PRIORITIZATION OF HEALTH SERVICES

A Report to the Governor and Legislature

Oregon Health Services Commission
1991

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The prioritization of health care is a project which has drawn significant comment and notice. It has also attracted the interest and time of individuals outside of the state and hundreds of Oregonians. All the names listed here are not necessarily supporters of prioritization; however, they are all interested in improving the existing health care system.

The Health Services Commission would like to thank each of the organizations and individuals listed here. So many people participated, a name or two may have been overlooked; we apologize if your name is missing.

Special thanks are extended to spouses, significant others, business partners and employers who were supportive of the project and patient with the time demands. The Oregon Medical Association also deserves special thanks. It has been especially accommodating in providing critically-needed meeting space month after month, sometimes on very short notice.

Meeting Locations:

Oregon Medical Association
Good Samaritan Hospital - Portland
Providence Hospital - Medford
Medford City Hall
St. Anthony's Hospital - Pendleton
Providence Hospital - Portland
Lane County Administrative Offices
Adult and Family Services - Bend
Neighborhood Facility Building - Coos Bay
Emanuel Hospital - Portland
Holladay Park Hospital - Portland
Oregon AFL-CIO - Salem
Kaiser Permanente - Portland
Marion County Health Department
Oregon Health Sciences University
Oregon State Hospital
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St. Vincent Hospital - Portland

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Community Action Program of East Central Oregon
HELP, Inc. - LaGrande
Rogue Valley Fair Share
Oregon Fair Share
Oregon Health Action Campaign
Oregon Health Decisions
Oregon Human Rights Coalition

Oregon Medical Organizations & Interest Groups:

Occupational Therapy Association
Academy of Otolaryngology
Psychiatric Association
Academy of Ophthalmology
Academy of Family Physicians
American College of Physicians
Society of Physicians' Assistants
Acupuncture Society
Society of Internal Medicine
Nurses Association
Association of Hospitals
Pediatric Society
Radiological Society
American College of Surgeons
Urological Society
Chiropractic Physicians
Association of Naturopathic Physicians
Society of Allergy & Immunology
American College of OB-GYN
Dental Association
Society of Physical Medicine and Rehabilitation
Western Orthopedic Association
Dermatology Society

Oregon Medical Organizations & Interest Groups: continued

Pathologists Association
Society of Anesthesiologists
Osteopathic Physicians and Surgeons
Pharmaceutical Manufacturers Association*
American Association for Marriage and Family Therapy
Mental Health Care and Chemical Dependency Coalition
Optometric Association
Society of Oral and Maxillofacial Surgery
Podiatric Medical Association
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Transplant Project
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EXECUTIVE SUMMARY

The Health Services Commission began its task of ranking health services in the fall of 1989. Each Commissioner understood that such a task had never before been done but met the challenge with eagerness albeit with some trepidation.

Hundreds of volunteers contributed thousands of hours.

The Commission sought the involvement of the general public in developing the methodology and collecting health-related values. Public hearings were held throughout Oregon; a telephone survey was done; and, community meetings were conducted on behalf of the Commission by Oregon Health Decisions. Oregon's health care providers responded to the Commission's call for assistance with healthy skepticism and with a spirit of excitement. They saw an opportunity to expand access to health care for Oregonians and participate in something that had never been tried.

After months of work and hundreds of volunteers contributing thousands of hours, the Commission has completed the first prioritized list of health services. The ranking of the health services in the list is responsive to public values and incorporates experience-based information on treatment effectiveness. **The Commission recommends the prioritized list as the basis for the benefit package of the Oregon Basic Health Services Act.** The prioritized list with actuarial pricing is included in this report in Appendix J.

In the accompanying report, the Commission has described its inception, organization and methodology in detail. Discussion has also been included about further study and contributions have been made by the Office of Medical Assistance Programs (OMAP) concerning program delivery and actuarial analysis.

Chapter 7 contains reflections of the Commissioners about the road they have traveled to produce this pioneering effort and their recommendations.

Two recommendations are especially significant in the acceptance and interpretation of the prioritized list:

A) A benefit package be funded which includes all* services in categories considered essential and most of those considered very important; and,

B) Mental health and chemical dependency services be integrated in a single prioritized list of health services for 1993-95 implementation.

The Commission defined basic health care as "a floor beneath which no person should fall." This definition is expanded by the identification of three areas of health service categories on the prioritized list which are termed:

1) Essential
2) Very Important
3) Valuable to Certain Individuals but Significantly Less Likely to Be Cost-effective or to Produce Substantial Long-term Gain

The categories of "essential" and "very important" are critical to basic health care. All of the "Essential" categories must be funded. They are categories of health services such as preservation of life, maternity care, preventive care for children and adults, reproductive services, and comfort care. These services are effective, contribute to quality of life, give good value for the dollar and demonstrate community compassion for those who are terminally ill. These services are responsive to the community expressions of health values and concerns. The "very important" categories must also be funded. These categories comprise treatment which is effective and improves quality of life.

Responding to the needs of both society and the individual mean earmarking more funds for investment in Oregon's medical assistance programs.

*Not all services in categories deemed "essential" are ranked contiguously (i.e., not all line items classified as Category 3, for example, will be grouped together). Due to Commission judgment, some line items were moved to "outlier" positions of greater or lesser importance than their category rank.

Funding of "essential" and "very important" will produce a minimum health benefits package. However, the Commission's definition of basic health care is from a societal perspective rather than the individual's perspective. What is essential for the overall well-being of society may not meet the desires of specific individuals. Responding to the needs of both society and the individual may mean earmarking more funds for investment in Oregon's medical assistance programs than has previously been the case.

The second recommendation significant to the interpretation of the prioritized list is integration of mental health and chemical dependency services with all other health services--an example of the integrated list can be found in Appendix H. The Commission will bring a total list of health services to the Legislature in 1992 and recommends implementation in the 1993-95 biennium.

Integration of all health services in one prioritized list from which is drawn a basic health care package is of utmost importance. Integration recognizes the inseparability of mind and body and the interaction between physical and mental function. Including mental health and chemical dependency services in basic health care is responsive to Oregonians' expression of an important need.

The Commission also recommended to the Legislature: (Detail on each can be found in Chapter 7)

- Addressing the gap in mental health and chemical dependency coverage for the participants in the state-sponsored insurance pools until such time as the integrated health services list is implemented.
- Enacting legislation which will allow the Commission to make technical revisions to the prioritized list other than those which may be included in the mandated biennial report.
- Funding the Commission at a level adequate to support further study described in Chapter 6.
- Considering the representation from the fields of mental health and chemical dependency on the Commission.

The work of the Health Services Commission will be a continuing effort.

Who Are the Uninsured?

A 1986 survey done by Oregon's State Health Planning and Development Agency (now the Office of Health Policy) is the most recent detailed information concerning Oregon's uninsured. A brief description of that information relevant to Senate Bill 27 follows [P-1]:

--- Sixteen (16) percent of households where the head is under 65 years old are estimated to be completely uninsured. This figure is extrapolated to about 350,000 individuals [400,000 in 1991] who do not have access to private or public (Medicaid/Medicare) insurance.

--- Uninsured household heads and spouses are less likely than insureds to see a doctor. Yet, uninsured who do see a doctor make a greater number of visits than insureds in the same time period.

--- The average out-of-pocket expenditure for hospitalization is higher among the uninsured.

The uninsured tend to be younger, single, less educated, low in financial status and unemployed or marginally employed. The uninsured are less likely to have a regular source of care and more likely to report delaying needed care because of cost. They are more likely to report disabling medical conditions and to experience more days away from work or usual activities because of illness.

Goal of Senate Bill 27

The goal of Senate Bill 27 is to provide people with access to health care who have been previously unable to access private or public insurance programs. In this way, Oregonians are likely to become healthier and more productive.

Expansion of income eligibility for the Medicaid program is expected to reach about one-third of Oregon's uninsured. This figure is estimated to be 118,200 Oregonians who are newly eligible families with children and adults of working age. [P-2]

Senate Bill 27 specifies mechanisms which enable expansion of service with limited resources: prioritization of health services and managed care. The legislation states:

> a list of health services ranked by priority, from the most important to the least important, representing the comparative benefits of each service to the entire population to be served. [And, Oregon's Office of Medical Assistance Programs] shall execute prepaid managed care health services contracts . . . [wherever there are qualified provider entities] [P-3]

Prioritization of health services is based on service effectiveness and the values of Oregon's residents determined in a community meeting process. Those services least effective and least valued are those ranked lower and are less likely to be funded than those more effective and more highly valued. The Oregon Legislature will determine the funding level based on revenue available for health services.

Senate Bill 27 excludes from prioritization health services for selected groups of people. The result is continuation of the current Medicaid package for:

-- the aged, blind and disabled

-- adults in official custody or residing in an institution

-- children who are wards of the Children's Services Division

The accompanying report addresses the organization of the Health Services Commission, the methodology employed in effecting a prioritization of health services, issues relating to mental health care and chemical dependency, actuarial analysis, implementation issues, subjects for further study, and recommendations.

CHAPTER 1

ORGANIZATION AND PROCESS DESIGN

Abstract *The Health Services Commission decided the most effective way to approach its task of ranking health services was to create subcommittees. The work of the subcommittees was determined by the language of the law and from a perspective that quality of life and benefit of service should be important elements in determining priority.*

Three subcommittees were created at the beginning of the Commission's work: Social Values, Health Outcomes, and Mental Health Care and Chemical Dependency. The Alternative Methodology and Ancillary Services Subcommittees were formed as the methodology evolved.

COMMISSION STRUCTURE

The Legislature required that the Commission be volunteer and representative of health care providers and consumers. The eleven (11) member Commission consists of "five physicians licensed to practice medicine in this state who have clinical expertise in the general areas of obstetrics, perinatal, pediatrics, adult medicine, geriatrics or public health. One of the physicians shall be a doctor of osteopathy. Other members shall include a public health nurse, a social services worker, and four consumers of health care." [1-1] (See Appendix B.)

BUDGET AND STAFFING

The Commission's work began with a biennial budget of $347,560. It soon became apparent that this was an insufficient sum considering the scope of the project. The scope is demonstrated by the number of public hearings planned, mailing and report costs, and the number of Commission and subcommittee meetings necessary. An additional $217,796 was added to the budget in early 1990. Even so, the project's success hinged upon the contribution of thousands of hours of work and counsel by Oregon's health care providers, Oregon Health Decisions, Oregon Fair Share, the Oregon Health Action Campaign, and the Oregon Medical Association--to name a few.

At maximum, six staff worked with the Commission. They provided support in the areas of methodology design and analysis, database development, data element identification and collection, survey design and interpretation, statistical analysis, and coordination of volunteers and supporting organizations. Two of the staff were hired on a short-term basis to do literature research on medical outcomes and ethical and resource allocation issues.

EVOLUTIONARY NATURE OF THE WORK

Social values must be integral to the process.

The Commissioners began their task with no existing work to guide them and no pre-existing ideas on how it might be successfully accomplished. They took direction from Senate Bill (SB) 27 in that they knew:

- -- a comprehensive list of health services had to be developed which would be detailed enough that benefit packages could be expanded and contracted with changing economic conditions;
- -- the public and providers had to be involved; and,
- -- the ranking of the list must reflect the comparative benefits of health services.

With this understanding, the Commission decided that health treatment effectiveness data as well as social values must be integral parts of the process and that effectiveness should be determined on a condition/treatment basis. However, they had no ideas as to how to incorporate this information into a prioritization methodology.

PRIORITIZATION APPROACHES

The Commission reviewed international health care systems, the Oregon Medicaid priority-setting project, changes occurring in other states, and three measurement systems of health and well-being as potential approaches to constructing a methodology for ranking health services.

