

**MEETING HIGHLIGHTS  
HEALTH OUTCOMES SUBCOMMITTEE**

*Meridian Park Hospital Health Education Center, Room 117A  
Tualatin, OR  
January 25, 2007  
8:00 a.m. – 11:00 a.m.*

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

**Members Absent:** Somnath Saha, MD, MPH.

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

**Also Attending:** Bruce Wolfe MD and Ariel Smits, MD, OHSU; Chris Kirk, MD, OHP Medical Directors; Wally Shaffer, MD, and Caroline Price, Division of Medical Assistance Programs (DMAP); Neal Gorrin, MD and Shannon Surber, Peace Health.

**Note:** The meeting was called to order at 8:10 am and adjourned 11:15 a.m. Next HOSC meeting was scheduled for Thursday April 26, 2007, and later rescheduled for Thursday, May 3, 2007, 8:30 - 11:30 am, Clackamas Community College, Wilsonville Training Center, 29353 SW Town Center Loop E, Room 111, Wilsonville, Oregon.

TOPIC	ACTION
<p><b>Continued Discussion on Bariatric Surgery</b></p> <p><u>Review of Previous Discussions</u></p> <p>Dr. Mangum started the discussion by stating that, in general, all of the testimony the subcommittee has heard has been positive.</p> <p><u>Testimony and discussion of outstanding issues</u></p> <p>Dr. Bruce Wolf, OHSU, recapped the previous testimony on bariatric surgery, including the efficacy of resolving certain co-morbid conditions such as type II diabetes.</p>	

TOPIC	ACTION
<p><b>Continued Discussion on Bariatric Surgery</b></p> <p><u>Testimony and discussion of outstanding issues (Cont'd)</u></p> <p>Dr. Chris Kirk reaffirmed the OHP Medical Directors opposition with covering bariatric surgery. A major concern was the cost, and the possibility that the Centers of Excellence might not accept Medicaid rates. Dr. Olson pointed out that contracting is beyond the scope of this commission.</p> <p>The group discussed whether this procedure would reduce costs. Dr. Wolfe added that there have been no complete studies as yet because the research community has not reached consensus on the criteria.</p> <p>Dr. Bryan Sohl asked if there should be more specific standards regarding co-morbid conditions. For example, would anyone with type II diabetes qualify or should there be a requirement of receiving pharmaceutical treatment. This would exclude patients with a diagnosis of pre-diabetes.</p> <p>Dr. Lisa Dodson asked about the capacity of the Centers of Excellence for OHP patients. Without speaking to administration or contracting issues, Dr. Wolfe and Dr. Neal Gorrin estimate their centers being able to help 50 OHP patients per year.</p> <p>Dr. Wally Shafer informed the members that this may be possible to run a DMAP pilot program on the fee- for service side of OHP to establish data.</p>	



TOPIC	ACTION
<p><b>Continued Discussion on Bariatric Surgery (Cont'd)</b></p> <p><u>Other patient selection criteria</u></p> <p>Should the commission set criteria or should that default to the Centers of Excellence criteria?</p> <p>The commission reviewed the HRC's recommendations.</p>	<p>Use the HRC patient selection criteria, with the following revisions:</p> <ul style="list-style-type: none"> <li>• Enrollment in a bariatric surgery program for six months, referral from OHP primary care physician.</li> <li>• No alcohol, tobacco or illegal drug abuse or dependence, with testing at 5 months</li> <li>• Only for BMI ≥ 35 with type II diabetes</li> </ul>
<p><b>Development of recommendation to HSC</b></p> <p>Accept the HRC's recommendations with editing to change co-morbidity, enrollment standards, wait time and other items.</p> <p>Make coding changes to the 2008-09 Prioritized List as necessary.</p>	<p>See Attachment A of the HSC January 25, 2007 minutes for the final recommended bariatric surgery guideline and Attachment B for the recommended coding and other changes to the obesity lines on new list.</p> <p>Add revision codes (43772-43774, 43848) to complications lines (lines 307 and 441) on new list.</p> <p>The guideline for line 8 (non-surgical treatment of obesity) will be deferred for further discussion until able to review HRC report on topic.</p>
<p><b>DMAP Issues</b></p> <p>Were not discussed.</p>	<p>Will be addressed at next meeting.</p>

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

Clackamas Community College  
Wilsonville Training Center, Room 111  
Wilsonville, OR  
May 3, 2007  
8:30-11:30

**Members Present:** Som Saha, MD, Chair; Bryan Sohl, MD; Lisa Dodson, MD; Kevin Olson MD; Daniel Mangum, MD

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

**Also Attending:** Kathy Weaver, MD, HRC Medical Director; Chris Kirk MD, OHP Medical Directors; Wally Shaffer MD, DMAP; Caroline Price RN, DMAP; Bruce Wolfe, MD, OHSU

*Note: Adjourned 12:10 PM. Next HOSC meeting is scheduled for Thursday, June 28<sup>th</sup>, 2007.*

<b>Topic</b>	<b>Action Recommended</b>
<p><b>General</b>  Minutes from 1/07 HOSC meeting reviewed and approved.  The committee expressed their appreciation for tabs in the meeting materials and encouraged their future use.</p>	<p>Minutes approved  Will continue tab usage</p>
<p><b>V Codes</b>  Coffman introduced a table of V codes currently being used by Samaritan health system which are not all being covered by OHP. Many V codes are used as first or first and additional diagnoses and should be on the list. Discussion was held about the need to correlate with what V codes are currently on the list and to determine which codes need to be added and where they should be placed. Coffman stated that Allison Little had done initial work on this topic prior to leaving as Medical Director. Smits pointed out that many V codes were already on the list. Saha stated that all V codes included in guidelines such as USPSTF should be on the list. Saha indicated there are codes that have no underlying diagnosis which should be on the list. The group decided to investigate which codes are currently on the list and those which need to be added, and bring this information for discussion to the June meeting.</p>	<p>Review V codes already on list; review additional V codes that should be added; create list of V codes to add or to discuss for June HOSC meeting. Responsible: Smits</p>

<b>Topic</b>	<b>Action Recommended</b>
<p><b>Unspecified Otitis Media</b>  Code for unspecified suppurative otitis media (382.4) is only on line 421 while the code for unspecified otitis media (382.9) is on the acute otitis media (line 421) and on the chronic otitis media line (530). Discussion was held about the most appropriate line for these non-specific codes. Saha felt that chronic OM has limited evidence for treatment and argued that both codes should be taken off chronic line. Kirk stated that most providers don't use this code and such a change likely won't affect billing. Philosophically, the group felt that no X.9 code should be on list. The group agreed to keep these codes on the acute otitis media line and remove from the chronic otitis media line.</p>	Delete from chronic otitis media line 530: 382.9 (unspecified otitis media)
<p><b>Comfort Care</b>  Coffman introduced a DMAP concern that if patient with a diagnosis giving him or her &lt;5% 5 year survival has &gt;6 months to live, he or she is being denied coverage for palliative care services such as wheelchairs. Saha pointed out that people who have &gt;5% survival are getting covered for these services. Coffman suggested adding wording to the &lt;5% 5 year survival line indicating that the Committee's intent was that comfort care should be covered regardless of life expectancy. Discussion included the importance of limiting coverage to comfort care (symptom modification or management), not care aimed at cure or disease modification. Saha stressed that the intent is not to cover intensive, long shot, nearly universally unsuccessful intent to cure treatment, put symptoms such as pain. Olson pointed out that some intensive treatments can really improve quality of life. Shaffer pointed out that it is beyond the scope of the committee to determine what is comfort care in particular situations. Prior authorization process can determine what is comfort care. Kirk suggested bringing this issue to the medical directors for discussion to make sure we are not covering futile care. Saha agreed, pointing out that discussion of how plans will handle comfort and futile care is an important discussion and information from the health plans would be helpful. Olson pointed out that we need to ensure that comfort care applies to more than cancer diagnoses. Olson and Kirk indicated that hospice care is not the issue as hospice payment is covered from a separate fund. Agreement was reached to add language to express intent to cover comfort care for terminal patients with &gt;6 months to live to the guideline for comfort care.</p>	Add "there is no intent to limit comfort care services according to the expected length of life (e.g. 6 months) for the patient with terminal illness" to guideline for line 262

<b>Topic</b>	<b>Action Recommended</b>
<p><b>Cleft palate repair</b>  Smits read a letter from ENT in Boise regarding CPT codes allowed palatoplasty for cleft palate repair with needed additional muscle flaps for soft palate movement. Recommended adding 15732 to lines 110 and 377 (cleft palate repair). Smits summarized the literature which shows that 25-30% of children require repeat surgery with older techniques while only 5-10% require repeat surgery with newer technique involving muscle flaps. The savings from avoidance of a second surgery would outway the costs of paying for the additional procedure. Email from Dr. Anna Kuang (reconstructive surgeon, OHSU) was read indicating that this newer technique is standard of care. Velopharyngeal insufficiency requiring the second surgery is a covered diagnosis on line 98. The committee felt that avoidance of a covered condition was a worthy goal and recommended payment of the more complex procedure.</p>	<p>Add to line 110 (CLEFT PALATE WITH AIRWAY OBSTRUCTION) and line 377 (CLEFT LIP/PALATE):  15732 Muscle flap pharyngoplasty</p>
<p><b>Croup</b>  OMAP has requested that CPT code 94640 (pressurized or non-pressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes) be paired with ICD9 464.4 croup. Severe cases of croup are treated with racemic epinephrine nebulizer treatments. This CPT code combines both acute airway obstruction, as well as sputum induction for diagnostic reasons. This CPT code does not include induced sputum for TB testing (87556, 87117, 87206).</p>	<p>Add to croup line 16:  94640 - Inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes</p>
<p><b>Non-surgical treatment of obesity</b>  Weaver presented background information for the non-surgical treatment of obesity and discussed the draft HRC report. Weaver informed the group that the HRC obesity subcommittee meetings on 5/24 and the full HRC meets on 6/15 to discuss this report.</p>	<p>Discuss HRC recommendations when final report available.</p>
<p><b>Bariatric surgery guidelines</b>  Smits discussed the recommendations of the medical directors work group which has reviewed the bariatric surgery guidelines. She presented information from other state Medicaid programs which covered bariatric surgery.</p> <p>The medical directors are concerned about the possible limitations of service with the requirement that Medicare Centers of Excellence only be authorized to provide this service. Saha stated that he was comfortable covering only Centers of Excellence as a pilot study. Olson pointed out that the guidelines do not limit by geography, only by expertise. Coffman pointed out that the requirement effectively limits by geography. Patients may get surgery, but may not be able to get appropriate follow up care</p>	<p>Change part 3a. of bariatric surgery guideline to read:  “No current of abuse or dependence of alcohol. Must remain free of abuse of or dependence on alcohol during a six-month observation period immediately preceding surgery. No current use of nicotine or illicit drugs and must remain abstinent from their use during the six-month observation period. Testing will be conducted within one</p>

<b>Topic</b>	<b>Action Recommended</b>
<p data-bbox="201 235 711 268"><b>Bariatric surgery guidelines (Cont'd)</b></p> <p data-bbox="201 273 1024 415">Smits discussed the recommendations of the medical directors work group which has reviewed the bariatric surgery guidelines. She presented information from other state Medicaid programs which covered bariatric surgery.</p> <p data-bbox="201 457 1062 1619">The medical directors are concerned about the possible limitations of service with the requirement that Medicare Centers of Excellence only be authorized to provide this service. Saha stated that he was comfortable covering only Centers of Excellence as a pilot study. Olson pointed out that the guidelines do not limit by geography, only by expertise. Coffman pointed out that the requirement effectively limits by geography. Patients may get surgery, but may not be able to get appropriate follow up care which would worsen outcomes. Wolf stated that present guidelines will limit access to pts who are in Portland area. He informed the committee that the American College of Surgeons is trying to get CMS to recognize a Level 2 certification which is less stringent. An AHRQ report issued 1/07 showed significant reduction in mortality from surgery, best explained by superior outcomes from high volume centers. There are places in Oregon which would reach Level 2 criteria that don't qualify for Level 1. Level 2 centers would also collect outcomes data like Level 1 centers. Shaffer: pointed out that OMAP could require outcomes information and accredit these level 2 centers. Dodson stated that one center in Eugene will likely be approved by time first surgery under this guideline could be approved. However, a huge chunk of state will never have good access no matter what. Weaver stated that PEBB uses centers in Eugene and Bend and will report on outcomes. Wolf pointed out that private insurance either does not cover this service or limits sites. Shaffer stated that no consensus existed from the medical director's workgroup. COE could be acceptable, but makes significant problems for the health plans such as transportation issues (pre, surgery and post), coverage of complications. Olson stated that the guideline could change if these issues really were found to exist after implementation. The group unanimously agreed to keep COE requirement in the guideline.</p> <p data-bbox="201 1661 1052 1871">The group then discussed the provision that lack of tobacco use be a requirement. Wolfe stated that the OHSU program does not require patients to not smoke, but tries to get pts to quit. Olson expressed concern that testing for nicotine use would detect the nicotine from replacement patches. Saha argued that the committee should keep in the requirement to not smoke, but not</p>	<p data-bbox="1084 235 1205 268"><b>(Cont'd)</b></p> <p data-bbox="1084 273 1422 373">month of the surgery to confirm abstinence from nicotine and illicit drugs.”</p>

<b>Topic</b>	<b>Action Recommended</b>
<p><b>Bariatric surgery guidelines (Cont'd)</b>  require urine cotinine checking. Mangum argued that not checking urine levels makes the physician dependent on self report. The committee agreed uniformly in favor of keeping tobacco cessation in the guideline and 3:2 to require testing.</p> <p>The committee discussed changing the wording of drug/tobacco abstinence to specify abstinence from tobacco and illicit drugs, and allow moderate alcohol use. Testing for excessive alcohol use was considered impractical.</p> <p>The weight loss requirement in the guidelines was discussed. Coffman indicated that the guidelines needed to be more explicit. Saha felt that there should be no mandate about specific amount of weight loss, but that there should be a documented 6 month attempt of supervised weight loss at some point. Wolf pointed out that the dietician evaluation was used in his program to detect patients with little or no prior attempts to lose weight, which was more effective than chart notes. Saha asked can the committee incorporate into dietician bullet: "if inadequate, pts should be prescribed a 6 month medically supervised wt loss." Weaver argued that we don't pay for this and such a requirement could affect access. The group decided to keep this requirement in the guideline.</p>	
<p><b>Fluoride treatment</b>  DMAP asked for clarification of the ICD9 codes regarding fluoride treatment. The same code covers treatment for fluoridosis, which is a cosmetic service, and treatment for enamel opacities, which can lead to tooth decay. Shaffer stated that fluoride varnish for enamel opacities is done in PCPs offices and should be covered as a preventive service. The committee agreed, but stressed that the intent of the committee was coverage for non cosmetic purposes.</p>	Add to line 298 (preventive dental services): 520.3 (mottled teeth).
<p><b>Pelvic ring fracture</b>  Pelvic ring fracture is not paired with surgery for repair of same. Committee agreed to pair.</p>	Add to line 474 (surgical repair of pelvic fracture): 805.6 (sacral fracture)
<p><b>Chronic mesenteric ischemia</b>  Should pair with 35471 (balloon angioplasty) and 37205 (intravascular stent). Commission agreed.</p>	Add to line 293 paired with 557.1 (chronic mesenteric ischemia): 35471 (percutaneous transluminal balloon angioplasty, renal or visceral artery) and 37205 (transcatheter placement of intravascular stent)

