

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

*Meridian Park Hospital Health Education Center, Room 117B&C  
Tualatin, OR  
January 26, 2006  
9:00 a.m. – 11:00 a.m.*

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

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

**Also Attending:** Mark Nichols MD, OHSU; Kerry Silvey, OHSU, DHS; Kelly Wright, Amgen; Chris Barber, Office of Medical Assistance Program; Jeanene Smith MD, Office of Health Policy & Research; Tina Kitchen, DHS; Kathy Kirk, Office of Medical Assistance Programs.

*Note: Adjourned 12:05 p.m. Next HOSC meeting is scheduled for Thursday, March 23, 2006 9:00 a.m. in Room 112, Clackamas Community College, Wilsonville Training Center, 29353 Town Center Loop East, Wilsonville, Oregon.*

TOPIC	ACTION
<p><b>Essure</b>  Utilization information reviewed showing in-patient, out-patient and ASC dollars paid for both FFS OMAP and MPCHP for the prior year, which showed that most procedures are done in an ASC for FCHP, but almost 90% of FFS procedures are performed in the out-patient hospital setting, at an approximate cost of \$2000. Weighted mean cost for FFS was \$1431 (exclusive of anesthesia and physician charge). Conclusion was that cost of Essure to the state overall was no more than for tubal ligation. Need for a guideline to specify place of service was discussed and rejected, feeling this could be implemented by the plans.</p>	<p>Place Essure device (CPT code 58565) on Line 53, Contraception.</p>
<p><b>Technical Corrections</b>  Discussion occurred regarding the following changes identified in the documents titled “xxx” and “xxx”:</p> <ul style="list-style-type: none"> <li>• PT for polymyositis – Mangum expressed concern about adding all therapy codes, some did not seem appropriate.</li> </ul>	<p>All proposed changes recommended for acceptance except the following:</p> <p>Line 314, Dermatomyositis, do not add therapy CPT codes 97012, 97014, 97112, 97113, 97124, 97140, 97150.</p>

TOPIC	ACTION
<p><b>Technical Corrections (cont'd)</b></p> <ul style="list-style-type: none"> <li>Pharmacologic management – there was discussion about indications for using this code, and it was thought that it is reimbursed at a lower amount than a corresponding E&amp;M code, and that psychiatrists have been told to use it.</li> <li>Vision codes – many of the codes appeared to be inappropriate. Little explained that the entire block of eye codes is placed on every eye line for simplicity.</li> </ul>	<p>Recommended approval, but have additional discussion with full Commission, seeking Theodorou's input, and follow up at next meeting regarding comparative cost.</p>
<p><b>Diagnostic codes</b></p> <ul style="list-style-type: none"> <li>76378/76377, 3D rendering of imaging studies – Sohl stated that the professional component is very low, while the technical component is fairly high. Often 3D is unnecessary, but occasionally it is very important, but these occasions are rare, and the potential for over-utilization is high. Saha suggested not adding it, allowing the provider to perform the 3D, but not receive additional reimbursement. Walsh was concerned that there did not seem to be an effect on outcome.</li> <li>80195, sirolimus drug assay</li> <li>82271/82272, occult blood</li> <li>83037, glyco HGB, home device</li> <li>83631, Fecal lactoferrin – agreed that it was unclear that this would change therapy</li> <li>83695 – 83704, lipoprotein tests – Olson stated that lipoprotein a is a test that is done as part of hypercoagulable work up, but concurred that this almost never influences management. Little found that none of these codes reflect the standard lipid measurements of HDL, LDL and total cholesterol, and are of unclear significance.</li> </ul>	<p>Approval to act as follows: Do not add 76378 and 76377 to diagnostic file.</p> <p>Add 80195 to diagnostic file. Add 82271/82272 to diagnostic file. Do not add 83037 to diagnostic file. Do not add 83631 to diagnostic file.</p> <p>Do not add codes 83685-83704 to diagnostic file.</p>

TOPIC	ACTION
<p><b>Diagnostic codes (cont'd)</b></p> <ul style="list-style-type: none"> <li>• 83900-83914, molecular diagnostics - Olson stated these tests are likely used to identifying particular mutations in cancer cells, and in only around 10% of the time does it affect treatment choices. It was suspected that these are all part of one process and should be dealt with similarly. Kerry Silvey explained that each code is a small portion of the entire assay. Walsh asked if this testing was mainstream or a research tool. Olson stated that for diseases such as CML, it is an essential part of the workup, and the potential for misuse is low.</li> <li>• 86200, cyclic citrullinated peptide antibody – Saha questioned the utility of earlier diagnosis of RA. Little stated that the description suggests that the test is significantly more specific than other autoimmune tests.</li> <li>• 86355, B cells, and 86357, natural killer cells – Olson stated that the need for both these tests is extremely rare, but also not likely to be overused.</li> <li>• 86367, stem cell count - Olson stated this test is frequently done in the process of bone marrow transplant, and should remain available.</li> <li>• 86480, Tb test – Allows use in patients with prior BCG exposure, but does not necessarily predict active disease. Walsh questioned the need for this, as there are accepted protocols for testing for Tb in these patients.</li> <li>• 86923, compatibility test, electronic</li> <li>• 86960, Volume reduction of blood products</li> <li>• 87209, Smear for O&amp;P</li> </ul>	<p>Add codes 83900-83914 to the diagnostic file.</p> <p>.</p> <p>Do not add 86200 at this time, but Little to do additional research regarding sensitivity, specificity and cost.</p> <p>Add codes 86355 and 86357 to the diagnostic file.</p> <p>Add 86367 to diagnostic file.</p> <p>Do not add 86480 to diagnostic file.</p> <p>Add 86923 to diagnostic file.</p> <p>Add 86960 to diagnostic file.</p> <p>Add 87209 to diagnostic file.</p>

TOPIC	ACTION
<p><b>Diagnostic codes (cont'd)</b></p> <ul style="list-style-type: none"> <li>• 87900, drug susceptibility – Walsh stated this was essential in management of HIV patients</li> <li>• 88384-88385, molecular probes – Olson explained that with the molecular diagnostic codes, one is searching for a single gene in a group of cells, while for these tests, one can test for up to 250 different genes in a tissue sample. The latter costs \$3000 and is used in breast cancer to estimate recurrence risk. Occasionally it is helpful in management (for example, whether or not chemo is necessary), but often it is not. It was suggested that a guideline be developed. Olson noted that the lab which runs this requires that FDA indications be met, which is essentially a guideline.</li> <li>• 89049 caffeine halothane test</li> </ul>	<p>Add 87900 to diagnostic file.</p> <p>Do not add 88384-88385 to diagnostic file at this time. Olson will get guidelines his group uses to Little, who will also consult with the lab who runs the test as well. Will discuss again at next meeting.</p> <p>Add 89049 to diagnostic file.</p>
<p><b>Acupuncture for smoking cessation</b></p> <p>Little explained that she had spoken with and emailed Tim McAfee, the physician in charge of the Free and Clear program, but had not had a response to her question yet. Saha stated that the issue is that even though there is no compelling evidence that acupuncture is effective for smoking cessation, there is also no compelling evidence that it is NOT effective, and the latter is required to remove something from the list. There was discussion about whether this was really required to remove something from the list, and also about the cost of the procedure.</p>	<p>Defer discussion to next month's meeting. Little to get cost of an average course of acupuncture for smoking cessation.</p>
<p><b>Disease education (98960-98962)</b></p> <p>Barber stated that there are 5300 members in the asthma program, 2200 in the diabetes program and 400 members in the CHF program monthly. Little stated that of the FCHPs, only 2 have formal disease management programs, but cover on a case by case basis and are supportive of the concept. Because FFS already offers</p>	<p>Do not add 98960-98962 to the List.</p>