International health care systems

A cursory review of health care systems in Canada, Great Britain, Japan, Sweden and West Germany was undertaken with the knowledge that each guarantees a level of health care for all its citizens. Because every country has limited resources, the hope was that one of the studied countries had a system the Commission could adapt for its purpose.

All of these countries prioritize health care by service limitation. Limitation is achieved through queues and limited benefits and service availability. [1-2] The Commission decided that while laudable in many respects, none of the systems met the requirements of its charge.

Oregon Medicaid Priority-Setting Project

The Oregon Medicaid Priority-Setting Project (MPP) [1-3] was undertaken in early 1989 as a precursor to the Health Services Commission's ranking of health services. These projects must not be confused with one another.

The MPP separated health services into ten groupings. It assigned a rank from one to ten to each health service within each grouping. Ten signified the most valuable services while one signified the least valuable. The result was ten levels of service with the majority of services ranked in level number 10.

The MPP offered many insights into the problem of prioritization. However, the process was not done in sufficient detail to allow prioritization of distinct services.

Other States

Many states are investigating ways to curtail and contain health care costs. Alaska is the only one which has attempted ranking services.

Alaska has adopted an "elimination" list. Should the cost of medical assistance exceed available resources, categories of health services can be eliminated.[1-4] This system does not discriminate between effective and ineffective services nor does it take public values directly into account.

Other states which have recently received attention for related efforts include Washington, California, New York and Massachusetts. They do not rank services but do attempt to contain costs. [1-5,1-6,1-7,1-8] Hawaii limits the number of visits included in a health care package. [1-9] For example, mental illness and alcohol or drug dependence care is covered but visits may not exceed three per year.

Measurement methods

Several methods have been developed to try to measure how people feel about their health. These measures may focus on pre- and post-treatment to try to understand the non-clinical impact of treatment. Conversely, some measures focus on the clinical assessments of the likelihood of successful treatment. The Commission reviewed four methods. It hoped one might serve as a starting point for developing a ranking system which would include treatment effectiveness and quality of life.

Hadorn classifications were developed by David C. Hadorn, M.D., from the University of Colorado. The system, as reviewed by the Health Services Commission late in 1989, placed medical treatments in categories related to productive outcomes based on a value system. For example:

> Treatment of medical conditions when a reasonable likelihood exists for increasing expected untreated life span by greater than five years or significantly enhancing quality of life. Typical examples are some treatments for certain types of cancer (radiation therapy, chemotherapy), gall bladder surgery for appropriate candidates and kidney dialysis. [1-10]

This classification system focuses on medical outcomes and does not incorporate public values.

The Commission looked for a method which would include treatment effectiveness.

Rand's method was rejected early in the evaluation process because the measure consists of a set of booklets each of which is specific to a particular condition (e.g., acne, anemia). The Commission required a measure of total health state. [1-11]

The **Sickness Impact Profile (SIP)** from the University of Washington is a questionnaire which assesses dysfunction. It makes 136 queries to determine dysfunction. It does not include relative importance of the dysfunctions to the respondent and does not include a valuation of an individual's total health state. [1-12]

The **Quality of Well-Being (QWB) Scale** was developed by Dr. Robert M. Kaplan, from the University of California at San Diego. This measurement involves a survey which assesses an

individual's total health state or quality of well-being. Assessment is done be measuring mortality, morbidity and return to former health state by asking for values for 25 symptoms and three functional impairment scales. [1-13]

The QWB Scale was chosen as a springboard for the Commission's methodology because of:

.... measurability of treatment effectiveness and individual values;

.... completeness in incorporating both mental and physical health;

.... brevity and ease of administration;

.... validation through use by the National Center for Health Statistics;

.... existing value measurements with which to compare Oregon's results; and,

.... flexibility to accommodate the Commission's evolving methodology.

The task was divided into social values, health outcomes, and mental health and chemical dependency.

SUBCOMMITTEES

The Commission divided its task into three major areas: health outcomes and comparative benefits, social values, and mental health care and chemical dependency. As the three subcommittees worked to develop and test a methodology, it became clear that two more subcommittees were necessary: Ancillary Services and Alternative Methodology. (See Figure 2)

Bill Gregory, Chairman of the Commission, named the subcommittee chairs:

·Health outcomes.....Harvey Klevit, M.D.

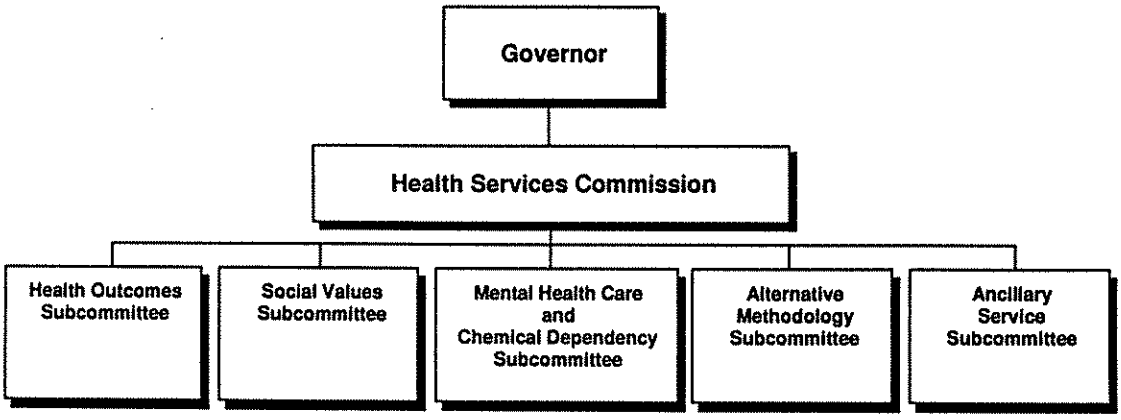
·Social values.....Yayoe Kuramitsu, M.S.W.

·Mental health care and chemical dependency.....Donalda Dodson, R.N., M.P.H.

·Alternative methodology.....Rick Wopat, M.D.

·Ancillary services.....Alan Bates, D.O.

Figure 2. Organizational Chart



An objective system to measure treatment effectiveness.

Social Values Subcommittee

The Social Values Subcommittee determined that its goals were the identification, collection and measurement of public values. Its contribution to the Commission methodology included:

- -- testimony received at the public hearings;
- -- values generated in community meetings; and
- -- data generated by the survey of Oregonians' health-state values.

Public hearings were intended to educate and collect public values. The hearing participants could learn about the prioritization project and the Commission could learn about the health-related needs and problems of Oregonians (see Appendix E).

Representatives of special interest groups, providers of health services, and the general public provided testimony. The testimony consisted of advocacy for more care and particular services, a change in Oregon's Medicaid system, universal health care, and views on the appropriateness of prioritization of health care. During these hearings, the subcommittee tested drafts of attitude and service preference instruments intended to collect health-related values. The tests provided guidance on which instruments were most effective and resulted in revisions of the instruments.

Community values More than 5,000 volunteer hours were contributed by Oregon Health Decisions (OHD) and the SB 27 Community Meetings Advisory Committee to construct a community meeting process.

The subcommittee had hoped that the meetings could be used as a forum for conducting a survey to collect health state values, obtain guidance as to peoples' service preferences, and build community consensus. OHD recommended that the process be limited to consensus building due to the two-hour limitation of the community meetings (see Appendix F).

Health-state values A telephone survey was developed to collect quality-of-life information represented by symptoms and functional impairment associated with illness. The resultant data was developed into weights for use in a cost-benefit ratio and net-benefit calculation in conjunction with data collected by the Health Outcomes Subcommittee.

The subcommittee discussed at length ethical considerations involved in decision-making. Discussion focused on how to elicit representative public health care values. The people attending community meetings and responding to the telephone survey would need a clear understanding of the choices they would be making (see Appendix C).

Health Outcomes Subcommittee

The subcommittee sought an objective system to measure effectiveness of treatment. It believed age cohort rather than population-wide data would be the most equitable basis for measuring effectiveness and simultaneously developed a benefit analysis and cost-benefit approach. This system functioned as a way to measure treatment effectiveness for a given diagnosis (condition/treatment pairs).

The cohort approach was based on the measurement of treatment effectiveness for the people most likely to present with a condition. For instance, "adolescent" is the cohort of people presenting with Type I Diabetes Mellitus. The average outcomes for this group of people are different from the average outcomes for the entire age spectrum.

The benefits analysis measures effectiveness based on quality of life represented by rates of morbidity, mortality and return to former state of health. The addition of cost of treatment provides a measure of the efficiency of the treatment.

Outcomes research Data collection began with an attempt to review medical research literature. It became apparent this approach was unwieldy and counterproductive because of the "shelf-life" of the data and a lack of conclusive studies of effectiveness. The Commission concluded that selective literature searches would be made on those areas of practice for which there is known, relevant research to corroborate or supplement Oregon-based information.

Provider judgments The subcommittee solicited testimony from health care providers. Clinical outcomes of condition/ treatment pairs, as seen in the Oregon experience, was gathered from allopathic and non-allopathic providers. The Mental Health Care and Chemical Dependency (MHCD) Subcommittee collected data on MHCD condition/treatment pairs.

Appropriate and necessary services integral to treatment success must be included with the ranked condition/ treatment pair.

Conditions were segregated by practice specialty using ICD-9 *(International Classification of Disease)*[1-14] and DSM-III-R *(Diagnostic and Statistical Manual of Mental Disorders)* [1-15] codes. Professional organizations and specialists from a wide range of disciplines were asked what services they provide for each diagnosis and the spectrum of results of treating or not treating. For example:

Condition (Diagnosis)	Service (Treatment)
ICD-9: 182 Uterine Cancer	CPT-4: 58150 Hysterectomy
DSM-III-R: 295.18-.95 Schizophrenia	CPT-4: 90220, 90800-90899 Medical/ psychotherapy

A data collection form was developed to facilitate provider presentation of data in a format compatible with the Commission's methodology (see Appendix D). This information included the expected outcomes of condition/ treatment pairs as well as the probability of each outcome at five years after onset.

Mental Health Care and Chemical Dependency Subcommittee

The MHCD Subcommittee was mandated by Senate Bill 27 to assist the Commission with the prioritization of MHCD services. It is unique in that it has only one Commission member, the chair. Its membership is twelve, evenly divided between representatives from mental health and from chemical dependency, including a mix of providers and consumers (see Appendix B).

The legislation required the subcommittee's work to be reported to the Sixty-Sixth Legislature (1991). The Commission was scheduled to report March 1, 1990. Consequently, the first list of prioritized health services would not include MHCD services. Even so, the subcommittee chose to participate in the creation of the prioritized list of health services rather than create a different methodology. In this way, they could learn if MHCD services could reasonably be ranked and if the system applied to other health services would treat MHCD services equally well.

Alternative Methodology Subcommittee

Once the Commission gained experience with the outcomes data collected from health care providers and community and health-state values had been gathered, it became clear that a ranking based on benefit or a cost-benefit ratio did not comprehensively reflect public values. Another factor that had become increasingly troublesome was how to position those services which are not condition/treatment pairs systematically and objectively. Services such as education and prevention are not treatments for diagnoses so data comparable to that of the condition/treatment pairs could not be gathered.

At this point, the Commission decided to create a subcommittee which would look for a system which would work in conjunction with the net-benefit and cost-benefit concept. Possibilities included: Hadorn's classification system; relying on Commission judgment as guided by the public hearings, community meetings, and survey data; and, a system of ranking service classifications.

