

**MEETING HIGHLIGHTS
HEALTH OUTCOMES SUBCOMMITTEE**

Meridian Park Hospital
Tualatin, Oregon
January 15, 2009
10:00-1:00

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

Member Absent: Carla McKelvey, MD

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

Also Attending: Wally Shaffer MD, DMAP; Caroline Price RN, DMAP; Chris Kirk, MD OHP Medical Directors; David Pass, MD, HRC Director; Jan Spence, Samaritan Health Systems; Judith Van Osdol, RN DMAP

Note: Next HOSC meeting is scheduled for June 11, 2009.

Topic	Action
<p>General Highlights from December 2008 HOSC meeting reviewed. No changes or corrections were noted.</p>	<p>Highlights approved without change.</p>
<p>New HCPCS Codes</p> <p>Smits introduced an Excel spreadsheet outlining recommendations for placement of new HCPCS codes. The recommendations were accepted as outlined in the meeting materials, with minimal discussion.</p> <p>Smits introduced a summary document regarding hip resurfacing. The group felt that the evidence supported coverage of hip resurfacing. Discussion centered around the guideline proposed to specify when hip resurfacing should be a covered benefit. The statement referring to the FDA contraindications was considered to not be specific enough. The actual contraindications were added to the guideline.</p>	<p>Final recommendations are as listed in Appendix A. These recommendations are as presented in the meeting materials, with the guideline listed in Appendix B.</p>
<p>Intrathecal pumps for chronic non-cancer pain control Smits reviewed a document regarding coverage of intrathecal pumps for chronic non-cancer pain. Washington state has done as extensive review of the topic and elected not to cover this service.</p> <p>In general, the Subcommittee felt that the evidence supported</p>	<p>1) Delete 62350-62355 and 62360-62362 from Lines 397 (DISORDERS OF SPINE WITH NEUROLOGIC IMPAIRMENT), 552 (ACUTE AND CHRONIC DISORDERS OF SPINE WITHOUT NEUROLOGIC IMPAIRMENT) and 624 (DISORDERS OF SOFT TISSUE).</p>

<p>not covering intrathecal pumps for non-cancer pain indications. Discussion centered around how to allow patients who currently have a pump in place have these pumps maintained or removed if indicated. 62355 (Removal of previously implanted intrathecal or epidural catheter) and 62365 (Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion) were <u>not</u> removed from lines 397, 552, and 624, as recommended. The group felt that these codes should be maintained on the list to allow existing pumps to be removed. There was some concern that patients who had pumps placed while on insurance other than OHP would not be able to have pumps maintained or removed without these codes.</p> <p>The group also decided to not remove 62367-62368 from the back pain lines. Patients with pumps in place would need these codes for maintenance. The following coding guideline was added to lines 397, 552, and 624: “Coding guideline: 62367-62368 is covered only if pump was implanted prior to April 2009.”</p> <p>There was discussion that trial non-implanted pumps should not be covered. However, these pumps are placed using CPT codes for implanted pumps and no further changes were found to be needed to not cover these devices.</p>	<ol style="list-style-type: none"> 2) Maintain these codes on cancer and dysfunction lines. 3) Add the following coding guideline to lines 397, 552, and 624: “Coding guideline: 62367-62368 is covered only if pump was implanted prior to April 2009.”
<p>Heart kidney transplants</p> <p>Smits reviewed a summary statement regarding coverage for dual heart kidney transplants. The group agreed that dual transplants had evidence for coverage. The group briefly discussed the situations for transplant. The evidence was felt to support kidney transplants when added to cardiac transplantation (i.e. heart transplant candidate who subsequently had renal failure would be a candidate for a dual transplant). However, renal transplant candidates who subsequently had cardiac failure would not have the option of a dual transplant as the evidence for that situation is not as strong. Similarly, heart-lung-kidney transplants were not found to have evidence supporting their coverage.</p> <p>A guideline was adopted specifying that candidates for the dual transplant need to qualify for each transplant individually, with the exception of heart and/or kidney disease.</p> <p>Note: Dr. Gubler abstained from voting on this topic due to conflicts of interest.</p>	<ol style="list-style-type: none"> 1) Add renal transplant codes (50300-50370,50547,76776) to Line 279 CONGESTIVE HEART FAILURE, CARDIOMYOPATHY, TRANSPOSITION OF GREAT VESSELS, HYPOPLASTIC LEFT HEART SYNDROME 2) Change name of line to “Cardiac transplant, heart/kidney transplant” 3) Renal transplant codes not added to heart-lung transplant lines. 4) Guideline added to Line 279 as listed in Appendix B.
<p>Chondromalacia patella</p>	<ol style="list-style-type: none"> 1) Remove 717.7 (Chondromalacia

