one or more of the following are present:”</p>
<p>ENT Considerations: Provider letter reviewed. Sinus guideline discussed. Coffman noted that nasal polyps are only on Line 542 (uncovered). Guideline also attached to Lines 470 (Acute sinusitis) and 480 (Chronic sinusitis). Suggested removing guideline from Line 542, since isolated nasal polyps without sinusitis would not be an indication for surgery.</p> <p>Adenoidectomy: Little felt there was reasonable evidence of additional effectiveness of adenoidectomy based on the NEJM article and a Cochrane review. Saha felt that the outcome of preventing</p>	<p>Revise guideline as follows, and keep attached only to Lines 470 and 480:</p> <p>Sinus surgery indicated in the following circumstances:</p> <ol style="list-style-type: none"> 1. 4 or more episodes of acute rhinosinusitis in one year <p>OR</p> <ol style="list-style-type: none"> 2. Failure of medical therapy of chronic sinusitis including ALL of the following: <ul style="list-style-type: none"> • Several courses of antibiotics • Trial of inhaled and/or oral steroids • Allergy assessment and treatment when indicated <p>AND one or more of the following:</p> <ul style="list-style-type: none"> • Findings of obstruction or active infection on CT scan

TOPIC	ACTION
<p>ENT Considerations (cont'd): insertion of a second set of tubes was not an appropriate measure, since there is no way to know if the procedure is necessary. Walsh noted that improved hearing and language development does not persist beyond 6 months. Little responded that an improvement of 1-2 decibels persisted to 12 months, but questioned the clinical significance of this. 1989 article comparing tube placement alone with tube placement and adenoidectomy discussed. Walsh reminded the Subcommittee of prior commitment to use of evidence-based sources over individual specialty journal articles. Saha again expressed concern about the significance of the NEJM study, noting that reduced subsequent hospitalization may only reflect decreased recurrent tube placement, which is not necessarily indicated and attached to no definite health outcome. No studies have found that chronic effusion and hearing loss have any long-term effects on language or development. Discussion continued regarding the article by Gates cited by the provider. Olson asked if it was unreasonable to have prevention of a second set of tubes be a desirable outcome, given that we cover tubes, and avoiding them would be cost-saving. Review of the article shows that one would need to perform 8-10 adenoidectomies to prevent 1 set of repeat tube placement. Little noted additional cost of \$138 for adenoidectomy, and cost of tube placement likely around \$1000. Saha admitted likely decreased utilization with adenoidectomy, but philosophically struggles with doing a procedure in order to decrease the use of another unnecessary procedure. Little noted that additional outcomes may be affected, such as decreased acute otitis, antibiotic use, etc. Walsh was concerned about reliance on back-of-the-envelope</p>	<ul style="list-style-type: none"> • Symptomatic mucocele • Negative CT scan but significant disease found on nasal endoscopy <ol style="list-style-type: none"> 3. Nasal polyposis causing or contributing to sinusitis 4. Complications of sinusitis including subperiosteal or orbital abscess, Pott's puffy tumor, brain abscess or meningitis 5. Invasive or allergic fungal sinusitis 6. Tumor of nasal cavity or sinuses 7. CSF rhinorrhea <p>Little to send letter to provider explaining the rationale for no change in guideline related to adenoidectomy or hearing tests.</p>

TOPIC	ACTION
<p>ENT Considerations (cont'd): cost-effectiveness analyses. Importantly, outcome data which reflect health status is lacking. Olson commented that a driving concern seems to be lack of trust in ENT physicians. Walsh reiterated that the evidence of effectiveness of tubes remains unclear, and that the algorithm states that items will not be removed from the list unless there is clear evidence of LACK of effectiveness, but that new procedures (in this case, adenoideotomy) will not be added unless there is good evidence of effectiveness. Little referred to the Cochrane review, noting that, when combined with adenoideotomy, tube placement results in a 6 decibel hearing improvement at 12 months. Saha responded that the evidence that this improvement affects long-term outcomes (language development, school performance) is lacking. Saha reported on the Gates study referred to by the provider, which randomized children to tubes alone, adenoideotomy alone or tubes + adenoideotomy. Both adenoideotomy groups had less time with effusion and fewer repeat procedures, but there was no difference in hearing. Turek commented that he believes the additional cost of adenoideotomy is higher than the professional fee component quoted by Little. It was agreed that the current guideline, which allows for adenoideotomy in patients over 4 with their second set of tubes, should remain unchanged. Regarding the requirement for hearing test, the Subcommittee was agreed that this requirement should remain.</p>	
<p>Genetic Testing: Walsh asked the origin of this topic, and Little reminded the Subcommittee that a new HCPCS code discussed last month led to the current review. It was agreed to not consider neonatal screening, since this is</p>	<p>Dr. Little will refine algorithm and members will review at the next meeting.</p>