Ancillary Services Subcommittee

The Commission agreed at the beginning of its deliberations that appropriate and necessary services not generally described as treatments or therapies but integral to the successful treatment of a condition be incorporated in the treatment component of the condition/treatment pair being ranked. The Commission felt it important to list those services which they felt were imperative to quality care in the SB 27 demonstration program (see Appendix J).

TIMELINES

The Commission began its task in September of 1989 with the goal of reporting to the Joint Legislative Committee on Health Care by March 1, 1990 as specified by law. The Commission's effort to meet that deadline involved an ambitious schedule of:

-- public hearings;
-- community meeting;
-- Commission and subcommittee meetings;
-- health care provider meetings;
-- telephone survey of health-state values; and,
-- expert reaction to the proposed methodology.

The schedule was not kept. By early spring, methodology testing was just beginning and outcomes data were incomplete. The Joint Legislative Committee on Health Care granted an extension to July of 1990. As July neared, it became evident that substantially more time was needed to complete the outcomes database and test the methodology.

The Commission and the Joint Legislative Committee concurred that prioritization of health services was too great a task to be accomplished in the time frame allotted. The choice was between presenting a prioritized list with incomplete information or evolving a methodology which would represent service effectiveness and Oregonians' values. The first option was unacceptable. A decision was made to report to the Legislature in 1991.

CHAPTER 2

METHODOLOGY: A COMBINATION OF VALUES AND DATA

Abstract *The prioritization methodology uses data and values. Data were supplied by health care providers. Values were contributed by the general public through public hearings, in community meetings, in a telephone survey, and by the Commissioners. This information was integrated in a three-step process:*

STEP 1 -- creation and ranking of health service categories and classification of services;

STEP 2 -- generation of net-benefit used to rank condition/treatment pairs within health service categories; and,

STEP 3 -- Commission judgement used in creating the methodology and making adjustments to the prioritized list of health services.

Senate Bill (SB) 27 (see Appendix A) directs the Health Services Commission to develop "a list of health services ranked by priority from the most important to the least important...." [2-1] Determining what information would be required, how it would be gathered, and how the information would be used in prioritization was a long and carefully considered process.

A health service is an intervention expected to maintain and/ or restore health or well-being.

There were no established methods for ranking health services, so the Commission began to try possibilities with the idea of adapting several methods to fit the task required by the statute.

The first method to be tried was cost-benefit with a quality of life component. Development of the components of a cost-benefit ratio was deceptively simple. Their complexity surfaced as work progressed and as modifications were made. After repeated testing, it was clear that a straight cost-benefit measure (as defined by the Commission) was not sufficient. A second approach, ranking categories of health services, was developed which allowed the Commission to take into account the full range of values expressed at community meetings and public hearings. The ranked categorization of health services resulted in a draft prioritized list which was a marked improvement over cost-benefit. However, the problem remained of how to rank services within their assigned categories.

In the final analysis, the ranked categorization of health services in conjunction with the net benefit component of the cost-benefit ratio defined the draft list of prioritized health services. Commission judgement played a significant role in refining the final list found in Appendix J.

This chapter confines itself to discussion of the final methodology used to rank health services. A detailed discussion of cost-benefit and other components in the development of the prioritization methodology can be found in Appendices C through G.

COMMISSION DEFINITIONS

Health Service

A health service is defined as "an intervention related to a specific condition expected to maintain and/or restore an individual's health or well-being. Each health service listed is presumed to include all necessary ancillary and supportive services." This definition includes services which are not treatments for diagnoses but interventions characterized by prevention, screening, and comfort care. Ancillary services are those not generally described as treatments or therapies but are integral to an intervention's success (e.g., laboratory services, prescription drugs, hospital services). (See Appendix J.)

Condition/Treatment Pair

Ranking treatments or conditions exclusive of one another is not logical because the effectiveness of treatment is apparent only when enlisted in the course of treatment for a condition. From that reasoning was borne the concept of ranking condition/treatment pairs.

Diagnostic-related groups (DRGS) were considered as a source of identification. They were rejected because they do not include outpatient therapies, are too broad, and may consist of co-morbidities which the Commission did not have the time to evaluate.

ICD-9 [2-2] and DSM-III-R [2-3] codes were used to specify diagnoses. They are accepted as the standard by the health care community internationally.

CPT-4 codes (*Physicians' Current Procedural Terminology*, Fourth Edition)[2-4] were used to identify treatments and procedures because they are currently in use by Medicaid in Oregon. If dental work is funded by the legislature and as a result becomes part of the SB 27 Medicaid package, the codes used by the American Dental Association will be incorporated as part of implementation.

ICD-9, DSM-III-R and CPT-4 codes number to the thousands. To reduce the list to a manageable number and preserve continuity of care, condition/treatment pairs were grouped.

This was done when services provided for similar conditions had similar expected costs and benefits (e.g., open shaft fractures of the bone). This is also true for conditions requiring different treatments for different stages of illness or differences in severity of illness (e.g., breast cancer).

Every patient will have the opportunity for a diagnosis.

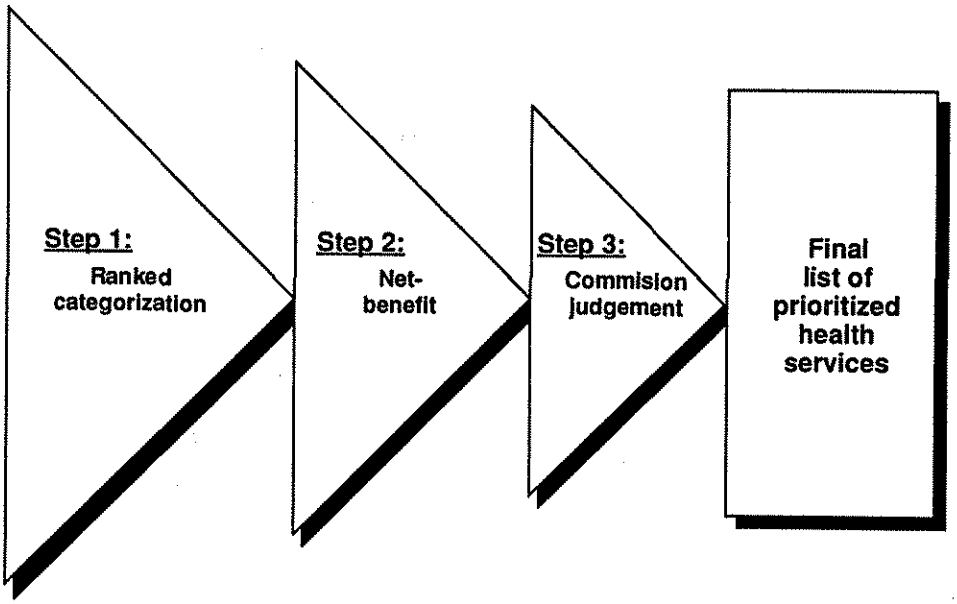
The Commission wants to preserve the ability of the patient, with the doctor's advice, to decide course of treatment. However, it believes it is important to rank options separately when cost effectiveness of one treatment shows a clear advantage over another.

ORDER OF PRIORITIZATION

Every patient will be allowed a diagnosis of presenting condition and recommendation of appropriate service. Whether treatment for the diagnosed condition is reimbursable by Medicaid will be subject to the extent the legislature funds the list of health services.

Figure 3 is a diagram of the Commission methodology divided into three steps:1) categorization and ranking of health service categories; 2) net-benefit; and 3) Commission judgement.

Figure 3. Three-Step Methodology.



The prioritized list is headed by the opportunity for diagnosis and comprises condition/treatment pairs and services (see Appendix J). The list of 709 health services and condition/ treatment pairs identifies service category only by number (1-17) and does not include net-benefit described later in this chapter.

STEP 1: HEALTH SERVICE CATEGORIES AND THEIR RANKING

Seventeen (17) categories of health services were determined by the Commission. The remaining categories are groupings of condition/treatment pairs which are acute or chronic and are further characterized by being fatal or non-fatal (e.g., chronic nonfatal, one-time treatment improves quality of life). The categories are ranked from most to least important.

1. **Acute Fatal,** treatment prevents death with full recovery: appendectomy for appendicitis; repair of deep, open wound in neck; medical therapy for myocarditis.
2. **Maternity Care**, including most disorders of the newborn: obstetrical care for pregnancy.
3. **Acute Fatal**, treatment prevents death without full recovery: surgical treatment for head injury with prolonged loss of consciousness; medical therapy for acute bacterial meningitis; reduction of an open fracture of a joint.
4. **Preventive Care for Children**: immunizations; medical therapy for streptococcal sore throat and scarlet fever--reduce disability, prevents spread; screening for specific problems such as vision or hearing difficulties or anemia.
5. **Chronic Fatal**, treatment improves life span and quality of life: medical therapy for Type I Diabetes Mellitus; medical and surgical treatment for treatable cancer of the uterus; medical therapy for asthma.
6. **Reproductive Services**, excludes maternity and infertility services: contraceptive management; vasectomy; tubal ligation.
7. **Comfort Care**, palliative therapy for conditions in which death is imminent.
8. **Preventive Dental Care**, adults and children: cleaning and fluoride applications.

9. **Proven Effective Preventive Care for Adults**: mammograms; blood pressure screening; medical therapy and chemoprophylaxis for primary tuberculosis.
10. **Acute Nonfatal,** treatment causes return to previous health state: medical therapy for acute thyroiditis; medical therapy for vaginitis; restorative dental service for dental caries.
11. **Chronic Nonfatal,** one-time treatment improves quality of life: hip replacement; laser surgery for diabetic retinopathy; medical therapy for rheumatic fever.
12. **Acute Nonfatal,** treatment without return to previous health state: relocation of dislocated elbow; arthroscopic repair of internal derangement of knee; repair of corneal laceration.
13. **Chronic Nonfatal,** repetitive treatment improves quality of life: medical therapy for chronic sinusitis; medical therapy for migraine; medical therapy for psoriasis.
14. **Acute Nonfatal,** treatment expedites recovery of self-limiting conditions: medical therapy for diaper rash; medical therapy for acute conjunctivitis; medical therapy for acute pharyngitis.
15. **Infertility Services**: medical therapy for anovulation; microsurgery for tubal disease; in-vitro fertilization.
16. **Less Effective Preventive Care for Adults:** dipstick urinalysis for hematuria in adults less than 60 years of age; sigmoidoscopy for persons less than 40 years of age; screening of non-pregnant adults for Type I Diabetes Mellitus.
17. **Fatal or Nonfatal,** treatment causes minimal or no improvement in quality of life: repair fingertip avulsion that does not include fingernail; medical therapy for gallstone without cholecystitis; medical therapy for viral warts.

·Value to society

·Value to an individual

·Essential to basic health

Category Ranking Process

To begin, each Commissioner gave a relative weight from zero to 100 to the attributes of:

-- value to society;

-- value to an individual at risk of needing the service; and,

-- essential to a basic health care package.

These attitudes are reflections of values designated in the community meetings (see page 21). In addition to weighting the attributes, the Commissioners assigned scores of 1 to 10 (10 being the best) to each of the health service categories.

The Commissioners rated each category three separate times: once on the basis of value to society; once on the basis of value to an individual at risk of needing the service; and, once on the basis of whether that category of service was essential to a basic health care package. Each time a Commissioner addressed a category, a number from 1 to 10 was assigned to each category.

> Example:
>
> A Commissioner might have assigned a 10 to infertility services based on "value to an individual;" a 2 based on "value to society;" and, a 1 based on "essential to a basic health care package."