<p>Smits introduced a summary document regarding chondromalacia patella. The subcommittee agreed with the recommendations in this document with minimal discussion.</p>	<p>patella) from Line 449 (internal derangement of the knee) 2) Maintain 717.7 on Line 628 (minor sprains/strains)</p>
<p>Intestinal malabsorption Smits introduced a summary document specifying issues with 579.8 (Other specified intestinal malabsorption). This diagnosis includes serious and minor conditions. Also 579.9 (Unspecified intestinal malabsorption) is a covered diagnosis, which is not consistent with the HSC policy of not covered unspecified codes. Discussion centered around whether to cover 579.8 at all. Gubler argued that this code should not be on the list. Saha felt that doctors’ visits should be covered for these diagnoses and only physician visit CPT codes pair with these diagnoses. Others expressed concern that taking the entire code off the list would lead to more diagnostic tests to see if the condition could be found to be a covered diagnosis. Saha argued that the more serious diagnoses included by this code, such as protein-losing enteropathy, are reasonable to include on line 241. The group concluded that the guideline listed in Appendix B specified which diagnoses under 579.8 should be covered (chronic steatorrhea, exudative enteropathy, and protein-losing enteropathy).</p>	<p>1) Remove 579.9 (Unspecified intestinal malabsorption) from Line 241 (Intestinal malabsorption) and place on Never Covered List 2) Add a guideline for 579.8 (Other specified intestinal malabsorption) to line 241 as listed in Appendix B.</p>
<p>Anesthetic injection codes Smits introduced a document highlighting issues around anesthetic injections and suggested changes to the Prioritized List. Discussion centered around whether the proposed Statement of Intent should cover “anesthetic procedures” or “nerve blocks.” Nerve blocks were thought to better represent the types of procedures to be covered by the SOI. Kirk also recommended specifying the CPT codes covered (CPT 64400-64530), but the Subcommittee did not feel this was necessary. Shaffer asked whether “nerve blocks” specifically included infusions? Gubler and Pass felt that continuous types of nerve blocks could be very useful perioperatively. Kirk asked whether infusional control for a joint should be covered. The group decided to cover both single and continuous nerve blocks.</p>	<p>1) 64400-64450 are Ancillary 2) 64470-64480 are Never Covered 3) 64483-64484 are on Line 165 4) 64505-64530 are Ancillary 5) Statement of Intent adopted as listed in Appendix B.</p>
<p>Guidelines 1) <u>Essure</u> Smits introduced a document with recommendations regarding Essure (permanent bilateral fallopian tube occlusion device). The Subcommittee agreed with the recommendation that Essure should only be covered as an outpatient procedure. The</p>	<p><u>Essure:</u> Guideline for Essure adopted as listed in Appendix B. <u>Breast Reconstruction:</u> 1) V16.3 (Family history of breast cancer), V16.41 (Family history of</p>

group suggested that the proposed guideline be strengthened, specifying that this procedure is not covered in the hospital or ambulatory care setting.

2) Breast reconstruction following prophylactic mastectomy

Smits introduced a summary document regarding coverage of breast reconstruction following prophylactic mastectomy. Gubler raised concerns regarding authorizing coverage for reconstruction. He felt that prophylactic mastectomy is done for prevention of breast cancer and subsequent reconstruction hinders the ability to screen the patient for breast cancer. Patients are still at some risk for breast cancer because mastectomy does not remove 100% of breast tissue. He felt that covering reconstruction would remove some of the benefit gained by covered prophylactic mastectomy. Olson felt that the incidence of cancer very low after bilateral prophylactic mastectomy and that the issue of subsequent screening would not be a major issue. Dodson felt that the psychological benefits in reconstruction outweighed the risks of impaired screening. Olson raised a concern that women at high risk for breast cancer may not elect a prophylactic mastectomy if reconstruction would not be covered. Saha agreed that the HSC did not want to create barriers to patients getting prophylactic mastectomies when doing them can reduce costs (MRIs, cancer, etc.). The group affirmed their December decision to cover prophylactic mastectomy and agreed to the guideline listed in Appendix B regarding when reconstruction is covered.

3) Lymphedema

Smits introduced a document outlining concerns from the PT community regarding limitations on coverage for lymphedema. The Subcommittee heard testimony from Jan Spence, a representative from Samaritan Health Systems. The group also heard testimony from Dr. David Pass, HRC Director and expert on lymphedema.

Spence agreed with the commission that LANA certification is the best qualification for therapists who perform lymphedema therapy. However, she argued that it is difficult to become certified in rural and outlying areas. Only 1 therapist in her system was LANA certified, and would be allowed to provide services for all the patients on OHP in that area. She had concerns for travel time for patients, increased expense for DMAP to provide transportation for patients, and increased

ovarian cancer), and V45.71 (Acquired Absence of Breast) added to Line 4 (Preventive Services)

2) The coding guideline removed from Line 198

3) Guideline adopted as listed in Appendix B.

Lymphedema

1) Guideline adopted as listed in Appendix B.

workload for the limited number of therapists. She felt that there should be more time for therapist to become qualified before this requirement was enforced, due to the difficulty of getting therapists to training programs.

Saha argued that the HSC required LANA certification because there is a very narrow therapeutic margin for lymphedema therapy, and unqualified therapists could cause harm. Why should we cover treatment that may not be effective until you get effective training?

Spence responded that non treatment can have horrible outcomes, worse than treatment with non certified providers.

Saha asked “What is the evidence that the non-certified therapists are actually providing beneficial treatments? Without certification, how do we know who is doing this? I could do this?” He argued that the HSC need to have some type of evidence that therapists providing this service are qualified, and LANA certification is the best available evidence of qualification.

Olson added that when the HSC discussed this before, they found that when lymphedema therapy is done right, it is effective, and we want to pay for effective service. However, LANA certification does put burdens on rural areas. The time commitment to do the training/certification is substantial. He felt that if a therapist was in training, it showed a level of serious commitment, and that therapists in training should be allowed to provide lymphedema therapy for OHP patients. Smits stated that the guideline change adopted in December already allowed for therapists in training to provide services, as long as they are within a 2 year period from coursework.

Spence stated that this requirement will force the hospital system to get their PTs trained, which would be a positive development.

Saha suggested that the HSC consider allowing therapists who are practicing under a qualified person to provide services. Smits asked how the HSC should define “supervised by.”