TOPIC	ACTION
<p><b>Disease education (98960-98962)</b>  <b>(cont;d)</b>  this, it was agreed that additional payment wasn't necessary, as plans could pay if they chose to.</p>	
<p><b>Genetic testing</b>  Coffman presented revised algorithm, noting the following changes:</p> <ul style="list-style-type: none"> <li>• applies to NON-prenatal testing</li> <li>• elimination of population screening</li> <li>• addition of reproductive or family implications to left side</li> <li>• addition of "or uncertain" to "No"</li> <li>• clarification that testing is a process and definition of the term lethal</li> </ul> <p>He pointed out that removal of V code 26.33, genetic counseling, meant that counseling couldn't be done to determine if testing is indicated. Silvey made general comments, making the distinction between symptomatic patients and those without symptoms. Determining risk or pretest probability is difficult for the latter, and usually requires genetic counseling first. Coffman suggested that V26.33 be considered diagnostic. Sohl expressed concern over access to genetic counselors. Silvey suggested convening a workgroup to further define this, which would include someone from the commission, OMAP and others. There was discussion about why genetic testing and counseling is being denied. Coffman noted that family history V codes have been removed from the prevention lines. Saha suggested firmer definition of "rare" and "reproductive implications".</p>	<p>Convene workgroup to investigate this further. In the mean time, adopt algorithm with testing process re-named as counseling process and moved up to be the second item. Also, add V16, V17, V18, V19 and V26.3 back to List where they were before.</p>
<p><b>Psoriasis</b>  Little explained that the Psoriasis Foundation submitted written material requesting a change to the current coverage. Kelly Wright, Amgen, provided testimony, requesting that all psoriasis be moved above the line. She stated that the current categorization of stage I-IV was not generally accepted, but the dermatology</p>	<p>Dr. Eric Simpson to be contacted for input on changes to the guideline.</p>

TOPIC	ACTION
<p><b>Psoriasis (cont'd)</b>  society uses mild, moderate and severe. Little reminded the subcommittee that they had adopted current stages after testimony from a dermatologist at OHSU, and reviewing an article he supplied. Walsh asked what Wright recommended be moved below the funding line if psoriasis were moved up. She did not answer this question, but cited statistics regarding prevalence of the disease, and stated that current guideline specifying moderate to severe as &gt;20% body surface area was “way outside the norm”. Saha pointed out that the current guideline includes provision for hand or foot psoriasis and functional limitations irregardless of the percentage of the body affected. He felt some modification of the guideline should be considered to decrease the BSA involvement. Walsh pointed out that Eric Simpson, who provided previous testimony, only asked for coverage of stage 4 (while the HSC approved the coverage of stages 3 and 4), and recommended that the Commission consult with him again before taking action.</p>	
<p><b>Endovascular AAA repair</b>  Little stated that effectiveness of this therapy was at least close to open repair, and that cost was likely similar as well (some articles reporting more costly, others less), hence addition of these codes would be reasonable. Others concurred.</p>	<p>Add 33880, 33881, 33883, 33884, 33886, 33889, 33891, 75956, 75957,75958,75959 to Lines 21 and 24.</p>
<p><b>Intracranial angioplasty</b>  Little referred to literature distributed today, including the position statement from the American Society of Interventional and Therapeutic Neuroradiology, Society of Interventional Radiology and American Society of Neuroradiology. The only studies found were case series, largest was of 61 patients, and outcomes appear to be similar to treatment with aspirin.</p>	<p>Add 61630, 61635, 61640, 64641, 61642 to the Non-OHP Services List.</p>

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

*Clackamas Community College, Wilsonville Training Center, Room 112  
Wilsonville, OR  
April 13, 2006  
8:00 a.m. – 11:00 a.m.*

**Members Present:** Eric Walsh, MD, Chair (arrived at 8:35); Daniel Mangum, DO; Somnath Saha, MD, MPH; Kevin Olson, MD.

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

**Also Attending:** Wally Shaffer, MD and Chris Barber, Office of Medical Assistance Programs; Tina Kitchen, Dept. of Human Services; Chris Kirk, MD, OHP Medical Directors; Kelly Wright, Amgen; Sheila Rittenberg, National Psoriasis Foundation.

*Note: Adjourned 11:15 a.m. Next HOSC meeting is scheduled for Thursday, May 25, 2006 8:00-10:00 a.m. in Room 117B&C, Meridian Park Hospital, Community Health Education Center, 19300 SW 65<sup>th</sup> Avenue, Tualatin, Oregon.*

TOPIC	ACTION
<p><b>Technical Corrections:</b></p> <p><u>Rhinoplasty, tip only:</u> Reviewed previously, decided to not place this on the cleft palate/cleft lip line as cosmetic, but repair with septum is covered, Little thought they should be treated the same. Question about whether this is done as a separate procedure, or bundled with the cleft lip repair. Little could not recall the specific case. Saha felt septal repair was more than cosmetic, and felt different treatment was appropriate.</p> <p><u>Allergy testing for chronic sinusitis:</u> Consensus was that there was limited evidence that immunotherapy for this condition was effective, and certainly wasn't cost-effective, hence no need to do testing. Primary treatment would remain topical steroids and antihistamines.</p> <p><u>Destruction of malignant lesions:</u> Concern was expressed about pairing these codes with actinic keratoses.</p>	<p>Do not add 30460 to Line 377.  Little to find out details of the case she reviewed and discuss at next meeting.</p> <p>Do not add 95004-95165 to Line 480.</p> <p>Little to obtain AHRQ review of actinic keratoses and consider this topic at the next meeting.</p>