A modified Delphi technique (see Appendix G) aided the Commission in arriving at consensus. Before a final ranking was determined for each of the categories, the Commissioners reviewed their 1 to 10 scoring to see if there were major discrepancies between their numbers and the numbers of the other Commissioners. This process afforded the Commissioners the chance to change their scoring or argue for a higher or lower score.

Staff applied the weights of the attributes to the 1 to 10 scoring. Then staff summed the weighted scores (11 scores--one score per Commissioner) for each category and averaged the result.

$$\sum_{i=1}^{11} \frac{\text{Attribute weight (1-100) x Service category rating (1-10)}}{\text{11 Commissioners}}$$

Assignment to Categories

Placement of a condition/treatment pair in a category depended first on whether the condition was chronic or acute. The Commission's physicians decided which conditions are never completely cured and those for which treatment does

cure. The Commission classified condition/treatment pairs as acute or chronic. This work was reviewed by the health care providers who had contributed data on treatment effectiveness.

Staff devised a computer algorithm to sort chronic and acute conditions into the previously defined health services categories by degrees of fatality and improvement in quality of life. Fatal is defined as a one percent or greater chance of death without treatment. Recovery from a fatal condition depends on a reduction of mortality by at least 25 percent five years after treatment and measures of quality of life (see Appendix H). The Commissioners reviewed the results of the algorithm and made changes based on their professional judgement with confirmation by contributing health care providers.

Social Values

Community Meetings and Value Gathering At the request of the Commission, Oregon Health Decisions (OHD) held 47 community meetings throughout Oregon. The purpose was to learn which health care values were seen as important by the community. From these meetings, 13 health-related values emerged (see Appendix F) but were not quantified or ranked.

Note that mental health and chemical dependency and prevention are included as community values. They are not values in and of themselves; but, the communities' insistence on the provision of these services has been interpreted as reflective of a community value. The 13 values were grouped by the Commission into three attributes which were then used to rank the categories of health services. Some values appear in more than one attribute.

Value to Society: This attribute takes into account the costs to society if a category of health service is not provided.

Prevention	Cost effectiveness
Benefits many	Community compassion
Impact on society	Mental health and chemical dependency
Quality of Life	
Personal responsibility	

Value to an Individual at Risk of Needing the Service: Certain categories of services may be very important to a person seeking the service (e.g., services for infertility) but makes very little difference on a societal level.

Prevention	Equity
Quality of life	Effectiveness of Treatment
Ability to function	Personal choice
Length of life	Community compassion
Mental health and chemical dependency	

Essential to Basic Health Care: The categories of service essential are those, with respect to public input and expert testimony, below which no person shall fall.

Prevention	Cost effectiveness
Benefits many	Impact on society
Quality of life	

Public Hearings Twelve (12) public hearings were held in Portland, Salem, Pendleton, Eugene, Bend, Coos Bay and Medford. The purpose was to accept testimony and information from advocates for seniors, handicapped persons, mental health services consumers, low income Oregonians, and providers of health services. Oregon Fair Share provided door to door canvasing to encourage attendance, supplied the media with public service announcements concerning meeting times and places, and posted flyers announcing meetings. Meeting announcements were also included with Medicaid card mailings from Oregon's Office of Medical Assistance Programs. The process was aided by the support of the Oregon Health Action Campaign which represents 72 grass-roots organizations.

Public hearings were useful in understanding public needs and concerns.

The number of people testifying to the Commission ranged from 13 in Coos Bay to 62 in a Portland hearing with a total of over 1500 people attending.

Testimony generally was not useful in measuring treatment effectiveness objectively but was useful for understanding the general tone of public needs and concerns (see Appendix E). The message was delivered that dental, preventive and mental health care and chemical dependency services should be a part of the covered health services.

STEP 2: NET-BENEFIT WITHIN THE CATEGORIES

The Commission began the prioritization process using a cost-benefit approach with a quality of life component. As it was tested, it became clear that net-benefit more accurately reflected relative value of the condition/treatment pairs. See Appendix D for detail on cost- and net-benefit.

Net-benefit

Net-benefit established the initial prioritization in categories where condition/treatment pairs exist. It is a number computed for each condition/treatment pair and is intended to represent the extent to which a person feels better or worse after having treatment or not.

The following information was specified as necessary to determine net-benefit:

-- outcomes likely to result from treatment or without treatment for health-related conditions as specified by health care providers; and,

-- quality of life quantified by telephone survey responses so public attitudes and clinical findings could be blended.

Assumptions were made so that comparable information could be collected for evaluation. All measures of effectiveness are for an average patient based on a median age likely for presentation and a blend of outcomes probabilities. Without treatment means absence of treatment. Finally, because the probability of treatment effectiveness can be a function of time, five years subsequent to treatment was selected as a reasonable time frame for assessment.

Below is a simplified version of the net-benefit calculation used to establish the initial prioritization within service categories where condition/treatment pairs exist. It does not convey the complexities involved but does show the basic components and their relationship to one another. (See Appendix D.)

Net-benefit is the extent to which a person feels better or worse after having treatment.

$$\text{Net-benefit} = \underset{\text{with treatment}}{[\text{outcomes} \times \text{probabilities}]} - \underset{\text{without treatment}}{[\text{outcomes} \times \text{probabilities}]}$$

The number is not significant in and of itself. It is simply a measure of the relative magnitude of the benefits of one service to another.

Outcomes

Outcomes are the measure of effectiveness of a health service. They are based on probabilities of:

- -- mortality (death);
- -- return to the former state of health; and,
- -- morbidities (quality of life as represented by presence or lack of symptoms and functional impairments).

Effectiveness of health services was determined on the basis of literature review and by data provided by Oregon's health service providers.

To date, there are few conclusive studies of treatment outcomes. Transplantation and cardiac surgery are notable exceptions. Even so, very little information exists beyond mortality rates. There is little information on quality of life and little is documented on outcomes without treatment for most conditions.

The Commission identified the best source for expected outcomes for health services as the individual practitioner or specialist. Professional specialty organizations and individuals known to be proficient in their field provided data based on collective experience and training. (See Appendix D for data collection instrument and instructions.)

For most condition/treatment pairs, outcomes probabilities with and without treatment were required.

Mortality The probability that death (which includes suicide and accident) will be the result of treatment or no treatment.

Return to former state of health is the return to the health state present before the onset of the condition being treated. A former state of health may not have been a state of perfect health.

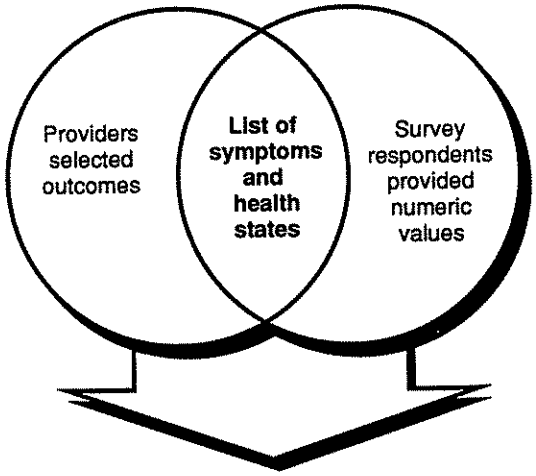
Morbidity Significant residual effects comprised of symptoms and functional impairment are morbidities. Conditions remaining because of the inability of the treatment to return patients to their former health state and conditions created by the treatment are also considered morbidities.

Each scenario contained functional modifiers to indicate severity and one major symptom.

Health professionals chose up to three scenarios to describe outcomes in addition to death and return to former health state. Each of these three scenarios was described by picking one major symptom from a list of symptoms provided. Functional impairment modifiers, also chosen from a list provided, were incorporated as a means of indicating severity. (See Appendix D for a list of symptoms and functional impairments supplied for provider use.)

The list of symptoms and functional impairments which health service providers used to described outcomes with and without treatment was the same list used in the telephone survey described later in this chapter (see Figure 4). The weights generated by the survey were given to quantify the providers' clinical judgments in the net-benefit calculation.

Figure 4. Integration of Provider Outcomes and Survey



Benefits: Quality of Life

Detailed information regarding the content of the telephone survey, how the results were calculated, and interpretation of the results can be found in Appendix C. A facsimile of the survey is also included in the appendix. Questions beyond those directed at symptoms and functional impairments include those on demographics, whether or not a respondent had actually experienced the health state, health insurance coverage, and general attitude about health care in Oregon.

Detail on the community meetings can be found in Appendix F. How the community values applied to the ranked categorization is described on page 21.

Health-state values A telephone survey was done to collect numeric values from the public which would represent their feelings about impaired health states. The same symptoms and functional impairment modifiers were used in the survey that the health services providers selected to describe residual effects, death, and return to former state of health. Symptoms ranged from loss of consciousness due to seizure, fainting, or coma to wearing eyeglasses or contact lenses. Functional impairments consisted of six scenarios depicting mobility, physical activity and social activity. Survey respondents, numbering 1,001, scored the severity of symptoms and functional impairments on a scale of 0 (death) to 100 (perfect health). The lower the score, the more serious the problem. Weights for each of the symptoms and functional modifiers were computed for use in the benefits portion of the cost-benefit ratio (See Appendix D).

The survey instrument is a modification of Dr. Robert Kaplan's Quality of Well-Being (QWB) Scale. [2-5] With the help of Dr. Kaplan, the QWB Scale was modified to make it suitable for self-administration or telephone interviewing. He also concurred with adding five mental health and chemical dependency items to make the instrument appropriate for surveying all health states.

Results of the survey indicate that of the symptoms presented for evaluation, problems with drugs and alcohol, burns, trouble

learning and thinking, and depression were considered among the worst. Needing only to wear glasses or contact lens was considered the next thing to perfect health. Of the functional impairments, being in bed most of the day, or in a wheelchair not under an individual's control, were considered to be very bad situations.

Community values The community meetings generated 13 values related to health services. Net-benefit takes three of these values directly into account.

1) Quality of life: the QWB Scale measures health-related quality of life and compares health states with and without treatment. These are the symptoms and functional impairments reacted to in the telephone survey described above.
2) Ability to function: this value is incorporated in the symptom/functional impairments weights derived from the telephone survey.
3) Effectiveness of treatment: outcomes probabilities, including return to former state of health, both with and without treatment, are included in net-benefit.

Summary of Step 2

Health care providers contributed treatment outcomes with probability of occurrence. Outcomes consisted of:

With Treatment	Without Treatment
death	death
return to former health state	return to former health state
impaired health states	impaired health states

A telephone survey measured the public's reaction to death, good health and impaired health states. (Note that these are the same factors the health care providers used in providing outcomes data.) These quality of life measures (benefits) were converted to weights.

Net-benefit was derived by subtracting the numeric value of benefits without treatment from benefits with treatment.

STEP 3: COMMISSION JUDGMENTS

Interpretation of community values and professional judgments

A draft list of prioritized health services resulted from the ranked categorization of health services with net-benefit ranking within categories. The Commission used professional judgments and their interpretation of the community values to re-rank "out-of-position" items on the draft list.

The Commissioners used a "reasonableness" test when they adjusted the objectively ranked health services. The "reasonableness" standard was applied by evaluating the public health impact, cost of medical treatment, incidence of condition, effectiveness of treatment, social costs, and cost of non-treatment to determine a new ranking. The Commissioners also observed that it was not reasonable--logically or economically--to rank preventable or readily treatable conditions in relatively unfavorable positions. In other words, where severe or exacerbated conditions were ranked in a relatively favorable position compared to prevention of disease, disability or exacerbation, these occurrences were reversed.

A cost-benefit ratio was developed for use in prioritization. In the final analysis it was a factor when the Commissioners applied the "reasonableness" test -- as was cost by itself. However, the measure of net-benefit was second only to ranked categorization in terms of importance in the ranking of health services.