Pass then provided testimony, and summarized materials given out at meeting/in packet. LANA certified therapists had better outcomes than non-certified (WA state Medicaid review). Requirement is 135 hours of training, 1 year of practice

<p>afterwards. Needs 2 weeks for the course, has come costs associated with it. There are 9-12 LANA certified therapists in Oregon, most in Portland area. WA has seen a significant increase in numbers of certified therapists as they put in this requirement. What is best for the patient is a highly qualified provider.</p> <p>Saha stated that for 13 ½ yrs, the HSC did not cover this. We need to ensure that what we pay for is effective. We have opened the door to therapy to a reasonable extent. If you really want to do this, do it effectively. Let the HSC motivate people to get the right training to do this effectively. Gubler agreed, stating that this is a quality of care issue.</p> <p>Dodson stated that “I am an advocate for rural health and I think we should stick with a standard.”</p> <p>Shaffer stated that DMAP must assure access to covered services. We are obligated to provide these services. The problem is that only 9 or 12 providers are not enough to ensure access. Saha replied that the HSC does not have perview over the delivery system.</p> <p>Price suggested that it would be appropriate to review in a few years and see if enough providers are out there.</p> <p>Olson proposed rejecting the new changes proposed for January. He had concern that the non specific wording leaves us open to some vague training program. The decision was made reject red changes (new changes for January). December changes were affirmed.</p>	
<p>Repair of blood vessels of the head and neck Smits reviewed proposed changes for placement of repair codes for injuries to blood vessels of the head and neck. Saha suggested that the HSC keep injuries on the injuries line. He proposed moving the repair CPT codes to line 143 to pair rather than moving 900.XX to line 302.</p>	<p>1) Add 35201 (Repair blood vessel, direct, neck), 35231 (Repair blood vessel with vein graft, neck), and 35261 (Repair blood vessel with graft other than vein; neck) to Line 143 (Crush injuries)</p> <p>2) Remove 35201, 35231, and 35261 from Line 302 (BUDD-CHIARI SYNDROME, AND OTHER VENOUS EMBOLISM AND THROMBOSIS)</p> <p>2) Keep 900.XX on Line 302</p>

Straightforward Issues

Smits reviewed the straightforward issues document in the meeting materials. The Subcommittee agreed with the suggested changes.

Add 35632 (Harvest of ilio-celiac vein) to:

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

Appendix A: 2009 HCPCS Code Placement

See attached Excel Spreadsheet

Appendix B

Guideline and Statement of Intent Changes from December 2008 HOSC Meeting

New Guidelines

GUIDELINE XXX HIP RESURFACING

Line 381

Hip resurfacing is a covered service for patients who are likely to outlive a traditional prosthesis, who would otherwise require a total hip replacement, and should only be done by surgeons with specific training in this technique.

Patients who are candidates for hip resurfacing must not be:

- i. Patients with infection or sepsis
- ii. Patients who are skeletally immature
- iii. Patients with any vascular insufficiency, muscular atrophy, or neuromuscular disease severe enough to compromise implant stability or postoperative recovery
- iv. Patients with bone stock inadequate to support the device, including severe osteopenia or a family history of severe osteoporosis or osteopenia
- v. Patients with osteonecrosis or avascular necrosis with >50% involvement of the femoral head
- vi. Patients with multiple cysts of the femoral head
- vii. Females of childbearing age
- viii. Patients with known moderate-to-severe renal insufficiency
- ix. Patients who are immunosuppressed with diseases such as AIDS or persons receiving high doses of corticosteroids
- x. Patients who are severely overweight
- xi. Patients with known or suspected metal sensitivity

GUIDELINE NOTE XXX HEART-KIDNEY TRANSPLANTS

Line 279

Patients under consideration for heart/kidney transplant must qualify for each individual type of transplant under current DMAP administrative rules and transplant center criteria with the exception of any exclusions due to heart and/or kidney disease.

GUIDELINE XXX INTESTINAL MALABSORPTION

Line 241

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

Guideline XXX HYSTEROSCOPIC BILATERAL FALLOPIAN TUBE OCCLUSION

Line 7

Placement of permanent implants in the fallopian tubes to induce bilateral occlusion (CPT code 58565) is covered only if the procedure is done in the office setting, not in the ambulatory surgical center or hospital setting.

GUIDELINE NOTE XXX: BREAST RECONSTRUCTION

Lines 4, 198

Breast reconstruction is only covered after mastectomy as a treatment for breast cancer or as prophylactic treatment for the prevention of breast cancer in a woman who qualifies under Guideline Note 3, and must be completed within 5 years of initial mastectomy.

New Statement of Intent

STATEMENT OF INTENT FOR NERVE BLOCKS

The Health Services Commission intends that single injection and continuous nerve blocks should be covered services if they are required for successful completion of, perioperative pain control for, or post-operative recovery from a covered operative procedure when the diagnosis requiring the operative procedure is also covered. Additionally, nerve blocks, are covered services for patients hospitalized with trauma, cancer, or intractable pain conditions, if the underlying condition is a covered diagnosis.

Revised Guideline

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 one of the accepted lymphedema training certifying organizations or a graduate of one of the National Lymphedema Network accepted training courses within the last 2 years. 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.