TOPIC	ACTION
<p><b>Technical Corrections (cont'd):</b>  <u>Endotracheal intubation/ thoracenteses:</u>  Commissioners felt these procedures should be considered ancillary.</p> <p><u>Limited lymphadenectomy for staging:</u>  Commissioners felt this should also be on lines for cervical, prostate, bladder and vaginal cancer, but did not need to be on the melanoma or skin cancer line. They also elected to add the other staging codes to the former lines as well.</p> <p><u>Gastrostomy tube placement:</u>  Commissioners also felt this should be considered ancillary.</p> <p><b>Dermal substitutes:</b> Consultant provided little guidance, but appears that the only area of concern is chronic stasis and diabetic ulcers. Medicare criteria reviewed, as well as Cochrane and CCOHTA reviews. Adopting the Medicare criteria was considered, but decided against. Ultimately, it was decided to add old codes (such as basic skin graft) to all lines, and newer codes (such as acellular products and dermal substitutes) to all lines except 350, 556 and 660.</p>	<p>Delete 31500 from Lines: 16, 17, 32, 107, 128, 156, 157, 158, 174, 448, and add to the ancillary file. Delete 32000 from Lines 5, 17, 59, 169, 225, 272, 598 and add to ancillary file. Delete 32002 from Lines 5 and 169 and add to ancillary file.</p> <p>Add 39562 to Lines 229, 232, 271, 273 and delete from Lines 137 and 346. Add 38564 to Lines 192, 229, 232, 271 and delete from Lines 137, 191 and 346. Add 38570 to Lines 192, 229, 232, 271 and 273. Add CPT codes 38571 and 38572 to Lines 192, 229, 232, 271, 273 and delete from Lines 666 and 694.</p> <p>Delete 43246 from Lines 216, 217, 249, 296 and add to ancillary file. Delete 43750 from Lines 216, 270 and add to ancillary file. Add 15040, 15110, 15111, 15130, 15131, 15300, 15301, 15115, 15116, 15135, 15136, 15320, 15321, 15420, 15421 to the following Lines: 40,99,137,146,162,196,224,296,303,346,350,360,375,556,660.</p> <p>Add 15340, 15341, 15430, 15431, 15150, 15151, 15152, 15170, 15171, 15330, 15331, 15360, 15361, 15155, 15156, 15157, 15175, 15176, 15335, 15336, 15365, 15366, 15430, 15431 to the following Lines: 40,99,137,146,162,196,224,296,303,346,360,375.</p>
<p><b>Hernias:</b> Little explained that there is disagreement among medical directors regarding the meaning of "obstruction" in the title of Line 6, and approximately half believe obstruction means incarceration, the other half that it means bowel obstruction. Kirk related that there was no great consensus from the medical</p>	<p>Add guideline to Line 6 as follows:  "Complicated hernias are included on this line if they are incarcerated and have symptoms of obstruction and/or strangulation."</p>

TOPIC	ACTION
<p><b>Hernias (cont'd):</b>  directors on how to proceed, and they were content to have differing interpretations. He also stated that, due to limitations of ICD-9 coding, a guideline would likely be needed to provide clarity. Coffman stated that the original commissioners considered the title as a guideline. He also stated it is problematic under Medicaid law to have differing interpretations. Kirk also noted that incarcerated ventral hernias are clinically different from incarcerated inguinal hernias. It was agreed that the Commission needs to make its intent known. There was discussion about whether symptoms (pain) should be part of the criteria. Saha suggested that the term strangulation could be used, which would imply severe pain. There was no debate about the definition of incarceration. It was ultimately agreed that the Commissioners wanted only incarcerated hernias that were painful on the higher line. No coding changes were needed, but a guideline was.</p>	
<p><b>PET Scans:</b> Little gave the history of the Commission's action on PET and outlined the literature in the packet. Olson noted the difficulty evaluating PET scans since studies are designed by radiologists and generally do not report patient outcomes, and because treatment advances occur so rapidly. He said there is significant heterogeneity in how well breast cancer shows up on PET. Saha stated that the Commission's prior decision was based on accuracy compared to conventional imaging, which is a low standard. He is unimpressed by the study showing physicians change their management based on PET results, as whether or not they SHOULD change their management remains unknown. Olson also noted difficulty in interpretation, but that at times</p>	<p>Add colon cancer and testicular cancer to the guideline for PET scans.</p>

TOPIC	ACTION
<p><b>PET Scans (cont'd):</b>  it can be useful in evaluating bone mets. He noted that Medicare covers PET for breast cancer, though he is not sure of their rationale, and that there is a lot of unexplained variation among oncologists regarding use. He also stated that eventually, the clinical picture usually becomes clear without a PET, but takes longer. A certain percentage of breast cancers are <u>not</u> PET avid, approximately 25%, which limits its usefulness. There was agreement that the evidence supports the use of PET for colon and testicular cancer. There was discussion about whether to include breast cancer, limiting use to evaluating bone mets. Saha questioned whether or not research would be done to address this question, and whether or not the Commission should wait for it. Shaffer noted that Medicare is starting a registry of PET scans to assist with research. Kirk stated that breast cancer is common enough that he believes the data will become available relatively soon. Olson stated that he very rarely sends an uninsured breast cancer patient for PET. Ultimately, it was decided that the evidence did not support the use of PET for this disease.</p>	
<p><b>Cyclic Citrullinated Peptide:</b> Little reported the cost to be no more than \$50, sensitivity and specificity to be 76% and 91% to 98%, respectively. There is an advantage to early treatment of RA.</p>	<p>Add CPT code 86200 to diagnostic file.</p>
<p><b>Treatment of Liver Cancer:</b> Little explained that the Commission previously considered embolization for tumor destruction using yttrium and elected not to place it on the list; however, the code for embolization remains. A case at OMAP resulted in her questioning whether appropriate treatments were listed on this line. Olson explained the different treatments, as follows:  Radiofrequency ablation is insertion of a</p>	<p>Do not delete any of the following codes from Line 489:  36260 - Insertion of implantable intra-arterial infusion pump  36262 - Removal of implanted intra-arterial infusion pump  37204 - Transcatheter occlusion or embolization  47370 - Laparoscopy, surgical, ablation of one or more liver tumors, RFA</p>