CHAPTER 3

MENTAL HEALTH AND CHEMICAL DEPENDENCY

Abstract *The Commission recommends an integrated list of health services to be used by the Legislature when allocating resources. Implementation is planned for the 1993-95 biennium although integrated preventive care is recommended to begin in 1992.*

Other recommendations are that the designation of mental health and chemical dependency representation on the Commission would be desirable and that the Legislature address the gap in MHCD coverage for the participants in the state-sponsored pools.

Further study is expected on methodological refinement, nicotine dependence, mental retardation, developmental disabilities, paraphilias and linked health care systems.

The full report of the Mental Health Care and Chemical Dependency (MHCD) Subcommittee can be found in Appendix H. It reports on the subcommittee's work preparatory to participating in and contributing to the prioritization methodology, basic health care and delivery system issues related to MHCD, and recommendations--including a prioritized list of health services with MHCD services.

BACKGROUND

The subcommittee did the following in pursuit of the goal of prioritizing MHCD services: collected research literature; received expert testimony; reviewed the outcomes data provided by invited MHCD specialists; reviewed testimony presented to the Commission; and, identified values related to both the prioritization process and the health care delivery system.

Many MHCD professionals, advocates, and consumers expressed the hope that this prospective planning process would be a positive step towards developing a comprehensive health care system which serves all Oregonians who have MHCD needs.

The subcommittee recognized that many MHCD professionals, consumers, and advocacy groups opposed the prioritization of MHCD services and their inclusion in a body with other health services. There was concern that the hard-won gains in mandated insurance coverage as well as recent improvements in the public mental health system would be lost. However, the subcommittee members believed it imperative that they participate in the process or risk having these services excluded from a basic health care package. The goal was to participate in developing a methodology giving equitable consideration to MHCD concerns.

RECOMMENDATIONS

This chapter focuses on the disposition of the subcommittee's recommendations to the Commission. The Commission

carefully considered all MHCD recommendations. Modifications were made to some, some required further study, and a few were not pertinent to legislative action and so will not be a part of the Commission's recommendations to the Legislature.

The Commission recommends to the Legislature:

- Integrating MHCD services into an overall prioritized list of health services for implementation in the 1993-95 biennium. This recommendation incorporates ancillary services, such as case management, necessary to the success of treatment. These services will be included within the Commission's definition of basic health care (see Chapter 7) to the extent of the services are ranked as part of essential and very important health services.
- Implementing provision of MHCD preventive services in 1992.
- Considering the inclusion of MHCD representation on the Commission.
- Addressing the gap in MHCD coverage for the participants in Small Business Insurance and Medically High-Risk Pools until such time as an integrated health services list is implemented.

The recommendation of integration is based on the following facts:

Implement MHCD preventive services in 1992.

1) The mind and body are inseparable and should be treated in an integrated manner. There is significant interaction between physical and mental function. Many medical/ surgical conditions have psychological symptoms or may appear to be MHCD conditions. Many MHCD conditions are at least partially caused by genetic or other biological factors.
2) MHCD services are effective for most MHCD conditions. These services improve functioning, quality of well-being, and extend the life of affected individuals.
3) Effective MHCD care contributes to decreased utilization of other health services. Lack of or improper treatment of MHCD conditions may create or exacerbate other health problems and may interfere with the treatment of those problems.

4) The costs of timely and effective treatment of MHCD conditions are less than the health care costs of delayed treatment and are much less than the combined social and health care costs when treatment does not occur.
5) MHCD conditions are associated with attitudes, such as stigma and denial, which can cause providers and consumers to avoid or delay appropriate treatment.

Designation of MHCD representation on the Commission is an effort to balance expertise. Representation on the Commission may expedite examination of the prioritization methodology and assessment of treatment effectiveness of MHCD conditions.

The Commission recognizes that the health care benefits of the Small Business Insurance Pool (SBIP), by law, must include "substantially similar medical services as those recommended by the Health Services Commission" [3-1] and be funded by the Legislature. However, the first list of services to be considered by the Legislature does not include MHCD services and the current MHCD mandates do not apply to SBIP. For that reason, the Commission recommends that the Legislature address the gap in MHCD coverage which will exist until such time as an integrated health services list can be implemented. The Commission also recommends that the same action be considered for the Medically High-Risk Pool.

The Commission has found the work of the subcommittee to be invaluable and will continue to prevail upon its membership to investigate issues pertinent to MHCD and contribute counsel. The Commission agrees that continuing work should include study:

- of the value of incorporating the effects of co-morbidity and indirect costs in the prioritization methodology; and,
- on the effectiveness of services for nicotine dependence, mental retardation, learning disabilities, profound developmental disabilities and paraphilias.

An integrated list of health services connotes the inseparability of mind and body and possibly requires linked health care delivery systems to effectively deliver services. The MHCD Subcommittee recommended that planning for linkages begin

immediately and defined values to inform and guide the process. The Commission does not disagree with the concept. However, further study is required of linked service delivery and the values listed below before making a recommendation. The subcommittee's delivery system values include:

1) Consumer-centered system. The delivery system must respond to cultural, ethnic, gender and other social factors. It must fit the consumers' needs for least restrictive treatment settings and least intrusive services rather than forcing consumers to accommodate the system's need for conformity and simplicity.
2) Access to services. The system must be designed to facilitate ease of referral and consultation among mental health, chemical dependency and other health delivery systems. Regardless of the consumers' point of entry into the health care system, patients and providers must have access to the benefits of referral, on site MHCD service delivery, and consultation from MHCD providers.
3) Early identification and early intervention. The assessment of all persons who seek health services should include attention to psychological and social factors. Early intervention includes case finding, outreach and prevention services.
4) Effective use of MHCD providers for assessment and treatment services. All persons seeking MHCD services deserve accurate and appropriate diagnostic evaluation and treatment services performed by providers whose expertise is supported by training, credentials, and experience suited to the task.

Mind and body are inseparable and should be treated in an integrated manner.

5) Clinically relevant care management and quality assurance. Care management criteria must be based primarily on clinical effectiveness rather than cost. Assessment measures of the outcomes of MHCD services need to be the same or comparable to those used to assess outcomes of other health services and should be relevant to the clinical and social factors involved in MHCD conditions.

PROCESS GAINS

In addition to the prioritization of MHCD services, the subcommittee found several other process gains it would like to share.

- Coalition building. Within the MHCD community, an alliance of providers, consumers and advocates was built. Although there is not a consensus on the methodology or the prioritization of services, there is a desire to create a better, comprehensive system which provides sufficient services to more people.
- Outcomes. This has been an historic attempt to systematically and thoroughly review outcomes data regarding MHCD services. There are limitations both in the methodology and data for MHCD outcomes research. Similar limitations are evident in outcomes research for other health services.
- Education. The process has informed others within the health care community and the Commission of the legitimacy and effectiveness of MHCD services. More parallels than divergences became evident in measuring outcomes of all health-related conditions.
- Prospective planning. The prioritization process has been a first step in prospective planning. It is an example of a revolution in health care planning occurring nationwide which may lead to a national health care system. This process brought attention to the need to include MHCD services in such a health care system.

CHAPTER 4

IMPLEMENTATION ISSUES

Abstract *Waivers of some Medicaid restrictions and regulations are necessary for program implementation. Waivers will be requested after the Legislature funds all or a portion of the prioritized list of health services.*

The Office of Medical Assistance Programs (OMAP) will contract with prepaid health plans and primary care case managers to provide care to those Oregonians who are eligible for the program.

Diagnostic services will be available to all program participants with a health-related complaint. Ancillary services integral to the success of covered treatments will be funded. Preventive care has been expanded and comfort care includes hospice. Quality assurance and program review will include utilization review, recipient feedback, peer review and monitoring of key indicators of quality.

Senate Bill (SB) 27 calls for a demonstration project testing the expansion of Oregon's Medicaid eligibility and prioritization of health services. This chapter addresses implementation issues of the Oregon Basic Health Services Program, of which SB 27 is the keystone. These issues include:

- Waiver of some federal regulations
- Delivery system development
- Eligibility and enrollment
- Diagnostic, ancillary, preventive, comfort care, and somatic services

The Oregon Basic Health Services Program will come to represent a basic health benefit package for all Oregonians.

Implementation of the program is scheduled for July of 1992. Mental health and chemical dependency (MHCD) services will not be included in the program until the 1993-95 biennium, if legislatively approved. (The exception is those preventive services cited in the Commission's definition of prevention included in Appendix J.) Planning and development have been underway since the summer of 1989. When fully implemented, the Senate Bill 27 demonstration program will provide health coverage to approximately 118,200 additional Oregonians through prepaid health plans and primary care case managers (see page 38). It is further intended that the Oregon Basic Health Services Program will come to represent a basic health benefit package to which all Oregonians will be entitled.

WAIVERS

Oregon will require waivers of statutory and regulatory requirements in the Medicaid program (Title XIX of the Social Security Act) in order to implement the SB 27 program. These federal waivers will permit Oregon to operate a demonstration program which differs in some respects from the traditional Medicaid program.

The Oregon Medicaid program currently includes both a traditional Medicaid program and an effective managed care program under waivers of requirements such as freedom of choice of provider (recipients in some areas are required to choose a managed care provider). Utilization, quality of care

and access to services by clients are monitored by the Office of Medical Assistance Programs (OMAP) to assure that recipients receive appropriate and effective services. Existing waivers and enhanced monitoring methods will be continued under the demonstration.

In addition to the current managed care waivers, Oregon will ask the Secretary of Health and Human Services to waive laws and regulations which limit the categories of eligibility for Medicaid and which require benefits to be delivered in the same way in all areas of the state. Other waivers will be needed to provide services to people with incomes below the federal poverty level who are not now financially eligible.

Oregon will also request a waiver of the sections of the Social Security Act and federal regulations which require the state to make the same services available to everyone who is eligible. The funded prioritized list of health services will be somewhat different from the standard Medicaid package. The amount, duration and scope of services will be different for people in the demonstration. The demonstration will not include those who are blind, disabled, age 65 or older, and children in foster care.

OMAP, in consultation with Lewin/ICF, has designed a service delivery system, eligibility management system and methods for monitoring and evaluating the results of the demonstration. A draft waiver application (developed by OMAP and Lewin/ICF) has been under preliminary review by the Health Care Financing Authority (HCFA) since April of 1990. Oregon will make its formal request for waivers when the benefit package and necessary administrative elements have been funded. Once the Oregon budget process is completed, the waiver application will be submitted. Because of the innovative nature of the demonstration, the application may be reviewed by HCFA for as long as six months.

When the final waiver application is submitted to HCFA following legislative action on the program, that document will contain a complete description of the Oregon Basic Health Services Program design. If the application, benefit package and funding allocation are acceptable to the HCFA review panel, the waivers may be granted as soon as January 1, 1992. This will permit implementation of the program by July 1, 1992.

DELIVERY SYSTEM

Senate Bill 27 requires that the State "execute prepaid managed care health services contracts for the health services funded...." [4-1] The bill stipulates, however, that "In the event that there is an insufficient number of qualified entities to provide for prepaid managed health services contracts in certain areas of the State, the division may institute a fee-for-service case management system...." [4-2] In addition, the State is permitted to provide stop-loss insurance and other risk management measures in order to "increase the interest of providers."

OMAP will contract with two types of managed care providers: prepaid health plans and primary care case managers. Prepaid health plans will include both full-service plans (such as health maintenance organizations--HMOs) and partial service plans (such as physician care organizations--PCOs). OMAP will build on the successful program already in place which has provided Medicaid services through one HMO and 15 PCOs for six years. This program currently covers approximately 60,000 Medicaid recipients in the Aid to Families with Dependent Children (AFDC) aid category, and will expand prior to implementation of the SB 27 program.