HCPCS Code	Code Description	List	Line(s)
G0406	FOLLOW-UP INPATIENT TELEHEALTH CONSULTATION, LIMITED, PHYSICIANS TYPICALLY SPEND 15 MINUTES COMMUNICATING WITH THE PATIENT VIA TELEHEALTH	List	Lines with telephone consultation codes
G0407	FOLLOW-UP INPATIENT TELEHEALTH CONSULTATION, INTERMEDIATE, PHYSICIANS TYPICALLY SPEND 25 MINUTES COMMUNICATING WITH THE PATIENT VIA TELEHEALTH	List	Lines with telephone consultation codes
G0408	FOLLOW-UP INPATIENT TELEHEALTH CONSULTATION, COMPLEX, PHYSICIANS TYPICALLY SPEND 35 MINUTES COMMUNICATING WITH THE PATIENT VIA TELEHEALTH	List	Lines with telephone consultation codes
G0409	SOCIAL WORK AND PSYCHOLOGICAL SERVICES, DIRECTLY RELATING TO AND/OR FURTHERING THE PATIENT'S REHABILITATION GOALS, EACH 15 MINUTES, FACE-TO-FACE; INDIVIDUAL (SERVICES PROVIDED BY A CORF-QUALIFIED SOCIAL WORKER OR PSYCHOLOGIST IN A CORF)	List	Any line with PT codes: 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
G0410	GROUP PSYCHOTHERAPY OTHER THAN OF A MULTIPLE-FAMILY GROUP, IN A PARTIAL HOSPITALIZATION SETTING, APPROXIMATELY 45 TO 50 MINUTES	List	Mental health lines containing inpatient and partial inpatient services
G0411	INTERACTIVE GROUP PSYCHOTHERAPY, IN A PARTIAL HOSPITALIZATION SETTING, APPROXIMATELY 45 TO 50 MINUTE	List	Mental health lines containing inpatient and partial inpatient services
G0412	OPEN TREATMENT OF ILIAC SPINE(S), TUBEROSITY AVULSION, OR ILIAC WING FRACTURE(S), UNILATERAL OR BILATERAL FOR PELVIC BONE FRACTURE PATTERNS WHICH DO NOT DISRUPT THE PELVIC RING	List	190 FRACTURE OF PELVIS, OPEN AND CLOSED
G0413	PERCUTANEOUS SKELETAL FIXATION OF POSTERIOR PELVIC BONE FRACTURE AND/OR DISLOCATION, FOR FRACTURE PATTERNS WHICH DISRUPT THE PELVIC RING, UNILATERAL OR BILATERAL, (INCLUDES ILIUM,	List	190 FRACTURE OF PELVIS, OPEN AND CLOSED
G0414	OPEN TREATMENT OF ANTERIOR PELVIC BONE FRACTURE AND/OR DISLOCATION FOR FRACTURE PATTERNS WHICH DISRUPT THE PELVIC RING, UNILATERAL OR BILATERAL,	List	190 FRACTURE OF PELVIS, OPEN AND CLOSED

Appendix A: 2009 HCPCS Code Placement

G0415	OPEN TREATMENT OF POSTERIOR PELVIC BONE FRACTURE AND/OR DISLOCATION, FOR FRACTURE PATTERNS WHICH DISRUPT THE PELVIC RING, UNILATERAL OR BILATERAL, INCLUDES INTERNAL FIXATION, WHEN	List	190 FRACTURE OF PELVIS, OPEN AND CLOSED
S2118	METAL-ON-METAL TOTAL HIP RESURFACING, INCLUDING ACETABULAR AND FEMORAL COMPONENTS	List	381 RHEUMATOID ARTHRITIS, OSTEOARTHRITIS, OSTEOCHONDRITIS DISSECANS, AND ASEPTIC NECROSIS OF BONE
S2270	INSERTION OF VAGINAL CYLINDER FOR APPLICATION OF RADIATION SOURCE OR CLINICAL BRACHYTHERAPY	List	145 CANCER OF CERVIX 219 CANCER OF UTERUS 252 CANCER OF OVARY, 310 CANCER OF VAGINA, VULVA AND OTHER FEMALE GENITAL ORGANS

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June 11, 2009

8:30-12:00

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

Members Absent: Carla McKelvey, MD; K. Dean Gubler, MD, MPH

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

Also Attending: Wally Shaffer MD, DMAP; Caroline Price RN, DMAP; Isabel Bickle, DMAP; Chris Kirk, MD OHP Medical Directors

Note: The meeting adjourned at 11:30 AM. The next HOSC meeting is scheduled for August 6, 2009.

Topic	Action
<p>General Highlights from January 2009 HOSC meeting reviewed. No changes or corrections were noted.</p>	<p>Highlights approved without change.</p>
<p>Autism spectrum disorders</p> <p>Smits reviewed the recommendations from the MHCD subcommittee review of the new autism line. It was noted that the CPT and HCPCS codes from the January MHCD meeting were not included. Smits will review those minutes and add those recommendations to the suggested List changes and return these recommendations for the August meeting.</p> <p>The new guideline for autism was reviewed and the HOSC felt that the wording should be worked on for clarity and brevity. Dodson and Smits will work on an edited version before the next MHCD meeting next week and bring the new guideline with MHCD input back to the August meeting.</p>	<p>Smits to bring back full CPT and HCPCS recommendations for the August meeting.</p> <p>Smits and Dodson will review the autism guideline and suggest wording changes for the next MHCD meeting on June 17.</p>
<p>Watch List</p> <p>Coffman reviewed the “Watch List” of procedures which the HSC has asked DMAP to monitor for utilization. DMAP is in the process of developing a system to better monitor these procedure codes. The HOSC members present did not have a particular procedure they were concerned about at this meeting. HSC staff and DMAP will continue to monitor these codes.</p>	<p>HSC and DMAP staff will continue to monitor “Watch List” codes.</p>

