

**MEETING HIGHLIGHTS
HEALTH OUTCOMES SUBCOMMITTEE**

Meridian Park Hospital
Tualatin, Oregon
December 4, 2008
8:00-3:00

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

Members Absent: Somnath Saha, MD, MPH

Staff Present: Darren Coffman; Ariel Smits, MD MPH

Also Attending: Wally Shaffer MD, DMAP; Caroline Price RN, DMAP; Chris Kirk, MD OHP Medical Directors; Tina Kitchin, MD, DHS-Senior & People with Disabilities; Beryl Fletcher, Oregon Dental Association; Catherine Livingston, MD, OHSU; Matt Krebs, Pfizer; Mary Sand, Chemeketa HIM Intern; Kennedy Smith, Oregon Health Forum; Derek Lipman, MD

Note: Next HOSC meeting is scheduled for January 15, 2009.

Topic	Action
<p>General Highlights from August 2008 HOSC meeting reviewed. No changes or corrections were noted.</p>	<p>Highlights approved without change.</p>
<p>New CPT Codes</p> <p>Smits introduced an Excel spreadsheet outlining recommendations for placement of new CPT codes. The recommendations were accepted as outlined in the meeting materials, with the following exceptions:</p> <ol style="list-style-type: none"> 1. 99466 and 99467 (CRITICAL CARE SERVICES DELIVERED BY A PHYSICIAN, FACE-TO-FACE, DURING AN INTERFACILITY TRANSPORT OF CRITICALLY ILL OR CRITICALLY INJURED PEDIATRIC PATIENT) were placed on the Ancillary List instead of the proposed lines on the Prioritized List. The Subcommittee felt that these codes should be covered, even if the final diagnosis was not on a covered line on the Prioritized List. These codes would be on the Ancillary list, similar to CPR codes. 99288 (Physician direction of EMS emergency care, ALS) would be removed from the List and also placed on the Ancillary List. 2. 88720 (BILIRUBIN TOTAL TRANSCUTANEOUS) was added to the Diagnostic List. McKelvey argued that this test is commonly used in practice and is standard of care in many pediatric settings. 	<p>Final recommendations are as listed in Appendix A. These recommendations are as presented in the meeting materials, except:</p> <ol style="list-style-type: none"> 1) (CRITICAL CARE SERVICES DELIVERED BY A PHYSICIAN, FACE-TO-FACE, DURING AN INTERFACILITY TRANSPORT OF CRITICALLY ILL OR CRITICALLY INJURED PEDIATRIC PATIENT) placed on Ancillary List. 2) 99288 (Physician direction of EMS emergency care, ALS) removed from Prioritized List and placed on Ancillary List. 3) 88720 (BILIRUBIN TOTAL TRANSCUTANEOUS) added to the Diagnostic List

3. 41530 (SUBMUCOSAL ABLATION OF THE TONGUE BASE) was placed on the Never Covered List. Olson felt that this code was not a useful procedure, and should not be covered. The literature reviewed was felt to be preliminary. The Subcommittee felt that this procedure could be re-reviewed in the future if stronger literature support became available.
4. Laparoscopic hernia repair (49652- 49657) was discussed. Smits pointed out that codes for incarcerated hernia and obstruction were both on the upper, complicated hernia line as well as the lower, uncomplicated hernia line. Kirk indicated that there are no ICD-9 codes for incarcerated hernia. There are cases in which an incarcerated hernia does not have obstruction or gangrene, and therefore does not need repair. He argued that the Commission should keep both types of hernias on both lines and that the hernia guideline applies. Gubler felt that incarceration is an indication for surgery, and is standard of care. Non coverage would put surgeons at risk. Strangulation is an emergent indication for surgery, incarceration is an urgent indication. Kirk stated that the hernia guideline would need to change to say that incarcerated hernia with or without pain should be covered. Gubler stated that all incarcerated hernias should appear on the upper hernia line. The hernia guideline wording was changed to reflect that complicated hernias are incarcerated OR have symptoms of obstruction (rather than AND).

Additionally, several additional list changes as outlined in the Excel Spreadsheet and the Word document on New CPT Code Issues were accepted as recommended in those documents. Included in these changes was the deletion of 99477 (Initial hospital care, per day, for the evaluation and management of the neonate, 28 days of age or less) from multiple mental health lines.

Compartment Syndrome

Smits reviewed a document regarding coverage of compartment syndrome as part of the CPT code review. Appropriate ICD-9 codes for compartment syndrome do not appear on the current Prioritized List. Codes for decompression fasciotomy are on various places on the list, not necessarily on the appropriate lines based on pairing with ICD-9 codes. Smits reviewed suggested changes for clarifying coverage of compartment syndrome, as outlined in the meeting material document. There was minimal discussion.

- 4) 41530 (SUBMUCOSAL ABLATION OF THE TONGUE BASE) was placed on the Never Covered List.
- 5) All incarcerated hernia CPT codes will appear only on the upper hernia line (176). Remove 49521, 49553, 49557, 49561, 49563, 49566 from Line 538 (Uncomplicated Hernia) and retain on Line 176 (Complicated hernias and hernias in children). Add new laparoscopic codes for repair of incarcerated hernias only to Line 176 (49653, 49655, 49657).
- 6) Change GUIDELINE NOTE 24, COMPLICATED HERNIAS to read:
Line 176
 Complicated hernias are included on this line if they are incarcerated ~~and~~ *or* have symptoms of obstruction and/or strangulation.

Additionally, several additional list changes as outlined in the Excel Spreadsheet and the Word document on New CPT Code Issues were accepted as recommended in those documents. Included in these changes was the deletion of 99477 (Initial hospital care, per day, for the evaluation and management of the neonate, 28 days of age or less) from multiple mental health lines.

- 1) Add 729.7 (Nontraumatic compartment syndrome) and 958.9 (Traumatic compartment syndrome).to Line 143 **CRUSH INJURIES OTHER THAN DIGITS**
 - a. Keep 729.9 (Other and unspecified disorders of soft tissue) on Line 624 **DISORDERS OF SOFT TISSUE**
 - b. Keep 958.8 (other complications of trauma) on Line 143

	<p style="text-align: center;">CRUSH INJURIES OTHER THAN DIGITS</p> <p>2) Change name of Line 143 to “Crush injuries other than digits; compartment syndrome”</p> <p>3) Add all fasciotomy CPT codes to Line 143 which are not currently there.</p> <ul style="list-style-type: none"> a. Remove all CPT codes described as “decompression fasciotomy” from current lines other than Line 143. b. Leave all CPT code described only as “fasciotomy” on their current lines as well as Line 143 <p>4) New CPT codes: add 27027 DECOMPRESSION FASCIOTOMY(IES), PELVIC (BUTTOCK) COMPARTMENT(S) and 27037 DECOMPRESSION FASCIOTOMY(IES), PELVIC (BUTTOCK) COMPARTMENT(S) WITH DEBRIDEMENT to Line 143</p>
<p>HSC Medication Policy</p> <p>Smits reviewed a policy statement regarding dealing with medications. The HOSC agreed with this statement with minimal discussion. HOSC staff will forward this policy statement to the Department of Justice for a legal review and bring back any required changes.</p> <p>As part of this discussion, it was agreed that J codes would be removed from the Prioritized List. CPT codes dealing with the infusion or administration of medications would be considered Ancillary and multiple of these codes would be removed from the Prioritized List.</p> <p>Changes were reviewed which were made to the enzyme replacement therapy guideline which were made in consultation with the HOSC Chair prior to implementation of the October 1, 2008 Prioritized List so as not to potentially place the OHP program in violation of the state law. These changes were approved.</p>	<p>The following statement was agreed to, pending DOJ review and full HSC discussion:</p> <p>HSC Policy Regarding Medications, DME, and Other Ancillary Services</p> <p>The Health Services Commission (HSC) has authority over the Prioritized List, including placement of conditions and treatments on the List. The HSC is expected to include cost-benefit assessments for treatments considered for inclusion on the List, balancing the needs of the OHP population as a whole and the expenditures of limited resources. The HSC can create, in an open and public manner,</p>

	<p>guidelines which recommend restrictions or limitations on the coverage of medications, durable medical equipment (DME), or other ancillary services, as they relate to conditions and treatments on the Prioritized List. Such guidelines are expected to be implemented to the best ability of DMAP and prepaid managed care health services organizations, as allowed by federal and state rules and regulations. These guidelines set a minimum coverage level for DMAP and the prepaid managed care health services organizations. Decisions of the HSC regarding medications, DME, or other ancillary services which are not placed into guidelines are considered advisory only.</p> <p>J codes would be removed from the Prioritized List. CPT codes dealing with the infusion or administration of medications would be considered Ancillary and removed from the Prioritized List.</p>
<p>Extended Counseling Codes Smits introduced recommendations from the MHCD Subcommittee regarding the placement of extended counseling codes. These recommendations were adopted with minimal discussion.</p>	<p>Extended counseling codes (90808-90809, 90814-90815, 90821-90822) added to Lines</p> <p>108 BORDERLINE PERSONALITY DISORDER 181 POSTTRAUMATIC STRESS DISORDER 315 ACUTE STRESS DISORDER 387 CONVERSION DISORDER, CHILD 395 SOMATIZATION DISORDER; SOMATOFORM PAIN DISORDER 412 SEPARATION ANXIETY DISORDER 414 PANIC DISORDER; AGORAPHOBIA 421 EATING DISORDER NOS 475 SIMPLE AND SOCIAL PHOBIAS 511 CONVERSION DISORDER, ADULT 514 GENDER IDENTIFICATION DISORDER, PARAPHILIAS AND OTHER PSYCHOSEXUAL DISORDERS</p>
<p>Neonatal Resuscitation Codes Smits introduced an issue raised by a Neonatology group regarding coverage of procedures used for neonatal resuscitation. Recommended changes were to place such codes on the Ancillary List to allow usage in all settings. These codes were not thought to be open to abuse. The recommended changes were accepted with minimal</p>	<p>32421 (Throacentesis, initial or subsequent), 32422 (Thoracentesis with insertion of tube), and 32551 (Insertion of chest tube) were removed from the Prioritized List and placed on the Ancillary List.</p>

<p>discussion.</p> <p>Reproductive Services Codes Smits introduced a document highlighting issues found on review of Line 7, Reproductive Services. Several infertility codes were found to mistakenly be on this line. Hysterosalpingograms (HSGs) are currently on the Diagnostic List, but should be on Line 7 paired only with Essure placement. A guideline to ensure this limited use was suggested.</p> <p>Bickle raised several issues DMAP is having with Essure placement in the operating room setting, which increases cost. Olson requested that the HOSC review this issue at the next meeting with Dr. Mark Nichols, who has previously discussed this issue with the HOSC. Gubler asked about increasing reimbursement for the device if done as an outpatient, but DMAP indicated that they must use the CMS RVU schedule. The Subcommittee agreed to the changes and the guideline. HSC staff will work with DMAP to see if further work needs to be done to ensure that Essure placement is done as an outpatient, and invite Dr. Nichols if needed to testify at the next meeting.</p>	<ol style="list-style-type: none"> 1) Never covered: <ol style="list-style-type: none"> a. V26.22 Infertility testing b. V26.21 Aftercare following sterilization reversal c. V26.29 Other investigation and testing 2) Place on Line 7 (Reproductive Services): <ol style="list-style-type: none"> a. 74740 (Hysterosalpingography, radiological supervision and interpretation) b. 58340 (Catheterization and injection for hysterosalpingography) 3) Adopt the following guideline for Line 7: <ol style="list-style-type: none"> i. "Hysterosalpingography (58340, 74740) is covered only for the follow up testing after placement of permanent implants in the fallopian tubes to induce bilateral occlusion."
<p>Guidelines</p> <p>1) V57/ PT and OT Guideline V57 (Need for PT) was placed on the Never Covered List at a recent HSC meeting. However, new coding guidelines require its use as a first code for certain types of PT/OT billing. Smits recommended adding to all lines with the PT/OT guideline, and amending the PT/OT guideline to reflect that these services must have a secondary diagnosis code which is in the covered area of the Prioritized List. This was accepted with minimal discussion.</p> <p>2) Tonsillectomy guideline Smits reviewed multiple comments which have been forwarded to the HSC regarding the Tonsillectomy Guideline initially adopted in May, 2008. Testimony was heard from Dr. Derek Lipman, a Portland ENT.</p> <p>The first area of discussion was concern about requiring documentation of strep infections. Lippman suggested substituting "episodes of bacterial tonsillitis" for "documented strep infections." McKelvey replied that the AAP recommends strep testing in all cases because studies have</p>	<p>See Appendix B for guidelines as adopted.</p> <p>Other changes were accepted as outlined in the meeting documents:</p> <ol style="list-style-type: none"> 1) V57 added to all lines referenced in the PT/OT guideline 2) Staff will bring back revised prophylactic treatment for prevention of breast cancer guideline, review the List for coverage of reconstruction as well as review the reconstruction guideline and bring these items back for discussion in January. 3) G0235 (PET imaging, any site, NOS) added to Line 167 (Hodgkins disease) and line 168 (colon cancer). G0219 (PET imaging whole body; melanoma for uncovered

shown that clinical judgment is only correct in 50% of the time. Gubler stated that the HSC tries to base guidelines on evidence. McKelvey stated that it's the referring physician's responsibility to collect this data for their ENT consultant. No changes were made to this portion of the guideline.

The second area of discussion was around peritonsillar abscesses. Lippman argued against surgery in the acute phase, but noted that it was an accepted form of treatment, however. He also stated that it is standard of care to do interval tonsillectomy regardless of complications. McKelvey suggested changing the second part of the guideline to reflect that all patients with peritonsillar abscess requiring surgical drainage are candidates for tonsillectomy.

The third area of discussion was around the obstructive sleep apnea indication for tonsillectomy. Lippman argued that sleep studies are expensive (\$2500-3000), daunting to children, and are not ideal if done by a sleep specialist with little experience with children. He felt that this test was best for diagnosis of OSA when CPAP is to be the treatment, which is not done in kids as first line tx. Dr. Lipman also argued that a good clinical history is the most important diagnostic criteria. McKelvey pointed out that the option of using the questionnaires would facilitate good history taking. She also wondered why, if there is no good definition for mild/moderate/severe, we have these categories in the guideline. Olson stressed that the HSC needs to focus on finding an objective way for the state to guarantee that tonsillectomies are only being done when they are indicated. Gubler argued that if the ENT is solely to determine need for tonsillectomy, then we could open the floodgates. However, no surgeons agree on criteria for most surgical issues. He also felt that there was a need for surgical indications that are objective and reproducible. McKelvey didn't think that there was objective evidence for tonsillectomy for OSA in kids yet. Smits pointed out that sleep studies are only required for kids 3 and under or with kids with co-morbidities. The guideline could change it so kids of all ages can be diagnosed by any method (Sleep study, questionnaire, consult). McKelvey replied that she thought the hSC should keep the guideline as it stands and readdress at a certain point (1 year?). Olson I agree. Decision: keep this portion of the guideline as is.

The fourth part of the discussion focused on unilateral tonsillar hypertrophy as an indication for tonsillectomy. Several specialists agreed that this was an indication; however, children should have other signs of symptoms indicative of malignancy as well. A fourth section was added to the guideline regarding unilateral tonsillar hypertrophy.

indications) added to Line 243 (Malignant melanoma Reference to the PET scan guideline was added to line 168 (Colon cancer).

- 4) 59897 (Unlisted fetal invasive procedure, including ultrasound guidance) was not added to Line 1 (Maternity Care). The guideline sentence regarding 59897 was struck from the proposed new guideline.
- 5) Preventive Dental Guideline changed to read "once per 6 months," the guideline should read "twice per 12 months" in regards to treatment of children.
- 6) Smits will work with DMAP to clarify how often fluoride treatments can be given, whether PCPs can apply varnish for children with limited access to dental practitioners, and to discuss billing issues for PCP application of fluoride.

3) Prophylactic Treatment for Prevention of Breast Cancer Guideline

Smits reviewed a proposed new guideline for prophylactic treatments to prevent breast cancer in high risk women. Members made editorial changes to the proposed new guideline.

Additional discussion included Gubler arguing that the evidence does not support prophylactic mastectomy. Olson replied that the data Gubler referred to does not take into account better treatments which reduce the death rate from cancers. The other costs associated with high risk women (MRI yearly, biopsies, etc.) may make this more cost-effective. Gubler pointed out that surveillance becomes harder post mastectomy. He argued in favor of keeping only BRCA+ as the only indication for prophylactic mastectomy. Olson replied that if our guideline is more restrictive than NCCN, then we put doctors in a position where they are not meeting quality guidelines.

McKelvey wanted to make sure that reconstruction is covered. Coffman replied that HSC staff need to review and make sure that all the codes are in the right place, and need to ensure that a guideline regarding reconstruction is applied to both lines with prophylactic mastectomy.

Shaffer brought up that DMAP has issues with payments for genetic counselors who do not bill with a supervising physician or health system. McKelvey replied that there are counselors available, it may just be a while to get in to be seen, which is not a problem for prophylactic mastectomy given that this is an elective procedure.

Smits agreed to bring back revised guideline, review the List for coverage of reconstruction as well as review the reconstruction guideline and bring these items back for discussion in January.

4) PET Scan guideline

Smits reviewed some code details which needed to be addressed after adoption of the revised PET scan guideline. PET scan HCPCS codes [G0235 (PET imaging, any site, NOS)] needed to be added to Line 167 (Hodgkins disease) and line 168 (colon cancer). G0219 (PET imaging whole body; melanoma for uncovered indications) was added to Line 243 (Malignant melanoma). Reference to the PET scan guideline was added to line 168 (Colon cancer).