OMAP will contract with two types of managed care providers: prepaid health plans and primary care case managers.

OMAP staff anticipate that it will not be feasible to rely entirely on full-service health plans. While every effort will be made to contract for full-service plan participation, it is doubtful the combined available capacity of full-service health plans will be sufficient for enrolling all who apply. Partial-service plans will also be recruited and encouraged to make the transition to full-service plans as their enrollment levels grow to a suitable level. Risk-management measures will be available to buffer these developing full-service plans from effects of adverse selection.[4-3]

Managed care will be a program element even if enrollment into a prepaid health plan is not an option. The "fee-for-service case management system" mentioned in the legislation is planned as part of the delivery system. A Primary Care Case Manager (PCCM) program will associate a given recipient with the primary care provider chosen by the recipient. The PCCM will be responsible for providing primary care and arranging for

specialty and inpatient care. In addition, the PCCM will coordinate all care, maintain a central medical record, and participate in quality assurance and utilization review activities. In effect, the PCCM program will function as a State-operated Primary Care Network with physicians paid on a fee-for-service basis and risk assumed by the State.

New eligibles include single persons, childless couples, and families with children who are not currently eligible.

Payments to prepaid health plans (both full- and partial-service) will be based on cost, as is mandated by the legislation. Payments to fee-for-service providers (including PCCMs) will be based on the current Medicaid rates as adjusted for future contract years. PCCMs will also be paid a monthly fee for case management services associated with the demonstration. Prior authorization of some services will be an element of case management for both health plans and PCCMs.

OMAP has been discussing program participation with plans, hospitals, physicians, and other practitioners since late 1989. Discussions will intensify after the benefit package and per capita costs have been set by the Legislature in the summer of 1991. Assuming that HCFA grants the waivers necessary to implement the program in July of 1992, review of applications and contract negotiations will take place beginning in January of 1992. It is expected that flexibility will be required to develop sufficient capacity in the delivery system to accommodate the approximately 118,200 additional recipients.

ELIGIBILITY AND ENROLLMENT

The Oregon Basic Health Services Program will serve the following current categories of eligible persons: Aid to Families with Dependent Children (AFDC), including unemployed and two-parent households; General Assistance (GA); and, Poverty Level Medical (PLM)(pregnant women and young children). Pregnant women and children under age six will be eligible with family incomes up to 133% of the federal poverty level. New eligibles will include families with children which do not meet the current eligibility standards, single persons, and childless couples who are below the federal poverty level.

The demonstration will not include those who are blind, disabled, age 65 or older, and children in foster care. Recipients in these categories will continue to be covered in the traditional Medicaid program.

The eligibility determination process will be simplified under the SB 27 program. Eligibility will be guaranteed for the six months following the date of application based on verification of current income which meets necessary requirements. Assets will not be considered in determining eligibility and eligibility will be redetermined semi-annually.

Diagnostic services are not identified on the prioritized list.

Eligibility and enrollment will be handled by Adult and Family Services Division (AFSD) and Senior and Disabled Services Division (SDSD). The branch offices in each division will process applications and provide program orientations. There will also be AFSD workers available in the community at various locations and times for group presentations explaining the program and answering questions. These presentations will be offered on days and during hours that are convenient for the potential recipients. A mail-in application to the local AFSD or SDSD office will be available for persons who wish to apply, are knowledgeable about the program, and have no significant questions or concerns about the available choices.

DIAGNOSTIC SERVICES

Diagnostic services are not identified on the prioritized list. The Commission decided early on that all services necessary to making a complete diagnosis must be part of the benefit package for the list to have utility. Therefore, the SB 27 program will cover those services and tests required to identify, within reason, the patient's condition to be treated. Diagnostic services will be monitored by OMAP to ensure that only necessary services and tests are provided. Quality assurance and utilization monitoring will pay close attention to both ancillary and diagnostic services.

All services necessary for a complete diagnosis must be part of the benefit package for the list to have utility.

ANCILLARY SERVICES

Each health service identified in the Commission's prioritized list is presumed to include all ancillary services necessary to successful treatment. Ancillary services are defined as those services which: 1) do not generally have a specific CPT-4 [4-4] code; 2) do not appear as line items on the list; and 3) are, in general, covered by OMAP as a part of the traditional Medicaid

program. Services considered to be ancillary are listed in Appendix J. Examples of ancillary services are hospital services and prescription drugs.

The Commission acknowledges OMAP's long history and experience working with ancillary services and its administration of such services in an efficient manner that meets federal guidelines and requirements. The Commission has deferred to OMAP the prerogative of establishing restrictions on utilization of ancillary services.

A concern for Oregon's children is reflected in ranking preventive services for children near the top of the prioritized list.

PREVENTIVE SERVICES

A concern for Oregon's children is reflected in ranking preventive services for children near the top of the prioritized list. Those preventive services for adults which have proven effective are considered an important contribution to quality of life and rank higher than those with unproven effectiveness.

Interventions include screening, counseling, immunizations, pap smears, and chemoprophylactic regimens. Preventive services for adults, including dental, are additional benefits beyond the current Medicaid benefit package. The frequency and content of periodic examinations need to be tailored to the unique health risks of the individual. Therefore, the Commission is silent on periodicity leaving it to the discretion of the provider and standards of quality assurance. Preventive services can be delivered when patients visit the primary care provider for treatment of illness as well as during a visit devoted exclusively to prevention. See Appendix J for detail on preventive services.

The Commission would like to make a point of the fact that most effective interventions available for reducing incidence and severity of the leading causes of disease and disability are those addressing personal health practices. Prevention as it relates to such risk factors as smoking, physical inactivity, poor nutrition, and alcohol and other drug abuse hold greater promise than most routine screening. Exceptions are pap smears and mammography.

COMFORT CARE

Comfort care is a category of care that includes the provision of services or items that give comfort and/or pain relief to a terminally ill person whose death is imminent--regardless of diagnosis.

This category of care does not include services that are diagnostic, curative or focused on active treatment of the primary condition and intended to prolong life. Examples of comfort care include:

Provision of services that give comfort and/or pain relief to the terminally ill...

1. Pain medication and/or pain management devices;
2. In-home and day care services and hospice services as defined by OMAP in Ancillary Services (see Appendix J); and,
3. Medical equipment and supplies (beds, wheelchairs, bedside commodes, etc.).

Currently, Oregon's Medicaid system provides home health care and pain management but not hospice care. The Commission recommends that hospice care be included and considers comfort care to be essential to a basic benefit package.

SOMATIC SERVICES

Mental health and chemical dependency conditions often require somatic (physical medicine) services. These somatic services will be administered by OMAP under the SB 27 program, just as they are now. Somatic services include:

Practitioner

* Laboratory drug screens for drug and alcohol abuse when related to a medical service or for diagnostic purposes (but not mandatory drug screening);
* Physical consultations under CPT codes 90600 -90654 in any treatment setting for the purpose of determining whether the problem is physical or mental;
* In the emergency room, CPT codes 90500-90580 for emergency psychiatric services only;

* Medical monitoring or pharmacologic management under CPT 90862 and administration of injectable psychotropic drugs under CPT 90782;
* Office visits under CPT 90000-90080 for management of a medical problem but not for psychotherapy; and,
* Psychiatric/psychological services by Federally Qualified Health Centers under OMAP unique procedure code 9600M.

Drugs

* Prescription drugs directly associated with psychiatric disorders or chemical dependency; and,
* Prescription drugs associated with ancillary treatment of psychiatric disorders or chemical dependency.

Hospital Inpatient

* Emergency psychiatric services needed to evaluate according to the criteria for a psychiatric admission;
* Non-emergency psychiatric services when prior authorized by OMAP according to the criteria for a psychiatric admission;
* Acute care hospitalization for detoxification; and,
* Non-emergency chemical dependency services when prior authorized by OMAP according to the criteria for a chemical dependency admission.

Hospital Outpatient

* Medical treatment for psychiatric disorders or for medical problems related to or causative of psychiatric disorders;
* Medical services related to treatment of effects of drug and alcohol abuse.

Inpatient and Outpatient Services With a Psychotherapeutic Component

* Physical therapy, occupational therapy, medication, diagnostic testing are covered; but,
* Psychotherapeutic and biofeedback components of services in settings such as pain clinics and eating disorder programs are not covered.

QUALITY ASSURANCE, MONITORING AND PROGRAM REVIEW

A requirement of any federal demonstration project is an evaluation designed as part of the application for waivers and conducted by an external evaluation resource. A demonstration such as Oregon's also requires continuous, rigorous, internal monitoring of quality of care, review of utilization of services, and assurance of access to funded services. These requirements will be met by enhancements to the existing system of quality assurance and utilization review for both ambulatory and inpatient care.

The existing system uses tools such as clinical review of a random selection of medical records, recipient complaints and grievances and surveys of recipient satisfaction to ascertain clinical and recipient perspectives on quality of care and access to services. In addition, all managed care entities are required to conduct internal peer review and quality assurance activities which monitor key indicators of quality using accepted principles and practices in quality assurance. These activities are monitored by OMAP with the assistance of a Medical Quality Task Force which advises OMAP on criteria, methods and processes of quality assurance.

Utilization of services will be monitored through claims and encounter data. This will help to assure that recipients are able to obtain appropriate access to services which are provided as part of standard health services. Utilization review, morbidity and mortality studies and individual recipient advocacy will provide long-term as well as immediate safeguards against inappropriate under-utilization or over-utilization.

Reviews of the eligibility and enrollment practices throughout the system will continue to be conducted by OMAP. All quality assurance, monitoring and program review activities are performed under the scrutiny of the Oregon Health Care Cost Containment Advisory Committee, appointed by the governor to advise on issues of quality, access and cost in the managed care system.

CHAPTER 5

ACTUARIAL ANALYSIS

Abstract *Coopers & Lybrand developed a rate-setting methodology based on reasonable provider costs rather than on an equivalency to the current fee-for-service Medicaid payment rates. Pricing is based on condition/treatment pairs rather than broad categories of service.*

When the Legislature decides the extent to which it will fund the prioritized list of health services, a cost per person per month will be calculated for full-service and partial-service prepaid health plans, and for fee-for-service coverage.

Senate Bill (SB) 27 directs that the report of the Commission "shall be accompanied by a report of an independent actuary retained for the commission to determine rates necessary to cover the costs of the services." [5-1] This chapter summarizes the approach taken by Coopers & Lybrand as an independent actuary performing analysis on behalf of the Health Services Commission.

Coopers & Lybrand began working with the Commission in late 1989 and have developed the payment levels associated with the line items in the Commission's prioritized list. These payment levels will form the price basis for the Legislature's deliberations on establishing a level of health care coverage and allocating resources for the Oregon Basic Health Services Program budget. The Coopers & Lybrand report which explains analysis results is attached to this report as Appendix I.

ANALYSIS REQUIREMENTS

On October 5, 1989, Oregon's Department of Human Resources issued a Request for Proposals (RFP) to provide actuarial consultation to the Commission. This RFP identified two general actuarial services and several specific tasks necessary to support the Commission:

General Services

- Develop a rate-setting methodology, based on costs rather than on fee-for-service equivalency, for health care services to be specified by the Health Services Commission; and,
- Apply this methodology to relevant and available data in order to calculate appropriate rates of payment (with necessary adjustments for geographic location and other factors affecting costs) for providers participating in the program described in SB 27.

The list of health services shall be accompanied by a report of an independent actuary.