<p>Scrotoplasty and penile anomalies Smits reviewed the codes in the 752.6 series, penile anomalies, and the suggested changes to the list regarding coverage of these conditions. No changes were made to the suggestions in the meeting document.</p>	<ol style="list-style-type: none"> 1) Move 752.63-752.65 to Line 678 (GENITOURINARY CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY), delete from line 452 (HYPOSPADIAS AND EPISPADIAS) 2) Add 55180 (Scrotoplasty, complicated) and 55175 (Scrotoplasty, simple) to Line 452
<p>Growth hormone Smits introduced the evidence regarding treatment with growth hormone for adult conditions, particularly isolated idiopathic growth hormone deficiency.</p> <p>Saha wanted to ensure that kids could be treated to prevent dwarfism. Kirk indicated that the MCOs did not consider treatment of kids to be an issue. Shaffer indicated that DUR board guidelines exist for treatment in kids which are effective for DMAP. Shaffer suggested a change to the suggested guideline to limit it to adults. Kirk indicated that the major problem for the MCOs was request for growth hormone in diabetics to increase glucose levels and for “I just don’t feel good.” Saha noted that the evidence reviewed related to adults and that there was no evidence presented on treatment for kids. He supported changes to the proposed guideline which limited the guideline to adults. Smits indicated that if medical directors find problems, then HSC staff can bring issue back to the HOSC.</p>	<ol style="list-style-type: none"> 1) No change to the location of codes for growth hormone treatment on the List. 2) Add a coding guideline to line 411 (Pituitary Dwarfism) <ol style="list-style-type: none"> a. “Treatment with growth hormone is included on this line only for pituitary dwarfism; treatment is not included for isolated deficiency of human growth hormone in adults.”
<p>Small bowel transplant Smits presented a summary document on small bowel transplants. Currently, DMAP is authorizing cadaveric donor transplants (approximately 2-3 in the last few years), but cannot authorize living related transplants due to the experimental nature of this treatment. Smits reviewed that the literature does indicate that this procedure is experimental. The HOSC agreed that it should not be covered, as long as patients have access to the standard cadaveric transplant.</p>	<ol style="list-style-type: none"> 1) Remove 44133 (Donor enterectomy from living donor) and 44136 (Intestinal allotransplantation, from living donor) from Line 253 (SHORT BOWEL SYNDROME - AGE 5 OR UNDER Treatment: INTESTINE AND INTESTINE/LIVER TRANSPLANT).
<p>Esophagoscopy Smits introduced a document highlighting suggested changes to clean up the codes for esophagoscopy on the List. No changes were made to the suggestions on the summary document.</p>	<ol style="list-style-type: none"> 1) Delete 43201 from Line 60; add 43201 to Lines 337, 406, 408, 416 2) Delete 43204 and 43205 from Line 60

	<p>3) Delete 43216 from the Ancillary list; add 43216 to Lines 337, 613, 656</p> <p>4) Delete 43217 from the Ancillary list; add 43217 to Lines 337, 613, 656</p> <p>5) Delete 42319 from Line 339; add 42319 to Lines 613 and 656</p> <p>6) Add 43220 and 43226 to Lines 613, 656</p> <p>7) Add 43220 and 43226 to Lines 408, 613, 656</p> <p>8) Add 43228 to Lines 61 and 408</p>
<p>Varicose veins Smits reviewed a suggestion to change the treatment codes associated with varicose vein diagnoses, as well as previous deliberations on these treatments from HOSC minutes. The HOSC did not change any treatments associated with varicose veins.</p>	<p>No changes made</p>
<p>Guidelines</p> <p><u>1) Lymphedema.</u> DMAP has requested clarifying wording changes to the lymphedema guideline. There was brief discussion over wording choices.</p> <p><u>2) PET scan guideline</u> Smits introduced recommended changes to the PET scan guideline, which serve to clarify previous HOSC/HSC intent. Specifically, the HSC did not intend to cover restaging of cervical cancer. Additionally, CPT codes for PET scans were suggested for addition to several lines which contain diagnoses covered in the new guideline. There was some editing of the new guideline to improve clarity.</p> <p><u>3) Palliative care guideline</u> Smits introduced a document outlining recommendations from the Palliative Care Taskforce regarding the palliative care guidelines. These guidelines have been sent to the OHP Medical Directors for comment and their suggestions were presented as well.</p> <p>Coverage of DME, such as motorized wheelchairs and expensive hospital beds, was discussed. The OHP medical directors have raised concerns about DME cost for patients with limited life expectancy who would not benefit from such expensive care for any reasonable length of time. The old</p>	<p><u>Lymphedema:</u> See appendix A for adopted wording changes to guideline.</p> <p><u>PET scan:</u></p> <ol style="list-style-type: none"> 1. Add 78811-78816 (PET scan CPT codes) to lines 171, 208, 209, 221, 276, 291, 311, 337 2. Guideline amended as seen in Appendix A <p><u>Palliative Care</u></p> <ol style="list-style-type: none"> 1) Statements of Intent adopted as seen in Appendix B. <p><u>Pickwickian Syndrome.</u></p> <ol style="list-style-type: none"> 1) Pickwickian Syndrome (278.8) was added to lines 8, 211, and 608. 2) A guideline was adopted as shown in Appendix A. <p><u>Bariatric Surgery</u></p> <ol style="list-style-type: none"> 1) Line 608 (Obesity) was deleted 2) Guideline 61 MEDICAL AND SURGICAL MANAGEMENT OF OBESITY NOT MEETING CRITERIA SPECIFIED IN

guideline had a clause limiting DME supplies to patients who would benefit for a reasonable length of time. Smits suggested adding this phrase to the 4th example of the palliative care statement of intent. Kirk thought that this change would result in lots of issues in hearings. Saha was concerned about the meaning of “reasonable.” Was it 24 hours of life or another period? Olson asked about what types of DME is this concerning. The concern from DMAP and the medical directors was specifically about motorized wheelchairs. Dodson suggested that the guideline should specify electric wheelchairs, and Olson further clarified that this specifically should refer to motorized wheelchair. Saha suggested taking this issue back to the palliative care taskforce to give us specific wording for this issue. However, Kirk suggested that the issue would be resolved with specifying specify “standard” wheelchairs in the wording, and this change was adopted.