The group debated making the guideline a diagnostic guideline. Olson argued that this is a readily abusable procedure, should not be diagnostic, need to make it more

difficult to order it. Gubler agreed that there was no benefit for PET scan for many diagnosis. However, there are lesions which cannot be reached for biopsy or other test where operation may be required. Olson replied that PET should be covered for solitary lung nodules. Smits indicated that PET was covered for this indication already. Shaffer replied that coverage of PET for unusual cases can do through the exceptions process

5) Colon Cancer screening

Smits reviewed new USPSTF recommendations to stop routine colon cancer screening at age 75. Changes to the prevention tables to reflect this change were adopted.

6) Fetoscopic surgery guideline

Smits reviewed the recommendations for changes around the fetal surgery guideline. These changes included adding 59897 (Unlisted fetal invasive procedure, including ultrasound guidance) to Line 1 (Maternity Care). However, McKelvey and Bickle argued that there was a more specific HCPCS code for this procedure that should be billed rather than the non-specific CPT code. The HCPCS code already appears on Line 1. Shaffer argued for adding the CPT code, as no other payer required using the HCPCS code. The Subcommittee agreed to not add the CPT code to Line 1.

Proposed changes to the guideline were accepted, except that the sentence referring to 59897 was struck.

Gubler asked why is diaphragmatic hernia is not covered. Smits replied that the HOSC voted to not cover in 2004. Shaffer indicated that it may not be cost effective to do fetally vs after delivery and that AHRQ is currently reviewing the topic. Smits suggested that the HSC could readdress after AHRQ review is released. Future review after the HARQ review is done was agreed upon by the Subcommittee.

7) Prophylactic Dental Guideline

Changes to the Preventive Dental Guideline recommended by the Dental Taskforce were reviewed. Coffman pointed out that the guideline in the packet material had an error in it: rather than allowing children to receive treatment “once per 6 months,” the guideline should read “twice per 12 months.”

McKelvey asked for clarification on how often fluoride treatments can be given, and at what age to start. Does the guideline restrict PCPs from doing fluoride varnish if the dentist already has recently? Dodson referred to the included DMAP rules: “kids must NOT have access to dental practitioner.” She wondered if this rule should be changed to read “have limited access.” Smits will bring this change up with Jacobo to clarify DMAP rules. McKelvey asked if Jacobo could clarify the lower age limit and whether treatment must stop at

<p>6 years of age. Her reading of the guideline and administrative rules indicated that treatment should be stopped at age 6.</p> <p>The Subcommittee had questions regarding billing. Coffman stated that varnish needs to be billed directly to DMAP based on current rules. McKelvey wondered if the HSC needed to work with DMAP to set up a different billing system. Coffman and Shaffer thought that this was probably the case. McKelvey suggested that billing for varnish by PCPS be brought up with the OHP medical directors so that local plans if they get bills to help providers. Smits will do so at a future OHP Medical Directors Meeting.</p> <p>8) Lymphedema guideline Smits reviewed suggested changes to the Lymphedema guideline. The group felt that rather than using the wording “or participating in the certification or training process for one of the accepted lymphedema training certifying organizations” that the guideline should read that a candidate must be a graduate “<u>or has graduated of one of the National Lymphedema Network accepted training courses within the past 24 months.</u>” This wording would clarify how long a candidate could be in training before certification would be required.</p>	
<p>Bronchoscopy Smits reviewed proposed changes for placement of bronchoscopy codes. There was minimal discussion.</p>	<p>Code placement for bronchoscopy codes were accepted as outlined in the meeting materials.</p>
<p>Straightforward Issues Smits reviewed the straightforward issues document in the meeting materials. The Subcommittee generally agreed with the suggested changes. The only addition was the recommendation to add 45303 (Proctosigmoidoscopy, rigid; with dilation) and 46604 (Anoscopy, with dilation) to the anal cancer line (line 168).</p>	<p>Changes accepted as proposed in the meeting materials with the following additions:</p> <ol style="list-style-type: none"> 1) 45303 (Proctosigmoidoscopy, rigid; with dilation) and 46604 (Anoscopy, with dilation) added to the anal cancer line (line 168).
<p>Silicone Oil Use in Retinal Detachment Smits reviewed proposed changes around CPT codes for removal of silicone oil from the eye that were proposed by a community Ophthalmologist. Rather than add multiple CPT codes to multiple lines, Coffman suggested simply adding the CPT code 67036 (Vitreotomy, mechanical, pars plana approach) to Line 441 (Complications of a procedure) were the ICD-9 code 996.59 (Mechanical complication of other implant and internal device, NEC) already reside. This would allow pairing of the diagnosis and procedure in the simplest manner. This change was accepted.</p>	<p>Proposed changes in the meeting materials were rejected.</p> <p>67036 (Vitreotomy, mechanical, pars plana approach) added to Line 441 (Complications of a procedure)</p>

Appendix A: 2009 CPT Code Placement

See attached Excel Spreadsheet

Guideline Changes from December 2008 HOSC Meeting

New Guidelines

GUIDELINE NOTE XXX, HYSTEROSALPINGOGRAPHY

Line 7

Hysterosalpingography (58340, 74740) is covered only for the follow up testing after placement of permanent implants in the fallopian tubes to induce bilateral occlusion.

GUIDELINE NOTE XXX ENZYME REPLACEMENT THERAPY

Line 672

~~Inclusion of code J3490 refers to~~ Enzyme replacement therapy is included on Line 672.

Revised Guidelines

GUIDELINE NOTE 2, FETOSCOPIC SURGERY

Line 1

Fetal surgery is only covered for the following conditions: repair of urinary tract obstructions via placement of a urethral shunt, repair of congenital cystic adenomatoid malformation, repair of extralobal pulmonary sequestration, repair of sacrococcygeal teratoma, and therapy for twin-twin transfusion syndrome.

Fetoscopic repair of urinary tract obstruction (S2401) is only covered for placement of a urethral shunt. Fetal surgery for cystic adenomatoid malformation of the lung, extralobal pulmonary sequestration and sacrococcygeal teratoma must show evidence of developing hydrops fetalis.

Certification of laboratory required (76813-76814).

GUIDELINE NOTE 3, PROPHYLACTIC TREATMENT FOR PREVENTION OF BREAST CANCER IN HIGH RISK WOMEN

Lines 4,198

Bilateral prophylactic breast removal is included on Line 4 for women without a personal history of invasive breast cancer who are at high risk for breast cancer. Prior to surgery, women without a personal history of breast cancer must have a genetics consultation. High risk is defined as:

- Having a BRCA1/BRCA2 mutation
- Having a strong family history of breast cancer, defined as one of the following:

- 2 first-degree or second degree relatives diagnosed with breast cancer at younger than an average age of 50 years (at least one must be a first-degree relative)
 - 3 first-degree or second-degree relatives diagnosed with breast cancer at younger than an average age of 60 years (at least one must be a first-degree relative)
 - 4 relatives diagnosed with breast cancer at any age (at least one must be a first-degree relative)
 - 1 relative with ovarian cancer at any age and, on the same side of the family, either 1 first-degree relative (including the relative with ovarian cancer) or second-degree relative diagnosed with breast cancer at younger than age 50 years, or 2 first-degree or second-degree relatives diagnosed with breast cancer at younger than an average age of 60 years, or another ovarian cancer at any age
 - 1 first-degree relative with cancer diagnosed in both breasts at younger than an average age of 50 years
 - 1 first-degree or second-degree relative diagnosed with bilateral breast cancer and one first-degree or second-degree relative diagnosed with breast cancer at younger than an average age of 60 years
 - a male relative with breast cancer at any age and on the same side of the family at least 1 first-degree or second-degree relative diagnosed with breast cancer at younger than age 50 years, or 2 first-degree or second-degree relatives diagnosed with breast cancer at younger than an average age of 60 years.
- A history of LCIS with a family history of breast cancer
 - A history of treatment with thoracic radiation between ages 10 and 30

Contralateral prophylactic mastectomy is included on Line 4 and Line 198 for women with a personal history of breast cancer and any of the high risk categories listed above. In addition, contralateral prophylactic mastectomy of the unaffected breast is indicated for women with invasive lobular carcinoma.

Prophylactic oophorectomy is included on Line 4 (Preventive Services Ages 10 and Over) for women who have the BRCA1/BRCA2 mutation.

Selective estrogen receptor modulators (SERMs) are appropriate for use in woman at high risk for breast cancer.

GUIDELINE NOTE 6, REHABILITATIVE THERAPIES

Lines: 12,50,51,52,63,74,75,76,78,80,85,89,90,94,95,98,99,100,101,109,110,116,117, 123, 130, 140,142,143,144,146,147,159,162,166,180,185,186,190,191,193,195,196,202, 203,209, 217,227,237, 239,270,271,273,274,279,287,288,292,296,301,303,306,307,308, 317, 334, 340, 347, 348, 362,366,368,372,373,375,379,381,382,384,397,403,404, 429, 435, 437,441, 449,461,481,498,509,540,552,570,588,611,628

Physical, occupational and speech therapy, and cardiac and vascular rehabilitation, are covered for diagnoses paired with the respective CPT codes, depending on medical necessity, for up to 3 months immediately following stabilization from an acute event. Thereafter, the following number of combined physical and occupational therapy visits are allowed per year, depending on medical necessity:

- Age < 8: 24
- Age 8-12: 12
- Age > 12: 2

Following 3 months of acute therapy, the following number of speech therapy visits are allowed per year, depending on medical necessity (with the exception of swallowing disorders, for which limits do not apply):

- Age < 8: 24
- Age 8-12: 12
- Age > 12: 2

An additional 6 visits of speech, and/or an additional 6 visits of physical or occupational therapy are allowed, regardless of age, whenever there is a change in status, such as surgery, botox injection, rapid growth, an acute exacerbation or for evaluation/training for an assistive communication device.

No limits apply while in a skilled nursing facility for the primary purpose of rehabilitation, an inpatient hospital or an inpatient rehabilitation unit.

If the admission/encounter is for rehabilitation, a V code from category V57 should be listed as the principle/first diagnosis. The underlying diagnosis for which rehab is needed should be listed as an additional diagnosis and this diagnosis must appear in the funded region of the Prioritized List for the admission/encounter to be covered.

GUIDELINE NOTE 17, PREVENTIVE DENTAL CARE

Line 105

Dental cleaning and fluoride treatments are limited to once per ~~calendar year~~ 12 months for adults and ~~twice per calendar year~~ twice per 12 months for children ~~18 and younger up to age 19.~~ (D0120, D0150, D1110, D1120, D1204) (D1110, D1120, D1203, D1204, D1206). More frequent dental cleanings and/or fluoride treatments may be required for certain higher risk populations.

~~Used up to 4 times per year (maximum once per week) for patients over 18 who are mentally disabled or are truly dental phobic in order to determine the need to use IV or GA sedation to render necessary treatment (D9920).~~

GUIDELINE NOTE 24, COMPLICATED HERNIAS

Line 176

Complicated hernias are included on this line if they are incarcerated ~~and~~ or have symptoms of obstruction and/or strangulation.

GUIDELINE NOTE 36, TONSILLECTOMY

Line 49, 84, 211, 392, 565

Tonsillectomy is an appropriate treatment in a case with:

- 1) Five documented attacks of strep tonsillitis in a year or 3 documented attacks of strep tonsillitis in each of two consecutive years where an attack is considered a positive culture/screen and where an appropriate course of antibiotic therapy has been completed;
 - 2) Peritonsillar abscess ~~unresponsive to medical management and~~ requiring surgical drainage ~~documented by surgeon, unless surgery performed during acute stage~~
 - 3) Moderate or severe obstructive sleep apnea (OSA) in children 18 and younger or mild OSA in children with daytime symptoms and/or other indications for surgery. For children 3 and younger or for children with significant co-morbidities, OSA must be diagnosed by nocturnal polysomnography. For children older than 3 who are otherwise healthy, OSA must be diagnosed by either nocturnal polysomnography, use of a validated questionnaire (such as the Pediatric Sleep Questionnaire or OSA 18), or consultation with a Sleep Medicine specialist.
4. Unilateral tonsillar hypertrophy in adults; unilateral tonsillar hypertrophy in children with other symptoms suggestive of malignancy

GUIDELINE NOTE 43, LYMPHEDEMA

Lines 441,589

Lymphedema treatments are included on these lines when medically appropriate. These services are to be provided by a licensed practitioner who is certified by, ~~or participating in the certification or training process for~~ one of the accepted lymphedema training certifying organizations or has graduated of one of the National Lymphedema Network accepted training courses within the past 24 months. The only accepted certifying organization at this time is LANA (Lymphology Association of North America; <http://www.clt-lana.org>). Treatments for lymphedema are not subject to the visit number restrictions found in Guideline Note 6, Rehabilitative Therapies.

Age 65 and Older

Interventions Considered and Recommended for the Periodic Health Examination

Leading Causes of Death

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

Interventions for the General Population

SCREENING

Blood pressure
Height and weight
Fecal occult blood test and/or sigmoidoscopy or colonoscopy
[through age 75](#)¹
Mammogram + clinical breast exam²
Bone density measurement (women)
Fasting plasma glucose for patients with hypertension or
hyperlipidemia
Vision screening
Assess for hearing impairment
Signs of elder abuse, neglect, family violence
Alcohol, inhalant, illicit drug use³
Anxiety and mood disorders⁴
Somatoform disorders⁵
Environmental stressors⁶
Abdominal aortic aneurysm (AAA) (men aged 65 to 75 who
have ever smoked)⁷

Tetanus-diphtheria (Td) boosters

CHEMOPROPHYLAXIS

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

COUNSELING

Substance Use

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

Diet and Exercise

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

Regular physical activity*
Assess eating environment

Injury Prevention

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

Dental Health

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

Sexual Behavior

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

IMMUNIZATIONS

Pneumococcal vaccine
Influenza¹

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

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

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PRIORITIZED LIST			
Code	Description	Recommended Placement	Recommended Lines
27027	DECOMPRESSION FASCIOTOMY(IES), PELVIC (BUTTOCK) COMPARTMENT(S) (EG, GLUTEUS MEDIUS-MINIMUS, GLUTEUS MAXIMUS, ILIOPSOAS, AND/OR TENSOR FASCIA LATA MUSCLE), UNILATERAL	List	143 CRUSH INJURIES OTHER THAN DIGITS
27057	DECOMPRESSION FASCIOTOMY(IES), PELVIC (BUTTOCK) COMPARTMENT(S) (EG, GLUTEUS MEDIUS-MINIMUS, GLUTEUS MAXIMUS, ILIOPSOAS, AND/OR TENSOR FASCIA LATA MUSCLE) WITH DEBRIDEMENT OF NONVIABLE MUSCLE, UNILATERAL	List	143 CRUSH INJURIES OTHER THAN DIGITS
35535	BYPASS GRAFT, WITH VEIN; HEPATORENAL	List	270 ARTERIAL EMBOLISM/THROMBOSIS: ABDOMINAL AORTA, THORACIC AORTA 306 DISSECTING OR RUPTURED AORTIC ANEURYSM 330 DISORDERS OF ARTERIES, OTHER THAN CAROTID OR CORONARY 347 NON-DISSECTING ANEURYSM WITHOUT RUPTURE 465 ATHEROSCLEROSIS, AORTIC AND RENAL
35570	BYPASS GRAFT, WITH VEIN; TIBIAL-TIBIAL, PERONEAL-TIBIAL, OR TIBIAL/PERONEAL TRUNK-TIBIAL	List	307 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT 375 ATHEROSCLEROSIS, PERIPHERAL
35633	BYPASS GRAFT, WITH OTHER THAN VEIN; ILIO-MESENTERIC	List	270 ARTERIAL EMBOLISM/THROMBOSIS: ABDOMINAL AORTA, THORACIC AORTA 306 DISSECTING OR RUPTURED AORTIC ANEURYSM 330 DISORDERS OF ARTERIES, OTHER THAN CAROTID OR CORONARY 347 NON-DISSECTING ANEURYSM WITHOUT RUPTURE 465 ATHEROSCLEROSIS, AORTIC AND RENAL
35634	BYPASS GRAFT, WITH OTHER THAN VEIN; ILIORENAL	List	270 ARTERIAL EMBOLISM/THROMBOSIS: ABDOMINAL AORTA, THORACIC AORTA 306 DISSECTING OR RUPTURED AORTIC ANEURYSM 330 DISORDERS OF ARTERIES, OTHER THAN CAROTID OR CORONARY 347 NON-DISSECTING ANEURYSM WITHOUT RUPTURE 465 ATHEROSCLEROSIS, AORTIC AND RENAL