<b>Topic</b>	<b>Action Recommended</b>
<p><b>Routine pairings</b>  Email from Price from 1/16/07 was reviewed. Suggested pairings:  -721.42 (lumbar spondylosis with myelopathy) with 97530 (therapeutic activities, 15 min) and 97535 (self care/home management training) on line 324 (spinal deformities, clinically significant).  -883.2 (open wound of finger(s) with tendon involvement) and 881.20 (open wound of elbow, forearm, and wrist with tendon involvement) with 97110 (therapeutic procedure, 15 min) on line 375 (deep open wound).  -540.1 (acute appendicitis with peritoneal abscess) on line 12 (appendicitis) with 99231, 99232, 99233 (in hospital aftercare).  -146.0 (malignant neoplasm of oropharynx-tonsil) with 21557 (radical dissection of tumor) on line 234 (cancer of oral cavity).  -161.1 (malignant neoplasm of larynx-supraglottis) with 21555 (excision of tumor) and 60220 (total thyroid lobectomy) on line 234 (cancer of oral cavity)  -871.3 (open wound of eyeball) with 65101 (enucleation of eye) on line 396 (purulent endophthalmitis)  -Remove from line 234 (cancer of oral cavity): 20955, 20956, 20957 (bone graphs to low extremity areas)</p>	<p>All pairings approved.</p>
<p><b>Lymphedema</b>  Letter from a lymphedema advocate was presented arguing that treatment of lymphedema should be covered as it can prevent cellulites and save cost. Olson argued that lymphedema is seen less often now with better surgical techniques. Also, lymphedema has different grades which affect treatment and complications. Treatment is generally done by pt at home with massage and wraps. Many therapists cover even when not paid, but some centers are stopping coverage. Cellulitis is not frequent and most who do get cellulites are treated with oral antibiotics. Discussion about moving lymphedema further up the list, covering more severe forms, and looking at research regarding effectiveness of treatment, complication rates, etc.</p>	<p>Smits will do research on the treatments and complications of lymphedema for the June HOSC meeting.</p>
<p><b>Central pain syndrome</b>  Currently central pain syndrome (ICD9 338.0) is currently on the never covered list. OHP Medical Directors has asked that this diagnosis be placed on the stroke line (line 284). Central pain syndrome is a neurological condition caused by damage to the CNS by stroke, trauma, etc. which is treated with opioids, tricyclics, or neurontin. The group noted that this diagnosis has been previously considered for inclusion on the list. No objections were raised.</p>	<p>Add ICD-9 code 338.0 central pain syndrome to the stroke line 284</p>

<b>Topic</b>	<b>Action Recommended</b>
<p><b>Percutaneous vertebroplasty</b>  Smits presented new research on percutaneous vertebroplasty showing significant improvement in short term (1 day to 6 weeks) pain, narcotic use and function. However, at 3 months and later, no differences in outcomes were seen between vertebroplasty and conservative management. Olson stated that he used this procedure a lot for malignant fractures and found it very effective for pain. Pointed out that narcotics can be problematic for the elderly. This procedure can make difference in living independently or not and the evidence shows dramatic short term effects. Saha pointed out that to take something off the list, need evidence of lack of benefit, not just insufficient evidence. Olson asked if we should add a guideline? Saha suggested having DMAP figure out if this procedure is being used/abused, what it is being used for, and then consider a guideline. Shaffer suggested that he or Smits should check for other guidelines for use (Medicare, etc) that might exist. Saha recommended putting the CPT code put on 112 (vertebral fx) and take off other lines.</p>	Remove from lines 140 (DISORDERS OF SPINE WITH NEUROLOGIC IMPAIRMENT), 324 (SPINAL DEFORMITY, CLINICALLY SIG) and 593 (SPINAL DEFORMITY, NOT CLINICALLY SIG) and add to line 112 (vertebral fractures): 22520 Percutaneous vertebroplasty, one vertebral body, thoracic; 22521 Percutaneous vertebroplasty, one vertebral body, lumbar; 22522Percutaneous vertebroplasty, one vertebral body, each additional thoracic or lumbar vertebral body
<p><b>Capsule endoscopy</b>  See document</p>	Tabled to June meeting
<p><b>Ventricular Assist Device</b>  VADs are possibly being used at home. The HSC has previously approved VAD for bridge therapy for cardiac transplant. VADs are being used for CHF treatment. As the HSC had previously indicated their intent to only cover VAD for bridge therapy for transplant, the question was raised whether guideline #10 should be added to line 154 CHF treated with cardiac transplant? HOSC minutes from 4/25/05 were reviewed which indicated that the following guideline should be added to Line 172 (Heart Failure): “Ventricular Assist Devices are only included on this line as a bridge to cardiac transplantation.” Saha noted that VAD could be used as an outpatient, as long as the intent is a bridge to transplant. This guideline does not indicate that the patient needs to be in the hospital for VAD treatment.</p>	Add VAD guideline #10 to Line 154.
<p><b>Cochlear stimulator</b>  The BAHA is a bone anchored hearing aid, usually used for patients with no ear canal. The CPT code for its use is on the cochlear implant line, and should be moved to the hearing aid line.</p>	Place CPT codes 69714 and 69715 on lines 299 and 499; delete from lines 300 and 501
<p><b>Tunneled catheter</b>  Removal of tunneled catheters is only on Line 145, “complications of a treatment always requiring treatment.” Some central line removal is not due to complications, but to end of required treatment, etc. These removals are being denied.</p>	Place CPT codes 36589 and 36590 to ancillary services list from line 145

<b>Topic</b>	<b>Action Recommended</b>
<p><b>Chronic anemia codes</b> Chronic anemia codes are on line 171 (relapsing fever) and should be on line 170 (anemia)</p>	<p>Add to line 170 and remove from line 171: 285.21 - Anemia in chronic kidney disease 285.22 - Anemia in neoplastic disease 285.29 - Anemia of other chronic disease</p>
<p><b>Skin graft for urinary anomalies</b> Remove skin grafts to sites other than trunk, legs, or genitals from line for surgical repair of congenital urinary anomalies (99)</p>	<p>Remove CPT codes from line 99: 15576 - Formation of skin flap transferred to eyelid, nose, ears, lips, intraoral areas; 15630 - Delayed flap to those sites to eyelid, nose, ears, lips, intraoral areas; 15732 - Skin flap to head or neck; 15734 - Skin flap to upper extremity</p>
<p><b>Tendon repair/ foot wound</b> Add 28208 (repair tendon, foot) with line 375, paired with 892.2: open wound of foot with tendon involvement</p>	<p>Add CPT code to line 375: 28208 - Repair of tendon of foot, extensor</p>
<p><b>Intrathecal pump codes</b> Codes for intrathecal pump insertion and maintenance (7 total) are all on 6 lines, but only some are on 5 lines. The decision was made to put all codes pertaining to intrathecal pumps on all lines that have some of these codes.</p>	<p>Add to lines 140 and 216: 62360 - Implantation of intrathecal pump; 62361 - Implantation of intrathecal non-reprogrammable pump</p> <p>Add to line 216: 62362 - Implantation of intrathecal programmable pump</p> <p>Add to line 216, 333, 574, and 578: 62367 - Electronic analysis of intrathecal pump; 62368 - Electronic analysis of intrathecal pump with reprogramming</p> <p>Add to line 333: 95990 - Refilling and maintenance of intrathecal pump; 95991 - Refilling and maintenance of intrathecal pump administered by a physician</p>

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8:00-11:30 am

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

**Members Absent:** Dan Mangum, DO

**Staff Present:** Darren Coffman; Ariel Smits, MD, MPH; Nathan Hierlmaier, MPH

**Also Attending:** David Pass, MD, HRC Medical Director; Chris Kirk MD, OHP Medical Directors; Wally Shaffer MD, Caroline Price RN, and Celeste Symonette RN, DMAP.

*Note: Adjourned at 11:50 AM. Next HOSC meeting is scheduled for Thursday, August 23rd, 2007.*

<b>Topic</b>	<b>Action</b>
<p><b>General</b>  Minutes from 5/07 HOSC meeting reviewed. Saha corrected the section dealing with the bariatric surgery guideline referring to tobacco use to read “to require testing” rather than “not to require testing” for nicotine. Corrected minutes approved.</p> <p>Meeting packets: Smits and Coffman offered various suggestions for meeting packet contents. After discussion, the HOSC opted to have issue summaries +/- paper abstracts sent out as one PDF to members with a separate PDF with all background materials to be emailed to members. Only the former document will be distributed at the meeting in hardcopy format and posted on the HSC website.</p>	<p>Minutes approved with correction</p> <p>HSC staff will provide meeting materials to commission members before the August meeting in the manner requested.</p>
<p><b>Treatments for pseudotumor cerebri/benign intracranial hypertension</b>  Smits reviewed a letter from Drs. Egan and Falardeau, OHSU Neuro-Ophthalmology, requesting coverage for effective treatments of pseudotumor cerebri. Pseudotumor cerebri/benign intracranial hypertension (348.2) is on line 701 INTRACRANIAL CONDITIONS WITH NO EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY and on line 86 ENCEPHALOCELE; CONGENITAL HYDROCEPHALUS with shunt placement as treatment. However, effective treatments</p>	<ol style="list-style-type: none"> <li>1) Delete 348.2 from line 701</li> <li>2) Rename line 86 “Encephalocele, <del>congenital</del> hydrocephalus, and benign intracranial hypertension”</li> <li>3) Change treatment description for line 86 to “<u>Medical and surgical treatment</u>”</li> <li>4) Add the following CPT codes to line 86: <u>31294, 62270, 67570, 92002, 92004, 92012, 92014, 92081, 92082, 92083, 92250</u></li> </ol>

Topic	Action
<p><b>Treatments for pseudotumor cerebri/benign intracranial hypertension (cont'd)</b> other than shunt placement exist for this condition.</p> <p>The group discussed whether visual field testing should be placed on the diagnostic line or on appropriate lines on the list. Saha pointed out that placing this code on the diagnostic line would only allow coverage for 1-2 visits, while this testing may need to be done several times to monitor therapeutic response to treatment. Unanimous vote to approve recommendation with visual field testing on the line.</p>	
<p><b>Spinal codes</b> Smits presented recommendations for adding and deleting CPT codes relating to spinal surgery from certain lines. Input for these recommendations was obtained from Dr. Nemecek and his coder at OHSU Neurosurgery. No new CPT codes were added; codes were simply added for completeness to lines containing some codes. Codes were removed from inappropriate lines.</p>	<p>Recommendations accepted as outlined on page 80 of the meeting materials (<a href="#">click here</a>).</p>
<p><b>Wound debridement/cesarean post-op debridement</b> Smits reviewed a letter from a provider regarding coverage of complications of surgical obstetrical wounds. Wound debridement is frequently used to treat Disruption of operation wound (998.3), Postoperative infection (998.5), and Non-healing surgical wound (998.83), which appear on lines 145 (COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT) and 296 (COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT). The CPT codes for wound debridement (11040-11044) do not appear on these lines. ICD-9 codes for complications of obstetrical surgical wounds [674.1 (Disruption of cesarean wound), 674.3 (other complications of obstetrical surgical wounds)] appear on line 54: PREGNANCY. Cesarean wound complications can't be coded with 998.83 (non-healing surgical wound) in the 6 week post-partum period. However, the CPT codes for wound debridement, 11040-11044, do not appear on Line 54; therefore debridement of c/s wounds is not covered during this 6 week interval.</p> <p>Saha pointed out that adding wound care codes to the maternity care line would pair many conditions with these codes. He felt it was most appropriate to add the ICD-9 codes for cesarean wounds to the line for complications of procedures always requiring treatment.</p>	<ol style="list-style-type: none"> <li>1) Add CPT codes 11040-11044 to lines 145 and 296</li> <li>2) <del>Add 11040-11044 to Line 54</del></li> <li>3) Add 674.1 and 674.3 to line 145</li> <li>4) Remove 674.1 and 674.3 from line 54</li> </ol>

Topic	Action
<p><b>Surgical treatment of pancreatitis</b> Smits presented recommendations for adding surgical codes for placement of pancreatic drains to the acute pancreatitis lines and removal of such codes from inappropriate lines. There was no discussion.</p>	<p>1) Add 48000, 48001, 48020, 48120 to line 330 2) Change name of line 330 to “Medical and Surgical Treatment” 3) Delete 48000 from line 77, 48105 from line 326, 48000 from line 671 4) Add 48020 and 48120 to line 671 5) Add 48000 to line 257</p>
<p><b>Surgical treatment of secondary hyperparathyroidism</b> Smits presented recommendations for moving secondary hyperparathyroidism of renal origin (588.81) from line 247 (Renal disorders), which has only CPT codes that are dialysis-related and medical management, to line 440 (Hyperparathyroidism), which has all types of management of this disease. Additionally, Smits recommended adding 60500 (Parathyroidectomy) to line 274 (Endocrine cancers) and deleting 60512 (Parathyroid autotransplantation) from line 319 (Medical therapy of hypothyroidism). There was no discussion.</p>	<p>1) Add 588.81 to line 440 2) Delete 588.81 from line 247 3) Add 60500 to line 274 4) Delete 60512 from line 319</p>
<p><b>Capsule endoscopy</b> Smits presented a summary of the research regarding wireless capsule endoscopy (WCE). Good evidence was found for use in diagnosis of obscure GI bleeding thought to be of GI origin and of Crohn’s disease, when upper and lower endoscopy have not yielded a diagnosis. Lack of evidence was found for use in colon cancer screening or diagnosis of esophageal conditions. Smits presented a recommendation to add WCE to lines 194 and 293 with a guideline. The HOSC agreed with adding this service to these lines, but altered the guideline to not exclude patients based on a history of abdominal surgery or radiation. The subcommittee instead elected to require radiological evidence of lack of stricture as a requirement to use of the capsule. The guideline was accepted with this change.</p> <p>Coffman brought up coverage of 91111 (esophageal procedure). Smits reviewed that the evidence regarding its use was mostly negative. The subcommittee voted to not cover this procedure.</p>	<p>Add 91110 to lines 194 [ULCERS, GI HEMORRHAGE; SURGICAL TREATMENT] and 293 [REGIONAL ENTERITIS, IDIOPATHIC PROCTOCOLITIS, ULCERATION OF INTESTINE; MEDICAL AND SURGICAL TREATMENT] with the following guideline:</p> <p>1) Wireless capsule endoscopy is covered for diagnosis of</p> <ul style="list-style-type: none"> <li>a. Obscure GI bleeding suspected to be of small bowel origin with iron deficiency anemia or documented GI blood loss</li> <li>b. Suspected Crohn’s disease with prior negative work up</li> </ul> <p>2) Wireless capsule endoscopy is not covered for</p> <ul style="list-style-type: none"> <li>a. Colorectal cancer screening</li> <li>b. Confirmation of lesions of pathology normally within the reach of upper or lower endoscopes (lesions proximal to the ligament of Treitz or distal to the ileum)</li> </ul>