Discussion then centered around the criteria for the evidence to be used in decisions regarding palliative care and end of life care. The Medical Directors had suggested “as supported by the best available peer reviewed literature” as the standard. However, Saha and Smits pointed out that some data (for example SEER or CDC data) does not go through the peer review process, but is still good evidence. Olson stated that having data this is published in some form would be a good requirement to prevent decisions based on word of mouth, or other unreliable sources. Kirk stressed the importance of having some control of the evidence presented by having it be published. Saha noted however that at times the best available evidence is expert opinion and that in other HSC guidelines evidence is not required to be published. What if there is no published evidence? Kirk noted that that is currently a problem, that currently for many conditions there is not any data available and therefore no grounds to deny coverage for a treatment which is ineffective. Saha noted that requiring published data could be a problem if what is published is limited and not actually the best evidence out there. Coffman stated that the problem is that the OHP medical directors and plans are the ones making these determinations and need to have decisions that can hold up in hearings. Shaffer stated that published is an important word for hearings. Saha agreed that it was okay to include wording about publication if it was necessary for the plans/DMAP. It was agreed to use the wording “the best available published evidence.”

Other changes which either clarified meaning or were

OTHER OBESITY-RELATED GUIDELINES was deleted.

Obesity:

Guideline 5 changed as shown in Appendix A.

suggested by Taskforce members were accepted with minimal discussion.

Saha expressed a desire to move the Death with Dignity SOI away from the palliative care and the end of life SOI, to stress that they were not related due to a lot of negative attention. Olson thought that separating them out as separate SOIs shows the HSC's intent that they are not connected.

4) Pickwickian Syndrome

Smits introduced a summary document outlining the issues around Pickwickian Syndrome, a diagnosis which does not currently appear on the Prioritized List. Because this syndrome is mainly just obesity with sleep apnea, the diagnosis will be added to the obesity and sleep apnea lines. A guideline specifying the 278.8 is included on these lines only for coverage of Pickwickian Syndrome.

Kirk asked the commission if the DSM-IV criteria for this syndrome had been considered. In his view, this syndrome is an eating disorder. Saha replied that the commission's intent was to treat the complications of this condition with sleep apnea and obesity. After staff looked up the other diagnoses under 278.8, Saha state that he felt that other hyperalimantation has several other conditions including hypervitaminosis, and cardiopulmonary obesity, and thus necessitated a guideline.

5) Bariatric surgery/Guideline 61

DMAP has expressed concern with the location of bariatric surgery CPT codes on lines both above (Line 8) and below (Line 608) the funding line. This duplication is causing non-diabetic obese patients to argue that they require payment for bariatric surgery under the co-morbidity rule. Several solutions to this issue were discussed. The commission decided that the cleanest solution was to delete Line 608 (Obesity), as without bariatric surgery codes it had very little other treatment CPT code differences from Line 8 (Obesity). Guideline 61, which refers to Line 608 also needed to be deleted.

6) Guideline 5, Obesity

Smits introduced a summary document regarding issues with the Obesity guideline. Specifically, the Medical Directors and DMAP are having issues with coverage of DME for obesity, and its lack of reference in this guideline.

Smits read an email from Tina Kitchen, from Aging and Disability Services regarding her concerns about changing the guideline to exclude DME.

- First and most importantly, it is inhumane to not provide a wheelchair to someone who can't walk (even if it is because of obesity - are people going to not treat gun shot wounds because of their life style choices?).
- Two, keeping people mobile, even in a chair, is a preventative step. It keeps them engaged in their life and not stuck in a bed, making hygiene easier, and decreasing the chances of decubiti, pneumonia, etc.
- Third, I am surprised that MPCHP has gotten away with this decision in the past. I think this is a violation of the ADA. If you are going to provide a wheel chair to one person who can't walk because of one type of disability and you can't refuse to provide it because of a different diagnosis. I don't think it would stand up to a law suit. This decision has nothing to do with efficacy of the treatment.
- Finally, it will just be a cost shift to SPD and in fact, end up costing the state more. We have folks already in NHs who are there solely because of their size. Not only will we have to provide the DME but some will be in a higher cost setting.

Shaffer argued that it would be very unusual to pick a single diagnosis like obesity and not cover ancillary services. He stated that such a change would still let patients with co-morbidities get these services, but would discriminate against obese patients. However, obese pt might need equipment Saha wondered if the HSC could put obesity on the dysfunction line(s) rather than include DME on the obesity line. Smits replied that DME is on every line because they are ancillary services. Olson thought the real question is whether we want to provide DME for obesity, and the best way to specify this. Saha asked about pairing of diagnoses with DME. Shaffer replied that DME is limited by administrative guidelines. Olson stated that obesity was below the line and this was not previously an issue until we moved the obesity line. Moving obesity appears to have unintended consequences. Coffman wondered if most people with obesity would still receive DME through co-morbid condition diagnoses. Kirk replied that it was rare to have obesity and nothing else. However, his MCO plan has interpreted the current guideline as the intent of the commission was just to

offer intensive counseling. Olson wondered whether the risks outlined by Dr. Kitchen worth the benefits of pulling these services out from this line. Kirk stated that his MCO has authorization criteria which limit these services. Saha stated that he thought it would be discrimination to call out obesity. Kirk replied that the OHP waiver would allow such discrimination. Saha replied that it might be legal under the waiver, but it would not be right. He was worried about other conditions below the line that would not have DME which would improve the quality of their life. We prioritized based on the fact that there are no treatments for the conditions themselves, not that there are some things that could improve their quality of life. Our palliative care SOI might apply here.