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Code	Description	Recommended Placement	Recommended Lines
43273	ENDOSCOPIC CANNULATION OF PAPILLA WITH DIRECT VISUALIZATION OF COMMON BILE DUCT(S) AND/OR PANCREATIC DUCT(S) (LIST SEPARATELY IN ADDITION TO CODE(S) FOR PRIMARY PROCEDURE)	List	60 CHOLELITHIASIS, CHOLECYSTITIS, COMMON BILIARY DUCT STONE 201 ACUTE PANCREATITIS 267 CHRONIC PANCREATITIS 318 ANOMALIES OF GALLBLADDER, BILE DUCTS, AND LIVER 339 CANCER OF PANCREAS 453 CANCER OF GALLBLADDER AND OTHER BILIARY 659 GALL STONES WITHOUT
43279	LAPAROSCOPY, SURGICAL, ESOPHAGOMYOTOMY (HELLER TYPE), WITH FUNDOPLASTY, WHEN PERFORMED	List	70 CONGENITAL ANOMALIES OF UPPER ALIMENTARY TRACT, EXCLUDING TONGUE 406 ESOPHAGEAL STRICTURE 408 ESOPHAGITIS; ESOPHAGEAL AND INTRAESOPHAGEAL HERNIAS 416 ACHALASIA, NON-NEONATAL
46930	DESTRUCTION OF INTERNAL HEMORRHOID(S) BY THERMAL ENERGY (EG, INFRARED COAGULATION, CAUTERY, RADIOFREQUENCY)	List	492 THROMBOSED AND COMPLICATED HEMORRHOIDS 668 UNCOMPLICATED HEMORRHOIDS
49652	LAPAROSCOPY, SURGICAL, REPAIR, VENTRAL, UMBILICAL, SPIGELIAN OR EPIGASTRIC HERNIA (INCLUDES MESH INSERTION, WHEN PERFORMED); REDUCIBLE	List	176 COMPLICATED HERNIAS; UNCOMPLICATED HERNIA IN CHILDREN UNDER AGE 18; PERSISTENT HYDROCELE 538 UNCOMPLICATED HERNIA
49653	LAPAROSCOPY, SURGICAL, REPAIR, VENTRAL, UMBILICAL, SPIGELIAN OR EPIGASTRIC HERNIA (INCLUDES MESH INSERTION, WHEN PERFORMED); INCARCERATED OR STRANGULATED	List	176 COMPLICATED HERNIAS; UNCOMPLICATED HERNIA IN CHILDREN UNDER AGE 18; PERSISTENT HYDROCELE
49654	LAPAROSCOPY, SURGICAL, REPAIR, INCISIONAL HERNIA (INCLUDES MESH INSERTION, WHEN PERFORMED); REDUCIBLE	List	176 COMPLICATED HERNIAS; UNCOMPLICATED HERNIA IN CHILDREN UNDER AGE 18; PERSISTENT HYDROCELE 538 UNCOMPLICATED HERNIA
49655	LAPAROSCOPY, SURGICAL, REPAIR, INCISIONAL HERNIA (INCLUDES MESH INSERTION, WHEN PERFORMED); INCARCERATED OR STRANGULATED	List	176 COMPLICATED HERNIAS; UNCOMPLICATED HERNIA IN CHILDREN UNDER AGE 18; PERSISTENT HYDROCELE
49656	LAPAROSCOPY, SURGICAL, REPAIR, RECURRENT INCISIONAL HERNIA (INCLUDES MESH INSERTION, WHEN PERFORMED); REDUCIBLE	List	176 COMPLICATED HERNIAS; UNCOMPLICATED HERNIA IN CHILDREN UNDER AGE 18; PERSISTENT HYDROCELE 538 UNCOMPLICATED HERNIA
49657	LAPAROSCOPY, SURGICAL, REPAIR, RECURRENT INCISIONAL HERNIA (INCLUDES MESH INSERTION, WHEN PERFORMED); INCARCERATED OR STRANGULATED	List	176 COMPLICATED HERNIAS; UNCOMPLICATED HERNIA IN CHILDREN UNDER AGE 18; PERSISTENT HYDROCELE

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61796	STEREOTACTIC RADIOSURGERY (PARTICLE BEAM, GAMMA RAY, OR LINEAR ACCELERATOR); 1 SIMPLE CRANIAL LESION	List	138 BENIGN NEOPLASM OF THE BRAIN 163 BENIGN NEOPLASM OF PITUITARY GLAND 319 CANCER OF BRAIN AND NERVOUS SYSTEM 340 STROKE 460 TRIGEMINAL AND OTHER NERVE DISORDERS
61797	STEREOTACTIC RADIOSURGERY (PARTICLE BEAM, GAMMA RAY, OR LINEAR ACCELERATOR); EACH ADDITIONAL CRANIAL LESION, SIMPLE (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	List	138 BENIGN NEOPLASM OF THE BRAIN 163 BENIGN NEOPLASM OF PITUITARY GLAND 319 CANCER OF BRAIN AND NERVOUS SYSTEM 340 STROKE 460 TRIGEMINAL AND OTHER NERVE DISORDERS
61798	STEREOTACTIC RADIOSURGERY (PARTICLE BEAM, GAMMA RAY, OR LINEAR ACCELERATOR); 1 COMPLEX CRANIAL LESION	List	138 BENIGN NEOPLASM OF THE BRAIN 163 BENIGN NEOPLASM OF PITUITARY GLAND 319 CANCER OF BRAIN AND NERVOUS SYSTEM 340 STROKE 460 TRIGEMINAL AND OTHER NERVE DISORDERS
61799	STEREOTACTIC RADIOSURGERY (PARTICLE BEAM, GAMMA RAY, OR LINEAR ACCELERATOR); EACH ADDITIONAL CRANIAL LESION, COMPLEX (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	List	138 BENIGN NEOPLASM OF THE BRAIN 163 BENIGN NEOPLASM OF PITUITARY GLAND 319 CANCER OF BRAIN AND NERVOUS SYSTEM 340 STROKE 460 TRIGEMINAL AND OTHER NERVE DISORDERS
61800	APPLICATION OF STEREOTACTIC HEADFRAME FOR STEREOTACTIC RADIOSURGERY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	List	138 BENIGN NEOPLASM OF THE BRAIN 163 BENIGN NEOPLASM OF PITUITARY GLAND 319 CANCER OF BRAIN AND NERVOUS SYSTEM 340 STROKE 460 TRIGEMINAL AND OTHER NERVE DISORDERS
63620	STEREOTACTIC RADIOSURGERY (PARTICLE BEAM, GAMMA RAY, OR LINEAR ACCELERATOR); 1 SPINAL LESION	List	209 CANCER OF BONES 319 CANCER OF BRAIN AND NERVOUS SYSTEM
63621	STEREOTACTIC RADIOSURGERY (PARTICLE BEAM, GAMMA RAY, OR LINEAR ACCELERATOR); EACH ADDITIONAL SPINAL LESION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	List	209 CANCER OF BONES 319 CANCER OF BRAIN AND NERVOUS SYSTEM
64455	INJECTION(S), ANESTHETIC AGENT AND/OR STEROID, PLANTAR COMMON DIGITAL NERVE(S) (EG, MORTON'S NEUROMA)	List	551 LESION OF PLANTAR NERVE; PLANTAR FASCIAL FIBROMATOSIS
64632	DESTRUCTION BY NEUROLYTIC AGENT; PLANTAR COMMON DIGITAL NERVE	List	551 LESION OF PLANTAR NERVE; PLANTAR FASCIAL FIBROMATOSIS

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65756	KERATOPLASTY (CORNEAL TRANSPLANT); ENDOTHELIAL	List	307 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT 335 CORNEAL OPACITY AND OTHER DISORDERS OF CORNEA
65757	BACKBENCH PREPARATION OF CORNEAL ENDOTHELIAL ALLOGRAFT PRIOR TO TRANSPLANTATION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	List	307 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT 335 CORNEAL OPACITY AND OTHER DISORDERS OF CORNEA
77785	REMOTE AFTERLOADING HIGH DOSE RATE RADIONUCLIDE BRACHYTHERAPY; 1 CHANNEL	List	138 BENIGN NEOPLASM OF THE BRAIN 145 CANCER OF CERVIX 168 CANCER OF COLON, RECTUM, SMALL INTESTINE AND ANUS 198 CANCER OF BREAST 208 CANCER OF SOFT TISSUE 219 CANCER OF UTERUS 275 CANCER OF PENIS AND OTHER MALE GENITAL ORGANS 277 CANCER OF RETROPERITONEUM, PERITONEUM, OMENTUM AND MESENTERY 278 CANCER OF LUNG, BRONCHUS, PLEURA, TRACHEA, MEDIASTINUM AND OTHER RESPIRATORY ORGANS 286 CANCER OF BLADDER AND URETER 310 CANCER OF VAGINA, VULVA AND OTHER FEMALE GENITAL ORGANS 311 CANCER OF ORAL CAVITY, PHARYNX, NOSE AND LARYNX 319 CANCER OF BRAIN AND NERVOUS SYSTEM 337 CANCER OF ESOPHAGUS 354 CANCER OF PROSTATE GLAND 399 BENIGN NEOPLASM OF RESPIRATORY AND INTRATHORACIC ORGANS 613 SECONDARY AND ILL-DEFINED MALIGNANT NEOPLASMS
77786	REMOTE AFTERLOADING HIGH DOSE RATE RADIONUCLIDE BRACHYTHERAPY; 2-12 CHANNELS	List	See 77785
77787	REMOTE AFTERLOADING HIGH DOSE RATE RADIONUCLIDE BRACHYTHERAPY; OVER 12 CHANNELS	List	See 77785
90951	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES MONTHLY, FOR PATIENTS < 2 YEARS OF AGE TO INCLUDE MONITORING FOR THE ADEQUACY OF NUTRITION, ASSESSMENT OF GROWTH AND DEVELOPMENT, AND COUNSELING OF PARENTS; 4 OR MORE FACE-TO-FACE PHYSICIAN VISITS PER MONTH	List	65 END STAGE RENAL DISEASE

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90952	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES MONTHLY, FOR PATIENTS < 2 YEARS OF AGE TO INCLUDE MONITORING FOR THE ADEQUACY OF NUTRITION, ASSESSMENT OF GROWTH AND DEVELOPMENT, AND COUNSELING OF PARENTS; 2-3 FACE-TO-FACE PHYSICIAN VISITS PER MONTH	List	65 END STAGE RENAL DISEASE
90953	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES MONTHLY, FOR PATIENTS < 2 YEARS OF AGE TO INCLUDE MONITORING FOR THE ADEQUACY OF NUTRITION, ASSESSMENT OF GROWTH AND DEVELOPMENT, AND COUNSELING OF PARENTS; 1 FACE-TO-FACE PHYSICIAN VISIT PER MONTH	List	65 END STAGE RENAL DISEASE
90954	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES MONTHLY, FOR PATIENTS 2-11 YEARS OF AGE TO INCLUDE MONITORING FOR THE ADEQUACY OF NUTRITION, ASSESSMENT OF GROWTH AND DEVELOPMENT, AND COUNSELING OF PARENTS; 4 OR MORE FACE-TO-FACE PHYSICIAN VISITS PER MONTH	List	65 END STAGE RENAL DISEASE
90955	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES MONTHLY, FOR PATIENTS 2-11 YEARS OF AGE TO INCLUDE MONITORING FOR THE ADEQUACY OF NUTRITION, ASSESSMENT OF GROWTH AND DEVELOPMENT, AND COUNSELING OF PARENTS; WITH 2-3 FACE-TO-FACE PHYSICIAN VISITS PER MONTH	List	65 END STAGE RENAL DISEASE
90956	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES MONTHLY, FOR PATIENTS 2-11 YEARS OF AGE TO INCLUDE MONITORING FOR THE ADEQUACY OF NUTRITION, ASSESSMENT OF GROWTH AND DEVELOPMENT, AND COUNSELING OF PARENTS; WITH 1 FACE-TO-FACE PHYSICIAN VISIT PER MONTH	List	65 END STAGE RENAL DISEASE
90957	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES MONTHLY, FOR PATIENTS 12-19 YEARS OF AGE TO INCLUDE MONITORING FOR THE ADEQUACY OF NUTRITION, ASSESSMENT OF GROWTH AND DEVELOPMENT, COUNSELING OF PARENTS; 4 OR MORE FACE-TO-FACE PHYSICIAN VISITS PER MONTH	List	65 END STAGE RENAL DISEASE

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90958	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES MONTHLY, FOR PATIENTS 12-19 YEARS OF AGE TO INCLUDE MONITORING FOR THE ADEQUACY OF NUTRITION, ASSESSMENT OF GROWTH AND DEVELOPMENT, AND COUNSELING OF PARENTS; WITH 2-3 FACE-TO-FACE PHYSICIAN VISITS PER MONTH	List	65 END STAGE RENAL DISEASE
90959	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES MONTHLY, FOR PATIENTS 12-19 YEARS OF AGE TO INCLUDE MONITORING FOR THE ADEQUACY OF NUTRITION, ASSESSMENT OF GROWTH AND DEVELOPMENT, AND COUNSELING OF PARENTS; WITH 1 FACE-TO-FACE PHYSICIAN VISIT PER MONTH	List	65 END STAGE RENAL DISEASE
90960	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES MONTHLY, FOR PATIENTS 20 YEARS OF AGE AND OLDER; WITH 4 OR MORE FACE-TO-FACE PHYSICIAN VISITS PER MONTH	List	65 END STAGE RENAL DISEASE
90961	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES MONTHLY, FOR PATIENTS 20 YEARS OF AGE AND OLDER; WITH 2-3 FACE-TO-FACE PHYSICIAN VISITS PER MONTH	List	65 END STAGE RENAL DISEASE
90962	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES MONTHLY, FOR PATIENTS 20 YEARS OF AGE AND OLDER; WITH 1 FACE-TO-FACE PHYSICIAN VISIT PER MONTH	List	65 END STAGE RENAL DISEASE
90963	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES FOR HOME DIALYSIS PER FULL MONTH, FOR PATIENTS YOUNGER THAN 2 YEARS OF AGE TO INCLUDE MONITORING FOR THE ADEQUACY OF NUTRITION, ASSESSMENT OF GROWTH AND DEVELOPMENT, AND COUNSELING OF PARENTS	List	65 END STAGE RENAL DISEASE
90964	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES FOR HOME DIALYSIS PER FULL MONTH, FOR PATIENTS 2-11 YEARS OF AGE TO INCLUDE MONITORING FOR THE ADEQUACY OF NUTRITION, ASSESSMENT OF GROWTH AND DEVELOPMENT, AND COUNSELING OF PARENTS	List	65 END STAGE RENAL DISEASE

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90965	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES FOR HOME DIALYSIS PER FULL MONTH, FOR PATIENTS 12-19 YEARS OF AGE TO INCLUDE MONITORING FOR THE ADEQUACY OF NUTRITION, ASSESSMENT OF GROWTH AND DEVELOPMENT, AND COUNSELING OF PARENTS	List	65 END STAGE RENAL DISEASE
90966	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES FOR HOME DIALYSIS PER FULL MONTH, FOR PATIENTS 20 YEARS OF AGE AND OLDER	List	65 END STAGE RENAL DISEASE
90967	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES FOR DIALYSIS LESS THAN A FULL MONTH OF SERVICE, PER DAY; FOR PATIENTS YOUNGER THAN 2 YEARS OF AGE	List	65 END STAGE RENAL DISEASE
90968	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES FOR DIALYSIS LESS THAN A FULL MONTH OF SERVICE, PER DAY; FOR PATIENTS 2-11 YEARS OF AGE	List	65 END STAGE RENAL DISEASE
90969	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES FOR DIALYSIS LESS THAN A FULL MONTH OF SERVICE, PER DAY; FOR PATIENTS 12-19 YEARS OF AGE	List	65 END STAGE RENAL DISEASE
90970	END-STAGE RENAL DISEASE (ESRD) RELATED SERVICES FOR DIALYSIS LESS THAN A FULL MONTH OF SERVICE, PER DAY; FOR PATIENTS 20 YEARS OF AGE AND OLDER	List	65 END STAGE RENAL DISEASE
93279	PROGRAMMING DEVICE EVALUATION WITH ITERATIVE ADJUSTMENT OF THE IMPLANTABLE DEVICE TO TEST THE FUNCTION OF THE DEVICE AND SELECT OPTIMAL PERMANENT PROGRAMMED VALUES WITH PHYSICIAN ANALYSIS, REVIEW AND REPORT; SINGLE LEAD PACEMAKER SYSTEM	List	76 ACUTE AND SUBACUTE ISCHEMIC HEART DISEASE, MYOCARDIAL INFARCTION 196 CHRONIC ISCHEMIC HEART DISEASE 303 LIFE-THREATENING CARDIAC ARRHYTHMIAS 373 CARDIAC ARRHYTHMIAS
93280	PROGRAMMING DEVICE EVALUATION WITH ITERATIVE ADJUSTMENT OF THE IMPLANTABLE DEVICE TO TEST THE FUNCTION OF THE DEVICE AND SELECT OPTIMAL PERMANENT PROGRAMMED VALUES WITH PHYSICIAN ANALYSIS, REVIEW AND REPORT; DUAL LEAD PACEMAKER SYSTEM	List	76 ACUTE AND SUBACUTE ISCHEMIC HEART DISEASE, MYOCARDIAL INFARCTION 196 CHRONIC ISCHEMIC HEART DISEASE 303 LIFE-THREATENING CARDIAC ARRHYTHMIAS 373 CARDIAC ARRHYTHMIAS