Topic	Action
<p><b>Capsule endoscopy (cont'd)</b></p>	<p>c. Wireless capsule endoscopy is covered only when the following conditions have been met:</p> <ul style="list-style-type: none"> <li>i. Prior studies must have been performed and been non-diagnostic</li> <li>ii. GI bleeding: Upper and lower endoscopy</li> <li>iii. Suspected Crohn's disease: Upper and lower endoscopy, small bowel follow through</li> <li>iv. Radiological evidence of lack of stricture</li> <li>v. Only covered once during any episode of illness</li> <li>vi. FDA approved devices must be used</li> <li>vii. Patency capsule should not be used prior to procedure</li> </ul> <p>Add 91111 [Esophageal use of wireless capsule endoscopy] to never covered list.</p>
<p><b>Bariatric surgery guideline changes</b>  Smits presented changes to the wording of the bariatric surgery guideline based on discussion from the May meeting. Alcohol and nicotine use wording changes were approved with no discussion. The subcommittee discussed the provision for requiring a measure of adequacy of prior weight loss attempts. The decision was made to put evaluation of these attempts into the dietician evaluation and then allow the expertise of the bariatric surgery program to define what is adequacy of weight loss attempts. Dodson raised concerns that coverage of treatments for weight loss is not currently on the list. Saha stated that the new list will cover non-surgical treatments of obesity, which will be decided at the HSC meeting.</p>	<p>Guideline approved with changes:</p> <p>D. Dietician evaluation: (Conducted by licensed dietician)</p> <ul style="list-style-type: none"> <li>i. Evaluation of adequacy of prior dietary efforts to lose weight. <i>If no or inadequate prior dietary effort to lose weight, must undergo 6 month medically supervised weight reduction program.</i></li> <li>ii. Counseling in dietary lifestyle changes</li> </ul> <p>4. Participate in additional evaluations: (<del>Conducted after completion of medically supervised weight reduction program</del>)</p>
<p><b>Comfort care wording changes</b>  Saha reviewed the previous discussion on comfort care from the May 2007 HOSC meeting. Olson approved of the wording change prohibiting treatment to "alter disease progression".</p>	<p>Smits, Shaffer, Coffman, interested medical directors to work on solution and bring back to August meeting.</p> <p>Smits to bring to the Medical Directors meeting in July.</p>

Topic	Action
<p><b>Comfort care wording changes (cont'd)</b></p> <p>Shaffer reviewed his email suggestion to eliminate line 674 [Treatment of conditions with &lt;5% 5 year expected survival] and add comfort care to all appropriate lines on the prioritized list. Saha pointed out that the comfort care ICD-9 code is a secondary code only, which would be problematic. The Commission would need to put the comfort care guideline on all appropriate lines. Saha pointed out that line 674 does not include non-cancer condition ICD-9 codes. Olson pointed out that cancer lines already have the 5% rule on them. Saha asked what stops people from giving chemotherapy or other treatments for cancer with a &lt;5% 5 year survival by coding for the cancer diagnosis which exists on higher lines for patients with &gt;5% 5 year survival. How do you tell when something has &lt;5% 5 year survival? Shaffer answered that the only administrative way to distinguish cancers with &lt;5% 5 year survival from forms of similar cancer with &gt;5% 5 year survival happens with prior authorized procedures for managed care health plans; it is not possible for open-card Medicaid. Saha asked what happens for procedures which do not need prior authorization? Shaffer replied that line 674 is just a place holder in those cases. Kirk stated that his health plan requires prior authorization for all chemotherapy agents which can also be used for salvage therapy. Line 674 allows his plan to deny futile care by citing the ORS regarding non-coverage of conditions below the funding line. Requiring approval of comfort care by prior authorization may be useful to allow review. Shaffer noted that the issue mainly affects fee-for-service Medicaid. Saha suggested eliminating line 674, putting guideline on all appropriate lines about comfort care. Olson suggested putting all the malignancy ICD-9 codes to the comfort care guideline. Coffman pointed out that this guideline refers is all medical conditions (more than just oncology). Kirk pointed out that line 674 title changed but ICD-9 codes did not change. Saha suggested putting all ICD-9 codes on the comfort care line with the comfort care guideline. The group debated whether lines 262 (comfort care) and 674 (terminal illness) should exist.</p> <p>Olson summarized HSC intent regarding treatment for comfort care: 1) non-coverage of futile care and 2) coverage of comfort care. The question is how to get to implement this intent administratively. Shaffer pointed out</p>	

Topic	Action
<p><b>Comfort care wording changes (cont'd)</b>  that HSC guidelines are enforceable as OAR. Olson pointed out that there are no ICD-9 codes to define terminal cancers and suggested a workgroup to deal with how to prevent inappropriate care. Coffman suggested using a statement of intent instead of a guideline associated with 100 lines or more. Saha suggested getting rid of lines 674 and 262 and put guideline on all appropriate lines. Smits stressed the need to avoid unintended consequences and suggested workgroup which would bring back suggestion to August meeting. Kirk suggested making futile care an exclusion. Olson disagreed, stating that some care may be worthwhile for patients in the 5% category, such as cheap care which might help a few. He argued that we would ration care by taking these people off the list except for that comfort care. Olson stressed that comfort care is a high priority for the HSC and any solution must reflect this. Olson concluded that the HSC intent is clear, and stressed the need for an administrative team to work on this and make recommendations at the August meeting.</p> <p>The subcommittee decided to create workgroup and bring back to August meeting.</p>	
<p><b>Percutaneous vertebroplasty guideline</b>  Smits reviewed that vertebroplasty was previously discussed at the May, 2007 HOSC meeting. The HOSC moved vertebroplasty from the spinal deformity lines (140, 324, 593) to the vertebral fracture line (112). HOSC members and the OHP medical directors suggested creating a guideline for the use of vertebroplasty. A review of the literature on vertebroplasty found that it provides significantly improved outcomes during the first 6 weeks of treatment, including less pain medication use, less nursing home placement, hospital days, and improved ability to do ADLs. After 6 weeks, vertebroplasty and conservative therapy had similar outcomes. Smits also reviewed guidelines regarding use of vertebroplasty from Blue Cross and Unicare. Smits offered a guideline recommendation based on this evidence. The subcommittee voted to accept this guideline.</p>	<p>Guideline adopted:  <b>VERTEBROPLASTY</b> Line: 112  Vertebroplasty is included on line 112, Vertebral Fracture, under the following criteria:</p> <ol style="list-style-type: none"> <li>1) Must be performed within the first 6 weeks after fracture <ol style="list-style-type: none"> <li>a. Acute nature of fracture must be documented by MRI, Xray or other modality</li> </ol> </li> <li>2) None of the following may be present: <ol style="list-style-type: none"> <li>a. Coagulation disorder</li> <li>b. Underlying vertebral infection</li> <li>c. Severe cardiopulmonary disease</li> <li>d. Extensive vertebral destruction (&gt;50% of height)</li> <li>e. Neurological symptoms related to spinal compression</li> <li>f. Lack of surgical back up for emergency decompression</li> </ol> </li> </ol>

<b>Topic</b>	<b>Action</b>
<p><b>Percutaneous vertebroplasty guideline (cont'd)</b></p>	<p>3) Must document</p> <ul style="list-style-type: none"> <li>a. Pain is caused by non healing vertebral fracture</li> <li>b. Vertebral height is not more than 50% collapsed</li> <li>c. Procedure is not performed on a prophylactic basis</li> <li>d. Risks of open surgical approach are greater than risks of percutaneous approach</li> </ul>
<p><b>Pinning of closed fracture</b>  Pinning a fracture (20650) appears on the open fracture line (131), but not the closed fracture line (460). Removal of implant, superficial (20670) is not on line 460, but removal of implant, deep (20680) is on this line. 20670 is on open fracture line (131)</p>	<p>Add 20650 to line 460  Add 20670 to line 460</p>
<p><b>Thoracic vascular repair</b>  Various codes for repair of blood vessels in the thorax are missing from line 114 (repair of injury to blood vessels in thoracic cavity)</p>	<p>Add 33320-33331, 33880-33891 and 35211-35272 to line 114</p>
<p><b>PET scans for colon and testicular cancer</b>  Per the April 06 HOSC minutes, testicular and colon cancer were added to PET scan guideline. However, PET CPT codes not added to colon (line 270) and testicular cancer lines (line 191). Lines 191 and 270 were also not added to line description of Guideline Note 4. Line 119 (Hodgkin's lymphoma, BMT) is on Guideline Note 4 list of lines but no PET codes are on this line (PET on line 27, medical treatment).</p>	<p>1) Add line 191 and line 270 to Guideline Note 4 list of lines  2) Remove line 119 from Guideline Note 4 list of lines  3) Add 78811-78816 to line 191 and line 270  4) Add reference to Guideline Note 4 to titles of lines 191 and 270  5) Remove reference to Guideline Note 4 from line 119</p>
<p><b>V codes</b>  Smits presented the staff review of V codes on list and their current location(s). DHS and Samaritan Health System coders met with HSC staff for their input on V code inclusion and placement. Smits presented her recommendations for V code placement on the list.</p> <p><u>Immunizations:</u>  Saha pointed out that it is not the Commission's intent to cover rabies vaccine for travel, etc. The intent is to cover rabies vaccination just for post-bite cases. The subcommittee voted to add V04.5 to the deep open wound line (375) rather than the preventive services lines (141, 181). The money spent on immunizations by DHS was</p>	<p><u>Immunizations (V01-V06):</u>  1) Add: V04.5, rabies vaccination, to <del>lines 141 and 181</del> to line 375 (deep open wound); V05.4, varicella vaccination, to lines 141 and 181  2) Add V06.8 to lines 141 and 181 for coverage of combined vaccination types  3) Remove V06.9 from lines 141 and 181</p>

Topic	Action
<p><b>V codes (cont'd)</b>  reviewed and it was determined that most vaccination CPT codes were on the “always covered” list for historical reasons. The subcommittee determined that it would be more appropriate to place vaccine CPT codes on appropriate list lines if indicated and place non-indicated vaccine CPT codes onto the “never covered” list.</p> <p><u>Miscellaneous:</u>  Smits presented the 2005 USPSTF recommendation that prophylactic postmenopausal hormone replacement therapy not be used for any indication. Dodson raised concerns that use of HRT is a moving target and recommendations are constantly changing. She felt that particular subset populations (for example, women with hysterectomies) are on some guidelines for HRT treatment. The subcommittee decided to review this code and other codes concerning HRT and bring revised recommendations to the August meeting.</p> <p><u>Personal History</u>  Smits presented coder recommendations that V10-V15.7 are used only as secondary codes and should be removed from the list. Olson pointed out that V10.05 used for follow-up of cancer patients. He later in the meeting contacted his coder, who indicated that the correct coding is V67 type codes. The subcommittee determined that there was need to further examine how coding is done for cancer screening in patients who have had cancer. V10 codes and V12.72 and V12.01 were tabled until further information could be brought to the August meeting.</p> <p><u>Family history</u>  Smits reviewed recommendations from coders that family history codes be removed from the list. V18.9 was suggested to add to the diagnostic line. Saha added that the genetic testing guideline should be applied to this diagnosis. Coffman added that such a change would require the addition CPT and ICD-9 codes to the genetic testing guideline, which currently has none. The intent of the Commission was to only cover these tests as guideline recommends. Saha suggesting putting this code on the preventive care lines (141, 181) with CPT codes. Saha wondered how adding a guideline to a code in the diagnostic list could be enforced. Kirk responded that the</p>	<p><u>Immunizations (cont'd)</u>  4) Add to never covered list: travel vaccinations V03.0, V03.1, V04.4, V06.0, V06.2; contact with smallpox (V01.3); non-specific vaccination codes: V01, V05.9, <del>V06.8</del>; vaccinations not on current CDC vaccine schedule: V03.3, V03.4, V04.1, V04.7, V05.2  5) <i>Take indicated vaccination CPT codes off the always covered list and place into appropriate lines; add non-indicated vaccine CPT codes to never covered list. Smits will come back to August meeting with vaccination CPT code placement suggestions.</i></p> <p><u>Miscellaneous 1 (V07-V08)</u>  1) Add V07.2, prophylactic immunotherapy including Rhogam, to pregnancy line 54 (maternity care)  2) <del>Remove V07.4 (Need for prophylactic postmenopausal hormone replacement therapy) from line 181 (preventive care)</del>  3) <i>Smits will review V07.4/similar codes on list and bring to revised recommendations for list placement to the August meeting</i>  4) Add to never covered list: non specific immunotherapy codes (V07.39, V07.8, V07.9)</p> <p><u>Personal history (V09-V15)</u>  1) Add V15.88 to line 181  2) <del>Add to never covered list: V10 to V15.7</del>  3) V09, V13.61, V14 and other V15 codes are secondary only and should be added to never covered list.  4) <i>Add to never covered list: V11, V12 (except V12.01 and 12.72), V13</i>  5) <i>Smits to review V10, V12.01 and V12.72 and bring revised recommendations to the August meeting</i></p>