TOPIC	ACTION
<p>Genetic Testing (cont'd): state-mandated. Turek noted that the task-force that has been meeting about cystic fibrosis has decided to recommend inclusion in the neonatal panel. Mangum asked if genetic testing is currently covered. Coffman clarified that, since the V26.3 (genetic counseling and testing) code was removed from the list, it will not be as of October 1, although prenatal testing will be covered by a separate prenatal code. Little stated that she took an informal poll of the medical directors and found the following:</p> <ul style="list-style-type: none"> • 1 plan refused referral for a pregnant patient with a normal AFP • 1 plan did not cover BRCA • 1 plan limited prenatal screening for CF to high-risk women, and did not cover testing for Fragile X syndrome <p>There was discussion about how to address the coding issues. It was suggested to include population screening on the prevention lines, including the definition of high-risk in the prevention tables. Saha noted that some of these procedures are not very cost effective, and could bankrupt the plan quickly if we are not cautious. He suggested a systematic approach to evaluation that would include cost, life-saving potential and prevalence of risk. Olson stated it was important to identify who is high-risk. Walsh suggested development of an algorithm, and proposed one, which Little will expand on and bring back to the next meeting. The important things to include are: existence of early treatment that affects outcome, treatment acceptable to patient, effect on reproductive decisions, cost, prevalence of the gene in high-risk population (pre-test probability based on personal or family history). Kirk stated that the issue commonly confronted by health plans is a child with</p>	<p>Commissioners will review literature in today's packet in light of algorithm and be prepared to discuss at the next meeting.</p> <p>Review full report from AHRQ on BRCA testing at the next meeting</p>

TOPIC	ACTION
<p>Genetic Testing (cont'd): dysmorphic features for whom genetic testing is requested. He does not approve those requests unless it is clear that treatment will change. It is also important to know whether the patient is willing to act on the results of the testing. Olson stated that most of the time he refers patients for genetic testing, they decline the test after they have the counseling. Saha mentioned the value of information should not be discounted, even though it is not a measurable health outcome. Kirk also mentioned that confirming a diagnosis often provides access to societal resources. Little noted the utility for reproductive planning. Magnum expressed concern that genetic counseling would increase the utilization of genetic testing, but Olson said he has seen the opposite occur.</p> <p>It was noted that AHRQ has reviewed BRCA and made recommendations, including a "B" recommendation for high-risk women and a "D" recommendation for the general population. Saha noted that the editorial on the report stated that the evidence did not support this conclusion. Little is to get entire report to determine how high-risk is defined.</p>	
<p>Acupuncture Little noted that acupuncture is currently on the following lines: HIV, tobacco cessation, 3 substance abuse lines and comfort care. She noted that the literature in the packet was derived strictly from the evidence-based sites used by HSC, and no further literature review was done. Audience member Kipp Bajaj, Central City Concern, stated additional literature was sent, but Little has not received it (was sent to DHS). Mangum noted the difficulty with placebo in studying this treatment. Saha asked what the Subcommittee's approach should be. It was agreed to limit action today to considering the lines it is currently on,</p>	<p>Little will send the citation for the tobacco cessation Cochrane review to Saha, who will obtain the full review and report back at the next meeting.</p>

TOPIC	ACTION
<p>Acupuncture (cont'd): rather than considering new diagnoses for which it might be effective. Walsh stated that the intent was not to remove acupuncture from lines, since there is no strong evidence of harm or lack of effectiveness. Mangum asked if acupuncture providers adhere to a treatment protocol, and if limits were placed on treatment by plans. Bajaj responded yes, but Turek responded no for fee-for-service. Walsh considered the utility of using acupuncture for the treatment of chronic pain conditions. Coffman noted that most of these are below the funding line. Saha noted that the difference between real and sham acupuncture was unimportant, if they are both effective. Olson noted that in his experience, acupuncture is effective for chemotherapy-induced nausea only in those who anticipate benefit. Saha noted a similar dynamic for low back pain. There was discussion about whether to add acupuncture to additional lines where it appears effective. Turek noted that a huge amount of money is spent on treatment of chronic pain, even though most of it is below the line. There was extensive discussion about treatment of chronic pain. Coffman reminded the Subcommittee that the HSC had suggested treating acupuncture as an ancillary service, so that it would be covered whenever medically appropriate, however, the acupuncturists on the Acupuncture Task Force did not want this to occur. Saha asked about the rationale for many pain conditions being below the line, since there is effective treatment in the form of pain relief. Little noted that many painful conditions are below the line, and that the reason some painful conditions are above the line is usually because there is a potential to significantly alter the disease process, often</p>	