Olson asked what evidence is there that DME would achieve the goals of improving health (prevent bedsore, etc). He also stated that he thought that the number of patients affected by the DME issue who had only obesity without comorbid conditions would be small enough that no change should be made. Saha stated that hopefully clinicians will use their discretion and plans will have restrictions in place. Kirk argued that it was difficult to have physician input with DME vendors. Coffman asked if we could make a SOI about DME for non covered diagnoses. Shaffer stated that OHP/DMAP are denying DME for below the line diagnoses, and not having any issues with this. Kirk returned to his argument that the HSC intent was to cover only counseling issues for obesity. Coffman argued that changing the coverage of DME for obesity will just move these services to other lines though comorbid conditions. Saha suggested changing guideline 5 to read “DME is included on this line only to improve physical activity.” Olson wondered whether this was mainly about motorized wheelchairs; Shaffer noted other expensive DME items such as bariatric beds were also issues. Saha stated that the HSC’s goal with this line was to help with the public health problem of obesity and promote better nutrition and physical activity. We have evidence that drugs do not help, that bariatric surgery helps in some cases. We did not consider DME when we created this line. Tina Kitchen’s argument applies to lots of things below the line. Olson agreed that Saha’s suggestion about covering DME to allow physical activity would follow intent of the line to cover exercise, but added that the HSC needed to limit this wording to normal physical activity (not any activity), not covering treadmills, etc. Kirk stated that the issue was that Line 8 is titled “obesity” not “morbid obesity.” Suggests specifying the DME

<p>is only included for morbid obesity. This suggestion was accepted. The modified guideline shown in Appendix A was adopted.</p>	
<p>Complex wound closure, trunk Smits reviewed a summary document regarding placement of wound closure codes for trunk wounds. There was no discussion.</p>	<ol style="list-style-type: none"> 1) Delete 13101 from Line 91 2) Delete 13101 from Line 198
<p>Syringomyelia and syringobulbia Smits introduced a summary document about syringomyelia and syringobulbia coverage. The suggested changes were accepted, except that the ICD-9 codes for these conditions were only added to line 397 to simplify the changes to the List.</p>	<ol style="list-style-type: none"> 1) Delete 63172 and 63173 from Line 429 2) Add 336.0 (Syringomyelia and syringobulbia) to Line 397: DISORDERS OF SPINE WITH NEUROLOGIC IMPAIRMENT.
<p>Bone flaps and cranioplasty Smits introduced a summary document outlining suggested changes to the placement of coverage for bone flaps and cranioplasty. There was no discussion.</p>	<ol style="list-style-type: none"> 1) Add 62142-62145 to lines 101, 138, and 273. 2) Add 62146-62148 to Line 138
<p>Straightforward Issues Smits reviewed the straightforward issues document in the meeting materials. The Subcommittee agreed with the suggested changes with the exception of 92081-92083 (Visual field testing). Saha stated that there was no support in the USPSTF recommendations for this service to be included on the prevention lines. Dodson echoed this opinion, stating that it could easily lead to abuse to add these codes to the prevention lines. These codes were not added to Lines 3 and 4. All changes accepted as stated in the meeting materials, except 92081-92083 was not added to Lines 3 and 4.</p>	<ol style="list-style-type: none"> 1) Change name of Line 512 to “Closed fractures of ribs, sternum, and coccyx” 2) Delete 27202 from Line 512 3) Delete 62270 from Line 22. Add 62270 to the Diagnostic List. 4) Delete 196.0 from Line 198. Add 196.0 to Line 613 5) Add 90828 and 90829 to lines 181, 315, 395, 414, 421 6) Add H0023 to all mental health lines. 7) Delete 99468-99480 from Lines 7, 43, 68 8) Delete V57.0, V57.4, and V57.9 from the Prioritized List and place on the Never Covered List. 9) Delete 96150-96154 from Lines 210 and 456. 10) Add 611.0 to Line 84. Delete 611.0 from Line 501. 11) Add 10061 to Line 84 12) Add 19020 to Line 84. Delete 19020 from Line 501. 13) Add 50542 and 50543 to Lines 84, 96, 229 and 286. 14) Add 50545 and 50546 to Line 539 15) Add 511.9 to Line 154. Delete 511.9 from Line 582.

	<p>16) Remove all C codes from all lines on which they appear on the list</p> <p>17) Invalid CPT codes will be removed as they are identified from all lines on the List</p>
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Appendix A: Guidelines

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 one of the accepted lymphedema training certifying organizations or a graduate of one of the National Lymphedema Network accepted training courses ~~and certified within the past 2 years of such a course~~. 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.

GUIDELINE NOTE 19, PET SCAN GUIDELINES

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

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

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

PET scan is covered only for the initial staging of cervical cancer and only 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:

Clinical management of the patient will differ depending on the stage of the cancer identified and either: 1) the stage of the cancer remains in doubt after standard diagnostic work up OR 2) PET replaces one or more conventional imaging studies when they are insufficient for clinical management of the patient

Restaging is covered only for cancers for which staging is covered, and for testicular cancer. Restaging is not covered for cervical 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 cardiac evaluation.