Topic	Action
<p><b>V codes (cont'd)</b>  prior authorization process allows enforcement. Additionally, the CPT codes for genetic testing are very nonspecific and adding them to lines would not be helpful. Symonette pointed out that unit limits in the current system act as a mechanism for catching these for review. Saha asked whether the commission should move all genetic tests out of the diagnostic line and into preventive care lines. Kirk and Olson argued that genetic tests are diagnostic, not preventive, and belong on the diagnostic line.</p> <p>Olson pointed out that V16.3 was used for BRCA testing and should be left on the list. Saha suggesting tabling V16 codes until the August meeting to allow time for HSC staff to determine how these codes are used for cancer screening/care. Olson recommended HSC staff speak with the coder for his group, who is very knowledgeable in this area.</p> <p><u>Maternal/child</u>  V26.3 should have the genetic testing guideline attached.</p> <p><u>Status</u>  Smits suggested removing V43.1 from line 406, as coders had indicated that this was a secondary only ode. Coffman stated that this code was used for glasses after cataract surgery. Smits pointed out that no funds had been spent on this code per DHS. The subcommittee decided to have HSC staff look into why no money associated with this code and whether this code should be removed and bring this information to the August meeting.</p> <p><u>Secondary only codes</u>  Smits reviewed a list of codes which CMS allows only as secondary codes. The amount of money DHS has spent on each code was presented. The recommendation was to remove all secondary only codes from the list and place them on the never covered list. Olson and Shaffer wanted further information on why V62.0 and V58.69 are being used so much and have such large expenditures associated with them before the Commission takes them off the list. Coffman suggested that HSC staff: can look at what treatment codes are associated with these two codes; Shaffer added that DMAP staff can look into this further as</p>	<p><u>Family history (V16-V19)</u>  1) Add V18.9 to diagnostic line <i>with genetic testing guideline</i>  2) <del>Remove all codes V16 to V19 currently on lines 141 and 181 (preventive services)</del>  3) <i>Table V16 until August to determine how used for cancer screening/care. HSC staff to bring revised recommendations to the August meeting.</i>  4) <i>Remove V17-V19 from lines 141 and 181 and place on the never covered list</i>  5) Add to never covered list: V18.51, V18.59</p> <p><u>Maternal/child (V20-39)</u>  1) Add V23.2 to line 54; V26.3 codes to diagnostic list <i>with genetic testing guideline</i>; V29 codes to diagnostic list.  2) Add to never covered list: V26.0-V26.2; V26.8, V26.9, V39  3) Place V21, V22.2, V26.5, V27 on never covered list</p> <p><u>Behavior/special senses (V40-V41)</u>  1) Add V40-V41 to never covered list</p> <p><u>Status (V42-V49)</u>  1) Remove V42.0 from lines 108, 109, 435; <del>V43.1 from line 406</del>; V43.3 from lines 147, 195, 310, 316  2) Add to never covered list: V43.22, V45-V49  3) <i>HSC staff to do further research and bring recommendations for V43.1 placement to the August meeting</i>  4) Place V42, V43 (except V43.1 and V43.22), V44, V45 (except V45.7), V46.0, V46.2, V46.8 on never covered list</p>

Topic	Action
<p><b>V codes (cont'd)</b>  well. The subcommittee voted to add all codes other than V62.0 and V58.69 to the never covered list and have HSC staff bring back more information and recommendations on V62.0 and V58.69 to the August meeting.</p>	<p><u>Secondary only codes</u>  1) <del>Add all to never covered list</del>  2) <i>Add all codes other than V62.0 and V58.69 to the never covered list and have HSC staff bring back more information and recommendations on V62.0 and V58.69 to the August meeting.</i></p>
<p><b>Lymphedema</b>  Dr. David Pass, Medical Director of the Health Resources Commission and expert in lymphedema treatment, provided a presentation on current evidence for various treatment types.</p> <p>The group discussed addition of the specialized PT treatments (MLD) for lymphedema. Saha wanted to know who can do the specialized PT treatments. Pass replied that you need a certified therapist. Saha pointed out that the current PT guideline was not appropriate for ensuring that only certain therapists be allowed to provide this service and that there was a need for a mechanism for ensuring only trained therapist were providing this care. He suggested adding a new guideline for MLD. Dodson was concerned that limiting treatment to trained therapists might restrict access geographically. Olson pointed out that even certified therapist vary in ability. Pass offered to find out information on numbers and locations of certified therapists and bring this information to the August HSC meeting. He pointed out that restricting access to good therapists is actually good—badly done therapy causes harm. Coffman pointed out that inclusion of coverage for MLD would require actuarial evaluation, as it involves moving an expensive treatment from a non-funded to a funded area. Saha wondered if the evidence of effectiveness and disability is enough to justify moving up list. Olson replied that in his experience, yes. Dodson argued that the evidence is not well established and that the discussion was based on anecdote. Olson and Pass replied that no RCTs will be able to be done on this type of treatment. Saha pointed out that the Cochrane review shows improvement in intermediate outcomes, which is better than many things on list. Olson added that the abuse potential for MLD is low, as it takes a motivated patient. Pass pointed out that some savings from reduced visits for</p>	<p>1) Move 457.0 to line 296  2) <i>Move 457.1 to line 296</i>  3) Add CPT codes 97001-97004, 97124, 97140 to line 694  4) <i>Create guideline for treatment by certified therapists.</i></p> <p>Dr. Pass will do research into the location and training of current MLD therapists and bring this information to the August meeting.</p> <p>HSC staff and Dr. Pass will develop a guideline for MLD therapy and suggestions for CPT codes for inclusion on the list, and bring these to the August meeting.</p>

Topic	Action
<p><b>Lymphedema (cont'd)</b>            complications and infections could be gained by covering MLD. It was pointed out that timing of onset of lymphedema from the surgery which caused it is very variable, making the current PT guideline of coverage for 90 days after the inciting event not applicable.</p> <p>Saha suggested that HSC staff create a guideline for MLD to bring to August HOSC meeting. The subcommittee decided to place a guideline limiting treatment to certified therapists. They directed HSC staff to explore best guideline to ensure best treatment for patients, balancing access with quality, taking into account therapist type, number of visits, and start of treatment after procedure.</p>	

**MEETING HIGHLIGHTS**  
**HEALTH OUTCOMES SUBCOMMITTEE**  
 Meridian Park Hospital  
 Tualatin, Oregon  
 August 23, 2007  
 8:00-11:30

**Members Present:** Som Saha, MD, Chair; Lisa Dodson, MD; Dan Mangum, MD

**Members Absent:** Kevin Olson, MD

**Staff Present:** Darren Coffman; Ariel Smits, MD MPH; Dorothy Allen; Nathan Hierlmaier, MPH

**Also Attending:** John Pelkey, DMAP; Sean Kolmer, OHPR; David Pass, MD, HRC Medical Director; Wally Shaffer MD, DMAP; Caroline Price RN, DMAP; Celeste Symonette RN, DMAP; Amy Goodall, OMA; Lori Almand, Ethicon Endo-Surgery.

*Note: Adjourned at 11:35 AM. Next HOSC meeting is scheduled for November 1<sup>st</sup>.*

<b>Topic</b>	<b>Action</b>
<p><b>General</b>            Minutes from 6/07 HOSC meeting reviewed and accepted without substantive changes.</p>	<p>Minutes approved.</p>
<p><b>New Codes</b></p> <p>Smits presented staff recommendations for placement of new ICD-9 and HCPCS codes (see section 12 of meeting materials). The majority of items were accepted without discussion.</p> <p>Specific discussion points:  <u>Avian flu.</u> Saha and Mangum were concerned that avian flu was being treated differently than other types of flus if it is placed on line 444, when other flus are on line 652. No effective treatments for avian flu are known, other than supportive care. Smits raised concerns for reporting of this condition has public health implications. Saha pointed out that this condition is already reportable. The HOSC voted to place avian flu on line 652 (flu).</p> <p><u>Breast reconstruction.</u> Smits provided information that these procedure codes involve harvesting tissue from the buttocks or abdomen for reconstructing the breast. These were not felt to be radical new procedures and the group agreed to place them on the breast cancer line.</p>	<p>ICD-9 and HPCPS code placement accepted as recommended, except:</p> <p><i>Add 488 (Avian flu) to line 652 (flu)</i></p> <p><i>Do not add 389.13 and 389.17 to lines 300 and 501</i></p> <p><i>Put 624.0 and all stems on line 223 (Vulvar dystrophy)</i></p>

<p><u>Bandemia</u>. Mangum raised a question about bandemia being placed on the Signs and Symptoms list. Coffman and Smits indicated that similar diagnoses such as eosinophilia, lymphocytosis, etc. were on the Signs and Symptoms list. The group agreed this would be an appropriate placement.</p> <p><u>Unilateral hearing loss</u>. Coffman pointed out that 389.13 and 389.17 should not be added to the cochlear implant lines (300 and 501) as these codes are specifically unilateral, and cochlear implants are only covered for bilateral hearing loss.</p> <p><u>VIN</u>. Saha and Mangum were concerned about separating the 624.0 codes (VIN of various types) and placing these codes on two lines, 223 (vulvar dystrophy) and 229 (vulvar cancer). Smits reported that VIN is treated like CIN for cervical cancer, while simple vulvar dystrophy is not treated like a cancer. Dodson pointed out that some of the vulvar dystrophy codes were not actually cancer. The group felt that all types of VIN should be placed on the vulvar dystrophy line as these conditions are precancerous and should not be on the cancer line. The group voted to place these quotes on line 223, Vulvar dystrophy.</p>	
<p><b>Health and Behavior Assessment Codes (96150 series)</b></p> <p>Smits requested that this issue be tabled and taken up with the full HSC to allow input from providers who planned to speak at the HSC later in the day.</p>	<p>Tabled to the HSC meeting. See HSC minutes for discussion and decision.</p>
<p><b>Discography</b></p> <p>Smits reviewed the evidence around the use of discography, as well as information received from providers. Mangum stated that he strongly felt this procedure should not be covered. There was no other discussion.</p>	<p>62290 (Injection for discography, lumbar) and 62291 (Injection for discography, cervical or thoracic) removed from lines 140 (Disorders of the spine with clinical significance) and 324 (Spinal deformity, clinically significant) and placed on the never covered list.</p>
<p><b>MEN/Urinary anomalies/lymph node biopsies</b></p> <p>Smits reviewed the materials regarding treatments which should be added to the lines for Multiple Endocrine Neoplasia (MEN, line 138) as well as the line for congenital hydronephrosis (line 365). She also presented a DMAP issue with having lymph node biopsy on both lines on the prioritized list as well as the diagnostic list. There</p>	<p>1) MEN (line 138)  a) Delete: 193 (Malignant neoplasm of thyroid gland), 198.4 (Secondary malignant neoplasm of other parts of nervous system), 237.4 (Neoplasm of other and unspecified endocrine glands)</p>

<p>was minimal discussion regarding MEN and congenital hydronephrosis. The group discussed whether lymph node biopsies which were used for staging rather than diagnosis should be placed on the appropriate line for the cancer being staged; however, it was decided that staging biopsies would function as a diagnostic test when used to determine whether the cancer was treatable and would be on a line above the funding line or had a &lt;5% 5 year expected survival, and would be on a line below the funding line. The group voted to move lymph node biopsy to the diagnostic line.</p>	<p>b) Add new ICD-9 codes: 258.01 (MEN I), 258.02 (MEN IIa), 258.03 (MEN IIb)</p> <p>c) Add CPT codes: 60500-60505 (Parathyroidectomy), 60540-60545 (Adrenalectomy), 60650 (Laparoscopic adrenalectomy), 60699 (Unlisted procedure, endocrine system), Medical codes: 99201-99215, Hospital codes: 99221-99233, Consultation (inpatient, outpatient): 99241-99255</p> <p>d) Change treatment description to “Medical and Surgical Treatment”</p> <p>2) Add 50220, 50225, 50234, 50236, 50240, 50600, 50605 to line 365 (congenital hydronephrosis)</p> <p>3) Remove lymph node biopsy CPT codes (38500, 38505, 38510, 38520, 38525, 38530) from lines 122 (Non-Hodgkin’s lymphomas), 190 (Cancer of thyroid), 225 (Cancer of breast), 274 (Cancer of endocrine system, excluding thyroid), and 456 (Lymphadenitis) and add to never covered list.</p>
<p><b>Comfort care</b></p> <p>Celeste suggested removing comfort care as new palliative care guidelines include treatment options. Saha and Mangum felt that palliation should be kept. Palliative care is a more common term.</p> <p>Saha: the intent of the commission is to not cover treatment with intent to prolong life for illnesses with &lt;5% 5 year survival. Shaffer recommended adding this explicitly to the SOI.</p> <p>Saha suggested adding examples of services which are not covered, such as chemotherapy for alternation of disease progression. Discussion about treatments such as blood transfusion.</p>	<p>Approved modified Statement of Intent; also approved deletion of comfort care and futile care lines on current list.</p> <p><u>Statement of Intent #1</u></p> <p>Comfort/Palliative Care</p> <p>It is the intent of the Commission that comfort/palliative care treatments for patients with <del>terminal conditions/illnesses (defined</del> with an illness with &lt;5% expected 5 year survival) be a covered service. Comfort/palliative care includes the</p>

Shaffer concerned about use of “medically necessary” and using “medically appropriate” instead, to be more consistent with DMAP rules.

Pelkey thanked the commission for trying to improve the situation, and asked DMAP representative if these changes would improve the situation at DMAP. Pelkey recommended these be approved for implementation Oct. 1st.

provision of services or items that give comfort to and/or relieve symptoms for such patients ~~with a terminal illness~~. There is no intent to limit comfort/palliative care services according to the expected length of life (e.g., six months) for ~~the~~ such patients ~~with terminal illness~~, except as specified by Oregon Administrative Rules.

It is the intent of the Commission to not cover ~~This category of care does not include services that are diagnostic, curative, or curative care for the primary illness or care focused on active treatment of the primary illness condition~~ which are intended to prolong life or alter disease progression for patients with <5% expected 5 year survival.