TOPIC	ACTION
<p>Acupuncture (cont'd): by surgery. She also questioned whether there was adequate evidence of LACK of effectiveness for tobacco cessation. Mangum questioned whether it was worth reviewing if utilization was very low. The 2005 Cochrane review was discussed. Confidence intervals are not available in the abstract, so the full review will be obtained and a decision will be made at the next meeting. Coffman reported on number of visits for acupuncture for OHP in 2000; 12,700 were done for substance abuse, 48 were done for tobacco cessation.</p>	
<p>Biennial Review Little asked what the Subcommittee would like to focus on for the biennial review, and which providers they would like to target. Walsh felt that the topic should be the prioritization principles that are being developed. It was agreed that a random sample of physicians would be done. Little will have sample questions ready for the next meeting.</p>	

MEETING HIGHLIGHTS
HEALTH OUTCOMES SUBCOMMITTEE
Clackamas Community College Wilsonville Training Center
Room 218
December 8, 2005
8:00 a.m. – 12:30 p.m.

Members Present: Daniel Mangum, DO, Chair; Eric Walsh, MD; Somnath Saha, MD; Kevin Olson, MD; Bryan Sohl, MD.

Staff Present: Darren Coffman; Alison Little, MD, MPH; Dorothy Allen.

Also Attending: Mark Nicholas, MD, OHSU/Planned Parenthood; Dr. Cedric Hayden, Hayden Family Dentistry Group; Chris Barber and Isabel Bickle, OMAP; Chris Kirk, MD, MVIPA.

Note: Adjourned 12:31 p.m. Next HOSC meeting is scheduled for Thursday, January 26, 2006, 9:00 - 11:00 a.m. in Room 117A, Meridian Park Hospital, Community Health Education Center, 19300 SW 65th Avenue, Tualatin, Oregon.

TOPIC	ACTION
Highlights of December 8, 2005 meeting	
<p>Essure Testimony from Dr. Nichols, new information available. FDA approved hysteroscopic sterilization device, general anaesthesia not required. 3 month post procedure hysterosalpingogram required to confirm tubal occlusion. Previous concern was failure to place rate (12-14%) and only 3 years of outcome data. Now have 5 years of data, and failure to place has now improved to only 2% in most recent series. His personal experience at Planned Parenthood has been similar. Long-term effectiveness is 2.6 per 1000 (cumulative for 5 years), which is better than tubal ligation. There have been no true method failures with Essure. Cost analysis at OHSU found Essure charges to be slightly</p>	<p>OMAP to provide data regarding average cost of tubal ligation statewide over previous 6 months to a year. Will review at January meeting.</p>

TOPIC	ACTION
<p>higher, costs not figured. Only around 20% require IV sedation, others are done under local. Case time has decreased with experience, currently about 8-10 minutes. No ectopic pregnancies reported, rare report of device being pushed though fallopian tube, but no infection or uterine perforations. Sohl asked if there was a sub-group of women who would not choose sterilization if this option were not available, Nichols responded yes. In addition to PP, there is a provider in Medford doing the procedure.</p> <p>Isabel Bickle reported on OMAP reimbursement for the procedures: Essure \$1500, BTL \$250 professional fee, \$513 for ASC, \$200 for anaesthesia. Outpatient hospital reimbursement unknown and variable. Walsh asked if procedures were of equal efficacy, and if so, should cost be considered. Saha was concerned that coverage would increase demand. Additional discussion occurred regarding costs ensued. <u>Walsh moved to add Essure to the list, all concurred.</u> Sohl asked if all plans will have to cover it. Kirk stated that his plan would never pay for it, since it is not the most cost effective method. Saha stated there was no point in adding a more costly procedure that was equally efficacious. There was discussion about different costs in different facilities; Sohl felt the majority of BTLs are done in hospitals, not ASCs. Saha stated it is the job of the Commission to consider cost. It was pointed out that complications and patient morbidity were less for Essure. It was agreed to obtain historical data from OMAP regarding how many tubals are done in ASCs vs. outpatient hospital, and the respective costs. The topic will be considered at the next meeting. <u>Motion amended to say approval is pending review of statewide costs.</u></p>	