TOPIC	ACTION
<p><b>Treatment of Liver Cancer (cont'd):</b> an ultrasound catheter with use of heat to kill tissue, cryotherapy is the same thing except using a liquid nitrogen probe, chemoembolization is when a catheter is inserted into an artery that feeds the tumor, chemotherapy is infused then the artery is embolized with gel foam. The yttrium procedure does not involve embolization. All of these are used to treat both primary liver cancer and metastatic colon cancer. Saha asked if any of these treatments were controversial except the yttrium. Olson stated that for colon cancer metastatic only to the liver, resection can result in 25% long-term survival. Hepatic artery infusion with 5-FU improved outcomes as well. The data on RFA and cryotherapy is weaker. Chemoembolization results in shrinkage of tumor, but causes severe side-effects. RFA and yttrium have fewer side effects. Hepatic artery infusion is also effective, but systemic chemotherapy has improved to the point that it is rarely done anymore. Saha clarified that the task today is to determine if any of these treatments should be removed from the List. Olson stated that there are some cases where an isolated metastasis is too close to the bile duct to operate, and in those cases it makes sense to use RFA or cryo. He also said that yttrium treatment costs approximately \$70,000.</p>	<p>Do not delete any of the following codes from Line 489 (cont'd):  47371 - Laparoscopy, surgical, ablation of one or more liver tumors, cryosurgical  47380 - Ablation, open, one or more liver tumors; RFA  47381 - Ablation, open, one or more liver tumors; cryosurgical  47382 - Ablation, percutaneous, one or more liver tumors; RFA  Do not delete CPT code 36261, Revision of implanted intra-arterial infusion pump, from Lines 145 or 489.  <b>Delete 79445 - Radoipharmaeaceutical therapy, by intra-arterial particulate administration, from Line 489.</b></p>
<p><b>Bell's Palsy:</b> Little explained that one of the OMAP medical directors felt this should be a funded diagnosis, treated the same as herpes simplex or zoster. The Up-To-Date review was discussed, showing limited evidence for efficacy of steroids and anti-virals. Mangum did not feel movement of this line was indicated. Others concurred that this was a relatively self-limited condition that did not require movement. There was discussion about zoster, which is currently on Line 203,</p>	<p>Change title of Line 203 to the following: "Herpes zoster, and herpes simplex with neurological or ophthalmological complications".</p>

TOPIC	ACTION
<p>which needs a new title. It was felt this was a more severe disease, for which treatment may be cost-effective.</p>	
<p><b>Genetic testing lab codes:</b> Little reported that the codes that were added at the last meeting to the diagnostic file (83900-83914) are what are used for BRCA testing. The codes that she was asked to research, 88384-88386, are used for non-specific chromosome abnormalities, or in research settings. Medicare criteria for BRCA testing were considered.</p>	<p>DO NOT add 88384-88386 to the diagnostic file. Await the recommendations of the genetic testing taskforce regarding a guideline for BRCA testing.</p>
<p><b>Speech Therapy guideline:</b> Little noted that Dr. Buckindorf, speech pathologist at CDRC, requested a change to the therapy guideline. He was concerned that the way it is worded, 3 months of acute therapy is required before any additional therapy is allowed. He recommends deletion of the phrase, "Following 3 months of acute therapy". Kitchen expressed concerns about his proposed change, and offered an alternate: "In addition to those visits authorized in the 3 months after an acute event...". Little asked for additional clarification regarding Commission intent for patients who never utilized 3 months of acute therapy, and asked if they should be allowed the 3 months of unlimited therapy even if they are in a chronic phase (example given was a fracture which was not treated with therapy initially). There was discussion about when the acute phase begins. There was agreement that the 3 month unlimited phase of treatment should be limited to acute events, but after stabilization. Kirk asked how this would apply to something like multiple sclerosis. Mangum and Saha didn't feel 3 months of intensive therapy was indicated for this diagnosis, and that some therapy would be allowed under the provision for exacerbations.</p>	<p>Revise therapy guideline as follows: Physical, occupational and speech therapy, and cardiac and vascular rehabilitation, are covered for diagnoses paired with the respective CPT codes, depending on medical necessity, for up to 3 months <del>after the initiation of the therapies</del> <i>immediately following stabilization from an acute event</i>. This revision is to be circulated to the medical directors for their comments, and will be reviewed for finalization next month.</p>

TOPIC	ACTION
<p><b>Psoriasis:</b> Testimony from Sheila Rittenberg, National Psoriasis Foundation. She reported no personal conflict of interest, but noted that the NPF does accept unrestricted grants from pharmaceutical and biomedical companies, which accounts for approximately half of their funding, the other portion coming from personal donations. From the foundation's perspective, there are two problems with the HSC guideline as it stands: 1) omits from coverage moderate to severe psoriasis with BSA of 5-20% and 2) limitation of biologics to severe psoriasis. They request coverage of these drugs starting at a BSA of 5-10%. Walsh asked what disease she recommended reducing funding for in order to liberalize the guideline. She didn't know, stating that was not her expertise. Walsh pointed out that the QOL article provided only had a 54% response rate, suggesting substantial bias. Olson noted that physicians have not complained to the Commission about the guidelines, and expressed concern about use of expensive medications for milder forms of the disease. Rittenberg is requesting step therapy for milder forms of disease, so that older agents can be used first, but if one, or two at the most, fail, then biologics will be available. Saha stated that, given the fiscal restraints of the plan, decreasing the barriers to the use of biologics is untenable, though he favors reducing the BSA requirement in the criteria. He stated that testimony from an advocacy organization with a financial conflict of interest is not very credible. Olsen re-iterated the lack of testimony from treating physicians expressing concern about the current limitations. Kirk stated that, in general, the guideline is workable, and he feels appropriate.</p>	<p>Written request will be sent to Dr. Simpson to answer the following:</p> <p>Is 20% still an appropriate BSA for defining moderate to severe psoriasis?</p> <p>Should biologics be allowed for lower percentages of BSA? Should there be step therapy?</p>

**MEETING HIGHLIGHTS  
HEALTH OUTCOMES SUBCOMMITTEE**

*Meridian Park Hospital Health Education Center, Room 117B&C  
Tualatin, OR  
May 25, 2006  
8:00 a.m. – 10:00 a.m.*

**Members Present:** Eric Walsh MD, Chair; Daniel Mangum, DO; Somnath Saha MD, MPH; Kevin Olson MD; Bryan Sohl MD (via phone).

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

**Also Attending:** Kelly Wright, Amgen; Bert Tavelli, MD; Sheila Rittenberg, National Psoriasis Foundation; Chris Kirk, MD, OHP Medical Directors; Lori Almand and Bill Struyk, Johnson & Johnson.

*Note: Adjourned 10:10 a.m. Next HOSC meeting is scheduled for Thursday, June 29, 2006, 8:00-11:00 a.m. in Room 117B&C, Meridian Park Hospital, Community Health Education Center, 19300 SW 65<sup>th</sup> Avenue, Tualatin, Oregon.*

TOPIC	ACTION
<p><b>Review of Highlights:</b> Little asked Commissioners to confirm the section in the April highlights on page 5 which is bolded. They confirmed that they intended to delete the code, 79445, Radiopharmaceutical therapy by intra-arterial particulate administration, from Line 489.</p> <p><b>Psoriasis:</b> Commissioners reviewed the letter from Dr. Simpson. Testimony from Dr. Tavelli, who stated that he has been in practice since 1981 and continues to see OHP patients. He stated that the task before the Commission is to decide when to consider the use of biologics. 10% body surface area involvement is used as a threshold in practice for when it becomes difficult to treat the disease with topical agents. The next step is usually phototherapy with UVB or PUVA (psoralin + UVA), but there are access problems with obtaining this, as there are few dermatologists with the necessary equipment who see OHP patients. In addition to phototherapy, oral retinoids</p>	<p>None required.</p> <p>Consider guideline at June 29, 2006 to be drafted by Little (see below) that combines moderate &amp; severe forms of psoriasis, reduced minimum body surface area affected from 20% to 10%, and incorporates step therapy.</p> <p><i>Note: Draft change to psoriasis guideline for Line 358 is as follows:</i></p> <p><i>Moderate and severe psoriasis is defined as involvement of 10% or more of body surface area, or hand, foot or mucous membrane involvement resulting in moderate to severe functional limitation. First line agents include topical agents, oral retinoids, phototherapy and methotrexate. Use of other systemic agents should be limited to</i></p>