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93281	PROGRAMMING DEVICE EVALUATION WITH ITERATIVE ADJUSTMENT OF THE IMPLANTABLE DEVICE TO TEST THE FUNCTION OF THE DEVICE AND SELECT OPTIMAL PERMANENT PROGRAMMED VALUES WITH PHYSICIAN ANALYSIS, REVIEW AND REPORT; MULTIPLE LEAD PACEMAKER SYSTEM	List	76 ACUTE AND SUBACUTE ISCHEMIC HEART DISEASE, MYOCARDIAL INFARCTION 196 CHRONIC ISCHEMIC HEART DISEASE 303 LIFE-THREATENING CARDIAC ARRHYTHMIAS 373 CARDIAC ARRHYTHMIAS
93282	PROGRAMMING DEVICE EVALUATION WITH ITERATIVE ADJUSTMENT OF THE IMPLANTABLE DEVICE TO TEST THE FUNCTION OF THE DEVICE AND SELECT OPTIMAL PERMANENT PROGRAMMED VALUES WITH PHYSICIAN ANALYSIS, REVIEW AND REPORT; SINGLE LEAD IMPLANTABLE CARDIOVERTER-DEFIBRILLATOR	List	76 ACUTE AND SUBACUTE ISCHEMIC HEART DISEASE, MYOCARDIAL INFARCTION 110 CARDIOMYOPATHY, HYPERTROPHIC MUSCLE 196 CHRONIC ISCHEMIC HEART DISEASE 303 LIFE-THREATENING CARDIAC ARRHYTHMIAS 373 CARDIAC ARRHYTHMIAS
93283	PROGRAMMING DEVICE EVALUATION WITH ITERATIVE ADJUSTMENT OF THE IMPLANTABLE DEVICE TO TEST THE FUNCTION OF THE DEVICE AND SELECT OPTIMAL PERMANENT PROGRAMMED VALUES WITH PHYSICIAN ANALYSIS, REVIEW AND REPORT; DUAL LEAD IMPLANTABLE CARDIOVERTER- DEFIBRILLATOR	List	76 ACUTE AND SUBACUTE ISCHEMIC HEART DISEASE, MYOCARDIAL INFARCTION 110 CARDIOMYOPATHY, HYPERTROPHIC MUSCLE 196 CHRONIC ISCHEMIC HEART DISEASE 303 LIFE-THREATENING CARDIAC ARRHYTHMIAS 373 CARDIAC ARRHYTHMIAS
93284	PROGRAMMING DEVICE EVALUATION WITH ITERATIVE ADJUSTMENT OF THE IMPLANTABLE DEVICE TO TEST THE FUNCTION OF THE DEVICE AND SELECT OPTIMAL PERMANENT PROGRAMMED VALUES WITH PHYSICIAN ANALYSIS, REVIEW AND REPORT; MULTIPLE LEAD IMPLANTABLE CARDIOVERTER-DEFIBRILLATOR	List	76 ACUTE AND SUBACUTE ISCHEMIC HEART DISEASE, MYOCARDIAL INFARCTION 110 CARDIOMYOPATHY, HYPERTROPHIC MUSCLE 196 CHRONIC ISCHEMIC HEART DISEASE 303 LIFE-THREATENING CARDIAC ARRHYTHMIAS 373 CARDIAC ARRHYTHMIAS
93286	PERI-PROCEDURAL DEVICE EVALUATION AND PROGRAMMING OF DEVICE SYSTEM PARAMETERS BEFORE OR AFTER A SURGERY, PROCEDURE, OR TEST WITH PHYSICIAN ANALYSIS, REVIEW AND REPORT; SINGLE, DUAL, OR MULTIPLE LEAD PACEMAKER SYSTEM	List	76 ACUTE AND SUBACUTE ISCHEMIC HEART DISEASE, MYOCARDIAL INFARCTION 196 CHRONIC ISCHEMIC HEART DISEASE 303 LIFE-THREATENING CARDIAC ARRHYTHMIAS 373 CARDIAC ARRHYTHMIAS
93287	PERI-PROCEDURAL DEVICE EVALUATION AND PROGRAMMING OF DEVICE SYSTEM PARAMETERS BEFORE OR AFTER A SURGERY, PROCEDURE, OR TEST WITH PHYSICIAN ANALYSIS, REVIEW AND REPORT; SINGLE, DUAL, OR MULTIPLE LEAD IMPLANTABLE CARDIOVERTER-DEFIBRILLATOR SYSTEM	List	76 ACUTE AND SUBACUTE ISCHEMIC HEART DISEASE, MYOCARDIAL INFARCTION 110 CARDIOMYOPATHY, HYPERTROPHIC MUSCLE 196 CHRONIC ISCHEMIC HEART DISEASE 303 LIFE-THREATENING CARDIAC ARRHYTHMIAS 373 CARDIAC ARRHYTHMIAS

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Code	Description	Recommended Placement	Recommended Lines
93288	INTERROGATION DEVICE EVALUATION (IN PERSON) WITH PHYSICIAN ANALYSIS, REVIEW AND REPORT, INCLUDES CONNECTION, RECORDING AND DISCONNECTION PER PATIENT ENCOUNTER; SINGLE, DUAL, OR MULTIPLE LEAD PACEMAKER SYSTEM	List	76 ACUTE AND SUBACUTE ISCHEMIC HEART DISEASE, MYOCARDIAL INFARCTION 196 CHRONIC ISCHEMIC HEART DISEASE 303 LIFE-THREATENING CARDIAC ARRHYTHMIAS 373 CARDIAC ARRHYTHMIAS
93289	INTERROGATION DEVICE EVALUATION (IN PERSON) WITH PHYSICIAN ANALYSIS, REVIEW AND REPORT, INCLUDES CONNECTION, RECORDING AND DISCONNECTION PER PATIENT ENCOUNTER; SINGLE, DUAL, OR MULTIPLE LEAD IMPLANTABLE CARDIOVERTER-DEFIBRILLATOR SYSTEM, INCLUDING ANALYSIS	List	76 ACUTE AND SUBACUTE ISCHEMIC HEART DISEASE, MYOCARDIAL INFARCTION 110 CARDIOMYOPATHY, HYPERTROPHIC MUSCLE 196 CHRONIC ISCHEMIC HEART DISEASE 303 LIFE-THREATENING CARDIAC ARRHYTHMIAS 373 CARDIAC ARRHYTHMIAS
93292	INTERROGATION DEVICE EVALUATION (IN PERSON) WITH PHYSICIAN ANALYSIS, REVIEW AND REPORT, INCLUDES CONNECTION, RECORDING AND DISCONNECTION PER PATIENT ENCOUNTER; WEARABLE DEFIBRILLATOR SYSTEM	List	76 ACUTE AND SUBACUTE ISCHEMIC HEART DISEASE, MYOCARDIAL INFARCTION 110 CARDIOMYOPATHY, HYPERTROPHIC MUSCLE 196 CHRONIC ISCHEMIC HEART DISEASE 303 LIFE-THREATENING CARDIAC ARRHYTHMIAS 373 CARDIAC ARRHYTHMIAS
93293	TRANSTELEPHONIC RHYTHM STRIP PACEMAKER EVALUATION(S) SINGLE, DUAL, OR MULTIPLE LEAD PACEMAKER SYSTEM, INCLUDES RECORDING WITH AND WITHOUT MAGNET APPLICATION WITH PHYSICIAN ANALYSIS, REVIEW AND REPORT(S), UP TO 90 DAYS	List	76 ACUTE AND SUBACUTE ISCHEMIC HEART DISEASE, MYOCARDIAL INFARCTION 196 CHRONIC ISCHEMIC HEART DISEASE 303 LIFE-THREATENING CARDIAC ARRHYTHMIAS 373 CARDIAC ARRHYTHMIAS
93294	INTERROGATION DEVICE EVALUATION(S) (REMOTE), UP TO 90 DAYS; SINGLE, DUAL, OR MULTIPLE LEAD PACEMAKER SYSTEM WITH INTERIM PHYSICIAN ANALYSIS, REVIEW(S) AND REPORT(S)	List	76 ACUTE AND SUBACUTE ISCHEMIC HEART DISEASE, MYOCARDIAL INFARCTION 196 CHRONIC ISCHEMIC HEART DISEASE 303 LIFE-THREATENING CARDIAC ARRHYTHMIAS 373 CARDIAC ARRHYTHMIAS
93295	INTERROGATION DEVICE EVALUATION(S) (REMOTE), UP TO 90 DAYS; SINGLE, DUAL, OR MULTIPLE LEAD IMPLANTABLE CARDIOVERTER-DEFIBRILLATOR SYSTEM WITH INTERIM PHYSICIAN ANALYSIS, REVIEW(S) AND REPORT(S)	List	76 ACUTE AND SUBACUTE ISCHEMIC HEART DISEASE, MYOCARDIAL INFARCTION 110 CARDIOMYOPATHY, HYPERTROPHIC MUSCLE 196 CHRONIC ISCHEMIC HEART DISEASE 303 LIFE-THREATENING CARDIAC ARRHYTHMIAS 373 CARDIAC ARRHYTHMIAS

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Code	Description	Recommended Placement	Recommended Lines
93296	INTERROGATION DEVICE EVALUATION(S) (REMOTE), UP TO 90 DAYS; SINGLE, DUAL, OR MULTIPLE LEAD PACEMAKER SYSTEM OR IMPLANTABLE CARDIOVERTER-DEFIBRILLATOR SYSTEM, REMOTE DATA ACQUISITION(S), RECEIPT OF TRANSMISSIONS AND TECHNICIAN REVIEW, TECHNICAL SUPPORT AND DISTRIBUTION OF RESULTS	List	76 ACUTE AND SUBACUTE ISCHEMIC HEART DISEASE, MYOCARDIAL INFARCTION 110 CARDIOMYOPATHY, HYPERTROPHIC MUSCLE 196 CHRONIC ISCHEMIC HEART DISEASE 303 LIFE-THREATENING CARDIAC ARRHYTHMIAS 373 CARDIAC ARRHYTHMIAS
95992	CANALITH REPOSITIONING PROCEDURE(S) (EG, EPLEY MANEUVER, SEMONT MANEUVER), PER DAY	List	530 VERTIGINOUS SYNDROMES AND OTHER DISORDERS OF VESTIBULAR SYSTEM
99460	INITIAL HOSPITAL OR BIRTHING CENTER CARE, PER DAY, FOR EVALUATION AND MANAGEMENT OF NORMAL NEWBORN INFANT	List	2 BIRTH OF INFANT
99461	INITIAL CARE, PER DAY, FOR EVALUATION AND MANAGEMENT OF NORMAL NEWBORN INFANT SEEN IN OTHER THAN HOSPITAL OR BIRTHING CENTER	List	2 BIRTH OF INFANT
99462	SUBSEQUENT HOSPITAL CARE, PER DAY, FOR EVALUATION AND MANAGEMENT OF NORMAL NEWBORN	List	2 BIRTH OF INFANT
99463	INITIAL HOSPITAL OR BIRTHING CENTER CARE, PER DAY, FOR EVALUATION AND MANAGEMENT OF NORMAL NEWBORN INFANT ADMITTED AND DISCHARGED ON THE SAME DATE	List	2 BIRTH OF INFANT
99464	ATTENDANCE AT DELIVERY (WHEN REQUESTED BY THE DELIVERING PHYSICIAN) AND INITIAL STABILIZATION OF NEWBORN	List	2 BIRTH OF INFANT
99468	INITIAL INPATIENT NEONATAL CRITICAL CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A CRITICALLY ILL NEONATE, 28 DAYS OF AGE OR LESS	List	99XXX code containing lines
99469	SUBSEQUENT INPATIENT NEONATAL CRITICAL CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A CRITICALLY ILL NEONATE, 28 DAYS OF AGE OR LESS	List	99XXX code containing lines
99471	INITIAL INPATIENT PEDIATRIC CRITICAL CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A CRITICALLY ILL INFANT OR YOUNG CHILD, 29 DAYS THROUGH 24 MONTHS OF AGE	List	99XXX code containing lines
99472	SUBSEQUENT INPATIENT PEDIATRIC CRITICAL CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A CRITICALLY ILL INFANT OR YOUNG CHILD, 29 DAYS THROUGH 24 MONTHS OF AGE	List	99XXX code containing lines
99475	INITIAL INPATIENT PEDIATRIC CRITICAL CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A CRITICALLY ILL INFANT OR YOUNG CHILD, 2 THROUGH 5 YEARS OF AGE	List	99XXX code containing lines

Health Outcomes Subcommittee Recommendations on the Designation of New 2009 CPT CDT Codes

Code	Description	Recommended Placement	Recommended Lines
99476	SUBSEQUENT INPATIENT PEDIATRIC CRITICAL CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A CRITICALLY ILL INFANT OR YOUNG CHILD, 2 THROUGH 5 YEARS OF AGE	List	99XXX code containing lines
99478	SUBSEQUENT INTENSIVE CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF THE RECOVERING VERY LOW BIRTH WEIGHT INFANT (PRESENT BODY WEIGHT LESS THAN 1500 GRAMS)	List	99XXX code containing lines
99479	SUBSEQUENT INTENSIVE CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF THE RECOVERING LOW BIRTH WEIGHT INFANT (PRESENT BODY WEIGHT OF 1500-2500 GRAMS)	List	99XXX code containing lines
99480	SUBSEQUENT INTENSIVE CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF THE RECOVERING INFANT (PRESENT BODY WEIGHT OF 2501-5000 GRAMS)	List	99XXX code containing lines

ANCILLARY

Code	Description	Recommended Placement	Recommended Lines
00211	ANESTHESIA FOR INTRACRANIAL PROCEDURES; CRANIOTOMY OR CRANIECTOMY FOR EVACUATION OF HEMATOMA	Ancillary	
00567	ANESTHESIA FOR DIRECT CORONARY ARTERY BYPASS GRAFTING; WITH PUMP OXYGENATOR	Ancillary	
96360	IV INFUSION HYDRATION INITIAL 31 MIN-1 HOUR	Ancillary	
96361	IV INFUSION HYDRATION EACH ADDITIONAL HOUR	Ancillary	
96365	IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST >1 HOUR	Ancillary	
96366	IV INFUSION THERAPY PROPHYLAXIS/DX EA HOUR	Ancillary	
96367	IV NFS THER PROPH/DX ADDL SEQUENTIAL NFS >1 HR	Ancillary	
96368	IV NFS THERAPY PROPHYLAXIS/DX CONCURRENT NFS	Ancillary	
96369	SUBCUTANEOUS INFUSION INITIAL 1 HR W/PUMP SET-UP	Ancillary	
96370	SUBCUTANEOUS INFUSION EACH ADDITIONAL HOUR	Ancillary	
96371	SUBQ INFUSION ADDITIONAL PUMP INFUSION SITE	Ancillary	
96372	THERAPEUTIC, PROPHYLACTIC, OR DIAGNOSTIC INJECTION (SPECIFY SUBSTANCE OR DRUG); SUBCUTANEOUS OR INTRAMUSCULAR	Ancillary	
96373	THERAPEUTIC, PROPHYLACTIC, OR DIAGNOSTIC INJECTION (SPECIFY SUBSTANCE OR DRUG); INTRA-ARTERIAL	Ancillary	

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Code	Description	Recommended Placement	Recommended Lines
96374	THERAPEUTIC, PROPHYLACTIC, OR DIAGNOSTIC INJECTION (SPECIFY SUBSTANCE OR DRUG); INTRAVENOUS PUSH, SINGLE OR INITIAL SUBSTANCE/DRUG	Ancillary	
96375	THERAPEUTIC, PROPHYLACTIC, OR DIAGNOSTIC INJECTION (SPECIFY SUBSTANCE OR DRUG); EACH ADDITIONAL SEQUENTIAL INTRAVENOUS PUSH OF A NEW SUBSTANCE/DRUG (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	Ancillary	
96376	THERAPEUTIC, PROPHYLACTIC, OR DIAGNOSTIC INJECTION (SPECIFY SUBSTANCE OR DRUG); EACH ADDITIONAL SEQUENTIAL INTRAVENOUS PUSH OF THE SAME SUBSTANCE/DRUG PROVIDED IN A FACILITY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	Ancillary	
96379	UNLISTED THERAPEUTIC, PROPHYLACTIC, OR DIAGNOSTIC INTRAVENOUS OR INTRA-ARTERIAL INJECTION OR INFUSION	Ancillary	
EXEMPT			
Code	Description	Recommended Placement	Recommended Lines
99465	DELIVERY/BIRTHING ROOM RESUSCITATION, PROVISION OF POSITIVE PRESSURE VENTILATION AND/OR CHEST COMPRESSIONS IN THE PRESENCE OF ACUTE INADEQUATE VENTILATION AND/OR CARDIAC OUTPUT	Exempt	
99466	CRITICAL CARE SERVICES DELIVERED BY A PHYSICIAN, FACE-TO-FACE, DURING AN INTERFACILITY TRANSPORT OF CRITICALLY ILL OR CRITICALLY INJURED PEDIATRIC PATIENT, 24 MONTHS OF AGE OR LESS; FIRST 30-74 MINUTES OF HANDS-ON CARE DURING TRANSPORT	Exempt	
99467	CRITICAL CARE SERVICES DELIVERED BY A PHYSICIAN, FACE-TO-FACE, DURING AN INTERFACILITY TRANSPORT OF CRITICALLY ILL OR CRITICALLY INJURED PEDIATRIC PATIENT, 24 MONTHS OF AGE OR LESS; EACH ADDITIONAL 30 MINUTES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY SERVICE)	Exempt	

Health Outcomes Subcommittee Recommendations on the Designation of New 2009 CPT CDT Codes