Examples of comfort/palliative care include:

- 1) Medication for symptom control and/or pain relief .
- 2) In-home, day care services, and hospice services as defined by DMAP
- 3) Medical equipment (such as wheelchairs or walkers) determined to be medically ~~necessary~~ appropriate for completion of basic activities of daily living ~~for a reasonable length of time~~
- 4) Medical supplies (such as bandages and catheters) determined to be medically ~~necessary~~ appropriate for management of symptomatic complications ~~of the terminal condition~~ or as required for symptom control.
- 5) Services under ORS 127.800-127.897 (Oregon Death with Dignity Act), to include but not be limited to the attending physician visits, consulting physician confirmation, mental health evaluation and counseling, and prescription

	<p>medications.</p> <p><u>Examples of services which are not covered include:</u></p> <ol style="list-style-type: none"> <li>1) <u>Chemotherapy or surgical interventions with the primary intent to prolong life or alter disease progression</u></li> <li>2) <u>Medical equipment or supplies which will not benefit the patient for a reasonable length of time</u></li> </ol>
<p><b>Vertebroplasty</b></p> <p>Smits reviewed Medical Director’s motion for review of the guideline. Commission agreed on the response.</p> <p>Saha suggested changes to the current guideline, indicating that the pain must be disabling. Saha suggested that this should only be covered if other analgesia is not effective. Smits pointed out that this procedure can reduce or eliminate the need for analgesia, which can be risky in the elderly. The group elected to add wording that the pain must be disabling and analgesic therapy either is not effective or the risks of such therapy outweighs the benefit.</p> <p>The group addressed the Medical Directors’ concerns about needing cost-effectiveness for this procedure. Smits reported that a literature search did not find any cost-effectiveness studies. However, given that this procedure results in significantly lower hospitalization and SNF placement rates, it can be conjectured that use of the procedure would result in cost savings.</p> <p>Saha pointed out that the HSC placed this procedure on the list with a high threshold for use and implemented a guideline to outline this high threshold. The changes made to the guideline today should clarify this high threshold for use.</p>	<p>Guideline for Vertebroplasty amended to read:</p> <p><b>VERTEBROPLASTY</b> Line: 112 Vertebroplasty is included on line 112, Vertebral Fracture, under the following criteria:</p> <ol style="list-style-type: none"> <li>1) Must be performed within the first 6 weeks after fracture       <ol style="list-style-type: none"> <li>a. Acute nature of fracture must be documented by MRI, Xray or other modality</li> </ol> </li> <li>2) None of the following may be present:       <ol style="list-style-type: none"> <li>a. Coagulation disorder</li> <li>b. Underlying vertebral infection</li> <li>c. Severe cardiopulmonary disease</li> <li>d. Extensive vertebral destruction (&gt;50% of height)</li> <li>e. Neurological symptoms related to spinal compression</li> <li>f. Lack of surgical back up for emergency decompression</li> </ol> </li> <li>3) Must document       <ol style="list-style-type: none"> <li>a. <u>Disabling pain</u> caused by non healing vertebral fracture</li> <li>b. Vertebral height is not more than 50% collapsed</li> <li>c. Procedure is not performed on a prophylactic basis</li> <li>d. Risks of open surgical approach are greater than risks of percutaneous approach</li> <li>e. <u>Analgesic therapy fails to</u></li> </ol> </li> </ol>

	<p><u>control pain or the risks of analgesic therapy outweigh the benefits</u></p>
<p><b>Obesity guideline</b></p> <p>Smits presented a guideline for medical treatment of obesity based on USPSTF and HRC guidelines and recommendations. Mangum raised concerns for lack of upper limit of frequency of treatments in the guideline. Saha agreed. Saha and Shaffer suggested that an upper limit of treatment frequency be added to the guideline of no more than once a week.</p> <p>There was debate about pharmacologic treatment. Coffman indicated that the HSC does not decide what is a covered service, which is a function of the legislature. He suggested wording changes to say that it is not the intent of the HSC to cover pharmacologic treatment. Pharmacologic treatment will be placed on the lower obesity line (below the funding line).</p> <p>CPT code placements were accepted as presented in the document in the packet.</p>	<p>1) Guideline adopted: Guideline Note 4: Non Surgical Treatment of Obesity; Line 6</p> <p>Medical treatment of obesity includes intensive counseling on nutrition and exercise, provided by health care professionals. Intensive counseling is defined as face to face contact more than monthly. Visits are not to exceed more than once per week. Pharmacological treatments are not intended to be included as a treatment on this line. See also Guideline Note 57.</p> <p>2. CPT code changes for line 8 (Obesity) of the 2007-2009 list approved as noted in meeting document.</p>
<p><b>Mediastinoscopy/ganglion cyst excision</b></p> <p>Smits introduced two issues DMAP has brought to the HSC's attention. The first involved mediastinoscopy, which appears both on the prioritized list and on the diagnostic list, which is causing administrative issues at DMAP. The group debated whether mediastinoscopy was related to only one diagnosis (lung cancer) and decided that it is a procedure which might be used to diagnose a variety of mediastinal problems, including lymphoma, sarcoidosis, and thymoma. Mangum and Dodson felt this procedure would be more appropriate placed on diagnostic list. Vote was to place on the diagnostic list and remove from the breast cancer line.</p> <p>The second issue was that ganglion cyst excision appeared on two lines, one above and one below the funding line. The lower line referred specifically to ganglion cysts. The group felt this procedure should be only on this lower line.</p>	<p>1) Remove 39400 (mediastinoscopy) from line 272 (Lung cancer) and place on diagnostic list.</p> <p>2) Remove 20612 (Aspiration and/or injection of ganglion cyst) from line 505 (disorders of shoulder); keep on line 662 (ganglion cysts)</p>
<p><b>Immunizations</b></p> <p>At the June 2007 HOSC meeting, the group requested that</p>	<p>Changes as outlined in meeting materials accepted as proposed.</p>

<p>Smits bring recommendations for vaccination CPT codes placement. Currently, these codes are on the ancillary list. Smits presented her recommendations for code placement, based on current CDC vaccination guidelines.</p> <p>Vaccinations indicated on the current vaccine schedule are placed on the preventive services lines (141, 181) where appropriate. Rabies vaccination is placed on the line for deep wounds (line 375), which includes bites. Travel vaccines, and those not currently recommended for routine use are placed on the never covered list.</p> <p>Mangum worried about adding vaccines only recommended for a certain age group, such as zoster for &gt;60, on a line which applies to other age groups without a guideline. Saha felt that physicians should be trusted to vaccinate according to current CDC guidelines.</p> <p>Shaffer indicated that DMAP would need to change admin rules to take these off line 0 and onto the prioritized list.</p> <p>Recommendations were accepted as presented.</p>	
<p><b>V codes</b></p> <p>Smits presented a document summarizing suggested placements of V codes V50-V83. Saha and Smits presented general principles for dealing with V codes which they had created.</p> <p><u>General principles</u></p> <ol style="list-style-type: none"> <li>1) If codes can be placed on 5 or fewer lines and appropriate lines can be identified, then place on list</li> <li>2) If codes would be appropriately placed on &gt;5 lines, then place on ancillary list <ol style="list-style-type: none"> <li>a. Multiple lines causes potential actuarial problems</li> <li>b. Placement on multiple lines is labor intensive</li> </ol> </li> <li>3) If codes are not used or are inappropriate therapy, then place on never covered list</li> <li>4) If code has high abuse potential or may be inappropriate care, the research the issue and bring for discussion in necessary</li> </ol> <p>These principles were accepted by the group.</p> <p>Smits then reviewed follow-up issues from the June V code discussion of V codes V01-V49. She summarized USPSTF and NIH guidelines against prophylactic use of</p>	<p>Approved suggested placements as noted in meeting document, except:</p> <ol style="list-style-type: none"> <li>1. V62.9 (other psychological or physical stress, NEC), V57 (encounter for physical and occupational therapy) and V58.6 (Long-term (current) use of medications) referred to the Line 0 Taskforce for recommendations on placement.</li> <li>2. V53.4 (Fitting and adjustment of orthodontics) not placed on Line 377 (Cleft palate); placed on lower orthodontic line 707</li> <li>3. More information required on V53.5 (fitting and adjustment of other intestinal appliance) and V53.02 (fitting and adjustment of neuropacemaker for brain or peripheral nerves); placement tabled until next meeting. Staff asked to research these codes further and bring information to next meeting.</li> </ol>

hormone replacement therapy and suggested that V07.4 (prophylactic use of HRT) be placed on the never covered list.

Research into use of personal history, family history, and status codes found that they were rarely used, and the recommendation was to place on the never covered list. Mangum: concern that putting these codes on never covered list would prevent someone with a family h/o cancer from getting screening at an earlier age or at a closer interval than generally recommended. Shaffer did not think that these changes would affect billing/payment at DMAP.

V62.9 (other psychological or physical stress, NEC) and V58.69 (Long-term (current) use of other medications) have large amounts of billing paid through DMAP and are currently on Line 0. Smits presented background data on what these codes are being used for. The group debated placing these codes on the ancillary list or on the never covered list. The group decided that more information and research was needed, and referred these two codes to the Line 0 Workgroup for recommendations on list placement.

New codes in the V01-V49 range were presented and recommended placement accepted without discussion.

#### Surgical codes (V50-V55)

Surgical codes (V50-V55) were accepted as recommended by staff, with the following exceptions. Orthodontics codes which were placed on line 707 (cosmetic dentistry/orthodontics) rather than the cleft palate line. The group debated whether V53.5 (fitting and adjustment of other intestinal appliance) should be placed on the ancillary list, due to applicability on multiple lines, or whether this code should be placed on the never covered list because covered services such as ileostomy and colostomy were covered with other V codes and therefore no covered service would fall under this code. Staff was requested to obtain more information about this code for the next meeting and code placement was tabled. There was debate about whether placement of neuropacemaker for brain or peripheral nerves was a covered services; if not, the group felt that V53.02 (fitting and adjustment of neuropacemaker for brain or peripheral nerves) should not be covered. Staff was requested to obtain more information and placement of

4. V53.09 (Fitting and adjustment of other devices related to nervous system and special senses) tabled. Staff requested to research what appropriate lines for this code, such as epilepsy, cerebral palsy, and similar lines, and bring back suggestions for next meeting.

5. V55.7 (attention to artificial vagina-cosmetic) placed on line 464 rather than never covered list.

6. V58.5 (Orthodontics aftercare) placed on line 707 (orthodontic line) rather than cleft palate line

7. V59-V84 tabled until next meeting.

this code was tabled. The group debated whether V53.09 (Fitting and adjustment of other devices related to nervous system and special senses) should be placed on particular lines. Research into secondary ICD-9 codes billed with this code found that the majority of services were being done with secondary diagnoses of epilepsy, chorea, cerebral palsy, etc. The group requested that staff research what types of lines this could go on, such as epilepsy, CP, etc. and bring back suggestions for next meeting. Coffman pointed out that there was a line for creation of an artificial vagina and that attention to an artificial vagina (V55.7) should be placed on this line rather than the never covered list.

#### Other procedures (V56-V58)

Placement of these codes was accepted as presented, except for the following: V58.5 (Orthodontics aftercare) was placed on line 707 (orthodontics) rather than on the cleft palate line. V58.6 (laboratory monitoring for medication use) was referred to the Line 0 Taskforce for investigation into why this code was used for laboratory studies rather than the underlying diagnosis code. Shaffer indicated that the use of this code may be an operational issue at DMAP. The group requested more research from DMAP, bring back to next meeting. The general feeling was that the HSC should do the right thing—not require coding which would conflict with CMS and help providers by not making billing for Medicaid patients onerous. The group debated the PT/OT codes (V57), which had \$10.3 million in DMAP billings for the last 2 years. Concerns of the group included possible use in circumventing the PT/OT guideline (use of these codes increased four fold after implementation of this guideline), the fact that V57.89 is being used for room and board for rehab facilities (\$1.5 million), which may not be appropriate. Smits and Coffman shared that these codes are Being discussed by the Line 0 Workgroup. That group is considering recommending that these codes be never covered; however both the Workgroup and the HOSC wished to make sure that there was no incidence where this was appropriate. The decision was to table V57 and have the Line 0 Workgroup come back with recommendations to a future meeting.

#### V59-V84

Discussion stopped just prior to V59, due to time

<p>constraints. These codes were tabled for discussion at a future meeting.</p>	
<p><b>Laparoscopic surgery</b></p> <p>Smits and Saha presented a set of guiding principles which the HSC should follow when a laparoscopic and an open surgical option exist for the same procedure. The laparoscopic procedure should be covered when the equivalent open procedure is on the list.</p> <p>Mangum raised a concern that laparoscopic procedures may be reimbursed at a high rate making a financial incentive for their use. Symonette replied that most laparoscopic procedures are actually covered at a lower rate. Saha pointed out that laparoscopic surgery is at this point in the development of laparoscopic technology just another approach option. Dodson and Saha pointed out that certain laparoscopic surgeries, such as carpal tunnel release, have fallen out of use when evidence was found that they had worse outcomes than their respective open alternatives. The thought was that surgeons should be trusted to do the right thing in choosing which approach (open or laparoscopic) was most appropriate to use in a particular case.</p> <p>The group agreed that laparoscopic surgery is generally standard of care and should be allowed as an option for the treating surgeon to consider. The group agreed that it is the general intent of the HSC that laparoscopic procedures should be covered when the equivalent open procedure is covered.</p>	<p>Adopt changes suggested in the meeting document titled “Laparoscopic Surgery for Gastrointestinal Diseases.”</p> <p>Smits directed to review Gynecologic, arthroscopic, vascular, and other surgical areas where laparoscopic type approaches are used and bring back recommendations to the next HOSC meeting for inclusion of such laparoscopic procedures on the prioritized list, following the general principle of covering the equivalent laparoscopic technique when the open technique is on the list.</p>
<p><b>Lymphedema</b></p> <p>Smits reviewed the concerns of the HOSC at the June review of this topic: 1) limit harmful treatment, which includes most untrained CDT tx, 2) ensure regional coverage of these services through the state, 3) concerns for needing limitations on number and/or frequency of visits. She also reviewed the OHP Medical Directors’ concerns about the changes in lymphedema care adopted in June.</p> <p>Smits presented a proposed guideline for CDT tx for lymphedema, which was created in conjunction with Dr. David Pass, HRC Medical Director and expert in lymphedema. This guideline specifies that such tx must be</p>	<p>1) The following guideline for Lymphedema Treatment (<i>Line 296</i>) was accepted:</p> <p>Lymphedema treatments are covered when medically <b>appropriate</b> necessary. These services will only be covered when provided by a licensed practitioner who is certified by, or participating in the certification or training process for, one of the accepted lymphedema training certifying organizations. The only accepted certifying organization at this time is LANA (Lymphology</p>

done by a professional with certification from a national organization, of which there is currently one (LANA). This guideline would help ensure that poor care not be done. Pass presented his research into the location of certified therapists, showing reasonable geographic distribution. Pass and Smits discussed with the group that there was no practical way to limit number or frequency of visits, as these are highly dependent on the clinical situation. Several people expressed concern that these types of procedures might be overused. Pass replied that these procedures take a motivated patient and are unlikely to be abused.