TOPIC	ACTION
<p>are used (acitretin (Psoritane)), although this can't be used in women of child-bearing years, as is methotrexate, which is effective and cheap, but can't be tolerated by all due to hepatotoxicity. Only patients who fail or are not candidates for these therapies are candidates for biologics, as they are no more effective than the former agents, although infliximab (Remicade) probably is, and the cost is around \$20,000/year. PUVA is used less than UVB now because of GI side effects of the acitretin and photosensitivity of the lens for 24 hours after UVA is administered. Effectiveness of both biologics and methotrexate is 50-70%. He feels that 20% requirement for any treatment is very high, and 10% is more reasonable. Olson noted that there are access problems for OHP patients, and that there does not appear to be inappropriate use of biologics. Saha felt that step therapy was still a good idea, but would like to see an exception process for those with very severe disease. It was ultimately decided that such a statement was unnecessary. There was discussion about the need to specify how many first line agents patients needed to fail to qualify for second line agents, it was decided that was unnecessary as well. It was clarified that cyclosporine should be considered second line. Walsh reminded the Commissioners that some OHP members would lose access to treatment for some conditions as a result of this increase in coverage for psoriasis, and that his personal experience with Remicade was one which included severe side effects for his patients (death).</p> <p><b>Technical Corrections:</b>  Prophylactic organ removal of breast: Little referred Commissioners to the ICSI review which found a gain in 4 life years for women who are high risk. Olson stated</p>	<p><i>those who fail, have contraindications to, or do not have access to first line agents.</i></p> <p><i>Note: Draft change to psoriasis guideline for Line 537 is as follows:</i></p> <p><i>Mild psoriasis is defined as uncomplicated, with less than 10% of body surface area involved and no functional limitation.</i></p> <p>Accept all changes outlined in the report titled, "Interim Modifications for Review on 5/25/06", except the following:</p>

TOPIC	ACTION
<p>this is one option (intensive screening and tamoxifen are others) for high risk women, either those who already have breast cancer in one breast, or those who are at high risk based on BRCA positivity. Kirk asked the Commission to specify who should be considered high risk. It was agreed to limit this to BRCA positive women, and that it needs to be added to the prevention line as well.</p> <p>Urinary Incontinence: Little reported that the guideline for incontinence surgery requires failure of physiotherapy, but those codes are not on that line. She referred to one article which demonstrated effectiveness. There was debate about whether electrical stimulation was used for this, and it was agreed that it was (it was referenced in the article).</p>	<p>In addition to Line 225, Add V50.41, Prophylactic organ removal; breast to Line 181, Preventive Services with Proven Effectiveness, over Age 10. Add a guideline to this line stating that high-risk is defined as BRCA positive. <i>Note: Addition of guideline was not discussed as part of recommendations to HSC and will need to be revisited.</i></p>
<p><b>Actinic Keratoses:</b> Little reminded the Commission that they had asked to see the review done by AHRQ which described the natural history of these lesions. She noted that only 2% of skin cancers originating in AKs metastasize, and 20-25% regress over the course of a year. There was discussion over whether this should be on a funded line. Saha suggested that it would not be unreasonable to wait until they become squamous cell cancer, given the very low rate of metastasis and the high regression rate. It was noted that biopsy results in cure, hence is part of the diagnostic procedure. However, treatment with liquid nitrogen or 5FU would not be covered if this were on a lower line. Olson opined that movement to a lower line likely would not affect practice, as more severe lesions would still be biopsied. Coffman pointed out that, in the past, CMS has objected to not funding actinic keratoses, resulting in its current placement on Line 351.</p>	<p>Move actinic keratosis, 702.0, to Line 586, Benign neoplasms of skin, as a biennial review change.</p>

TOPIC	ACTION
<p><b>Rhinoplasty:</b> Little clarified that there is a separate code for repair of the cleft lip nasal deformity when it is done at the same time as the cleft lip repair (40700), therefore, the code which was questioned at the last meeting (30460) refers only to the nasal repair done separate from lip repair. She noted that there does not appear to be a consensus as to the best time to do the repair, whether concurrent or not. Details about the specific OMAP case discussed at the last meeting were not available. Saha felt it should be covered. Little raised the concern about covering cosmetic surgery, which traditionally has not been part of the OHP benefit package. Sohl thought that functional and congenital deformities should be covered, and should not be considered cosmetic. Kirk expressed concern about covering any cosmetic surgery, noting that absence of ear is currently not funded. Coffman noted the following diagnoses were also not currently funded: absence of nose, accessory nose, cleft nose, and others. This led to unanimous agreement that deformities of the nasal tip should not be funded.</p> <p><b>Congenital Cardiac Anomalies:</b> Little reviewed the proposed changes, which are an attempt to increase the consistency and accuracy of this set of lines as part of the biennial review. She noted that treatment of coarctation of the aorta currently has two lines, one for surgical treatment, the other for balloon dilation. She referred to a review article showing good long-term outcomes, at least for older children. She recommended combining the lines.</p>	<p>Do not add 30460, Rhinoplasty for nasal deformity secondary to congenital cleft lip or palate, tip only, to Line 377, Cleft Palate and/or Cleft Lip.</p> <p>Recommend changes appearing in Attachment B of May 25, 2006 HSC minutes. This includes all changes originally outlined by Little except for the following (<i>Note: these modifications were not discussed at the HSC meeting and will need to be revisited</i>):</p> <p>Leave 33610, repair of complex cardiac anomalies by surgical enlargement of VSD, on Line 96.</p> <p>Add 35452, Balloon angioplasty to Line 195, Cong. stenosis &amp; insufficiency of aortic valve, Line 310, Diseases/disorders of aortic valve, and Line 368, Cong. pulm. valve stenosis.</p>

TOPIC	ACTION
<p><b>V codes:</b> Little explained a handout of all V codes, whether they currently exist on the List, and a recommendation for those which are not. Coffman noted that there has never been a systematic review of V codes. General guidance was solicited.</p>	<p>The Subcommittee will review only those codes which Little recommends be placed on the list, but not those which currently exist there, or those which she does not recommend be added.</p>

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

*Meridian Park Hospital Health Education Center, Room 117B&C  
Tualatin, OR  
June 29, 2006  
8:00 a.m. – 10:00 a.m.*

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

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

**Also Attending:** Chris Barber and Wally Shaffer, MD, OMAP; Chris Kirk, MD, OHP Medical Directors; Ariel Slazman, PT Northwest; Lori Almand, Krustina Frey and Julie Crawford, Ethicon Endo-Surgery; Shiela Rittenberg, National Psoriasis Foundation.