DIAGNOSTIC			
Code	Description	Recommended Placement	Recommended Lines
55706	BIOPSIES, PROSTATE, NEEDLE, TRANSPERINEAL, STEREOTACTIC TEMPLATE GUIDED SATURATION SAMPLING, INCLUDING IMAGING GUIDANCE	Diagnostic	
62267	PERCUTANEOUS ASPIRATION WITHIN THE NUCLEUS PULPOSUS, INTERVERTEBRAL DISC, OR PARAVERTEBRAL TISSUE FOR DIAGNOSTIC PURPOSES	Diagnostic	
78808	INJECTION PROCEDURE FOR RADIOPHARMACEUTICAL LOCALIZATION BY NON-IMAGING PROBE STUDY, INTRAVENOUS (EG, PARATHYROID ADENOMA)	Diagnostic	
83876	MYELOPEROXIDASE MPO	Diagnostic	
85397	COAGULATION AND FIBRINOLYSIS, FUNCTIONAL ACTIVITY, NOT OTHERWISE SPECIFIED (EG, ADAMTS-13), EACH ANALYTE	Diagnostic	
88720	BILIRUBIN TOTAL TRANSCUTANEOUS	Diagnostic	
93228	WEARABLE MOBILE CARDIOVASCULAR TELEMETRY WITH ELECTROCARDIOGRAPHIC RECORDING, CONCURRENT COMPUTERIZED REAL TIME DATA ANALYSIS AND GREATER THAN 24 HOURS OF ACCESSIBLE ECG DATA STORAGE (RETRIEVABLE WITH QUERY) WITH ECG TRIGGERED AND PATIENT SELECTED EVENTS	Diagnostic	
93229	WEARABLE MOBILE CARDIOVASCULAR TELEMETRY WITH ELECTROCARDIOGRAPHIC RECORDING, CONCURRENT COMPUTERIZED REAL TIME DATA ANALYSIS AND GREATER THAN 24 HOURS OF ACCESSIBLE ECG DATA STORAGE (RETRIEVABLE WITH QUERY) WITH ECG TRIGGERED AND PATIENT SELECTED EVENTS	Diagnostic	
93285	PROGRAMMING DEVICE EVALUATION WITH ITERATIVE ADJUSTMENT OF THE IMPLANTABLE DEVICE TO TEST THE FUNCTION OF THE DEVICE AND SELECT OPTIMAL PERMANENT PROGRAMMED VALUES WITH PHYSICIAN ANALYSIS, REVIEW AND REPORT; IMPLANTABLE LOOP RECORDER SYSTEM	Diagnostic	
93290	INTERROGATION DEVICE EVALUATION (IN PERSON) WITH PHYSICIAN ANALYSIS, REVIEW AND REPORT, INCLUDES CONNECTION, RECORDING AND DISCONNECTION PER PATIENT ENCOUNTER; IMPLANTABLE CARDIOVASCULAR MONITOR SYSTEM, INCLUDING ANALYSIS OF 1 OR MORE RECORDED PHYSIOLOGIC CARDIOVASCULAR DATA ELEMENTS FROM ALL INTERNAL AND EXTERNAL SENSORS	Diagnostic	

Health Outcomes Subcommittee Recommendations on the Designation of New 2009 CPT CDT Codes

Code	Description	Recommended Placement	Recommended Lines
93291	INTERROGATION DEVICE EVALUATION (IN PERSON) WITH PHYSICIAN ANALYSIS, REVIEW AND REPORT, INCLUDES CONNECTION, RECORDING AND DISCONNECTION PER PATIENT ENCOUNTER; IMPLANTABLE LOOP RECORDER SYSTEM, INCLUDING HEART RHYTHM DERIVED DATA ANALYSIS	Diagnostic	
93297	INTERROGATION DEVICE EVALUATION(S), (REMOTE) UP TO 30 DAYS; IMPLANTABLE CARDIOVASCULAR MONITOR SYSTEM, INCLUDING ANALYSIS OF 1 OR MORE RECORDED PHYSIOLOGIC CARDIOVASCULAR DATA ELEMENTS FROM ALL INTERNAL AND EXTERNAL SENSORS, PHYSICIAN ANALYSIS, REVIEW(S)	Diagnostic	
93298	INTERROGATION DEVICE EVALUATION(S), (REMOTE) UP TO 30 DAYS; IMPLANTABLE LOOP RECORDER SYSTEM, INCLUDING ANALYSIS OF RECORDED HEART RHYTHM DATA, PHYSICIAN ANALYSIS, REVIEW(S) AND REPORT(S)	Diagnostic	
93299	INTERROGATION DEVICE EVALUATION(S), (REMOTE) UP TO 30 DAYS; IMPLANTABLE CARDIOVASCULAR MONITOR SYSTEM OR IMPLANTABLE LOOP RECORDER SYSTEM, REMOTE DATA ACQUISITION(S), RECEIPT OF TRANSMISSIONS AND TECHNICIAN REVIEW, TECHNICAL SUPPORT AND DISTRIBUTION OF RESULTS	Diagnostic	
93306	ECHOCARDIOGRAPHY, TRANSTHORACIC, REAL-TIME WITH IMAGE DOCUMENTATION (2D), INCLUDES M-MODE RECORDING, WHEN PERFORMED, COMPLETE, WITH SPECTRAL DOPPLER ECHOCARDIOGRAPHY, AND WITH COLOR FLOW DOPPLER ECHOCARDIOGRAPHY	Diagnostic	
93351	ECHOCARDIOGRAPHY, TRANSTHORACIC, REAL-TIME WITH IMAGE DOCUMENTATION (2D), INCLUDES M-MODE RECORDING, WHEN PERFORMED, DURING REST AND CARDIOVASCULAR STRESS TEST USING TREADMILL, BICYCLE EXERCISE AND/OR PHARMACOLOGICALLY INDUCED STRESS, WITH INTERPRETATION	Diagnostic	
93352	USE OF ECHOCARDIOGRAPHIC CONTRAST AGENT DURING STRESS ECHOCARDIOGRAPHY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	Diagnostic	

Health Outcomes Subcommittee Recommendations on the Designation of New 2009 CPT CDT Codes

EXCLUDED			
Code	Description	Recommended Placement	Recommended Lines
20696	APPLICATION OF MULTIPLANE, UNILATERAL, EXTERNAL FIXATION WITH STEREOTACTIC COMPUTER-ASSISTED ADJUSTMENT, INCLUDING IMAGING; INITIAL AND SUBSEQUENT ALIGNMENT(S), ASSESSMENT(S), AND COMPUTATION(S) OF ADJUSTMENT SCHEDULE(S)	Excluded	
20697	APPLICATION OF MULTIPLANE (PINS OR WIRES IN MORE THAN ONE PLANE), UNILATERAL, EXTERNAL FIXATION WITH STEREOTACTIC COMPUTER-ASSISTED ADJUSTMENT (EG, SPATIAL FRAME), INCLUDING IMAGING; EXCHANGE (IE, REMOVAL AND REPLACEMENT) OF STRUT, EACH	Excluded	
22856	TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH...SINGLE INTERSPACE, CERVICAL	Excluded	
22861	REVISION INCLUDING REPLACEMENT OF TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, SINGLE INTERSPACE; CERVICAL	Excluded	
22864	REMOVAL OF TOTAL DISC ARTHROPLASTY (ARTIFICIAL DISC), ANTERIOR APPROACH, SINGLE INTERSPACE; CERVICAL	Excluded	
41512	TONGUE BASE SUSPENSION, PERMANENT SUTURE TECHNIQUE	Excluded	
41530	SUBMUCOSAL ABLATION OF THE TONGUE BASE, RADIOFREQUENCY, ONE OR MORE SITES, PER SESSION	Excluded	
83951	ONCOPROTEIN; DES-GAMMA-CARBOXY-PROTHROMBIN (DCP)	Excluded	
87905	INFECTIOUS AGENT ENZYMATIC ACTIVITY OTHER THAN VIRUS (EG, SIALIDASE ACTIVITY IN VAGINAL FLUID)	Excluded	
88740	HEMOGLOBIN, QUANTITATIVE, TRANSCUTANEOUS, PER DAY; CARBOXYHEMOGLOBIN	Excluded	
88741	HEMOGLOBIN, QUANTITATIVE, TRANSCUTANEOUS, PER DAY; METHEMOGLOBIN	Excluded	
95803	ACTIGRAPHY TESTING, RECORDING, ANALYSIS, INTERPRETATION, AND REPORT (MINIMUM OF 72 HOURS TO 14 CONSECUTIVE DAYS OF RECORDING)	Excluded	

Health Outcomes Subcommittee Recommendations on the Designation of New 2009 CPT CDT Codes

NEW CDT CODES			
Code	Description	Recommended Placement	Recommended Lines
D0417	collection and preparation of saliva sample for laboratory diagnostic testing	Excluded	
D0418	analysis of saliva sample - Chemical or biological analysis of saliva sample for diagnostic purposes	Excluded	
D3222	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development - Removal of a portion of the pulp and application of a medicament with the aim of maintaining the vitality of the remaining portion to encourage continued physiological development and formation of the root. This procedure is not to be construed as the first stage of root canal therapy.	List	59 DENTAL CONDITIONS (EG. INFECTIONS) Treatment: URGENT AND EMERGENT DENTAL SERVICES 357 DENTAL CONDITIONS (EG. DENTAL CARIES, FRACTURED TOOTH) Treatment: BASIC RESTORATIVE
D5991	topical medicament carrier - A custom fabricated carrier that covers the teeth and alveolar mucosa, or alveolar mucosa alone, and is used to deliver topical corticosteroids and similar effective medicaments for maximum sustained contact with the alveolar ridge and/or attached gingival tissues for the control and management of immunologically medicated vesiculobullous mucosal, chronic recurrent ulcerative, and other desquamative diseases of the gingiva and oral mucosa.	List	59 DENTAL CONDITIONS (EG. INFECTIONS) Treatment: URGENT AND EMERGENT DENTAL SERVICES

**MEETING HIGHLIGHTS
HEALTH OUTCOMES SUBCOMMITTEE**

Meridian Park Hospital

Tualatin, Oregon

August 21, 2008

8:00-1:30

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

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

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

Also Attending: Wally Shaffer MD, DMAP; Caroline Price RN, DMAP; Chris Barber, DMAP; Chris Kirk, MD OHP Medical Directors; Tina Kitchin, MD, DHS-Senior & People with Disabilities; Gary Allen, DMD, Willamette Dental; Beryl Fletcher, Oregon Dental Association; Gayle Pizzuto, MultiCare Dental; Leann Dooley, Multnomah County Health Department; Lisa Bozzetti, Virginia Garcia Memorial Health Center; Deborah Loy, Capitol Dental Care; Irene Crosswell, PJ Pitts and Carole Van Horn, Oregon Pharmacy Association; Blake Rice, Sdhealth.

Note: Next HOSC meeting is scheduled for December 4, 2008.

Topic	Action
<p>General Highlights from January 2008 HOSC meeting reviewed. Dr. McKelvey requested that the spelling her first name be corrected.</p>	<p>Highlights approved with noted change.</p>
<p>New ICD-9 Codes</p> <p>Smits introduced an Excel spreadsheet outlining recommendations for placement of new ICD-9 codes. The recommendations were accepted as outlined in the meeting materials, with the following exceptions:</p> <ol style="list-style-type: none"> 1. 695.12 (Erythema multiforme major). Proposal was to place on Line 594 (Erythema multiforme). Kirk noted that this diagnosis involves mucous membranes or disease with complications such as dehydration and as such should likely be a covered diagnosis. McKelvey noted that she would likely hospitalize a child with this condition because of the high likelihood of complications. Coffman suggested adding a guideline, which was not supported by the Subcommittee. The Subcommittee voted to place this diagnosis on Line 	<p>Recommendations accepted as outlined in the meeting materials, except:</p> <ol style="list-style-type: none"> 1) 695.12 (Erythema multiforme major) placed on Line 226 (TOXIC EPIDERMAL NECROLYSIS AND STAPHYLOCOCCAL SCALDED SKIN SYNDROME; STEVENS-JOHNSON SYNDROME; ECZEMA HERPETICUM). 2) Functional quadriplegia (780.72) was added to the Watch List

<p>226 (TOXIC EPIDERMAL NECROLYSIS AND STAPHYLOCOCCAL SCALDED SKIN SYNDROME; STEVENS-JOHNSON SYNDROME; ECZEMA HERPETICUM).</p> <p>2. Functional quadriplegia (780.72) was added to the Watch List after Dodson expressed concerns that this code could be misused.</p> <p>3. V07.51 (Prophylactic use of selective estrogen receptor modulators (SERMs) was suggested for placement on the Never Covered List due to its designation as a secondary billing code. Olson stated that this diagnosis is used for women at high risk for breast cancer (BRCA+, atypical hyperplasia found on breast biopsy) who are treated with SERMs. Tamoxifen is the only SERM currently with good evidence for use. Aromatase inhibitors and other prophylactic agents (V07.52 and V07.59) do not have good evidence for use. Other services which may prevent breast cancer, such as prophylactic mastectomy, are located on Line 4 Preventive Services, Over Age of 10. Olson suggested this code would better be located on Line 4. Coffman suggested that if V07.51 is added to Line 4, then GUIDELINE NOTE 3, PROPHYLACTIC BREAST REMOVAL could be expanded to define who should get these drugs. The Subcommittee agreed to the following modification to the Guideline: SERMs are appropriate for use in woman at high risk for breast cancer. It was also agreed to change name of guideline to "Prophylactic treatment for prevention of breast cancer in high risk women." Shaffer suggested that we should expand the guideline for prophylactic mastectomy to include high risk women other than BRCA positive. Kirk noted that this was somewhat of an issue in his plan. Dodson suggested that we change the guideline to add SERM, and readdress mastectomy indications after more info/research.</p> <p>Additionally, several additional list changes as outlined in the Word document on New ICD-9 Code Issues were accepted as recommended in the document.</p>	<p>3) V07.51 (Prophylactic use of selective estrogen receptor modulators (SERMs) was added to Line 4 (Preventive Services, Over Age of 10).</p> <p>4) Guideline note 3 was changed to the following:</p> <p><u>GUIDELINE NOTE 3, PROPHYLACTIC BREAST REMOVAL - PROPHYLACTIC TREATMENT FOR PREVENTION OF BREAST CANCER IN HIGH RISK WOMEN</u> <i>Lines 4,198</i></p> <p>Prophylactic breast removal is included on this line in the case of high risk for breast cancer defined as being BRCA positive.</p> <p><u>Selective estrogen receptor modulators (SERMs) are appropriate for use in woman at high risk for breast cancer.</u></p> <p>5) Smits will investigate indications for prophylactic mastectomy other than BRCA positivity and readdress that portion of the guideline at a future meeting.</p> <p>Additionally, several additional list changes as outlined in the Word document on New ICD-9 Code Issues were accepted as recommended in the document.</p>
<p>Guidelines</p> <p>I. Dental Prophylactic visits Smits reviewed suggested changes to the Preventive Dental Care guideline. Extensive testimony was heard from the</p>	<p>See Appendix A for guidelines as adopted.</p> <p>Other changes were accepted as outlined in the meeting documents:</p>

dental provider community. Written testimony was submitted as well.

The dental experts who testified recommended that coverage be increase to include a cleaning twice a year and fluoride treatments 4 times a year due to the high risk nature of the Medicaid population. McKelvey asked whether these recommendations change based on fluoridated water/oral fluoride treatment and was told that some modification of these guidelines would hold in such cases.

The major concern of the HOSC regarding increasing coverage for more visits per year would decrease overall dental access. Discussion centered around the fact that if the overall number of visit slots available to Medicaid patients did not change, then increasing the number of visits allowed per patient per year would only serve to improve the visits for a small number of patients and would result in other patients not getting seen at all. Dodson requested data on the percent of Medicaid kids who have seen a dentist in the past year. The DCO representatives present from Multnomah county indicated that 31% of kids 0-23 months and 64% of older kids in their plans had been seen once in the past year. Gary Allen testified that the dental community was aware that access was a problem and that lots of work is ongoing to improve access. Allen also noted that if you take into consideration the other types of dental access (hygienist outreach, etc) then access is better. Kirk pointed out that services such as fluoride varnish can be done in the PCP office, which also increases access.

The HOSC debated whether just fluoride treatment should be increased to twice a year or whether both preventive visits and fluoride treatment should be increased. It was decided to increase both the visits and the fluoride applications to twice a year. However, data on percent of Medicaid patients with a single dental visit in the past year will be reviewed 1 year after the guideline takes effect. If the percent of patients seen for at least one visit decreases with this change, then the HOSC will change the guideline back to one visit per year.

Discussion also centered around current DMAP administrative rules regarding dental visits, which have a more explicit definition of high risk patients that the current HOSC guideline. The dental representatives were concerned that the current guideline could limit current coverage. It was noted that the definition of high risk in the current guideline has been

- 1) Add all VAD codes (33979-80, 33975-78) to any line with one of these types of codes: Lines 90, 109, 279, 366
- 2) Add personal history of breast (V10.3) and ovarian (V10.43) cancer to the diagnostic list
- 3) Add family history of breast (V16.3) and ovarian (V16.41) cancer to the diagnostic list
- 4) Delete 474.1 (Hypertrophy of tonsils and adenoids) from Lines 392 (leave on Line 565
- 5) Change the Title of Line 392 to “STREPTOCOCCAL SORE THROAT AND SCARLET FEVER; VINCENT’S DISEASE; HYPERTROPHY OF TONSILS AND ADENOIDS; ULCER OF TONSIL”
- 6) Add Hunter’s syndrome and similar conditions (277.5 Mucopolysaccharidosis) to Line 672
- 7) Add Gaucher’s syndrome and similar conditions (272.7 Lipidoses) to Line 672
- 8) Change the name of all Lines (669-680) including “WITH NO EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY” to “WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY”
- 9) Add the J code (J3490) for Elaprase to Line 672

in place for years and has not conflicted with DMAP administrative rules to date. DMAP administrative rules define pregnant women as a high risk group, and McKelvey thought this group should be included in the HOSC guideline. Coffman suggested taking out the high risk part of the HOSC guideline and let DMAP rules stand. The second sentence was deleted and a modified second sentence which does not define higher risk groups was adopted.