TOPIC	ACTION
<p>Technical corrections The reports titled, "Recommended Interim Modifications for Review on 12/8/05" and "Recommended Interim Modifications for Review on 12/8/05 II", were reviewed. Significant discussion occurred on the following codes:</p> <p>50592 Ablation, renal tumors, RFA - Olson stated that radiographic response did not necessary correlate well with clinical response, and his experience was that any patient with malignant renal tumor underwent surgery, hence didn't feel RFA was necessary. Subcommittee concurred.</p> <p>33548 Surgical ventricular restoration procedure - Outcomes look promising, but since first RCT is currently ongoing, procedure should be considered still experimental.</p> <p>33880-33891, 75956-75959 Endovascular AAA Repair - No long-term outcomes discussed in NICE review. Concern that aneurysms may rupture 5 years out, and have worse outcome than open repair.</p> <p>46505 Chemodenervation of internal anal sphincter - Not as effective as surgery, but less incontinence. Relative costs discussed, cost of botox assumed to be greater than surgical procedure.</p> <p>61630-61642 Intracranial angioplasty/ stent placement - Little unable to find any literature about this. Asked to consult neurosurgery and possibly interventional radiology, and review at next meeting.</p> <p>77421 Stereotactic X-ray guidance for localization of target volume for delivery of RT - Consensus was that benefits were theoretical, and not proven.</p>	<p>All changes listed in the reports were recommended for approval to the Health Services Commission except, or in addition to, the following:</p> <p>Add to NON-OHP services List</p> <p>Add to NON-OHP services List.</p> <p>Recommend addition but have Little to do brief literature review to search for long-term outcomes, and present at next meeting.</p> <p>Add to NON-OHP services List.</p> <p>Do not add to list at this time, but review at next meeting.</p> <p>Add to NON-OHP services List.</p>

TOPIC	ACTION
<p>Technical corrections (cont'd)</p> <p>91022 - Duodenal motility study - Not clear how this would effect management or outcome.</p> <p>98960-98962 Patient education by non-physician - Barber pointed out that OMAP will not reimburse at this time, because these professionals are not considered providers. Walsh is supportive of adding this, regardless of OMAP action. Saha questioned benefit of this for prenatal classes/ lactation. Sohl asked if this applied to coagulation clinics. Barber stated that this will result in increased costs for OMAP, which may result in elimination of some services to balance the budget. She also noted that OMAP is supportive of the concept, and has an internal disease management program to perform this function. Olson questioned the need for this, if an internal system is available. Sohl questioned geographic accessibility, and Barber responded that the disease management services provided by FFS are available statewide. Hayden asked if tobacco cessation and oral hygiene might qualify for this service. Barber asked if guidelines regarding number of visits would be considered. Olson asked that information be obtained from the plans regarding existence of disease management program, and guidelines around number of visits.</p> <p>G0110-G0116 Pulmonary rehab - Mangum questioned the need for nutritional and psychological counseling as part of this service. Barber stated that nutritional counseling is given to prevent weight loss. Olson and Saha felt this service was similar to the prior issue of disease management,.</p>	<p>Add to NON-OHP services List.</p> <p>No action taken, will be discussed at next meeting with additional information from plans on the current provision of these services, and financial impact from OMAP.</p> <p>No action taken, will be discussed at next meeting with additional information from plans.</p>

TOPIC	ACTION
<p>Technical corrections (cont'd) 01965 Anesthesia for incomplete or missed abortion - this should be placed on the ancillary list, with other anesthesia, not on line 297 (01966 is separate because funding is from a different source (no federal match)).</p>	<p>Add to ancillary list.</p>
<p>15040-15366 Skin grafting and dermal substitutes - Saha expressed concern about the cost, and lack of data on these procedures, and requested specialist input regarding possible limitations.</p>	<p>No action taken, Little to solicit input from plastic surgery on these codes, consider again at the next meeting.</p>
<p>99051-99060 Services provided after hours - OMAP currently covers these codes as long as the service occurs after regularly scheduled office hours, unless they occur in the ER. There was extensive discussion regarding the fairness of additional reimbursement, and the affect of this incentive on access. Approximate additional payment is \$12. 99060 should be added to all medical therapy lines.</p>	<p>99051 Services provided during regularly scheduled evening, weekend or holiday hours - Discuss with full commission. 99053 Services provided between 10 PM - 8 AM at 24-hour facility - Keep on non-OHP services list. 99060 Services provided on an emergency basis out of the office which disrupt scheduled office services - Add to all medical lines.</p>
<p>76376-87900, 88384-89049 Various X-ray and lab procedures - Discussion about the potential costs, and the lack of efficacy information, and the difficulty in examining this group of codes. Saha gave example of 83701, lipoprotein fractionation, the results of which do not change patient management.</p>	<p>Little to identify which codes have similar prior codes, which are entirely new and which are simply more specific codes, and review at the next meeting.</p>
<p>88333-88334 Pathologic consult during surgery.</p>	<p>Add to diagnostic list.</p>
<p>96101-96120 - Psychological and neuropsych testing - these codes have been broken out to include providers other than physician or psychologist. Barber noted that some are not considered qualified mental health professionals.</p>	<p>Confer with MHCD subcommittee before taking action.</p>