Smits presented a document with recommended CPT code additions to the lymphedema line (line 694). These codes are already present on the higher complications of a procedure line (296) and were suggested to be added for completeness.

Smits presented a draft reply to the OHP Medical Directors concerns, which was adopted with some wording changes (MLD was changed to CDT to better reflect the actual treatment covered).

Association of North America;  
<http://www.clt-lana.org>).

2) Added to line 694 (Lymphedema):  
97110 (Therapeutic procedure and exercises), 97530 (Therapeutic activities, use of dynamic activities to improve function), 97760 (Orthotics management and training)

3) Reply to Medical Directors' motion approved with MLD changed to CPT in appropriate areas.

**MEETING HIGHLIGHTS**  
**HEALTH OUTCOMES SUBCOMMITTEE**  
 Clackamas Community College  
 Wilsonville, Oregon  
 November 1, 2007  
 8:00-11:30

**Members Present:** Som Saha, MD, Chair; Lisa Dodson, MD; Dan Mangum, MD; Kevin Olson, MD

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

**Also Attending:** Wally Shaffer MD, DMAP; Caroline Price RN, DMAP; Celeste Symonette RN, DMAP; John Balmer MD, Mid Valley IPA

*Note: Adjourned at 11:45 AM. Next HOSC meeting is scheduled for December 6th.*

<b>Topic</b>	<b>Action</b>
<p><b>General</b>            Highlights from 8/07 HOSC meeting reviewed and accepted without substantive changes.</p>	<p>Highlights approved.</p>
<p><b>Gynecologic laparoscopy</b>             Smits reviewed laparoscopic gynecology procedures, with recommendations of which line they should appear on. The laparoscopic procedures were added to lines with the equivalent open or vaginal approach. Additionally, lines with laparoscopic procedures without the equivalent abdominal or vaginal approach listed had these approaches added. The proposed changes were accepted without discussion.</p>	<p>Changes approved as outlined in meeting materials.</p>
<p><b>Shoulder lines</b>             Smits reviewed a DMAP question regarding where various shoulder conditions should appear on the list. Recommendations based on discussion with Orthopedists were reviewed.             Discussion centered around what extent of shoulder injury should be placed on the higher shoulder injury line. Given that shoulder strains are graded 1-6, the HOSC felt that “minor” sprains, felt to be grades 1 and 2, should remain on the lower line while grades 3-6 should be included on the upper line. Line name changes were proposed to reflect this.</p>	<ol style="list-style-type: none"> <li>1) Delete shoulder dislocation (718.31) from Line 437</li> <li>2) Add Bankart repair (23455) to Line 296</li> <li>3) Put all sprain/strain (840 series) on Line 437, delete from Line 403</li> <li>4) Delete 23430 from line 403</li> <li>5) Add 23430 to line 437</li> <li>6) Change name of Line 437 to “Disorders of Shoulder, including sprains/strains grade 3 through 6”</li> <li>7) Change name of Line 628 to “Sprains and strains of adjacent muscles and joints, minor”</li> </ol>

<p><b>Shoulder arthroscopy</b></p> <p>Smits reviewed the placement of shoulder arthroscopy codes based on matching with similar open codes and on discussions with Orthopedists. There was no discussion.</p>	<p>Changes approved as outlined in meeting materials.</p>
<p><b>Knee lines</b></p> <p>Smits reviewed a DMAP question regarding placement of various knee conditions on lines above or below the funding line. Recommendations based on discussion with Orthopedists were reviewed. Recommendations accepted as proposed without discussion.</p>	<p>1) Remove 718.56 from Line 542 2) Remove knee dislocation ICD-9 codes (718.26/718.36) from Line 449</p>
<p><b>Knee arthroscopy</b></p> <p>Smits reviewed the placement of shoulder arthroscopy codes based on matching with similar open codes and on discussions with Orthopedists.</p> <p>Three procedures (29866-29868) involving osteochondral autografts and meniscal transplantation were proposed for addition to the list by the Orthopedic consultants. However, no literature was forwarded for review. The Subcommittee decided to table these codes until supporting information is received.</p>	<p>Changes approved as outlined in meeting materials.</p> <p>29866-29868 tabled until more information received.</p>
<p><b>Ancillary list</b></p> <p>Smits reviewed the current state of the Ancillary List. This list has been a place the HSC has assigned procedures which can be applied to many lines on the list, such as suture removal or IV start. Any procedure placed on the Ancillary List is paired with any diagnosis which is on the Prioritized List. DMAP to date has not been able to create an actual Ancillary List, however. With the creation of their new MMIS system, DMAP will now have the ability to have an actual Ancillary List. Smits and Coffman have been working to create an Ancillary List based on previous work by Coffman and others, as well as minutes of HSC meetings placing procedure codes on this list. Smits brings this topic to the HOSC asking for guidance. Staff have found multiple items on the newly created Ancillary List which need placement on the Prioritized List, and others which already appear on the Prioritized List. How should staff proceed at this point?</p> <p>Olson recommended ranking candidates for the Ancillary List based on money. Prioritize work based on possible</p>	<p>Smits will create several lists for review at the next meeting(s):</p> <ol style="list-style-type: none"> <li>1) List of CPT codes to add to the Prioritized List which currently reside on the Ancillary List</li> <li>2) List of CPT codes to add to the Never Covered List which currently reside on the Ancillary List</li> <li>3) List of CPT codes to add to the formal Ancillary List which currently reside on the informal Ancillary List</li> </ol>

<p>cost savings.</p> <p>Saha suggested first “cherry picking” obvious codes which could be added to the list, such as the maternity care ultrasound codes</p> <p>Mangum suggested looking for things we don’t want to cover and take off.</p> <p>Som suggested organizing codes into groups (all going to List, etc.) and brining to the next meeting(s) for review</p> <p>Symonette asked whether DMAP or another entity can publish this so providers can see it? Can it be published on the HSC website?</p> <p>Coffman asked whether the MMIS system have some element of publicly available interface?</p> <p>Allen suggested that DMAP should publish the Ancillary List and the HSC can link to it on our website.</p>	
<p><b>Gastrostomy tubes</b></p> <p>Smits reviewed that G-tube procedure codes currently exist on both lines on the Prioritized List as well as on the Ancillary List. She proposes putting all G-tube procedure codes on the Ancillary List. The Subcommittee agreed to this change with no discussion.</p>	<ol style="list-style-type: none"> <li>1) Place gastrostomy tube CPT codes (43750-43832) on the Ancillary List</li> <li>2) Remove gastrostomy tube CPT codes (43750-43832) from the Prioritized List</li> </ol>
<p><b>Line 674 “orphans”</b></p> <p>At the August, 2007 HSC meeting, Line 674 (613 on 2008 list) was deleted when the new Comfort Care Statement of Intent went into effect. There were 32 ICD-9 codes and 2 CPT codes which appeared only on line 674 which were also deleted from the list. The ICD-9 codes were all for malignant neoplasms with other or unknown primaries.</p> <p>Smits brought forward a recommendation to “un-delete” line 613, rename it “Secondary and Ill-Defined Malignant Neoplasms.” ICD-9 codes, and place the ICD-9 codes that do not appear elsewhere on the list which did appear on the old Line 674 on this new line. She proposed leaving the ICD-9 codes that appeared elsewhere on the list on those other lines. She also recommended some alternative line placements which appear in the meeting materials. All the CPT codes which appeared on line 674 (2007) should remain on line 613 (2008)</p> <p>Saha advocated for putting all “orphan” ICD-9 codes on Line 613, and take off any other lines.</p> <p>Olson requested that two of these diagnoses be placed on</p>	<ol style="list-style-type: none"> <li>1) Undelete line 613 and rename “Secondary and Ill-Defined Malignant Neoplasms”</li> <li>2) All CPT codes which appeared on the 2007 list Line 674 will appear on the 2008 list Line 613</li> <li>3) ICD-9 codes to be placed on line 613: 159, 195, 196 (except 196.0 and 196.3), 197, 198.8, 199.</li> <li>4) Any ICD-9 codes listed in #3 above that appear on other lines will be deleted from those lines</li> <li>5) 196.0 add to Line 198 (Breast Cancer)</li> <li>6) 196.3 add to Line 311 (Head and Neck Cancers)</li> </ol>

<p>other lines and not 613:  196.0 (Secondary malignant neoplasm of lymph nodes; head/face/neck)—put on head and neck cancer line  196.3: Secondary malignant neoplasm of lymph nodes; axilla/upper limb -- should be on breast cancer</p> <p>These suggestions were agreed upon unanimously.</p>	
<p><b>Keratoconjunctivitis sicca</b></p> <p>Smits reviewed a provider question about coverage for various treatments for Keratoconjunctivitis sicca (370.33). These treatments are currently on two lines (397 and 541), one above and one below the funding line. This is causing administrative issues at DMAP and confusion for providers. The least and most invasive treatments are on the upper line, while the moderately invasive treatments are on the lower line. Furthermore, on reviewing this topic with Ophthalmologists, suggestions were made for deletion of unused procedures from both these lines. The suggested changes to lines 397 and 541 were presented as outlined in the meeting materials.</p> <p>Saha asked whether the HSC could look at usage of these codes in 6 months or another timeframe to evaluate how much of an increase in usage was seen.</p>	<p>Delete 65780-65782 (Ocular surface reconstruction procedures), 68371 (Harvesting conjunctival allograft) from Line 397 (Keratoconjunctivitis, corneal abscess and neovascularization)</p> <p>Add 67880-67882 (Construction of intermarginal adhesions, tarsorrhaphy procedures), 68760-68761 (Closure of lacrimal punctum procedures), 68801-68840 (Probing of nasolacrimal duct procedures) to Line 397</p> <p>Delete 370.33 (keratoconjunctivitis sicca) from Line 541 (Dysfunction of nasolacrimal system)</p> <p>Delete 68440 (Snip incision of lacrimal punctum), 68700 (Plastic repair of canaliculi) from list</p>
<p><b>Urological issues</b></p> <p><u>Renal/Ureteral/Bladder Calculi</u></p> <p>Smits reviewed a provider question regarding kidney/ureter/bladder stones. A urology group found multiple non-pairings on these lines. The Urologists in these groups were having significant issues caring for OHP patients due to non-payment based on these codes. HSC staff review of these lines found multiple CPT codes which needed to be added to both lines. These changes were reviewed with Rogue Valley Urology. Lines 187, 376, and 418 were reviewed and recommendations for additions and deletions were presented.</p> <p>Discussion centered around whether there should be 3 separate lines for these types of stones. Olson suggested combining lines 376 and 418. Saha suggested looking at</p>	<p><u>Renal/Ureteral/Bladder Calculi</u>  Changes approved as outlined in meeting materials.</p> <p><u>Communicating Hydrocele</u></p> <p>Move hydrocele (603.0, 603.8, 603.9) and CPT codes 54040 (excision of hydrocele, unilateral), 54041 (excision of hydrocele, bilateral), and 54060 (repair of tunica vaginalis hydrocele) to line 176 (complicated hernias; uncomplicated hernias in children). Remove from line 558 (Hydrocele).</p> <p>Add the following guideline to line 176:  “Excision of hydrocele is only covered</p>

this for the upcoming biennial review. The group decides to adopt the recommended changes to these lines, and address combining lines 378 and 418 with the biennial review.

### Communicating Hydrocele

Several providers and plan medical directors had asked about coverage of communicating hydrocele for boys over the age of 18 months. Previous HSC discussion of this condition had centered around lack of evidence of harm with non treatment and lack of ability to distinguish communication from non-communicating hydroceles based on ICD-9 codes.

Experts feel that hydrocele is the same condition as hernia, repair of which is covered for children currently. Hernia repair is covered in children due to the higher percentage of incarceration in children, compared to adults. Information from Dr. Steven Skoog from OHSU was reviewed, which indicated that he felt that this condition should be repaired, and felt it would be reasonable to put in guideline restricting repair to children older than 18 months. Movement of this condition and treatment codes to the higher line was recommended, with a guideline limiting to children 18 months and older.

The Subcommittee agreed with coverage, but requested that the suggested guideline have an upper age limit. The group approved the suggested change, and approved the guideline pending the addition of an upper age limit.

### Bladder Catheters/Bladder Obstruction

Smits reviewed the problem that CPT codes for bladder catheterization are not uniformly distributed on list. Diagnoses of various bladder conditions also need to be cleaned up on the list. She reviewed recommended changes as outlined in the meeting materials.

### Repair of Complications of Circumcision

Smits reviewed a provider question about coverage of repair of complications of circumcision. Routine circumcision (54150-54161, Elective circumcision) currently resides on three lines:

for children with hydroceles which persist after 18 months of age.”

Smits with contact Dr. Skoog for recommendations for an upper age limit; the Subcommittee authorized her to approve a guideline with his recommended upper age limit.

### Bladder Catheters/Bladder Obstruction

1) Catheterization (straight cath or Foley) add to Ancillary List

2) Line 78 (Neurologic dysfunction in bladder control): add suprapubic catheter placement (51010) and ICD-9 codes for neurologic conditions of the bladder [Atony of bladder (596.4), Paralysis of bladder (596.4), Neurogenic bladder NOS (596.54)]

3) Line 349 (Bladder outlet obstruction): add aspiration of bladder by needle or trochar (51000, 51005), Insertion of suprapubic catheter (51010), Urethral stricture from infection (598.00) or classified elsewhere (598.01), Atresia or stenosis of bladder neck (753.6)

### Repair of Complications of Circumcision

Smits to review medically indicated circumcision line placement, propose possible line changes and/or guideline for coverage for next meeting.

### Miscellaneous Urological Issues

Move 53060 (Drainage of Skene's gland abscess or cyst) and 53070 (Excision of Skene's gland) to line 215 (Superficial abscess and cellulitis

- a. Line 643 (Redundant pupice; not 54160)
- b. Line 349 (Mechanical disorders of genitourinary system)
- c. Line 517 (Phimosis)

Symonette asked about coverage for medically indicated circumcision, such as in the case of phimosis. Saha agreed that phimosis which results in ischemia should be covered.

The Subcommittee requested that Smits research placement of medically indicated circumcision, particularly phimosis, and bring recommendations to the next HOSC meeting.

Miscellaneous Urological Issues

Smits reviewed three additional Urology issues:

1) 597.0 (Abscess of periurethral gland) appears only on line 215 (Superficial abscess and cellulitis), needs to pair with 53060 (Drainage of Skene's gland abscess or cyst) and 53070 (Excision of Skene's gland). These CPT codes currently appear only on line 503 (Cysts of Bartholin's gland and vulva). The subcommittee voted to move 53060 and 53070 to line 215.