Specific Tasks

- Define the term "cost" so as to conform with the legislation's intent and to support the development of capitation rates for the services identified by the Commission;
- Advise the Commission on the specification of services to ensure that these specifications would be suitable for actuarially sound rate-setting;
- Identify options for a cost-based methodology for setting capitation rates;
- Develop (with review by the Actuary Advisory Committee) a methodology for calculating capitation rates which meets the needs of the Commission, the state Legislature, and OMAP in designing, funding, and implementing the program;
- Obtain necessary data on costs and utilization of services for the population to be covered;
- Identify appropriate utilization assumptions and cost factors to be used in calculating capitation rates;
- Calculate capitation rates for health services as defined and prioritized by the Commission;
- Prepare and present a report to the Governor and the Legislature;
- Refine and adjust the capitation rates as appropriate to reflect the benefit package established by the Legislature; and,
- Explain and defend the capitation rates and the report to the Health Care Financing Authority (HCFA) and to other actuaries as a part of formal peer review.

Coopers & Lybrand described an important characteristic of their work as follows:

> The needs of the Health Services Commission in prioritizing services require that a much finer distinction be used for defining services than is typically used for calculating capitation rates under commercial plans and under the current Medicaid prepaid plan program. [5-2]

A second important characteristic is that the SB 27 rate-setting approach must conform to the definition of a covered benefit package based on condition/treatment pairs rather than on broad categories of service. The approach must allow for adjustments reflecting the substitution of covered services (for a given condition) in place of services which are not covered.

Example:

Condition	Treatment	List Position
Epilepsy	a) medical therapy	159
	b) surgery	615

This characteristic is important because the point of prioritizing services is to identify the relative importance of various condition/treatment pairs and thereby to support public policy decisions about which services should be covered when resources are limited.

GENERAL APPROACH

Coopers & Lybrand (San Francisco office) was selected through a competitive bidding process. Shortly after, an Actuary Advisory Committee was established to include provider, government, legislative, and Commission perspectives in the ongoing review of the actuary's work. Coopers & Lybrand was encouraged to communicate with the Health Services Commission and its staff, and with Lewin/ICF, a consulting firm working with OMAP, to prepare the waiver application to HCFA and to plan for program implementation.

Capitation rates are based on a much finer definition of services than is used under commercial plans and the current Medicaid prepaid plan program.

Coopers & Lybrand developed a definition of "cost" for general groupings of services that might be included in the SB 27 covered benefits. The groupings were used by the actuary as a tool in moving from a "global" rate (total capitation payment for an all-inclusive package of services) to the adjusted rates for subsets of the all-inclusive benefit package. These sample benefit packages are made up of line items drawn in sequence from the Commission's prioritized list and will be examined by the Legislature as part of its funding deliberations.

Rate-setting is based on a package of condition/treatment pairs.

The broad range of services to be prioritized and the level of detail in the Commission's prioritized list made it imperative that the actuary work closely with the Commission on key issues. For example, Coopers & Lybrand consulted with the Commission about how to define service for purposes of prioritizing and rate-setting.

If the Legislature accepts the Commission's report, a basic level of health care coverage for Oregonians will be established based on available resources. This standard of health care will in turn determine a cost per person per month, as calculated by the actuary. This cost per person per month (including pre-paid health plans and fee-for-service payments) will serve two important functions:

1) OMAP will use it to develop the program budget.
2) It will be used to calculate the capitation payments for prepaid health plans.

CAPITATION AND RATE-SETTING

The actuary's work includes the development of capitation rates to be paid to prepaid health plans (both full-service and partial-service) for the funded benefit package. These rates may differ based on category of eligibility. These eligibility categories reflect the complexity of current Title XIX eligibility and include the following:

* Aid to Families with Dependent Children (AFDC), up to AFDC income standard[5-3]
* General Assistance (GA)[5-4]
* Poverty Level Medical (PLM), from 100% to 133% of Federal Poverty Level (FPL), pregnant women [5-5]
* PLM, from 100% to 133% of FPL, children [5-5]
* Demonstration-only eligibles who would be in the AFDC category if not for "too much" income
* Demonstration-only eligibles with no relationship to the AFDC category (e.g., single men and women under age 65, and childless couples)

Utilization Assumptions

The actuary developed utilization assumptions for the six population groups previously identified. Estimated utilization levels were developed for approximately 75 groupings of services (e.g., anesthesia, dental preventive, family planning, home health service, inpatient maternity, outpatient lab, physician office visits, prescription drugs, surgery, vision care). These utilization assumptions are based on claims history from three sources: Oregon Medicaid; Blue Shield of California (BSC); and Blue Cross/Blue Shield of Oregon (BCBSO). Oregon Medicaid data was used for populations covered under Medicaid (AFDC, GA, PLM). BSC data were used for commercial (non-Medicaid, non-Medicare) populations in order to make certain that claims history was available in suitable format for all services, including those provided very rarely. BSC data were adjusted using BCBSO data to reflect Oregon differences from California experience.

Anticipated changes in average duration of eligibility were also accounted for in estimating changes in utilization levels over time for certain categories of service.

Cost Factors

There will be two types of payments to providers under the program: capitation and fee-for-service. Different cost factors were used for the capitation estimates and the fee-for-service estimates.

Payment to providers should cover the cost of care but not beyond a reasonable level.

Capitation estimates were developed using data derived from several sources. Data sources included BSC average allowed charges which were adjusted to reflect Oregon average charge levels, and cost-to-charge ratios for each grouping of services. Cost-to-charge ratios were based on information reported in hospital cost reports, information on managed care contracting arrangements, Resource Based Relative Value Scale (RBRVS) values calculated for Oregon, and published data. [5-6]

A guiding principle in developing cost factors for estimating capitation rates was that payments to providers should cover the cost of care but not beyond a reasonable level. That is, capitation payments should be high enough to avoid the need

for cost-shifting and to encourage access to services, but not so high as to compromise funding resources for a public program. In order to achieve this goal, four adjustments were made to the available data:

1) High-end outliers were identified and removed from the average allowed charges;
2) California average allowed charges were adjusted to reflect Oregon average charge levels;
3) A cost-to-charge ratio was developed and applied for each major category of service, including an adjustment based on RBRVS factors developed by the federal Physician Payment Review Commission; and,
4) A managed care baseline was developed based on a survey of prepaid health plans to determine feasible levels of discounting on payments for primary care.

Fee-for-service estimates were developed using data from Oregon Medicaid claims history and OMAP budget projections.

Calculations

For capitation estimates, cost factors were trended forward to reflect the contract period of July 1, 1992 through June 30, 1993. Information from HCFA on changes in the "medical market basket" and the Medicare cost index was the basis for trending. In addition, administrative cost allowances were developed to reflect costs associated with participating in the demonstration. These allowances are 6% of the overall capitation rate for full-service health plans, and approximately 8% of the capitation rate for partial-service health plans. A managed care savings factor was also included in the calculation for prepaid health plans. Finally, demographic adjustments were made to reflect the characteristics of the eligible population which would affect utilization levels.

For fee-for-service estimates, Coopers & Lybrand used information on changes in fee levels allowed by the Legislature in past years and expected changes in fee levels for fiscal years 1992 and 1993. A managed care savings factor also was applied to the primary care case manager program. Primary care case

management is managed fee-for-service care without the financial incentives (or financial risks) involved in prepaid health plan risk-contracting.

CHAPTER 6

FURTHER STUDY

Abstract *This is a pioneering effort to measure the effectiveness of health services for the purpose of allocating resources. As with any other first effort, there are opportunities for further study and improvement.*

The Health Services Commission is mandated to report an updated prioritized list of health services to the legislature every two years. In this way, the list will be revised to account for new or refined information and the development of new treatments and therapies. It is also an opportunity to strengthen the methodology.

Time constraints did not allow research into the scope of all possible relevant factors. Nevertheless, the Commission considered the following issues and believes they require further study. The scope and relative significance of these issues are not known. They are listed in random order and divided between issues the Commission intends to study and those of more significance to others.

1. Ripple effects of communicable diseases Subverting the onset of contagious disease in one person affects more than just that one individual. The effect is currently measured for an individual only.

2. Ripple effects of fertility/birth control measures Neither the environmental effects nor the effects on the expectant family are measured.

3. Costs of health maintenance when a life is saved When return to a former state of health is achieved, health care resources are likely to be drawn upon to some extent until death occurs. These costs are not measured against the cost of death. They may prove to be less expensive when compared to overall costs.

4. Co-morbidity is the simultaneous presence of two or more health problems (e.g., a heart patient with diabetes). The presence of a diabetic problem complicates the probable effectiveness of treatment for the heart condition. This factor is not included in the methodology but is of utmost importance for further study.

5. Preventive services The effectiveness of preventive services must be measured. The Commission relied upon the work of the U.S. Preventive Services Task Force for a base of information on service effectiveness. The Task Force

assessed the effectiveness of 169 interventions. This work should be expanded upon particularly in the areas of well-child visits.

6. Total number benefitted by treatment The value "benefits many" is incorporated in the ranking of health service categories and the Commissioners' adjustments to the prioritized list. A more objective approach is to quantify the incidence of a given condition and determine all the costs to the community as well as the benefits with and without treatment.

7. Responsibility for condition No distinction is made between conditions resulting from the patient's voluntary behavior and those resulting from other causes.

8. Costs of non-treatment Two classes of costs of non-treatment should be distinguished: (a) health care costs that would be incurred if the preferred treatment or service is not given in a timely manner and (b) social costs (e.g., incarceration, unemployment due to disability, crime).

This is a pioneering effort to measure the effectiveness of health services for the purpose of allocating resources. As with any other first effort, there are opportunities for further study and improvement.

9. Definitive analyses of health-state values The public hearings, community meetings, and telephone survey were very successful; however, greater contribution by the poor and minorities would be desirable. Another consideration might be inclusion of children's perspectives.

10. Severity of illness Functional impairment is included in net-benefit; it is indirectly a measure of severity of illness. A more direct measure might be desirable.

11. Linked health care delivery systems An integrated list of health services may require linked delivery systems. The concept, impact and implications of this recommendation made by the Mental Health Care and Chemical Dependency Subcommittee must be studied.

12. Evaluation of data validity and prioritization methodology A panel of experts might be convened to validate existing outcomes data and examine the prioritization methodology. Solicitation could be made of the opinions of experts in health policy, ethics, economics, decision analysis, sociology and other areas of expertise.

13. Measurement of the effectiveness of prioritization Quality assurance review must be done to measure access, demographics of participants, change in health status, and program satisfaction.

14. Feasibility of including services in prioritization for the groups of Oregonians excluded in Senate Bill 27 Health services excluded from prioritization are those for the aged, blind and disabled, adults in official custody or residing in an institution, and services to children who are wards of the Children's Services Division. Services included in the list are appropriate to all age groups, as well as those with disabilities or in custody. Once the initial program has been implemented and fine-tuned, research should be done on the feasibility of gradually folding excluded health care services for the excluded groups of people into the prioritized list.

15. Effectiveness of services for nicotine dependence, mental retardation, learning disabilities, profound developmental disabilities and paraphilias The preceding conditions with an associated treatment are not on the prioritized list although other conditions coexisting or resulting from these conditions are ranked. Further study must be done to evaluate the services offered for each of the conditions.

16. Innovation in health care delivery for promotion of consumer responsibility and self-care It may be true that providers other than traditional health care professionals can provide more effective intervention in the realm of prevention and self-care. Strategies utilizing such approaches should be studied and perhaps incorporated into the health care system.