*Note: Adjourned 9:55 a.m. Next HOSC meeting is scheduled for Thursday, October 26, 2006, 8:00-11:00 a.m. in Room 112, Clackamas Community College, Wilsonville Training Center, 29353 SW Town Center Loop, Wilsonville, Oregon.*

TOPIC	ACTION
<p><b>Review of Highlights:</b>  Little asked the members to review the draft psoriasis guideline from the May 25, 2006 highlights (page 1-2).</p> <p><b>Technical Corrections:</b></p> <p>Reduction mammoplasty on contralateral breast, used in conjunction with breast reconstruction after a mastectomy, where the healthy breast is very large – Input from OMAP indicates that this procedure has been approved on a case by case basis. The members discussed that the federal law mandates procedures for symmetry are covered, but it does not state that to achieve symmetry that reduction of a healthy breast be covered.</p>	<p>The draft psoriasis guideline accurately captures the discussions of the May meeting.</p> <p>Accept all changes outlined in the report titled, “Interim Modifications for Review on 6/29/06,” except the following:</p> <p>Do not add 19318 (Reduction mammoplasty) to Line 225. Cases can be individually reviewed.</p>
<p><b>V codes</b>  Little shared that OMAP would like to leave missing V-codes off of the list, unless there is a specific need.</p>	<p>Add V-codes to the list as they come up rather than try to add every V-code to the appropriate line(s) of the list at this time.</p>

TOPIC	ACTION
<b>Psoriasis Guideline</b>	
Concerns raised by OHP Medical Directors, who requested adding the phrase “functional impairment.”	<p>The complete guideline will now read:</p> <p>Moderate to severe psoriasis is defined as having functional impairment and one or more of the following:</p> <ul style="list-style-type: none"> <li>a) 10% body surface area and/or</li> <li>b) Hand, foot or mucus membrane involvement.</li> </ul> <p>First line agents include topical agents, oral retinoids, phototherapy and methotrexate. Use of other systemic agents should be limited to those who fail, have contraindications to, or do not have access to first line agents.</p>
<b>Therapy Guideline</b>	
OMAP questioned the definition of the phrase “immediately following stabilization from an acute event.”	OMAP agreed to use the guideline as revised and report back with issues.
<b>Obesity</b>	
Testimony heard from Julie Crawford, Ethicon Endo-Surgery, regarding surgical treatment of obesity. She cited JAMA and other studies showing clinical evidence of co-morbid resolution and long term outcomes. Further, information about Centers of Excellence was shared, noting lower complication risks in those facilities.	Discussions were tabled until the Health Resources Commission evidence-based study is complete.

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

*Wilsonville Training Center, Room 112*

*Wilsonville, OR*

*October 26, 2006*

*8:00 a.m. – 11:00 a.m.*

**Members Present:** Daniel Mangum DO, Chair; Somnath Saha MD, MPH; Kevin Olson MD; Bryan Sohl MD; Lisa Dodson MD.

**Staff Present:** Darren Coffman; Dorothy Allen.

**Also Attending:** Chris Kirk, MD, OHP Medical Directors; Wally Shaffer MD, Monica Herrera and Caroline Price, Division of Medical Assistance Programs (DMAP); Kathleen Weaver MD & Ruth Medak MD, Health Recourses Commission; Neal Gorrin MD, Oregon Bariatric Center; Bruce Wolfe MD, Professor of Surgery OHSU.

**Note: Adjourned 11:05 a.m. Next HOSC meeting is scheduled for Friday, December 8, 2006, 8:00-1:00 p.m. in Room 117, Meridian Park Hospital, Community Health Education Center, Tualatin, Oregon.**

TOPIC	ACTION
<p><b>Technical Corrections</b></p> <p><u>Inappropriate Pairings</u>            Vasovasostomy, Vasovasorrhaphy, (reversal of vasectomy) is listed on Line 431, Functional And Mechanical Disorders Of The Genitourinary System Including Bladder Outlet Obstruction.</p> <p><u>Non-pairings</u>            DMAP suggested the following pairings be included on the list:</p> <p>10060, Incision And Drainage Of Abscess, Simple Or Single, with conditions on line 243.</p> <p>35221, Repair Blood Vessel, Direct; Intra-Abdominal, with 902, Injury To Blood Vessels Of Abdomen and Pelvis.</p> <p>Several pancreatectomy codes with 863.94, Injury of Pancreas. These codes currently only reside on cancer lines.</p>	<p>Delete code 5540 from Line 431.</p> <p>Add code 10060 to line 243, Peritonsilar Abscess.</p> <p>Add code 35221 to line 146, Crush Injuries: Trunk, Upper Limbs, Lower Limb Including Blood Vessels.</p> <p>Add codes 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154 to Line 10, Injury to Internal Organs.</p>

TOPIC	ACTION
<p><b>Technical Corrections (cont'd)</b></p> <p>61795, Stereotactic Computer Assisted Volumetric Procedure, Intracranial, Extracranial Or Spinal, with xxx on Line 166, Benign Cerebral Cysts. This is a new procedure that may not affect outcomes. More information required.</p> <p>62140, Cranioplasty for Skull Defect with 801.70, Open fracture of base of skull w/ hemorrhage.</p> <p>69000, Drainage External Ear, Abscess Or Hematoma; Simple, with conditions on line 492.</p> <p>97110 (therapeutic exercises) and 97112 (neuromuscular re-education of movement) with 882.2, Open Wound of Hand.</p> <p>97530 (dynamic activities to improve functional performance) &amp; 97535 (Self-care/home management training) with 882.2, Open Wound of Hand.</p> <p><u>Previously Discusses Issues</u></p> <p>83631, Lactoferrin, fecal, quantitative. This is a lab test that has no current utilization and is used to diagnose a condition that is uncovered.</p> <p>86395, Lipoprotein (a). This is a lab test for cholesterol that is not currently used but may become more greatly used in the future.</p> <p>83700, 83701, 83704, Lipoprotein, blood; Replaces old codes 83715 &amp; 83716. There is no current utilization of old codes.</p>	<p>Seek advise from a Neurosurgeon.</p> <p>Add code 62140 to line 51, Deformities Of Head And Compound/ Depressed Fractures Of Skull.</p> <p>Add code 69000 to line 492, Non-Malignant Otitis Externa. On the 2007-09 List, this will also be added to line 215, Superficial Abscesses and Cellulitis.</p> <p>Add codes 97110, 97112 to line 375, Deep Open Wounds.</p> <p>Add codes 97530 &amp; 97535 to lines 375, Deep Open Wounds, &amp; 593, Spinal Deformity, Not Clinically Significant.</p> <p>No action. Upheld previous decision to put this on Non-OHP Services List.</p> <p>Saha will study the systematic review and bring this issue back to the HOSC for further discussion.</p> <p>No action. Upheld previous decision to put this on Non-OHP Services List.</p>