TOPIC	ACTION
<p>Technical corrections (cont'd)</p> <p>90714 Td, preservative free, for use in age >7</p> <p>S2114 Tenodesis of biceps - Minimal differences in outcomes.</p> <p>S2117 Subtalar arthroereisis - two procedures, one involves a device insertion, the other does not. Aetna considers the device procedure experimental.</p> <p>931 Foreign body in ear - Discussion regarding placement of this code. Discussed the equity of cerumen impaction being on a lower line; was noted that if it causes hearing loss, it would be covered by co-morbidity rule.</p> <p>62272 Spinal puncture, therapeutic - should also add to Line 86.</p>	<p>Little to compare cost to prior vaccine. No action taken today.</p> <p>Place on non-OHP services list, NOT Line 504.</p> <p>Add to PAC-5 list, not Lines 446, 556, 557, 571 with intention being that the device procedure would be non-covered, the other procedure would be covered.</p> <p>Recommend this code be moved at the time of the biennial review, with revision of Line titles.</p> <p>Add to Line 86 to pair with normal pressure hydrocephalus, 331.3, in addition to Line 31.</p>
<p>Acupuncture for Tobacco Cessation</p> <p>Little explained that she had communication with staff in the Oregon tobacco cessation program, as well as the state epidemiologist in charge of the program, who stated that their interpretation of the Cochrane review is different than the Commission's, and they do not consider acupuncture effective for tobacco cessation. Discussion is on-going.</p>	<p>Little to continue discussion with other state programs, and HOSC to reconsider this issue at the January meeting.</p>
<p>Biennial Review Letter</p> <p>Walsh suggests a reordering of the text so that the goal of the reprioritization is stated early in the letter. He also recommends changing the attachment so that it compares the current prioritization of categories with the proposed one, and including an example with each category. Mangum recommends shortening the letter, possibly eliminating the first paragraph, and using more specific examples. Little stated</p>	<p>The letter will be finalized by email, with a goal of mailing in the first part of January.</p>

TOPIC	ACTION
<p>Biennial Review Letter (cont'd) her intent to send the letter to a random sample of physicians across the state. Walsh recommended expanding the recipients to advocates, hospitals, etc. Saha noted the limitations of focusing too much on specifics, as well as suggesting piloting the letter before sending. Mangum asked that an example be included in the question section of the letter.</p>	
<p>Genetic testing The draft algorithm created by Coffman was reviewed and tested using several genetic conditions. Walsh suggested changing “No” to “No or unknown”. There was discussion about the difference between genetic testing and genetic screening. Sohl pointed out that genetic counseling needs to precede genetic testing in all cases. Discussing Down’s syndrome as an example, he noted that the threshold for offering genetic testing is a risk of 1/300, which is much lower than a 10% risk as stated in the algorithm. It was agreed to add reproductive implications to the left side of the algorithm. Little pointed out that they would apply to essentially all prenatal testing, hence it was agreed to have a separate algorithm for prenatal genetic testing. Sohl suggested consulting a genetic counselor to finalize the algorithm, to help identify what type of disorders should be covered. Sohl suggested Kathryn Murray, Walsh suggested Susan Hayflick. Olson noted that sometimes the implications are not necessarily reproductive for the individual, but may be for the individual’s family member (i.e., BRCA).</p>	<p>Little and Coffman will consult a genetic counselor to review the algorithm (after making suggested changes), with the focus on NON-prenatal genetic testing. They will ask about the possibility of setting a threshold for positive predictive value.</p>
<p>Venous angioplasty Little explained that this request came from a radiology group. Though long-term success is poor, Saha noted that it is not much different than coronary angioplasty.</p>	<p>Do not add 35476 to Lines 39, 145 and 669.</p>

TOPIC	ACTION
<p>Venous angioplasty (cont'd) Little noted that it appears to be more successful and potentially important for AV fistulas, and it was questioned whether this would be coded differently. Walsh referred to an article which found no evidence of difference in outcome between angioplasty and no intervention. Saha noted that all these procedures are covered by Medicare, and since the evidence supporting effectiveness was minimal, it was agreed to not add this code to the List.</p>	