2) 236.91 (Neoplasm of kidney or ureter of uncertain behavior) on line 229 (Cancer of kidney and other urinary organs) pairs with 50557 (Renal endoscopy with fulguration and/or incision) which currently appears only on line 187 (Ureteral stricture or obstruction, hydronephrosis). 50557 did not pair with codes on line 187 and was deleted with GU Calculi review; it now appears nowhere on the list. The group decided to add 50557 to line 229 to pair with 236.91

3) Hemolytic uremic syndrome (HUS, 283.11) only appears on lines 111 (Acute renal failure, kidney transplant) and 158 (Acquired hemolytic anemias). Neither of these lines have codes for dialysis (peritoneal or hemodialysis). Dr. Skoog is requesting that HUS pair with peritoneal dialysis codes (90945-90947). The subcommittee felt that there were other important treatments for other aspects of HUS, including plasmapheresis, which should be paired with this condition which would not be appropriate for a dialysis line. The group decided to add dialysis CPT codes to Line 158

Add 50557 (Renal endoscopy with fulguration and/or incision) to line 229 (Cancer of kidney and other urinary organs)

Add dialysis CPT codes to Line 158 (Acquired hemolytic anemias). Add 36514 (plasmapheresis) to line 158. Add TTP (446.6) to Line 158.

<p>(Acquired hemolytic anemias). Smits pointed out that plasmaphoresis was not on this line, and actually did not appear on the current list. Olson felt that 36514 (plasmapheresis) needed to be added to line 158. Additionally, Olson felt that TTP (446.6) should be moved to Line 158 to pair with 36514.</p>	
<p><b>Guidelines</b></p> <p><u>Bariatric surgery</u> Smits presented suggested changes to the bariatric surgery guideline from Dr. David Labby of CareOregon, which seek to clarify the HSC’s intent. These changes were accepted without discussion.</p> <p><u>Non-surgical treatment of obesity/nutrition guidelines</u> Smits introduced OHP medical directors’ concerns with the open ended nature of the current guideline around non-surgical treatment of obesity. Other MDs felt that this guideline might preclude them from using removal of these benefits as a motivating tool.</p> <p>Olson argued that nothing in this guideline precludes not providing service if seems not medically useful or indicated. Should not preclude Coos Bay plan from stopping service if not medically indicated Symonette replied that the plans need legal back-up if challenged. Can the Medical Directors propose a guideline? Saha: USPSTF recommendations were used for this guideline. We don’t want folks in lifelong therapy. Olson: should we limit the number of visits a year? Saha: look at what USPSTF studies showed for frequency of visits, time limit/duration. Mangum suggested adding a guideline such as “Services are to be continued only if there is documented progressive weight loss and are no longer covered once goals have been met.” Shaffer recommended looking at the length of treatment in studies in the EPC and HRC reports. Saha agreed and added that the HSC may put in one threshold for showing improvement, another for when then get to goal Coffman noted that this should this be like PT guideline, with intensive treatment for a period, then maintenance Shaffer recommended focusing on most the most effective</p>	<p><u>Bariatric surgery</u> Changes outlined in the meeting materials accepted.</p> <p><u>Non-surgical treatment of obesity/nutrition guidelines</u> Smits to review HRC and EPC reports and determine the length of treatment used in studies which showed benefit from intensive interventions. She will bring back a revised guideline reflecting these upper time limits to the next meeting.</p> <p><u>Lymphedema/PT Guideline</u> Change Guideline to read: “Lymphedema treatments are covered when medically appropriate. These services will only be covered when provided by a licensed practitioner who is certified by, or participating in the certification or training process for, one of the accepted lymphedema training certifying organizations. The only accepted certifying organization at this time is LANA (Lymphology Association of North America; <a href="http://www.clt-lana.org">http://www.clt-lana.org</a>). <u>Treatments for lymphedema are not subject to the visit number restrictions found in Guideline Note 1, Rehabilitative Therapies”</u></p> <p><u>Health and Behavior Assessment Codes</u> Approved use of the CMS guideline</p>

<p>guidelines</p> <p><u>Lymphedema/PT Guideline</u></p> <p>Smits brought up that the lymphedema guideline adopted at the last meeting contradicts the current PT guideline. The HOSC decided to modify the lymphedema guideline to specify that the PT guideline does not apply in this situation.</p> <p><u>Health and Behavior Assessment Codes</u></p> <p>The HSC approved the use of the Medicare guideline for Health and Behavior Assessment CPT codes (96150-96154) when these codes were added to the Prioritized List in August, 2007. A formal guideline needs to be added to the lines where these codes appear to clarify the HSC's intent. The group approved the use of the current CMS guidelines. Discussion centered around updating this guideline. Smits noted that old versions of CMS guidelines are still available on their website, with notation that they have been superceded. It was agreed that the 2/1/06 CMS guideline should be applied, and at some point a search would be done for updated guidelines.</p>	<p>from 2/6/06 for the Health and Behavior Assessment Codes.</p>
<p><b>V Codes</b></p> <p><u>Follow up from August review:</u>  V53.02 (fitting and adjustment of neuropacemaker for brain or peripheral nerves), V53.09 (Fitting and adjustment of other devices related to nervous system and special senses), and V53.5 (fitting and adjustment of other intestinal appliance) line placements were approved with the change that V53.09 was added to only one of the 4 dysfunction lines (317).</p> <p><u>V Code Review V59-V84</u></p> <p>1) Donor (V59): the suggested code placements were accepted, with the exception that Olson requested that V59.3 (blood donor) be added to all lines with bone marrow donor.</p> <p>2) Family/Social (V61-V65): the suggested code placements were accepted, with the exception that V65.5 (Person with feared complaint in whom no diagnosis was made) be tabled so that more information can be gathered. Smits was directed to</p>	<p>1) V53.02 (fitting and adjustment of neuropacemaker for brain or peripheral nerves) add to lines with 95970 (Electronic analysis of implanted neurostimulator) located on:</p> <ul style="list-style-type: none"> <li>i. Line 183 (Generalized convulsive or partial epilepsy)</li> <li>ii. Line 441 (Complications of a procedure usually requiring treatment)</li> <li>iii. Line 460 (Trigeminal and other nerve disorders)</li> <li>iv. Line 509 (Peripheral enthesopathies)</li> <li>v. Line 624 (Disorders of soft tissue)</li> </ul> <p>2) V53.09 (Fitting and adjustment of other devices related to nervous system and special senses) add to lines:</p>

bring this code to the Line Zero group, and bring back recommendations to the HOSC. The discussion around this code was that Coffman felt that it should be added to the diagnostic list, Saha to the Never Covered List, Smits to the Ancillary List.

Discussion stopped after V65, and the remainder of these codes were tabled until the next meeting.

1. 183 (Epilepsy, focal surgery)
2. 268 (MS)
3. 317 (Dysfunction in posture and movement)
4. 385 (Dystonia)

3) V53.5 (fitting and adjustment of other intestinal appliance) add to lines:

1. 35 (REGIONAL ENTERITIS, IDIOPATHIC PROCTOCOLITIS, ULCERATION OF INTESTINE)
2. 48 (INTUSSCEPTION, VOLVULUS, INTESTINAL OBSTRUCTION, AND FOREIGN BODY IN STOMACH,INTESTINES, COLON, AND RECTUM)
3. 78 (Dysfunction in eating, bowel control)
4. 97 (NECROTIZING ENTEROCOLITIS IN FETUS OR NEWBORN)
5. 112 (Congenital anomalies of GI system)
6. 164 (ACUTE VASCULAR INSUFFICIENCY OF INTESTINE)
7. 168 (Colon/intestinal cancer)
8. 337 (Esophageal cancer)
9. 406 (Esophageal stricture)

V59.0 (blood donor) to be added to all lines with bone marrow donor.

Add to never covered list: V59.1- V59.2 (Skin, bone donor), V59.5 (Cornea donor), Egg donor (V59.7), V59.8 (Other specified organ donor), V59.9 (unspecified organ donor)

V59.3 (bone marrow donor) to be kept on all lines with bone marrow donor.

	<p>Add V65.3 (dietary counseling) to Lines 3, 4 (preventive lines)</p> <p>V65.5 (Person with feared complaint in whom no diagnosis was made): decision on placement was tabled, Smits will gather more information, bring to Line Zero group, and bring back recommendations to the HOSC.</p> <p>Add to never covered list: V61 (Special circumstances) other than V61.20 (Counseling for parent-child problem, unspecified-see above), V63 (Social circumstances), V65.0 (Healthy person accompanying sick person), V65.1 (Person consulting on behalf of another person), V65.8 (Other reasons for seeking consultation), V65.40 (Counseling NOS), V65.49 (Other specified counseling), V65.9 (Unspecified reason for consultation), V65.2 (malingering)</p>
<p><b>Straightforward Issues</b></p> <p>Recommended changes under straightforward issues were approved as suggested.</p>	<ol style="list-style-type: none"> <li>1. Delete 726.5 from line 523 (Peripheral enthesopathies)</li> <li>2. Delete 43289 from Line 70 (Congenital anomalies of upper GI system); Add to PAC-5</li> <li>3. Delete 58957 and 58958 from Line 464 (Tourette's Syndrome and Tic Disorder)</li> <li>4. Delete 60699 from Line 272 (Multiple Endocrine Neoplasia) Add to PAC-5 List</li> <li>5. Delete 99071 from line 6 (Tobacco Dependence)</li> <li>6. Delete 96150-96154 from lines 78, 317, 372</li> <li>7. 692.71 deleted from line 546 and added to line 625</li> <li>8. 692.77 deleted from line 376 and added to line 188</li> </ol>
<p><b>VAD Guideline</b></p>	<p>Add VAD (33979-33980) to lines 90 (Myocarditis, non-viral) and 366</p>

Dr. Howard Song from OHSU presented information about use of VADs for bridge to recovery therapy and for treatment of pulmonary hypertension as a step toward cardiac transplant. There was discussion about the cost and the use of VAD for destination therapy as well. The HOSC agreed to the guideline changes as recommended by Smits and Song, allowing VAD use for recovery therapy and for treatment of pulmonary hypertension with the end goal of cardiac transplant. Dr. Song was invited back to give another presentation when newer VAD devices receive FDA approval for possible consideration of use of these newer devices for destination therapy.

(Myocarditis, viral).

Change Guideline Note 16 to read:

“Ventricular assist devices are covered only in the following circumstances:

1. as a bridge to cardiac transplant
2. as treatment for pulmonary hypertension when pulmonary hypertension is the only contraindication to cardiac transplant and the anticipated outcome is cardiac transplant
3. as a bridge to recovery.

Ventricular assist devices are not covered for destination therapy.”

**MEETING HIGHLIGHTS  
HEALTH OUTCOMES SUBCOMMITTEE**

Clackamas Community College

Wilsonville, Oregon

December 6, 2007

8:00-2:00

**Members Present:** Som Saha, MD, Chair; Lisa Dodson, MD; Dan Mangum, MD; Kevin Olson, MD

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

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

*Note: Adjourned at 1:15 PM. Next HOSC meeting is scheduled for January 10, 2008.*

<b>Topic</b>	<b>Action</b>
<p><b>General</b> Highlights from 11/07 HOSC meeting reviewed. Saha noted that under “knee arthroscopy” section, should have “shoulder” changed to “knee.”</p> <p>The subcommittee expressed their approval of the electronic meeting packet with bookmarks, noting that it was easier to navigate than the paper packet. They recommended that paper packets only be made available for members who request them at future meetings.</p>	<p>Highlights approved with noted change.</p> <p>For the January meeting, the email containing the meeting materials will have a request for members to respond with their preference for a paper packet or use solely of the electronic version.</p>
<p><b>CPT/HCPCS Code review</b></p> <p>Smits reviewed the proposed additions and non-additions for 2008 CPT and HCPCS codes. Specific comments and discussion regarding codes were as follows:</p> <p>49203-5: Olson wanted to ensure that the code was included on the ovarian cancer line (line 252). He also wanted to ensure that 238.1 also should be covered and recommended that staff look for any additional line(s) to add to ensure that this code pairs with these procedures. 238.1 appears on line 208 (cancer of soft tissue), and these codes will be added to this line.</p> <p>20555: Olson wanted to ensure that sarcoma ICD-9 codes were on line 208. Soft tissue sarcomas appear to be included on this line.</p>	<p>Suggested placement of the new CPT codes and HCPCS codes was approved as outlined in the meeting materials, except for the following:</p> <ol style="list-style-type: none"> <li>1) Add 49203-205 to line 252 (ovarian cancer) and line 208 (cancer of soft tissue)</li> <li>2) Place 89331 (semen analysis for retrograde ejaculation) and 608.87 (retrograde ejaculation) on the Never Covered List.</li> <li>3) Add 99406-99407 to line 6 (Tobacco Dependence)</li> </ol>

89331: The proposal was to include on line 349 (functional and mechanical disorders of the GU system) because retrograde ejaculation (608.87) was also found on this line. Saha did not want to cover retrograde ejaculation at all. Olson felt that this diagnosis should be put on the infertility line. Coffman pointed out that there was no infertility line, as this was on the Never Covered list. The group decided to place both 89331 and 608.87 on the Never Covered List.

99406-99407 (Tobacco cessation counseling): the suggested placement was the preventive services line. The HOSC felt that the Tobacco Dependence Line (Line 6) was more appropriate.

99408-99409 and G0396 and G0397 (alcohol cessation counseling): the HOSC wanted all codes related to tobacco/alcohol/drug abuse to be placed on both the adult/teen preventive services line (line 4) and the child preventive services line (Line 3).

90284: IVIG (90283) to be added to same lines. Symonette indicated that non coverage of IVIG is in rule. We would need to change rule. Olson wondered if there was a J code associated with use. Shaffer responded that J codes must be reported with CPT code for administration. Olson recommended that should we research use of J code use in this situation and bring suggestions for possible J code addition to the next meeting. Saha responded that the J codes could not be used without CPT codes; therefore adding the CPT code would be sufficient.

80047: the HOSC pointed out that this is a diagnostic test and should be on the Diagnostic List, not the Ancillary List.

86356: The proposed placement was the Diagnostic list. Mangum raised concerns for abuse of this code. Olson: suggested adding to Never Covered and see what complaints come up. Olson reported that this test is not used much in general, and remarked that this test is probably not needed for diagnosis. The decision was made to place on Never Covered list.

98966-98968 and 99441-99443 (telephone assessment codes): Saha commented that this change expands primary care access and Olson commented that it may decrease costs by cutting

4) Add 99408-99409 and G0396 and G0397 to line 3 (preventive services, ages 10 and under) as well as line 4.