TOPIC	ACTION
<p><b>Technical Corrections (cont'd)</b></p> <p>86480, TB blood test. The Health Division is advocating for this test to be used, though it is expensive. It may be used for those who have had prior exposure to TB, used as a confirmation after a positive PPD test or for those who may not come back for follow-up.</p> <p><u>Inappropriate Pairings: Straightforward:</u> S4989, Contraceptive Intrauterine Device. Suggested to delete from line 53, Birth Control as no other supply codes appear on list and should appear on in Ancillary Services list. Because of how devices currently appear, there is a potential for inappropriate billing for all devices, not just this particular one. Commissioners felt it was appropriate to keep this code on line 53.</p> <p><u>Non-pairings: Straightforward</u> 92002, 92004, 92012, 92014, ophthalmologic exams to with insulin dependent diabetes mellitus, herpes simplex and herpes zoster with ophthalmologic complications, and non-insulin dependent diabetes mellitus.</p> <p>92626, 92627, 92630, 92633, Auditory Rehab with sensorineural hearing loss.</p>	<p>Darren will contact the Health Division to present at the next meeting and to help develop appropriate guidelines for this test's use.</p> <p>No action. S4989 to remain on line 53. Other supply codes may be added to the list in the future.</p> <p>Add codes 92002, 92004, 92012, 92014 to lines 2, Type I Diabetes Mellitus, 203, Herpes Simplex and Herpes Zoster with Ophthalmologic Complications, and 311, Type II Diabetes Mellitus.</p> <p>Add codes 92626, 92627, 92630, 92633 to lines 300, Sensorineural Hearing Loss – Under Age five and 501, Sensorineural Hearing Lost – Age Five and Over.</p>
<p><b>Outstanding Issues 07-09 List</b></p> <p>Does 478.22, Parapharyngeal Abscess, need to be added to new DEEP ABSCESSSES line?</p> <p>Add cardiology medical codes to SLE, RA lines?</p>	<p>Add code 478.22 to new line 84, DEEP ABSCESSSES.</p> <p>No action, not necessary to add.</p>

TOPIC	ACTION
<p><b>Outstanding Issues 07-09 List (cont'd)</b></p> <p>Delete other codes of form 719.x on new list and add to signs &amp; symptoms list?</p> <p><i>719.0 - Effusion of Joint, 719.1 - Hemarthrosis (hydrarthrosis, swelling of joint), 719.2 - Villonodular Synovitis, 719.3 - Palindromic Rheumatism (Hench-Rosenberg syndrome, intermittent hydrarthrosis), 719.4 - Pain in Joint (arthralgia), 719.5 - Stiffness of Joint, 719.6 - Other Symptoms Referable to Joint (joint crepitus, snapping hip), 719.7 - Difficulty in Walking, 719.8 - Other Specified Disorders of Joint (calcification of joint, fistula of joint), 719.9 - Unspecified Disorder of Joint.</i></p> <p>Delete 389.03, Conductive Hearing Loss, Middle Ear, from new line 573, OPEN WOUND OF EAR/MEDICAL THERAPY, and new line 450, OPEN WOUND OF EAR/SURGERY?</p> <p>Add "WITH PROVEN EFFECTIVENESS" to the title of new line 3, PREVENTIVE SERVICES, BIRTH TO AGE 10? Discussion: That phase should be assumed for all lines on the list.</p> <p>Add missing hyphen on new line 84, DEEP ABSCESSSES?</p> <p>Move prophylactic breast removal from new line 3, PREVENTIVE SERVICES, BIRTH TO AGE 10, to line 4, PREVENTIVE SERVICES, AGE 10 AND OVER?</p>	<p>Delete all occurrences of codes 719.4, 719.5, 719.6, 719.7, 719.9 from new list and add to Signs and Symptoms list. All other codes should remain on list.</p> <p>Delete code 389.06 from new lines 573 and 450.</p> <p>Do no add to new line 3. Delete the phrase "WITH PROVEN EFFECTIVENESS" from new line 4, PREVENTIVE SERVICES, AGE 10 AND OVER WITH PROVEN EFFECTIVENESS.</p> <p>Add a hyphen on new line 84, changing "478.21478.24" to read "478.21-478.24."</p> <p>Delete code V50.41 from line 3 and add to line 4.</p>
<p><b>Bariatric Surgery Report from HRC</b></p> <p>Dr. Ruth Medak, chair of the Health Resources Commission (HRC) Obesity Management MedTAP, and Dr. Kathleen Weaver, HRC Director, presented the HRC's report on bariatric surgery.</p>	<p>The members acknowledged the financial implications to covering this condition and treatment, which are beyond the scope of this Commission. The HOSC will continue to study this topic and may want to form a subcommittee for further exploration.</p>

TOPIC	ACTION
<p><b>Bariatric Surgery Report from HRC (cont'd)</b></p> <p>The HRC evidence report is based on a recent systematic review by the Oregon Evidence-based Practice Center for PEBB and subsequent published literature, asking the following questions:</p> <ul style="list-style-type: none"> <li>• Does it work for sustained weight loss?</li> <li>• Does it reducing co-morbid conditions?</li> <li>• Does it reduce mortality?</li> <li>• What are the associated complications?</li> <li>• Cost effectiveness</li> </ul> <p>There are only a handful of old randomized trials, all using procedures no longer in use. Most of the evidence presented is observational which may have issues of selection-bias, meaning there is a chance that subjects are selected because they are better candidates for surgery. They stressed that when an effect is so dramatic, one must conclude the weight loss and co-morbidity reduction were due to the surgery, regardless if the patients were more motivated than the majority of the populace. The best case for the least complications is when surgeries are performed in a high volume center by a high volume surgeon. There is no evidence regarding cost effectiveness.</p>	
<p><b>Public Testimony</b></p> <p>Neal Gorrin MD, Oregon Bariatric Center; Bruce Wolfe MD, Professor of Surgery OHSU offered testimony regarding bariatric surgery, stressing the good results in reduction of co-morbid conditions, especially diabetes. Both stressed that complications are greatly reduced if the surgery is performed in a</p>	