Discussion also occurred regarding the last sentence of the current guideline, which discusses D9920. The dental community expressed confusion as to the meaning of this sentence. The problem discussed was that this D code is not used for sedation as the sentence implies. There is a need to clarify what is meant by this sentence further. Also, members questioned whether other groups other than people with mental disabilities might need sedation and aren't included here. Suggestions for inclusion were persons with physical disabilities and people under 18. A suggested change was "Use of IV or GA sedation for necessary dental treatment for patients over 18 who are mental disabled or are truly dental phobic is allowed up to 4 times per year (D9920)."

In order to determine the need for the use of IV or GA sedation to render necessary treatment, patients over 18 who are mentally disabled or are truly dental phobic may have D9920 services provided up to 4 times per year (maximum once per week) (D9920). It was decided that staff would review info and bring suggestions and more information to next meeting.

Shaffer pointed out that the changes to the guideline which would be implemented October 1 would be problematic for DMAP from an administrative point of view. This change would increase costs and capitation rates would need to be recalculated. Coffman suggested that we add a separate section to our notification letter saying that this guideline has been adopted but we are working with DMAP on a timeline for implementation

II. Pharmacy medication management

Smits presented two suggested modifications to the current guideline, one developed by the Board of Pharmacy and DMAP, the other by a taskforce of community pharmacists. Community pharmacy representatives gave testimony in favor of the second suggested guideline.

There was minimal discussion and the community pharmacist guideline was adopted as suggested.

III. PET scans

Smits reviewed suggested changes to the PET scan guideline. The Subcommittee decided that restaging of testicular cancer should be covered, but not staging for this diagnosis. Olson stated that PET scans are used in cases of testicular cancer where surgery needs to be done in patients with residual masses. Utilization is not high and benefit/cost savings is good.

The Subcommittee agreed to the addition of coverage for limited use in cervical and head and neck cancers.

Use of PET scans in restaging was discussed. Restaging should be covered only in cases where staging is covered, with the exception of testicular cancer. The Subcommittee reiterated their intent that PET scans not be used for routine surveillance of asymptomatic patients.

Shaffer indicated DMAP issues with the proposed last sentence, which restricted PET scans to only the diagnoses listed. DMAP covers other diagnoses when obligated by federal rules; for example, in the case of coverage for comorbid conditions.

IV. VAD guideline

Smits introduced suggested changes to the VAD guideline. The HOSC agreed with the sentiment that VAD should be used only as a bridge to transplant for cardiomyopathy; however, they suggested stating this as a sentence rather than a clause in part 3. Other changes were accepted as stated in the document.

V. BRCA Guideline

Smits introduced two documents with proposed changes to the Prevention Tables and the Genetic Testing Guideline regarding BRCA testing. Additionally, V codes for personal and family history of breast and ovarian cancer were added to the Diagnostic List.

VI. Second solid organ transplant guideline

No discussion was held on the proposed changes.

<p>VII. <u>Tonsillectomy</u> Smits introduced suggested modifications to the Tonsillectomy guideline as well as suggested changes for specific codes on Line 392 and a name change for Line 392. 474.1 (Hypertrophy of tonsils and adenoids) will be deleted from Line 392, but will remain on Line 565.</p> <p>Kirk requested that the HOSC alter the guideline to reflect what constitutes an abnormal sleep study. Smits agreed to work on this issue and speak with specialists in the field.</p> <p>VIII. <u>Coverage for minimally effective treatments</u> Smits introduced suggestions regarding coverage for minimally effective treatments. The specific discussion centered around Elaprase, an expensive and relatively ineffective treatment for Hunter’s Syndrome which the HSC had voted not to cover at their May 2008 meeting. The J code for Elaprase was not a specific code and therefore could not be added to a low line. Olson suggested adding the J code to the lower line, and adding a coding guideline. The guideline proposed in the meeting document was discussed, with the HOSC members expressing concern for using a dollar figure for a QALY. Coffman pointed out that QALY’s can vary by study, and can be a range of numbers. In general, the HOSC was uncomfortable with an absolute number in this guideline. McKelvey suggested taking the diagnosis for Hunter’s Syndrome off the list if this is the only effective treatment. Coffman replied that this diagnosis is on the 4 dysfunction lines and therefore many ancillary and supportive services are covered for people with this condition. The decision was to place the J code on the lower line, with a guideline stating: “Inclusion of code J3490 refers to enzyme replacement therapy.” The proposed guideline in the meeting document was rejected. The other changes proposed in the meeting document were accepted as presented.</p>	
<p>Adenoidectomy for Chronic Sinusitis Smits reviewed recommendations for adding coverage of adenoidectomy for chronic sinusitis. There was minimal discussion.</p>	<ol style="list-style-type: none"> 1) Delete 519.8 (Other diseases of the respiratory system, NEC) from Line 49 2) Add adenoidectomy for children younger than age 12 (42830, 42835) to line 489 (Chronic sinusitis)
<p>Hemangiomas Smits reviewed the issues around coverage for complicated hemangiomas and other benign vascular lesions. The HOSC was given the option of adopting a guideline around when such</p>	<p>No guideline regarding hemangiomas and other benign vascular lesions was adopted. The current exceptions process for</p>

<p>lesions would have covered treatment or continue with the current system of allowing the plans to cover these through an exceptions process. The group was divided in their sentiment. Shaffer felt that the guideline did not add much to the current situation. The decision was to not adopt the suggested guideline, and to allow the current exceptions process to continue.</p>	<p>coverage should continue.</p>
<p>Balloon Dilation of Intracranial Vasospasm Smits reviewed balloon dilation of intracranial vasospasm, which currently has little evidence supporting its use. There was little discussion; the decision was made to not add the procedure to the list at this time.</p>	<p>Balloon dilation of intracranial vasospasm (CPT 61640) was not added to the Prioritized List</p>
<p>Vertebroplasty for Malignant Indications Smits reviewed a suggested addition of vertebroplasty to Line 209 (Cancer of Bones) for use in malignancy without fracture. The HOSC felt that there great difficulty in predicting which bones would fracture. Olson felt that use of vertebroplasty to prevent neurologic damage from a future fracture is way outside of current literature. Vertebroplasty was not added to the bone cancer line.</p>	<p>22520 was not added to Line 209 (Cancer of Bones)</p>
<p>Line Zero Taskforce Recommendations Smits reviewed recommendations from the Taskforce, which were accepted with minimal discussion.</p>	<ol style="list-style-type: none"> 1. V62.9 (Other psychological or physical stress, NEC) placed on the Administrative List 2. V65.5 (Person with feared complaint in whom no diagnosis was made) placed on the Diagnostic list, but use limited to ED, basic E&M (no hospital or diagnostic or consult) 3. V70.8 (Other specified routine exam) kept on the Never Covered List 4. V72.5 (Radiological examination, not elsewhere classified) placed on the Never Covered List 5. V58.6 (laboratory monitoring for medication use) placed on the Diagnostic List <ol style="list-style-type: none"> a. Keep V58.61 on current lines <p>An Administrative List was created, with the following codes:</p> <ol style="list-style-type: none"> a. V68.89 (encounters for other specified administrative

	<p>purposes)</p> <p>b. V62.9 (other psychological or physical stress, NEC)</p>
<p>Chronic and Recurrent Urticaria Smits reviewed coverage for chronic and recurrent urticaria. There was minimal discussion.</p>	<p>Leave 708.8 (urticaria specified type NEC) on Line 559</p>
<p>Straightforward Issues Smits reviewed the straightforward issues document in the meeting materials. 438.82 (dysphagia) was thought to be best left on the 4 dysfunction lines to allow coverage of the treatment of this condition, even when the underlying reason for the dysphagia is an uncovered diagnosis. Coverage of the diagnostic work-up for dysphagia would still be covered.</p> <p>19120 (Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion, open, male or female, one or more lesions) was thought to be a diagnostic test in the majority of cases. This procedure was removed from the list and placed on the Diagnostic List</p>	<p>Changes accepted as proposed in the meeting materials with the following exceptions:</p> <ol style="list-style-type: none"> 1) 438.82 (dysphagia) was left on the 4 dysfunction lines 2) 19120 deleted kept on the Diagnostic List; deleted from Lines 198, 501, 646
<p>Bronchoscopy codes Accepted as proposed with minimal discussion.</p>	<p>Changes accepted as proposed in the meeting materials.</p>
<p>Palliative Care Statement of Intent Discussion centered around whether the 5% 5 year survival rule was obsolete. However, most commissioners liked this rule, and felt that this was consistent with how data was reported in studies. Further discussion centered around treatment of cancer. Should chemotherapy which prolonged life or significantly improved quality of life be covered? Should we cover this type of end of life care at all or should we use this money to pay for more preventive care, cover more people, or other priorities?</p> <p>The discussion was continued at the full HSC meeting.</p>	<p>No action was taken. See HSC meeting minutes for actions.</p>

Appendix A: Guideline changes adopted at the August HSC meeting

GUIDELINE NOTE 3, ~~PROPHYLACTIC BREAST REMOVAL~~ PROPHYLACTIC TREATMENT FOR PREVENTION OF BREAST CANCER IN HIGH RISK WOMEN

Lines 4,198

Prophylactic breast removal is included on this line in the case of high risk for breast cancer defined as being BRCA positive.

Selective estrogen receptor modulators (SERMs) are appropriate for use in woman at high risk for breast cancer.

GUIDELINE NOTE 16, SECOND SOLID ORGAN TRANSPLANTS

Lines 92,170,253,254,255,256,279,332,575

Second solid organ transplants of the same type of organ are not covered except for acute graft failure that occurs during the original hospitalization for transplantation.

GUIDELINE NOTE 17, PREVENTIVE DENTAL CARE

Line 105

Dental cleaning and fluoride limited to once per calendar year. Dental cleaning and fluoride treatments are limited to once per calendar year for adults and twice per calendar year for children 18 and younger. Additional provision of prophylaxis for persons with disabilities who cannot perform adequate daily oral health care, severe periodontal disease and/or rampant caries, or with disabilities who cannot perform adequate daily oral health care by report. (D0120, D0150, D1110, D1120, D1204). More frequent dental cleanings and/or fluoride treatments may be required for certain higher risk populations.

Used up to 4 times per year (maximum once per week) for patients over 18 who are mentally disabled or are truly dental phobic in order to determine the need to use IV or GA sedation to render necessary treatment (D9920).

GUIDELINE NOTE 18, ~~HEART FAILURE~~ VENTRICULAR ASSIST DEVICES

Lines 109,279 [90, 366]

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;
- or,
3. as a bridge to recovery

Ventricular assist devices are not covered for destination therapy.

VADs are covered for cardiomyopathy only when the intention is bridge to cardiac transplant.

GUIDELINE NOTE 19, PET SCAN GUIDELINES

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

PET Scans are indicated only for diagnosis and staging of the following cancers:

- Solitary pulmonary nodules and non-small cell lung cancer
- Lymphoma
- Melanoma
- Colon
- ~~—Testicular~~

PET scan is covered only for the initial staging of cervical cancer when initial MRI or CT is negative for extra-pelvic metastasis.

PET scan of head and neck cancer is only covered for 1) initial staging when initial MRI or CT is equivocal, 2) evaluation of cervical lymph node metastases when CT or MRI do not demonstrate an obvious primary tumor, and 3) evaluation of suspected recurrence of head and neck cancer when CT or MRI does not demonstrate a clear cut recurrence.

For diagnosis, PET is covered only when it will avoid an invasive diagnostic procedure, or will assist in determining the optimal anatomic location to perform an invasive diagnostic procedure.

For staging, PET is covered in the following situations:

The stage of the cancer remains in doubt after standard diagnostic work up

OR

PET replaces one or more conventional imaging studies when they are insufficient for clinical management of the patient

AND

Clinical management of the patient will differ depending on the stage of the cancer identified

Restaging is covered only for cancers for which staging is covered, and for testicular cancer. For restaging, PET is covered after completion of treatment for the purpose of detecting residual disease, for detecting suspected recurrence or to determine the extent of a known recurrence. PET is not covered to monitor tumor response during the planned course of therapy. PET scans are NOT indicated for routine follow up of cancer treatment or routine surveillance in asymptomatic patients.

PET scans are also indicated for preoperative evaluation of the brain in patients who have intractable seizures and are candidates for focal surgery. PET scans are NOT indicated for ~~routine follow up of cancer treatment or~~ for cardiac evaluation.

GUIDELINE NOTE 36, TONSILLECTOMY

Line 392

Tonsillectomy is an appropriate treatment in a case with:

- 1) Five documented attacks of strep tonsillitis in a year or 3 documented attacks of strep tonsillitis in each of two consecutive years where an attack is considered a positive culture/screen and where an appropriate course of antibiotic therapy has been completed;
- 2) Peritonsillar abscess unresponsive to medical management and drainage documented by surgeon, unless surgery performed during acute stage;
- 3) In children 18 and younger, moderate or severe obstructive sleep apnea (OSA), or mild OSA with daytime symptoms or other indications for surgery. For children 3 and younger or for children with significant co-morbidities, OSA must be diagnosed by nocturnal polysomnography. For children older than 3 who are otherwise healthy, OSA may be diagnosed by either nocturnal polysomnography or by use of a validated questionnaire (such as the Pediatric Sleep Questionnaire or OSA 18).

GUIDELINE NOTE 64, PHARMACIST MEDICATION MANAGEMENT

Included on all lines with evaluation & management (E&M) codes

Pharmacy medication management services must be provided by a pharmacist who has:

1. A current and unrestricted license to practice as a pharmacist in Oregon.
2. ~~One of the following qualifications:~~
 - a. ~~Graduated from a college of pharmacy after May 2003.~~
 - b. ~~Passed Accreditation Council of Pharmacy Education (ACPE) Medication Therapy Management certification program (e.g. American Pharmacist Association MTM training program)~~
23. Services must be provided based on referral from a physician or licensed provider or health plan.
34. Documentation must be provided for each consultation and must reflect collaboration with the physician or licensed provider. Documentation should model SOAP charting; must include patient history, provider assessment and treatment plan; follow up instructions; be adequate so that the information provided supports the assessment and plan; and must be retained in the patient's medical record and be retrievable.

Guideline Note XXX ENZYME REPLACEMENT THERAPY

Line 672

Inclusion of code J3490 (Unspecified drug) on this line represents treatment using enzyme replacement therapy.

PREVENTION TABLES

Footnote referring to the definition of persons at high risk for breast cancer in the tables for interventions for high risk populations ages 11 and older:

= a family history of breast or ovarian cancer that includes a relative with a *known* deleterious mutation in *BRCA1* or *BRCA2* genes; 2 first-degree relatives with breast cancer, 1 of whom received the diagnosis at age 50 years or younger; a combination of 3 or more first- or second degree relatives with breast cancer regardless of age at diagnosis; a combination of both breast and ovarian cancer among first- and second- degree relatives; a first-degree relative with bilateral breast cancer; a combination of 2 or more first- or second-degree relatives with ovarian cancer regardless of age at diagnosis; a first- or second-degree relative with both breast and ovarian cancer at any age; and a history of breast cancer in a male relative. For women of Ashkenazi Jewish heritage, an increased risk family history includes any first-degree relative (or 2 second-degree relatives on the same side of the family) with breast or ovarian cancer.

GUIDELINE NOTE D1, NON-PRENATAL GENETIC TESTING GUIDELINE

I. Coverage of genetic testing in a non-prenatal setting shall be determined the algorithm shown in Figure C.1 unless otherwise specified below.

II. Related to genetic testing for patients with breast/ovarian and colon/endometrial cancer suspected to be hereditary, or patients at increased risk to due to family history.

A. Services are provided according to the Comprehensive Cancer Network Guidelines.

1. NCCN Clinical Practice Guidelines in Oncology. Colorectal Cancer Screening. V.1.2006 (1/3/06). www.nccn.org

2. NCCN Clinical Practice Guidelines in Oncology. Genetic/Familial High-Risk Assessment: Breast and Ovarian. V.1.2006 (12/14/05). www.nccn.org

2.. BRCA1/BRCA2 testing services for women without a personal history of breast and/or ovarian cancer should be provided to high risk women as defined by the US Preventive Services Taskforce definition given in the Prevention Tables (footnote 17 to the high risk adult screening tables).

3. BRCA1/BRCA2 testing services for women with a personal history of breast and/or ovarian cancer and for men with breast cancer should be provided according to the NCCN Clinical Practice Guidelines in Oncology. Genetic/Familial High-Risk Assessment: Breast and Ovarian. V.1.2006 (12/14/05). www.nccn.org

B. Genetic counseling should precede genetic testing for hereditary cancer. Very rarely, it may be appropriate for a genetic test to be performed prior to genetic counseling for a patient with cancer. If this is done, genetic counseling should be provided as soon as practical.

1. Pre and post-test genetic counseling by the following providers should be covered.

i. Medical Geneticist (M.D.) – Board Certified or Active Candidate

Status from the American Board of Medical Genetics

ii. Clinical Geneticist (Ph.D.) - Board Certified or Active Candidate Status from the American Board of Medical Genetics.

iii. Genetic Counselor - Board Certified or Active Candidate Status from the American Board of Genetic Counseling, or Board Certified by the American Board of Medical Genetics.

iv. Advance Practice Nurse in Genetics – Credential from the Genetic Nursing Credentialing Commission.