Guideline XXX Pickwickian Syndrome

Lines 8, 211, 608

278.8 (Other hyperalimantation) is included on these lines only for coverage of Pickwickian Syndrome/ Obesity Hypoventilation Syndrome.

GUIDELINE NOTE 5, OBESITY

Line 8

Medical treatment of obesity is limited to accepted intensive counseling on nutrition and exercise, provided by health care professionals. Intensive counseling is defined as face to face contact more than monthly. Visits are not to exceed more than once per week. Intensive counseling visits (once every 1-2 weeks) are covered for 6 months. Intensive counseling visits may continue for longer than 6 months as long as there is evidence of continued weight loss. Maintenance visits are covered no more than monthly after this intensive counseling period. Pharmacological treatments are not intended to be included as a treatment ~~services~~ on this line. Durable medical equipment, prosthetics/orthotics and supplies are included on this line only for patients with morbid obesity and only for promoting normal physical activity. See also Guideline Note 61.

Appendix B Statements of Intent

PALLIATIVE CARE STATEMENT OF INTENT

It is the intent of the Commission that palliative care services be covered for patients with a life-threatening illness or severe advanced illness expected to progress toward dying, regardless of the ~~patient's expected length of life, or~~ goals for medical treatment and with services available according to the patient's expected length of life. (See examples below).

Palliative care is comprehensive, specialized care ideally provided by an interdisciplinary team (which may include but is not limited to physicians, nurses, social workers, etc.) where care is particularly focused on alleviating suffering and promoting quality of life. Such interdisciplinary care should include assessment, care planning, and care coordination, emotional and psychosocial counseling for patients and families, assistance accessing services from other needed community resources, and should reflect the patient and family's values and goals.

Some examples of palliative care services that should be available to patients with a life-threatening/limiting illness,

- 1) without regard to a patient's expected length of life:
 - Inpatient palliative care consultation; and,
 - Outpatient palliative care consultation, office visits.
- 2) with an expected median survival of less than one year, as supported by the best available published evidence:
 - Home-based palliative care services ~~for those patients with a life-threatening/limiting illness, without regard to life expectancy, and/or who have the primary goal of prolonging life (home-based palliative care services (to be defined by DMAP), with the expectation that the patient will move to home hospice care.~~
- 3) with an expected median survival of six months or less, as supported by the best available published evidence:
 - Home hospice care ~~for those patients with a life-threatening illness and a life expectancy of 6 months or less, where the primary goal of care is quality of life (hospice services to be defined by DMAP).~~

It is the intent of the Commission that certain palliative care *treatments* be covered when these treatments carry the primary goal to alleviate symptoms and improve quality of life, without intending to alter the trajectory of the underlying disease.

Some examples of covered palliative care treatments include:

1. Radiation therapy for painful bone metastases with the intent to relieve pain and improve quality of life;
2. Surgical decompression for malignant bowel obstruction; and,
3. Medication therapy such as chemotherapy with low toxicity/low side effect agents with the goal to decrease pain from bulky disease or other identified

complications. Cost of chemotherapy and alternative medication(s) should also be considered.

4. Medical equipment and supplies (such as non-motorized wheelchairs, walkers, bandages, and catheters) determined to be medically appropriate for completion of basic activities of daily living, for management of symptomatic complications or as required for symptom control.
5. Acupuncture with intent to relieve nausea.

Cancer treatment with intent to palliate is not a covered service when the same palliation can be achieved with pain medications or other non-chemotherapy agents.

It is NOT the intent of the Commission that coverage for palliative care encompasses those treatments that seek to prolong life despite substantial burdens of treatment and limited chance of benefit. See Statement of Intent on Treatment of Cancer with Little or No Benefit Provided Near the End of Life.

STATEMENT OF INTENT ON TREATMENT OF CANCER WITH LITTLE OR NO BENEFIT PROVIDED NEAR THE END OF LIFE

All patients receiving end of life care, either with the intent to prolong survival or with the intent to palliate symptoms, should have/be engaged with palliative care providers (for example, have a palliative care consult or be enrolled in a palliative care program).

Treatment with intent to prolong survival is not a covered service for patients with any of the following:

- Median survival of less than 6 months with or without treatment, as supported by the best available published evidence peer-reviewed literature
- Median survival with treatment of 6-12 months when the treatment is expected to improve median survival by less than 50%, as supported by the best available published evidence peer-reviewed literature
- Median survival with treatment of more than 12 months when the treatment is ~~not~~ expected to improve median survival by less than 30%, as supported by the best available published evidence peer-reviewed literature
- Eastern Co-operative Oncology Group (ECOG) performance score of 3 or higher

The Health Services Commission is reluctant to place a strict \$/QALY (quality adjusted life-year) or \$/LYS (life-year saved) requirement on end-of-life treatments, as such measurement are only approximations and cannot take into account all of the merits of an individual case. However, cost must be taken into consideration when considering treatment options near the end of life. For example, in no instance can it be justified to spend \$100,000 in public resources to increase an individual's expected survival ~~from six to nine~~ by three months when hundreds of thousands of Oregonians are without any form of health insurance.

Treatment with the goal to palliate is addressed in the Palliative Care Statement of Intent.

DEATH WITH DIGNITY STATEMENT OF INTENT

It is the intent of the Commission that services under ORS 127.800-127.897 (Oregon Death with Dignity Act) be covered for those that wish to avail themselves to those services. Such services include but are not limited to attending physician visits, consulting physician confirmation, mental health evaluation and counseling, and prescription medications.