5) Add 80047 to the Diagnostic List, not the Ancillary List.

6) Place 86356 on Never Covered list.

7) 98966-98968 and 99441-99443 (telephone assessment codes), 98969 and 99444 (online assessment codes) and 99605-99607 (pharmacist medication management codes): Smits to draft guidelines to bring back to the next meeting.

8) 75557-75564 (cardiac MRI): pended until next meeting when more information can be presented.

9) C8921-C8928 (transthoracic ECHO with contrast): Smits to consult with cardiologist/pediatric cardiologist/thoracic surgeon/neurologist for more information. Adding these codes to the list was pended until the next meeting when more information could be considered.

back on ER use. Kirk did not feel that adding these codes would really be concerning in terms of cost. Shaffer asked whether these codes are really medical home enhancing codes? Symonette wanted to ensure that we restricted use to licensed professionals. Shaffer responded that we already restrict to licensed professionals in the DMAP billing system. Kirk raised concerns about HIPPA compliance issues, recommended adopting rules like Providence about documentation, HIPPA compliance, etc. Shaffer pointed out that current OHP rules prevents telephone consults, but Symonette pointed out that telemedicine is covered. Shaffer again raised concerns about budget impact over time.

98969 and 99444 (online assessment codes): Shaffer requested that the HOSC consider guidelines for some or all of these codes (telephone and/or email). Saha suggested accepting these codes (both telephone and email), and having Smits draft guidelines for these codes to bring back to the next meeting.

99605-99607 (pharmacist medication management codes): Kirk pointed out if the pharmacy codes are added, it makes pharmacists providers and we would need to credential them. There was debate about who qualifies as a pharmacist (clinical, PharmD, etc.). Kirk suggested limiting to PharmDs. Saha suggested that staff ask Dean Haxby what the credentials of pharmacists who should do this type of activity. The decision was made to adopt these codes with intent to have guidelines.

75557-75564 (cardiac MRI): The suggestion was to put these tests on the Diagnostic List with the Medicare use guideline. Saha thought it would be more appropriate to put these codes on the List. Smits pointed out that this would go on many lines. Coffman advised caution as in the future, some of these lines might fall below funding line. Mangum wondered if you would do this instead of another test? Coffman added a question about whether this would ever be used without a presumptive diagnosis?

Saha thought this was very unlikely. Saha suggested that Smits will go through the ICD-9 codes covered under the Medicare guideline with a Cardiologist and/or Thoracic surgeon and select those (the "short list") that might need MRI and put these codes on the lines with these codes. Even with this input, he felt that these codes would still need a guideline. Decision: pend all until next meeting when more information can be presented.

<p>C8921-C8928 (transthoracic ECHO with contrast): The initial suggestion was to place on the diagnostic list, with ECHO without contrast. Saha felt that these codes should put only on congenital heart lines on the Prioritized List or on the Never Covered list. Smits offered to consult with specialists and/or conduct a literature review to see if contrast adds anything to traditional ECHO. Mangum and Dodson wondered when adding contrast adds benefit to the test. Saha wanted to know if adding contrast improves outcomes. Shaffer recommended that if specialists are consulted, that pediatric cardiology input should be sought as this may be a special case. Mangum also recommended talking to a Neurologist re stroke care. Decision was to pend, gather more information and suggestions for next meeting.</p>	
<p><b>Prenatal Genetic Testing</b></p> <p>Smits reviewed that currently the tests (laboratory and ultrasound) required for prenatal genetic testing exist on both line 1 (maternity care) and the Diagnostic List. She proposed adding all of the tests used only during pregnancy to Line 1. This was agreed upon with minimal discussion. Additionally, some ectopic pregnancy CPT codes were moved to the ectopic pregnancy line.</p>	<p>Changes accepted as outlined in meeting materials.</p>
<p><b>Epidural injections</b></p> <p>Smits reviewed a DMAP Hearings Division request for clarification on coverage of epidural injections. The HOSC reduced the number of lines to which they would consider adding 62310-62311, 62318-62319, and 64479-64482 to only include line 78 NEUROLOGICAL DYSFUNCTION IN BREATHING, EATING, SWALLOWING, BOWEL, OR BLADDER CONTROL CAUSED BY CHRONIC CONDITIONS), Line 307 (COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT), Line 397 (DISORDERS OF SPINE WITH NEUROLOGIC IMPAIRMENT), Line 513 (SPASTIC DIPLEGIA), Line 552 (ACUTE AND CHRONIC DISORDERS OF SPINE WITHOUT NEUROLOGIC IMPAIRMENT).</p> <p>Saha recommended adding only to line 397. Olson indicated that these codes did not include chemotherapy and all cancer lines should be deleted from the list of lines to consider. Suggested adding these codes to Lines 397 and 552</p> <p>The decision was to table a decision on these codes and bring</p>	<p>Pended to January meeting. Smits to research these codes further and bring back information and revised recommendations.</p>

<p>these back for further discussion in January, with input from specialists/experts and the literature.</p>	
<p><b>Femoral non-union/hip arthroplasty</b></p> <p>Smits reviewed a provider question about coverage of hip arthroplasty for femoral non-union. There was minimal discussion of this issue.</p>	<p>Add 27130 (Arthroplasty, including total hip replacement) to line 461 (Malunion and nonunion of fracture)</p>
<p><b>ERCP</b></p> <p>Smits reviewed a provider question about location of ERCP on the list. The CPT codes for various ERCP procedures are not uniform in their placement. The Committee felt that ERCP and ERCP with biopsy should be added to all lines with other ERCP codes rather than placed on the diagnostic list, as these procedures are not done in cases with an unknown diagnosis.</p>	<p>Changes accepted as outlined in the meeting materials, except: 43260 and 43261 (ERCP and ERCP with biopsy) were added to lines 60, 318, 339, 453, and 659. These codes were left on line 267 and were not added to the diagnostic list.</p>
<p><b>Guidelines</b></p> <p><u>Bariatric surgery</u> Smits presented suggested changes to the Bariatric surgery guideline made in conjunction with DMAP. There was minimal discussion.</p> <p><u>Non surgical treatment of obesity</u> Smits presented proposed wording changes to the non-surgical treatment of obesity guideline. Mangum felt that such services should covered as long as there is evidence of weight loss. Smits pointed out that the proposed guideline allowed 6 months of coverage for intensive therapy, coverage of maintenance therapy for as long as evidence of weight loss Mangum wondered if intensive therapy should continue if there was a lack of weight gain? Saha felt that there should be 6 months of intensive, then no limit on maintenance. Mangum felt that maintenance could only be continued if there is evidence of weight loss or lack of weight gain. Kirk felt that abuse potential is small for this procedure. Saha suggested covering maintenance no more than monthly, favor not limiting to lack of weight gain. Kirk added continuing frequent visits beyond 6 months if patient shows significant weight loss.</p> <p>The following wording was approved to be added to the suggested guideline: “Intensive counseling visits (once every 1-2 weeks) are covered for 6 months. Intensive counseling visits may continue for longer than 6 months as long as there is evidence of continued weight loss. Maintenance visits are covered no more than monthly after this intensive counseling</p>	<p><u>Bariatric surgery</u>: changes accepted as outlined in the meeting materials.</p> <p><u>Non surgical treatment of obesity guideline</u>: Medical treatment of obesity includes intensive counseling on nutrition and exercise, provided by health care professionals. Intensive counseling is defined as face to face contact more than monthly. Visits are not to exceed more than once per week. Intensive counseling visits (once every 1-2 weeks) are covered for 6 months. Intensive counseling visits may continue for longer than 6 months as long as there is evidence of continued weight loss. Maintenance visits are covered no more than monthly after this intensive counseling period. Pharmacological treatments are not intended to be included as a treatment on this line. See also Guideline Note 57</p> <p><u>Communicating hydrocele guideline</u>: changes accepted as outlined in the meeting materials.</p>

<p>period.”</p> <p><u>Communicating hydrocele</u> Smits presented the revised guideline with the upper age limit of 18 for approval. No discussion.</p> <p><u>Stress incontinence</u> Smits presented a DMAP Hearing Division question regarding diagnoses covered by the current Stress Incontinence guideline. There was minimal discussion. The decision was made to apply the urinary incontinence guideline to all diagnoses on the line 470.</p>	<p><u>Stress incontinence</u> Apply the urinary incontinence guideline to all diagnoses on the line 470.</p>
<p><b>Ancillary list</b></p> <p>Smits presented recommendations for placement of CPT codes on to a formal Ancillary List, as well as movement of CPT codes from the previous informal Ancillary List onto the Prioritized List.</p> <p>The group discussed whether the Ancillary List will be maintained and published by the HSC or by DMAP. The decision was that the HSC will take ownership of the Ancillary list, as well as the Never covered and Diagnostic list.</p> <p>There was discussion about whether the HSC could designate procedures as “PAC-5,” a DMAP acronym indicating automatic review required. The decision was that such codes would be placed on a list titled “Review required.” Such procedures would not be covered unless a plan Medical Director or DMAP Medical Director or their designee approved it.</p> <p>Suggested CPT placements were accepted as noted in the meeting materials except for the following:</p> <p>S9558 (home injection of growth hormone) should also be added to line 411 (pituitary dwarfism)</p> <p>S9560 (injectable hormone therapy) was suggested for addition to ancillary list. The HOSC voted to add this code to appropriate lines on the prioritized list (breast cancer, prostate cancer, endometriosis, other lines to be determined by HSC staff). Bring back suggestions to the next HOSC meeting if additional lines are identified.</p>	<p>Suggested CPT placements were accepted as noted in the meeting materials except for the following:</p> <ol style="list-style-type: none"> <li>1) S9558 (home injection of growth hormone) added to line 411 (pituitary dwarfism) in addition to line 486</li> <li>2) S9560 needs research into line placement, bring back to next meeting if more than breast/prostate cancer and endometriosis</li> <li>3) 20662 (application of halo) should only be added to line 397 (disorders of spine with neurologic impairment)</li> <li>4) 20665 (removal of pelvic halo) added to line 397 (disorders of spine with neurologic impairment)</li> <li>5) 93572 and 93662: pended, more information needed for next meeting</li> <li>6) 62280-62282 (injection of neurolytic substances, spinal): pended. Will not be added to cancer lines. Smits will collect this data and bring back to the next HOSC meeting.</li> </ol>

<p>20662 (application of halo) should only be added to one line (397) because the application of a halo to the pelvis would not be used for cranial or cervical conditions. 20665 (removal of pelvic halo) was added to line 397 as well.</p> <p>93572 and 93662: Saha requested additional information on what these procedures are and have a more informed discussion at the next meeting.</p> <p>62280-62282 (injection of neurolytic substances, spinal): Olson pointed out that these codes were not used for chemotherapy administration. Lines with cancer diagnoses should not be considered for placement. Other HOSC members requested additional information about use of the procedure and evidence for such use. Smits will collect this data and bring back to the next HOSC meeting.</p> <p>64445: add to spinal lines with and without neurologic impairment</p>	<p>7) 64445: add to spinal lines with and without neurologic impairment (397 and 552) rather than place on ancillary list</p> <p>8) A9507 and A9505 (Thallium and indium, diagnostic) were pended for additional information</p>
<p><b>V codes</b></p> <p>The V code review continued with V66.</p> <p>V 67.01 (Follow up Pap) also added to line 4 (preventive care, older than age 10) as this service may not be done solely for precancerous type results.</p> <p>V68.2 (Encounter for administrative purposes; Request for expert evidence) was thought to be a non-necessary service and was added to the never covered list.</p> <p>V70.1-V70.5 were thought to provide services which are not generally covered by insurance, such as camp and sports physicals, pre-employment screening, and drug testing. The committee decided to add these codes to the Never Covered list. V70.6 (Health exam in population screening) was added to line 3 as well as line 4. V70.8 (Other specified routine exam) was debated. The OHSU donor program has requested that this code is added to the list to allow billing for organ donor exams. Intend to bill the recipient, not the donor. Caroline Price raised concerns about this. Dodson requested more information from the OHSU donor program or other donor program to confirm that commercial plans don't pay for this (Kirk says they are). Price indicated that the DMAP transplant program pays for procurement services for donation. Saha thought this was best put on transplant lines.</p>	<p>Changes were accepted as presented in the meeting materials, except:</p> <ol style="list-style-type: none"> <li>1) V 67.01 (Follow up Pap) also added to line 4 (preventive care, older than age 10)</li> <li>2) V68.2 (Encounter for administrative purposes; Request for expert evidence) was added to the never covered list.</li> <li>3) V70.1-V70.5 added to the Never Covered list.</li> <li>4) V70.6 (Health exam in population screening) was added to line 3 as well as line 4.</li> <li>5) V70.8 (Other specified routine exam) was pended</li> <li>6) V71.01, V71.02, V71.1, V71.3, and V71.7 were added to the never covered list.</li> <li>7) V71.81 was added to line 131</li> </ol>

<p>V71 (observation for suspected conditions) codes were reviewed. Several of these codes have substantial costs associated with them by DMAP. Several of these codes are on lines currently. The committee felt that these codes could remain on these lines; however, the rest of the codes were thought to be non-specific. The committee felt that more specific codes could be used for many of the situations where these codes might be used. The decision was to place these on the never covered list. V71.4 and V71.6 involve observation after an accident, and are likely to be used in an ER setting where no diagnosis is eventually made. The committee felt these should be on the Ancillary List. V71.81 (Observation for suspected abuse and neglect) was added to line 133 (abuse). V71.81 (Observation for other suspected conditions) had substantial funds running through it and was referred to the Line Zero workgroup for more info.</p> <p>V72.4 (Pregnancy testing) was proposed to be placed on line 1 (maternity care); however it was pointed out that pregnancy testing is done for a variety of reasons (pre-op, etc.) and this should be placed on the Ancillary list. V72.7 (Diagnostic skin and sensitization tests) was proposed for the ancillary list. However, it was pointed out that this is a diagnostic code, not a testing/procedure code, and should be placed on the never covered list. This testing can still be done, but the underlying diagnosis (asthma, anaphylaxis, etc.) should be coded as the diagnosis.</p>	<p>(Abuse and neglect)</p> <p>8) V71.81 (Observation for other suspected conditions) was referred to the Line Zero workgroup</p> <p>9) V72.4 (Pregnancy testing) removed from Line 1 (maternity care) and placed on the Ancillary list</p> <p>10) V72.7 (Diagnostic skin and sensitization tests) was placed on the never covered list.</p>