C. If the mutation in the family is known, only the test for that mutation is covered. For example, if a mutation for BRCA 1 or 2 has been identified in a family, a single site mutation analysis for that mutation is covered, while a full sequence BRCA 1 and 2 analyses is not.

D. Costs for rush genetic testing for hereditary breast/ovarian and colon/endometrial cancer is not covered.

III. Related to genetic testing for infants and children with developmental delay:

A. Chromosome studies and Fragile X testing is covered without a visit or consultation with a specialist.

B. A visit with the appropriate specialist (often genetics, developmental pediatrics, or child neurology), including physical exam, medical history, and family history is covered. Physical exam, medical history, and family history by the appropriate specialist, prior to any genetic testing is often the most costeffective strategy and is encouraged.

C. Coverage for genetic testing for other conditions should continue to be made on a case-by-case basis according to the algorithm in Figure C.1.

MEETING HIGHLIGHTS
HEALTH OUTCOMES SUBCOMMITTEE
 Clackamas Community College
 Wilsonville, Oregon
 May 22, 2008
 8:00-11:30

Members Present: Lisa Dodson, MD, Chair; Som Saha, MD; Kevin Olson, MD; Carla McKelvey, MD; Dean Gubler DO

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

Also Attending: Wally Shaffer MD, DMAP; Caroline Price RN, DMAP; David B. Coutin, MD, OSAAI; Jon Hassett MD, OSAAI; Robert Bennett MD, OHSU Rheumatology; Matt Krebs, Pfizer; Dr. Jill Kerrick Walker, Pfizer; Jennifer Wayne, DHS and Oregon Governor’s Office; Courtni Dresser, OMA; Roberta Connors, Innovative Care Management; Vicki Wrigely, Innovative Care Management; William J. Byrne, MD, OHSU Pediatric GI; David Pass, MD, HRC; Dave Roberts, Lilly

Note: Adjourned at 11:50 AM. Next HOSC meeting is scheduled for August, 21 2008.

Topic	Action
<p>General Highlights from January 2008 HOSC meeting reviewed and no changes were requested.</p>	<p>Highlights approved.</p>
<p>Biennial Review</p> <p>I. <u>Kidney stone line movement</u> Smits presented a proposal to combine the two current kidney stone lines into one line, and add urinary tract codes from one additional line. This change would serve to consolidate the urinary tract stones onto one line. Line 418 would be consolidated into line 376. The changes were accepted as outlined in the meeting materials with the following changes:</p> <ul style="list-style-type: none"> a) whether 593.89 (other specified disorder of kidney or ureter) had obstructive ureteral codes). Further investigation found several obstructive diagnoses under this code; it will therefore remain on Line 187 (Ureteral stricture or obstruction) b) 50392-50395 to be added to Line 187, as these procedures were appropriate to this line c) Remove 50590 (Lithotripsy) from Line 187 as it is no longer necessary to be on that line once all urinary tract calculi ICD-9 codes were removed <p>II. <u>Allergy conditions</u></p>	<ul style="list-style-type: none"> 1) Urinary tract stone line consolidation: changes accepted as outlined in the meeting materials, except a) 50392-50395 added to Line 187 and 50590 removed from Line 187. 2) Allergy conditions: no movement of allergy conditions on the list, no addition of any allergy treatments to lines that do not currently have such treatments. Smits to work with Medical Directors to see if there are any barriers to patient access to allergist care for conditions paired with such care. Smits also to research chronic and recurrent urticaria and bring back recommendations to the next HOSC meeting.

Testimony heard from Dr. Coutin and Dr. Hassett, from the state allergy association

The major issue outlined by the Allergist was that the number of visits and types of treatments allowed for patients with Allergists is limited by many health plans. Saha noted that it is not the HSC's place to come between a specialty society and health plans. OHP covers allergy treatments for asthma; it is up to the plans to determine how to administer this benefit.

Saha noted that urticaria, which covers a range of diagnoses from minor to major, is currently not covered due to its location on Line 559 (Symptomatic urticaria). Some of the more severe forms of this diagnosis might have evidence for coverage. Smits pointed out that if evidence was found for adding coverage for severe forms of urticaria, then these diagnosis codes could be moved to another line, such as Line 341 (Angioneurotic edema) as part of an interim modification. It was decided that Smits will research chronic and recurrent urticaria and bring back recommendations to the next HOSC about possible movement of these diagnoses higher on the list and, if moved, what treatments are effective and should be paired with this diagnosis.

The decision was to bring the Allergist concerns to the OHP Medical Directors meeting in June and work with the plans to facilitate allergist treatments where indicated on the Prioritized List and determine if there are any barriers to patient access of these services which must be addressed. Allergy conditions were not moved on the list, and no new allergy treatment procedures were added to any line. The HOSC requested that if the Allergy association had any evidence that interventions for allergic conditions reduces or prevents downstream issues, the HOSC would like to have this information brought to them for consideration for adding additional allergy treatments to the list where appropriate.

III. Fibromyalgia

The HOSC heard testimony from Dr. Bennett, a rheumatologist at OHSU who reported multiple conflicts of interest, including funding from Merck, Beringer, Pfizer, and other pharmaceutical companies. Dr. Bennett testified about the prevalence of fibromyalgia, its affects on quality of life, and the high health care utilization of fibromyalgia patients. He then reviewed accepted treatments. Jennifer Wagner from the DHS and the Governor's office also spoke as an advocate

3) Fibromyalgia: no line movement. No change in current treatment coverage.

4) Constipation in children: no change in current coverage.

5) Gastroparesis: no change in current coverage

6) Autism/dementia line split: Line 210 (Chronic organic mental disorders including dementias) will be split into two lines: Line 210 (Chronic organic mental disorders including dementias) and Line 211 (Autism spectrum disorders; Treatment: medical/psychotherapy). Both lines will hold all the CPT codes current on Line 210. These treatment codes will be re-evaluated at a later time. Referral to Guideline regarding health and behavior assessment codes will be removed from both lines.

for pain patients. She stressed how important this issue was from both patients and providers prospective.

Smits reviewed the current evidence on effectiveness of various treatments for fibromyalgia.

DMAP input on restrictions for treatment for fibromyalgia was elicited. Shaffer noted that the PA for Neurontin is being eliminated, but a PA was being instituted for Lyrica.

HOSC members briefly discussed whether the HSC would need to make a guideline regarding treatments covered for fibromyalgia if fibromyalgia is moved above current funding line.

Olson pointed out that the HSC covers office visits and most medications for the coverage of fibromyalgia currently, despite the placement of fibromyalgia below the current funding line. Shaffer responded that in FFS Medicaid, fibromyalgia is a below the line diagnosis and therefore providers are not paid for office visits for this diagnosis.

Saha pointed out that the evidence for effectiveness of the current medications is not strong; therefore coverage of such medications would not be evidence based.

Gubler raised concerns that prevalence of the disease outstrips the disease prevalence (i.e. fibromyalgia is overdiagnosed). Dr. Bennett did not feel that fibromyalgia is overdiagnosed, and noted that most Rheumatologists and Psychiatrists, as well as well educated primary care physicians, are able to make the diagnosis.

Dodson wondered what would the HSC move below the line to make room for moving fibromyalgia above the line.

McKelvey pointed out that the major benefit of moving fibromyalgia is access to medications, and the evidence for the effectiveness of these medications is lacking. Olson agreed and stated that the HSC needed to keep the bar high, otherwise the HSC will have many arguments about other conditions with weak effectiveness that should be covered.

The final decision was to maintain fibromyalgia on its current line with no guideline or other change.

IV. Constipation in children

The HOSC heard a brief presentation from Dr. Byrne of OHSU pediatric GI regarding the cost-effectiveness of covering constipation in children. Discussion centered around why children would be singled out for treatment as a special population. Gubler argued that there was higher burden of disease in the elderly. Dodson agreed that constipation/encopresis is a problem in the adult/elderly population

Other discussion centered around whether coverage of constipation in children would really reduce costs (from prevention of downstream problems). McKelvey felt that moving constipation above the line will result in increased referrals to GI and possibly higher costs.

Discussion also occurred regarding the poor evidence for effectiveness of treatments for constipation. Olson argued that the HSC needs evidence for some effective treatments to move this, which is not currently there. Dodson concurred that there was no compelling new evidence for moving constipation in kids into the funded region. Saha requested that Byrne be given the opportunity to send us evidence of effectiveness of treatment and then readdress at a future HSC meeting. Coffman noted that the HSC could move constipation as a non-biennial review item in the future if evidence is found.

Decision: no change in coverage for constipation in children. If Dr. Byrne or other expert comes forward with evidence of effectiveness of treatment, then the HSC would readdress at a future meeting.

V. Gastroparesis

Smits reviewed a request to move coverage of gastroparesis, and the evidence for various treatments for this condition. There was general consensus that there was no good evidence for the effectiveness of any treatment. No change to current coverage was recommended. recommended

VI. Autism/dementia line split

Smits brought forward a late agenda item submitted by the Mental Health and Chemical Dependency Subcommittee. The recommendation was to move autism diagnoses off the line that holds dementia diagnoses. The treatments for both of these conditions need to be reviewed, but such a review was thought to be best done after the HRC completes its report on

the effectiveness of treatments for autism. The HOSC agreed to the proposed line split as a placeholder, and will readdress treatment options for these conditions at a later date.

Guidelines

I. Prevention tables

Smits presented recommendations for updates to the Prevention Tables based on USPSTF recommendations since 2004. There was some discussion about whether BRCA testing should have an upper age limit. However, the recommendation was only for referral for genetic counseling, and it was pointed out that older women would have the limited benefits of this testing in their case discussed at that time. The recommendations were accepted as outlined in the meeting materials.

II. Cervical dysplasia

Smits presented a new guideline which adopts the ASCCP guidelines for management of cervical dysplasia. McKelvey raised concerns about adding a guideline which refers to a specific date of the ASCCP guideline, which this guideline is expected to change. Coffman stated that the Attorney General’s office has specified that the Prioritized List must refer to an actual document, not a changing guideline. HSC staff will be cognizant of monitoring for new ASCCP guidelines and bringing new guidelines back to the HSC when they are available to keep the HSC guideline current. The subcommittee approved the new guideline, with HSC to bring back any new changes as they become available.

III. Chronic otitis media

Smits presented an updated guideline for chronic otitis media. Discussion centered around having a consistent wording in the guideline, to refer to the condition as “chronic nonsuppurative otitis media with effusion” wherever chronic otitis media, effusion or other term was used. Also, the subcommittee wanted to clarify that hearing testing and ear tubes should only be done for bilateral chronic otitis media, not unilateral. Dr. McKelvey stressed that chronic otitis media with effusion did not include acute otitis media that has failed one or more courses of antibiotics. This condition should be treated with antibiotics. There was discussion about whether the “total of 4-6 months” prior to surgery was after first diagnosis of the effusion or after hearing testing. The HOSC decided it was after diagnosis of the effusion. The group accepted the guideline changes as amended.

I. Prevention tables: changes accepted as outlined in the meeting materials.

II. Cervical dysplasia: a guideline for Line 31 (cervical dysplasia) was adopted.

“Work up and treatment of cervical dysplasia should follow the American Society for Cervical Colposcopy and Pathology guidelines as published in the American Journal of Obstetrics & Gynecology, October 2007.”

III. Chronic otitis media: guideline was changed to read
GUIDELINE NOTE 51, CHRONIC OTITIS MEDIA
Line 493

Antibiotic and other medication therapy are not indicated for children with bilateral chronic nonsuppurative otitis media. Observation OR antibiotic therapy are treatment options for children with effusion that has been present less than 4 to 6 months and at any time in children without a 20 decibel hearing threshold level or worse in the better hearing ear. Children with bilateral chronic nonsuppurative otitis media present for 3 months or longer or with language delay, learning problems, or significant hearing loss at any time should have hearing testing. Children with bilateral chronic nonsuppurative otitis media who are not at risk should be reexamined at 3- to 6-month intervals until the effusion is no longer present, significant

IV. Tonsillectomy

Smits reviewed recommendations to update the tonsillectomy guideline to reflect stricter standards for infectious indications and allow for tonsillectomy for treatment of pediatric obstructive sleep apnea. The HOSC members discussed the use of tonsillectomy for OSA, reviewed data on the rates of tonsillectomy in the Medicaid population, and reviewed expert input. The decision was to accept the changes to the guideline as recommended, with deletion of the 4th category entirely (rather than an alternate modification which was suggested). The sleep apnea guideline was changed to reflect that surgery is second line for adults, but not for children.

V. Bariatric surgery

Smits introduced several concerns raised by DMAP and the health plans regarding the bariatric surgery guideline. The subcommittee felt that the first proposed change, which added a clarifying footnote to the guideline, was simply an administrative clarification and accepted this change with minimal discussion. The second proposed change was rejected, which would have added coverage for bariatric surgery with obesity as the primary diagnosis and diabetes as the secondary diagnosis to Line 8, Obesity (rather than the current coverage only on the diabetes line with diabetes as the primary diagnosis and obesity as the secondary diagnosis). The general discussion centered around the fact that the limited number of surgery centers would quickly learn how to code the diagnoses to get reimbursement and that therefore this change was not needed. The third proposed change was to explicitly add medical marijuana use as a contraindication. This change was also rejected, with discussion centering around the group's sense that the Centers of Excellence would best decide whether medical marijuana use made a patient a poor surgical candidate. The outcomes of bariatric surgery are being tracked, and if medical marijuana use is found to be associated with poor outcomes, then the subcommittee will readdress whether to add this as a contraindication.

Lap band refills coverage approved as recommended

VI. VAD guideline

Deferred to August meeting

VII. PET scan

Deferred to August meeting

hearing loss is identified, or structural abnormalities of the eardrum or middle ear are suspected.

For the child who has had bilateral chronic nonsuppurative otitis media and who has a bilateral hearing deficiency diagnosed by formal audiometry testing (defined as a 20-decibel hearing threshold level or worse in the better hearing ear), bilateral myringotomy with tube insertion recommended after a total of 4 to 6 months of bilateral effusion with a documented bilateral hearing deficit.

Adenoidectomy is an appropriate surgical treatment for bilateral chronic nonsuppurative otitis media serous otitis media with persistent effusion in children over 3 4 years with their second set of tubes. First time tubes are not an indication for an adenoidectomy.

III. Tonsillectomy

GUIDELINE NOTE 27, SLEEP APNEA

Line 211

Surgery for sleep apnea for adults is only covered after documented failure of both CPAP and an oral appliance.

GUIDELINE NOTE 36, TONSILLECTOMY

Line 392

Tonsillectomy is an appropriate treatment in a case with:

1) Five ~~three~~ documented attacks of strep tonsillitis in a year or 3 documented attacks of strep tonsillitis in two consecutive years where an attack is considered a positive culture/screen and where ~~10~~

VIII. Pharmacy medication management

DMAP has worked with the Oregon Board of Pharmacy to draft a refined guideline for pharmacy medication management. The subcommittee raised concerns about whether the proposed guideline is rigorous enough. Dodson also raised the concern that there should be a specific “or” placed between the alternate qualifications in requirement #2.

Smits to check with statewide pharmacy experts, obtain documentation about required school of pharmacy training on medication management which have been required since 2003.

~~days of continuous an appropriate course of antibiotic therapy has been completed;~~

2) ~~Peritonsillar abscess unresponsive to medical management and drainage documented by surgeon, unless surgery performed during acute stage~~ Second occurrence of peritonsillar abscess, or if first abscess, has to be drained under general anesthesia;

3) ~~Airway obstruction with presence of right ventricular hypertrophy or cor pulmonale; and/or, Moderate or severe obstructive sleep apnea (OSA) in children 18 and younger, or mild OSA in children with daytime symptoms and/or other indications for surgery. For children 3 and younger or for children with significant co-morbidities, OSA must be diagnosed by nocturnal polysomnography. For children older than 3 who are otherwise healthy, OSA must be diagnosed by either nocturnal polysomnography, use of a validated questionnaire (such as the Pediatric Sleep Questionnaire or OSA 18), or consultation with a Sleep Medicine specialist.~~

4) ~~4+ tonsils, which result in obstruction of breathing, swallowing and/or speech~~

Other recommended changes:
Add Guideline #36 to lines 49 (Cleft palate), 84 (Deep abscesses [includes peritonsillar abscesses]), 211 (Sleep Apnea), and 565 (Chronic diseases of tonsils and adenoids)

IV. Bariatric surgery

A footnote was added to the current guideline: **“⁴The patient must meet criteria #1 and #2, and be referred by the”**

	<p><u>OHP primary care provider as a medically appropriate candidate, to be approved for evaluation at a qualified bariatric surgery program.</u></p> <p>Proposals to add bariatric surgery to the obesity line (Line 8) with restriction to diabetic patients and to explicitly accept or reject medical marijuana use were both rejected.</p> <p>Lap band refills were added to the type II diabetes/bariatric surgery line</p> <p>V. VAD guideline, PET guideline, and Pharmacy Medication Management guidelines not acted upon; deferred to August meeting</p>
<p>Xolair Deferred to HSC</p>	Action deferred to HSC meeting
<p>Elaprase Deferred to HSC</p>	Action deferred to HSC meeting
<p>Stem Cell Transplants Deferred to HSC</p>	Action deferred to HSC meeting
<p>Line Zero Workgroup Deferred to August meeting</p>	Deferred to August meeting
<p>EGD coding Smits reviewed recommendations for “cleaning up” the current coverage for EGDs and esophagoscopy. No new codes were added to the list. Changes were accepted as proposed with minimal discussion.</p>	Changes accepted as proposed in the meeting materials.
<p>Shoulder disorders Smits reviewed whether PT services should be covered for shoulder disorders which do not involve surgery. When the shoulder lines were collapsed at an earlier meeting, the treatment description of the new line referred to post-operative treatments only. The HOSC voted to change the treatment description of the line to “Repair/reconstruction, medical therapy” and reinforced their intent that PT be covered for these conditions, subject to the PT guideline, regardless of whether the condition required or resulted from surgery.</p>	Change the treatment line of Line 437 to “Repair/reconstruction, medical therapy”
<p>Straightforward issues Accepted as proposed with minimal discussion.</p>	Changes accepted as proposed in the meeting materials.
<p>New Vaccine codes Accepted as proposed with minimal discussion.</p>	Changes accepted as proposed in the meeting materials.