TOPIC	ACTION
<p><b>Public Testimony (cont'd)</b></p> <p>high volume center by a high volume surgeon.</p> <p>Neal Gorrin MD, Oregon Bariatric Center; Bruce Wolfe MD, Professor of Surgery OHSU offered testimony regarding bariatric surgery, stressing the good results in reduction of co-morbid conditions, especially diabetes. Both stressed that complications are greatly reduced if the surgery is performed in a high volume center by a high volume surgeon.</p> <p>The members discussed how well the Medicaid population would do compared to the general population, given the pre-surgery counseling and therapy requirements and aftercare of the surgery, especially diet restrictions, vitamin supplements and need for follow-up appointments. There are many unanswered questions.</p> <p>Dr. Chris Kirk presented reaction from the OHP Medical Directors, who discussed this issue at their last meeting and were unanimously opposed to making bariatric surgery a funded service, citing selection criteria and other issues with the population served by Medicaid. He urged the HSC to start with a pilot project if it is decided to cover surgical treatment of obesity.</p>	

**MEETING HIGHLIGHTS  
HEALTH OUTCOMES SUBCOMMITTEE**

*Meridian Park Hospital Health Education Center, Room 117A  
Tualatin, OR  
December 8, 2006  
8:00 a.m. – 3:00 p.m.*

**Members Present:** Daniel Mangum, DO, Chair; Somnath Saha, MD, MPH; Kevin Olson, MD; Bryan Sohl, MD (via teleconference); Lisa Dodson, MD.

**Members Absent:** Kevin Olson, MD.

**Staff Present:** Darren Coffman; Kathleen Weaver, MD; Dorothy Allen.

**Also Attending:** Chris Kirk, MD, OHP Medical Directors; Wally Shaffer, MD, Isabel Bickle and Caroline Price, Division of Medical Assistance Programs (DMAP); Kerry Silvey, OHSU; Tina Kitchin, MD, and Sean Schafer, MD, Department of Human Services (DHS); Neal Gorrin, MD, Oregon Bariatric Center; Rebecca Sweatman, Public Employees Benefit Board; Devon O'Brien, Willamette Dental.

**Note:** The meeting was called to order at 8:10 am and adjourned 2:55 p.m. Next HOSC meeting is scheduled for Thursday January 25, 8:00-11:00 a.m. in Room 117B&C, Meridian Park Hospital, Community Health Education Center, Tualatin, Oregon.

TOPIC	ACTION
<p><b>Tuberculosis (TB) blood test –</b> Presented by Sean Schafer, MD, Medical Epidemiologist, HIV/STD/TB Program</p> <p>Dr. Schafer noted that current TB skin testing has poor inter-reader reliability, meaning if a test is on the cusp of the threshold between a positive and negative reading that the same test might be read as positive and negative by multiple readers. The skin test reads false positive if a patient has been vaccinated with CGB or been exposed multiple times, but who does not have the disease.</p> <p>The skin test requires a follow-up visit within 48-72 hours for a reading. Many patients do not return. Retesting and staff time adds to costs.</p>	

TOPIC	ACTION
<p>The Qanti-FERON TB Gold (QFT-G) blood test has been developed to test for latent tuberculosis and tuberculosis disease. The test is more accurate and does not require a return visit; however, it is more expensive.</p> <p><b>Benefits:</b></p> <ul style="list-style-type: none"> <li>• Patients do not need to return for readings or additional testing.</li> <li>• There is a hope that the test will be more reasonably priced with automation of laboratories.</li> <li>• Fewer false positives reducing unnecessary costly treatments.</li> <li>• Helpful to quickly (less than 24 hours) diagnose confirmed contacts of those infected for public health interventions.</li> </ul> <p><b>Test Costs:</b>  Skin test: \$9.79  QFT-G: \$30.00</p> <p>Isabel Bickle mentioned that DMAP's reimbursement rate may differ.</p> <p><b><i>Interim Modifications:</i></b></p> <p>Discussed were:</p> <ol style="list-style-type: none"> <li>1) <u>Misc. Technical Corrections</u> <ol style="list-style-type: none"> <li>a) Lipoprotein(a) test</li> <li>b) DMAP items</li> <li>c) MHCD Subcommittee recommendations <ol style="list-style-type: none"> <li>i) Additional HCPCS code pairings</li> <li>ii) Health &amp; behavioral assessment/intervention (96150-96155)</li> </ol> </li> </ol> </li> </ol>	<p>Recommend to the HSC adoption of the following guideline and to place the test on line zero.</p> <p><i>QFT-G may be used in the following circumstances:</i></p> <ol style="list-style-type: none"> <li>1. <i>Instead of Tuberculin Skin Test (TST) for investigation of contacts to confirmed cases of active TB disease.</i></li> <li>2. <i>Instead of TST for screening for latent TB in persons with definitive history or Bacillus Calmette-Guérin (BCG) or who have immigrated from countries with high prevalence (&gt;10%) of latent TB where BCG is commonly given.</i></li> <li>3. <i>As a supplementary test to TST in foreign-born persons with a positive TST, history of BCG vaccination against tuberculosis, and no clinical evidence of current TB disease.</i></li> <li>4. <i>As a supplementary test in persons with a positive TST who are members of otherwise low-risk populations (e.g., U.S.-born persons and others who have immigrated to the U.S. &gt; 5 years previously or more recently from low TB prevalence countries; absence of immunosuppressive conditions such as HIV infection, renal failure, diabetes mellitus or alcoholism; homelessness or incarceration; known exposure to someone with active TB), and no clinical evidence of current TB disease.</i></li> <li>5. <i>In populations that need rapid (within 24 hours) diagnosis in order to guide appropriate public health interventions such as isolation for infectious tuberculosis or contact evaluation.</i></li> <li>6. <i>In a high-risk patient (e.g. homelessness, immune suppression or deficiency, recent immigrant) who the treating clinician believes is unlikely to return on time for the TST reading.</i></li> </ol>



TOPIC	ACTION
<p>The members discussed potential parameters of starting with a pilot program for bariatric surgery in morbidly obese individuals who also have type II diabetes.</p> <p>PEBB representative Rebecca Sweatman shared a few of their guidelines:</p> <ul style="list-style-type: none"> <li>• Performed only in Centers of Excellence</li> <li>• BMI of 35 with significant co-morbidity, 40 without co-morbidity</li> <li>• Pre-screening of patients including a 5% weight loss over 6 month period</li> <li>• Non-smoker</li> </ul> <p>She will provide the full guideline to the members for review.</p> <p>Outcomes for this procedure are best when the surgery is performed in a high volume center by a high volume surgeon.</p> <p>Coffman added that the actuaries would price bariatric surgery separately if it is moved above line 503 in the 2007-09 list.</p> <p>Should only gastric by-pass be covered or should lap-band be considered? Discussion included lower complications rates for banding vs. additional patient follow-up, and to not restricting the surgeon's choice about what is best for the patient.</p>	<p>Discussion will continue at the next meeting. Representatives from the bariatric departments of Legacy and OHSU will be invited.</p>