**MEETING HIGHLIGHTS
HEALTH OUTCOMES SUBCOMMITTEE**

Clackamas Community College

Wilsonville, Oregon

January 10, 2008

8:00-11:30

Members Present: Som Saha, MD, Chair; Lisa Dodson, MD; Dan Mangum, MD; Kevin Olson, MD (arrived at 9:10)

Staff Present: Darren Coffman; 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; Dr. Kevin Wei, OHSU Cardiology; Tina Kitchen, MD, Office of Development and Disabilities Services

Note: Adjourned at 11:20 AM. Next HOSC meeting is scheduled for May 22, 2008.

Topic	Action
<p>General Highlights from 12/07 HOSC meeting reviewed. Smits pointing out corrections made between the first version of the minutes distributed initially and the second version distributed just prior to the meeting. There were no further errors noted or changes requested.</p>	<p>Highlights approved.</p>
<p>Cardiac MRI Debate centered around whether cardiac MRI improves outcomes. Saha wondered if this expensive test was better than other, less expensive and more readily available imaging. Kirk indicated that the FCHPs require a prior authorization for this test. Shaffer indicated that DMAP does not have the ability to prior authorize this test. Saha suggested placing on the Diagnostic List with referral to the Line Zero Taskforce. Alternatively, he argued that we could place these codes on the congenital heart disease lines only and have those providers who feel that this is appropriate for other indications to prove its worth. Saha expressed concerns about the low funds available for the OHP and stressed that the HSC should be cognizant of how these funds are used. Argued that we should only pay for things that improve outcomes, through evidence based medicine. Mangum wanted to know if this test would replace other expensive tests such as cardiac catheterization. Dr. Wei stated that gadolinium used as contrast gives</p>	<p>Cardiac MRI (75552-75564) was placed on congenital heart lines only (Lines 74, 77, 94, 95, 98, 99, 116, 117, 123, 140, 142, 149, 185, 193, 195, 237, 247, 274, 279, 673). Smits will consult with experts to determine if there are other indications for cardiac MRI with are cost effective compared to other technology and improve outcomes. If other indications are found, Smits and experts will propose additional line placement for these CPT cdes with guideline(s) if necessary for the next meeting in May.</p>

information which can distinguish myocarditis from CAD. In this type of case, it can prevent cardiac catheterization. Other testing would not be as definitive. He stated that MRI is becoming the gold standard for determining cardiac viability, particularly prior to CABG or other revascularization or stenting procedures. He testified that better knowledge of cardiac viability have better outcomes after CABG. Patients with cardiomyopathy with question about viability being considered for CABG are very helpful.

Saha was concerned about inappropriate use and cost. Kirk thought that restricting payment might facilitate further discussion between consultants. Saha felt that the best compromise would be to place on congenital lines and allow prior authorization for FCHPs. Smits suggested having experts come and testify. Saha would like experts to testify on when this test would be effective and not abused. He suggested having Cardiology input to help craft guidelines to guide utilization to cover only those indications which are cost effective and improve outcomes.

Smits brought up an issue that arose with the cardiac MRI codes. The old codes become obsolete and the new codes are not yet in the DMAP system. Symonette indicated that the HSC decision today can be implemented in a few days.

ECHO with contrast

Dr. Wei provided testimony about the uses and indications for ECHO with contrast. He testified that the addition of contrast would reduce the use of further imaging studies, reduce the number of non-diagnostic studies, and improve outcomes. Saha raised concerns about whether non-diagnostic studies are from operator issues or from need for contrast. Dr. Wei replied that contrast actually improves reading regardless of the readers experience level. Adds \$120 to the cost of the ECHO. Dr. Wei felt that adding contrast reduces “patient through-put” and therefore is not likely to be abuse. Stress ECHOs are more likely to need contrast due to more difficulty to obtain stress images. Dr. Mangum stated that he did not think that contrast was community standard. He asked whether adding contrast improves outcomes. Saha asked for which signs or symptoms would require contrast ECHO to be on the Diagnostic list. Wei replied that not allowing diagnostic use would penalize patients. Use of contrast for ECHOs with patients with soft tissue issues (obesity, etc.) is especially helpful.

C8923, C8924, C8927, and C8928: place on the Diagnostic List with the following guideline: “Need for contrast should be assessed and if indicated implemented at the time of the original ECHO and not as a separate procedure.”

Place ECHO with contrast for congenital anomalies (C8921, C8922, C8926) on congenital cardiac anomaly lines (74, 77, 94, 95, 98, 99, 116, 117, 123, 140, 142, 149, 185, 193, 195, 237, 247, 274, 279, 673).

Saha asked about the use of this technology for stroke. Wei replied that contrast was not very useful in stroke cases. Looking for a patent foramen ovale utilizes no contrast agitated saline.

Kirk states that ECHO with contrast is frequently billed after a billing for an ECHO in the community. He recommended that the HSC only allow billing for one type of ECHO. He stated that if a facility did not have the ability to read an ECHO at the time of initial patient contract or did not have the ability to do a contrast ECHO, then the plans could authorize a follow-up ECHO which would be likely to occur in the next day to weeks. Dr. Wei indicated that most techs who read ECHOs can be trained to determine whether a scan is adequate and could use contrast for those which are not adequate. Dr. Wei indicated that the community only has a 1% rate of using contrast for ECHOs and that the payment for contrast generally does not result in profit, just coverage for the cost. Kirk wondered if ECHO with contrast would avoid the cost of a cardiac MRI.

Saha suggested putting this on the Diagnostic List and following it to see if it is an issue. Kirk suggested taking to the Medical Directors for input. Symonette suggested putting in a guideline that only one test can be billed (ECHO or ECHO with contrast). Saha wanted to restrict use of contrast to the time of the original ECHO, rather than as a separate study. Saha felt that this could be a guideline: "Need for contrast should be assessed and if indicated implemented at the time of the original ECHO and not as a separate procedure." No time interval would be in place to allow for ECHOs to be done at a separate site if the original site did not have the ability to do contrast.

Telephone and Email consultation guideline

CPT codes for these types of visits were approved in December. The Commission was presented with a draft guideline for their use based on a guideline from Providence Health Plans. Discussion centered around who can bill these codes. MD, NP, PA should be included. The group debated allowing RNs to bill. Symonette recommended including RNs, as they provide valuable patient access. Kitchen indicated the importance of RNs for care management services.

Guideline adopted as follows:
Guideline XX Telephone and Email Consultations

Telephone and email consultations are a covered service only when the following criteria are met:

- 1) Patient must have a pre-existing relationship with the provider as demonstrated by at least one prior office visit within the past 12 months.
- 2) E-visits must be provided by a physician or licensed provider within their scope of practice.

<p>Shaffer brought up concerns about paying for these codes and their budget impact. Suggested that these codes should be included in the biennial review to allow the actuaries to analyze the effects on cost.</p> <p>Dodson stated that she did not see much risk of abuse for these codes. Recommended adding and then seeing if any issues arise. Symonette suggested putting these codes on a “watch list.” Other codes could be added for further review.</p> <p>The proposed guideline was altered to include examples of included and non-included services. RNs were added to the list of providers who can bill for these services.</p>	<p>3) Documentation should model SOAP charting; must include patient history, provider assessment, and treatment plan; follow up instructions; be adequate so that the information provided supports the assessment and plan; must be retained in the patient’s medical record and be retrievable.</p> <p>4) Telephone and email consultations must involve permanent storage (electronic or hard copy) of the encounter.</p> <p>5) Telephone and email consultations must meet HIPAA standards for privacy.</p> <p>6) There needs to be a patient-clinician agreement of informed consent for E-visits by email. This should be discussed with and signed by the patient and documented in the medical record.</p> <p>Examples of Covered Telephone and Email Visits:</p> <ol style="list-style-type: none"> 1. Extended counseling when person-to-person contact would involve an unwise delay. 2. Treatment of relapses that require significant investment of provider time and judgment. 3. Counseling and education for patients with complex chronic conditions. <p>Examples of Non Covered Email and Telephone Consultation:</p> <ol style="list-style-type: none"> 1. Prescription renewal. 2. Scheduling a test. 3. Scheduling an appointment. 4. Reporting normal test results. 5. Requesting a referral. 6. Follow up of medical procedure to confirm stable condition, without indication of complication or new condition. 7. Brief discussion to confirm stability of chronic problem and continuity of present management.
<p>Pharmacy Medication Management codes</p> <p>The HOSC adopted CPT codes covering pharmacy medication management at their December meeting and requested a guideline addressing the qualifications of a pharmacist who could perform these services. Smits presented input from the School of Pharmacy and a guideline based on North Carolina requirements for certifying pharmacists.</p> <p>Mangum felt that certifying pharmacists should be a state or</p>	<p>Guideline adopted as follows:</p> <p>Guideline XXX Pharmacist Medication Management</p> <p>Pharmacy medication management services are covered when provided by a pharmacist who has:</p> <ol style="list-style-type: none"> 1) A current and unrestricted license to practice as a pharmacist in Oregon 2) One of the following qualifications:

<p>pharmacy board function. Shaffer stated that this type of certification would be a whole new area for DMAP. Dodson agreed that this type of regulation could be done by the board of pharmacy by administrative rules. Olson agreed that the HSC should refer this to the board of pharmacy. Kirk stated that the health plans still need to credential pharmacists for billing. Symonette indicated that DMAP has limited ability to credential pharmacists; she felt it was more appropriate to have Board of Pharmacy do any necessary certification.</p> <p>Saha stressed that the HSC want this service paid only in context of medical home. Shaffer pointed out that other states use pharmacists for polypharmacy management and other situations outside the medical home. Discussion centered around requiring these services to be done by referral from a provider and that a consult note return to that referring provider.</p>	<ul style="list-style-type: none"> a. Certification from the Board of Pharmaceutical Specialties b. Certified Geriatric Practitioner c. Completion of an accredited residency program with two years of clinical experiences approved by the Boards, d. Holds the academic degree of Doctor of Pharmacy and has three years of clinical experience approved by the Boards and has completed a American Council on Pharmaceutical Education (ACPE) approved certificate program in the area of practice e. Has successfully completed the course of study and holds the academic degree of Bachelor of Science in Pharmacy and has five years of clinical experience approved by the Boards and has completed two ACPE approved certificate programs with at least one program in the area of practice <p>3) Services must be provided based on referral from a physician or licensed provider.</p> <p>4) Documentation must be provided for each consultation and must reflect collaboration with the physician or licensed provider. Documentation should model SOAP charting; must include patient history, provider assessment, and treatment plan; follow up instructions; be adequate so that the information provided supports the assessment and plan; must be retained in the patient's medical record and be retrievable.</p>
<p>Epidural steroid injections</p> <p>Epidural steroid injection procedures were not on the Prioritized List, ancillary list, diagnostic list, nor never covered list, except 62280 and 62281 which were on the Ancillary List. The HSC had asked Smits to bring information back to them about placement recommendations.</p> <p>Smits presented information from Dr. David Sibell, and expert in Pain Medicine, regarding coverage of epidural steroid injections. Kitchen wanted to make sure that placing these codes only on suggested lines would not this restrict baclofen epidural injections. Symonette indicated that it would not. Kirk pointed out that OHP patients can't go to pain clinics,</p>	<p>62280-62282 were added to the Review List for use for comfort care only.</p> <p>62310-62311 were placed on the Never Covered list.</p> <p>62318-62319 were added to the Review List for use for inpatient indications only.</p> <p>64479-64480 were placed on the Never Covered list.</p>

<p>which prevents 90% of the use of these codes. Saha felt that the evidence pointed to lack of effectiveness for use in back pain and recommended not placing these codes on any line with back conditions. Symonette indicated that patients can go through an exceptions process if they are in the minority that find this type of procedure effective. The subcommittee voted to cover these types of injections only for herpes zoster pain. Other types of injections were adopted as proposed in the meeting materials.</p>	<p>64481 and 64482 were only added to Line 165. [Note: these codes are actually 64483 and 64484]</p>
<p>Miscellaneous Cardiac Codes</p> <p>Smits presented her recommendations, based on discussion with Cardiologists, for intravascular Doppler studies and intracardiac ECHOs. These tests were proposed for the Diagnostic List; however Mangum and Dodson did not feel that they added benefit and should be placed on the Never Covered list.</p>	<p>93571- 93572 and 93662 were added to the Never Covered List.</p>
<p>Miscellaneous Ancillary list codes</p> <p>Injectable hormone therapy and Samarium treatment were discussed briefly. There was minimal discussion. Recommendations were accepted as outlined in the meeting material.</p>	<p>A9507 was added to Line 354 (Prostate Cancer)</p> <p>A9605 was left on Ancillary list</p>
<p>V codes</p> <p>Several V codes have been referred to the Line Zero Taskforce. Three codes have had recommendations from this Taskforce. Smits presented the Taskforce findings and recommendations. Shaffer argued that V71.89 should be covered, rather than placed on the Never Covered list, as there was not much billing, and likely this code was used when providers couldn't code anything else. These types of visits may be encounters to observe young kids for ingestions or illnesses with no other appropriate codes. He suggested placing V71.89 on the Diagnostic List.</p> <p>V57 series has had dramatic increases in billing since the PT guidelines were put in place. The Commission felt that these diagnostic codes were being misused and that providers could code for the actual covered diagnosis and still be paid for covered services.</p>	<p>V68.89 (Encounters for other specified administrative purpose) was left on the Ancillary list.</p> <p>V71.89 (Observation for other suspected conditions) placed on the Diagnostic list.</p> <p>V57 (PT/OT series) was placed on the Never Covered List</p>
<p>ABCD</p> <p>Smits presented information on the ABCD Learning Collaborative, which is a statewide taskforce seeking to</p>	<p>96110 (<i>Developmental testing; limited, with interpretation and report</i>) moved from Ancillary list to Line 3 (<i>Preventive Services, Birth to</i></p>

<p>increase developmental screening in early childhood. This group is requesting that 96110 (Developmental testing) be moved from the Ancillary list to Line 3 (preventive services, birth to age 10) to allow their use to be counted toward provider incentives offered by DMAP.</p> <p>Saha stated that the HSC ties our line 3 guidelines to USPSTF recommendations. Speech and language development screening received an I recommendation: insufficient evidence. Staff offered to find additional information on the evidence for developmental screening. The Commission adopted the change without further discussion, with the coding clarification and changes recommended to the Prevention Table.</p>	<p><i>10 years of Age)</i></p> <p>The following coding specification was added to Line 3 “CPT code 96110 can be billed in addition to other CPT codes, such as evaluation and management (E&M) codes or preventive visit codes.”</p> <p>Changes to the Prevention Table were accepted as outlined in the meeting materials.</p>
<p>Anesthesia</p> <p>Smits presented possible placements for the top 25 Anesthesia codes by billing costs. These codes are currently on the Ancillary List. Kitchen raised concern that restricting these codes to certain line would prevent patients from accessing services. Particularly patients with developmental delay or other special needs require anesthesia for services which normally do not need anesthesia, such as dental work. Symonette noted that placing these codes on lines may increase costs by increasing administrative work and raised concern for the probability that there were appropriate pairings which were missed in this review. Symonette also felt that the proposed changes could reduce access by making providers frustrated. Saha suggested keeping all anesthesia on the Ancillary list unless we come across some type of anesthesia procedure that the HSC only wants to cover for some, not all, conditions. Smits concurred that it would be most appropriate to leave these codes on the Ancillary list. Symonette indicated that DMAP already has controls which deny coverage if the matching procedure is not covered.</p>	<p>Keep all anesthesia CPT codes on Ancillary List</p>
<p>Fetal surgery</p> <p>Smits presented a recommended change in the fetal surgery guideline, as outlined in the meeting materials. There was minimal discussion and the change was accepted as recommended.</p>	<p>The following change was made to GUIDELINE NOTE 1, FETOSCOPIC LASER SURGERY</p> <p><i>Line 1</i> Fetoscopic repair of urinary tract obstruction (S2401) is only covered for placement of a urethral shunt. <u>Fetal surgery for cystic adenomatoid malformation of the lung, extralobar pulmonary sequestration and sacrococcygeal teratoma is only covered when there is evidence of developing hydrops fetalis.</u> Certification of laboratory required (76813-76814).</p>
<p>“Watch List”</p>	<p>The following procedures were</p>

The HOSC discussed procedures which have been recently adopted which they would like to follow utilization. DMAP has offered to put utilization data on these codes on a quarterly basis, and monitor for changes in utilization. If there are dramatic changes seen, these codes will come back to the HOSC/HSC for further discussion.

placed on the "Watch List:"

- Vertebroplasty
- Surgical treatment of obesity
- Non-surgical treatment/nutrition counseling for obesity
- Telephone and email consultation
- Pharmacy medication management
- Behavior and assessment codes