The items identified for further study refer to:

- issues relevant to the ongoing review process;
- omissions that can be addressed for methodological improvements;
- public health observations; and/or,
- aspects of implementation that can be prospectively studied.

The Commission is comprised of volunteers. This fact coupled with limited state funds will necessitate limiting further study to those items considered to be most relevant to the ongoing review process of the Health Services Commission. The volunteer nature of the Commission also suggests a distribution of workload by the formation of subcommittees to study particular topics. Volunteers outside of the Commission would be recruited but the subcommittees would be chaired by a Commissioner--as in the case of the Mental Health Care and Chemical Dependency Subcommittee.

CHAPTER 7

REFLECTIONS AND RECOMMENDATIONS

Abstract *The Health Services Commission recommends to the Legislature:*

1) *Adopting the prioritized list of health services included in this report;*
2) *Funding a benefit package which includes, at a minimum, all* services in categories considered essential and most of those considered very important;*
3) *Integrating mental health and chemical dependency services into a single prioritized list of health services for 1993-95 implementation;*
4) *Addressing the gap in mental health and chemical dependency coverage for the participants in the state-sponsored insurance pools until such time as the integrated health services list is implemented;*
5) *Enacting legislation which will allow the Commission to make technical revisions to the prioritized list other than those which may be included in the mandated biennial report;*
6) *Funding of the Commission at a level adequate to support further study described in Chapter 6;*
7) *Considering inclusion on the Commission of representation from the fields of mental health and chemical dependency;*
8) *Assuring access to affordable health insurance for all Oregonians which provides, at a minimum, a benefit package as defined in recommendation 2;*
9) *Continuing efforts to promote health care cost containment and development of practice guidelines; and,*
10) *Evaluating the impact on Oregon of implementation of the prioritized list of health services.*

The preceding pages have reported in some detail the process that the Commission developed and utilized to produce the list of the ranked health services. The Commissioners' recommendations are listed in the latter part of this chapter-- but at this stage the Commission would like to share its reflections on the last 18 months.

The individual Commissioners were sympathetic with the principal premise of Senate Bill (SB) 27. They believed that at a time of limited resources and increasing demands, it was rational for the state to identify the most important health services and to make those services available to a larger number of underserved residents. It was immediately apparent that no methodology existed to accomplish this task, but the Commission was determined to attempt a systematic and scientific approach to the establishment of a list.

It is not easy to find a word to describe the first few months of the Commission's work. Perhaps the best is "struggle." The struggle was not among Commissioners, but was apparent as each individual on the Commission recognized the scale of the task which appeared enormous. At the same time, they recognized that the limits of the bill's instruction (to provide a list) prevented them from responding to much of the public testimony which urged a wider overhaul of the health care system.

These struggles are well illustrated by the discussions held on the subject of basic health care. The Commission, supported by much public testimony, had no difficulty in strongly supporting the principle of making basic health services available to all, nor was there any difficulty in establishing a definition of basic health-care-- that level of services below which no one should fall. At a philosophical level, the basic health care issue was fairly straightforward; but, at a practical level, the Commission found it much more difficult to describe the content of that basic care given the format of the list and given the uncertainty of the State's ability to fund any particular level. The resolution was to urge coverage of all* services in categories considered essential and most services in those categories considered very important. The Commission recognized that a definition of basic health care along these lines establishes a working model of basic care from society's viewpoint, but will not cover every individual contingency.

The Commission recognized that a definition of basic health care along these lines establishes a working model of basic care from society's viewpoint, but will not cover every individual contingency.

At the beginning of this process, many critics objected that because there was no existing methodology with which to establish a list, the final product would be invalid, and these criticisms were somewhat unsettling as the Commission struggled to evolve its own methodology. Response to these criticisms, however, was found in the direction of the bill to seek community participation. This resulted in two effects.

The great ethical dilemma in balancing health care expectations against health care resources is captured in the prioritization process.

First, the Commission heard testimony at public hearings, that the underserved exist and are rapidly growing. Most of the public felt there was nothing inherently wrong (or unethical) in the state establishing a priority list though there were real concerns about how many services would be covered. The state, via the Commission, was urged to ensure that services considered to be basic would be covered.

Second, the Commission received values, as a direct consequence of the community meeting process, which assisted it in the ranking of categories described in Chapter 2. The ranking of the categories eventually proved to be the most fundamental step in the ordering of the list. It was at a relatively late stage in the process that the net-benefit and cost-benefit analyses were used to order services within the categories. Observers and reporters of the Commission's early work may be confused by this remark, as much energy and time was expended early in the process using many hours of volunteer time to gather data for the net-benefit and cost-benefit analyses. The Commission became increasingly aware that to rely on that data alone would be a mistake.

The attention that the process of prioritization has attracted is easy to understand because SB 27 has been seen as both innovative and controversial. The very great ethical dilemma faced by society in balancing health care expectations against health care resources is captured in this controversy. The Commission considered including a chapter on these ethical issues in this report; however, it was decided they have been and will be extensively discussed and analyzed in other, more appropriate arenas. Further discussion in this report would be redundant, and in this regard, the Commission hopes that the list will speak for itself.

It is inevitable that individual critics will focus on and will draw attention to line items which are seen as inappropriate placements, inclusions, or exclusions. The Commission is not troubled by this because it sees the first prioritized list of health services as a prototype to be refined and improved as the debate and process continue. The Commission hopes and believes that it has acted according to widely accepted ethical principles. It hopes that its product will be used ethically to improve access to those Oregonians currently denied much needed health care.

The Commission owes thanks to many individuals and organizations listed elsewhere is this report. But, it would like to express particular thanks to its critics for making it think and react, to its supporters for much needed ideas and encouragement, and, to its staff for extraordinary dedication to a daunting task.

The Commission extends particular thanks to its critics for making it think and react.

RECOMMENDATIONS

1) Adopting of the prioritized list of health services.

   The list is found in Appendix J and represents the relative value of services in terms of effectiveness and value to Oregonians. Services ranked in the top part of the list are those which are life-saving, maternity care and preventive services for children (mental health care and chemical dependency screening are included). These are closely followed by reproductive services, comfort care, preventive dental services and preventive care for adults.

2) Funding a benefit package which includes, at a minimum, all* of the services in categories considered essential and most of those services considered very important. Although this recommendation is beyond the Commission's mandate, it believes ethical considerations extend its responsibilities beyond simply building a ranked list of health services with no further comment.

   To attempt a definition of basic health care is a task that has confounded many experts and scholars and challenged the Commission as well. The Commission was reluctant to draw

a line on the list of health services which would define all those services above the line as basic and all those below the line as something other than basic. The difficulty is that what is basic to one person may not be basic to the next.

Therefore, the Commission defined basic health care in terms of society as a whole: Basic health care is a minimum below which no person should fall. Given this definition, the Commission went further to describe basic in terms of **essential** and **very important** categories of health services. All* of the "essential" services and most of the "very important" must be included in a basic health care package. These broadly defined services fall into the following categories of health services. See Appendix G for information about the third area of health services which comprise categories 14 through 17 named **valuable to certain individuals but significantly less likely to be cost-effective or to produce substantial long-term gain.**

Essential

1. Acute fatal, prevents death, full recovery
2. Maternity care
3. Acute fatal, prevents death without full recovery
4. Preventive care for children
5. Chronic fatal, improves life span and quality of well-being
6. Reproductive services (excluding maternity and infertility)
7. Comfort care
8. Preventive dental services
9. Preventive care for adults which has proven effectiveness

Basic health care is a minimum below which no person should fall.

Very Important

10. Acute nonfatal, return to previous health
11. Chronic nonfatal, one time treatment improves quality of well-being

12. Acute nonfatal, without return to previous health
13. Chronic nonfatal, repetitive treatment improves quality of well-being

The services in the above categories tend to rank in the order dictated by category ranking (i.e., services classified in category 1 are found listed beginning with number one on the prioritized list followed by services classified in category 2). However, the prioritization of services does not strictly conform to the ranking of their respective categories.

3) Integrating mental health and chemical dependency (MHCD) services with other health services on the prioritized list for 1993-95 implementation.

Testimony heard from the public, values cited in community meetings, and the seriousness Oregonians attach to MHCD conditions attest that MHCD services are requisite to necessary health care.

Beyond community support, scientific facts support an all-inclusive list of health services:

--- mind and body are inseparable;
--- there is significant interaction between physical and mental function;
--- many medical/surgical conditions have psychological symptoms or may appear to be MHCD conditions; and,
--- many MHCD conditions are at least partially caused by genetic or other biological factors.

4) Addressing the gap in MHCD coverage for the participants in the state sponsored insurance pools until such time as the integrated health services list is implemented.

The Small Business Insurance Pool (SBIP) health care benefits packages, by law, must include "substantially similar medical services as those recommended by the Health Services Commission" and funded by the Legislature. However, the first list of services to be considered by the Legislature does not include MHCD services. The Commission's work is not legislatively tied to the Medically High-

Risk Pool (MHRP). However, as a self-insured entity the MHRP is not covered by Oregon law which requires inclusion of MHCD services in health benefits packages. As a result adequate MHCD services may not be available to pool participants.

The prioritization of services does not strictly conform to the ranking of their respective categories.

5) Enacting legislation which will allow the Commission to make technical revisions to the prioritized list other than those which may be included in the mandated biennial report.

   The nature of the health care field is such that new information frequently becomes available. The Commission requests authority to adjust the prioritized list as new information becomes available and as corrections need to be made.

6) Funding the Commission at a level adequate to support necessary study described in Chapter 6.

   When the Commission's budget was originally drafted, there was no experience on which to base the cost of its work--or, indeed, the scope of work.

   The Commission is a small group of volunteers who must employ staff and utilize subcommittees and task forces utilizing expertise outside of the Commission proper. This work will require general support (e.g., printing, postage) and reimbursement of costs for subcommittee and task force members.

7) Considering representation from the MHCD disciplines or consumer groups for Commission membership.

   Examination of prioritization methodology and assessment of treatment effectiveness of MHCD conditions can best be done with balanced Commission expertise and representation. This should be considered when a Commission vacancy next occurs.

8) Assuring access for all Oregonians to affordable health insurance providing, at a minimum, a benefit package as defined in recommendation #2.

This recommendation has two points:

a) All Oregonians must have access to health care insurance whether the payor is public or private.

b) All public and private insurance must offer, at a minimum, a health benefits package which includes **all* essential and most very important health services.**

9) Continuing efforts to promote health care cost containment and development of practice guidelines.

Senate Bill 27 addresses cost containment in two ways: a) capitated managed care programs are to be used wherever possible and b) by virtue of prioritization, the least effective and least necessary health services are ranked at the bottom of the list. A low rank means those services are least likely to be funded.

The Commission believes these measures address cost-containment but many other measures may be as or more effective.

10) Evaluating the impact on Oregon of the implementation of the prioritized list of health services.

Prioritization is an innovative concept. The effects of public funding of prioritized health services must be tested. Evaluation must consist of the numbers and demographics of the people using packages of prioritized health benefits and the resultant change in health status. There are two points subsumed by this recommendation: 1) all Oregonians may be affected and 2) measurement of change can occur only if pre-prioritization health status is measured.

In conclusion, the Health Services Commission believes that the prioritized health care system is more fair than the existing system which denies health care to some persons on the basis of income, family status, age and gender.

However, the Commission would like to point out that health services alone do not ensure a healthy individual. Oregonians require good nutrition, decent housing, good education, clean environment, employment and supportive family and friends. These are requirements of a healthy and productive person in addition to basic health care.

The Commission sees prioritization as a first step towards providing just one of the components necessary for the health and well-being of Oregonians.

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*Not all services in categories deemed "essential" are ranked contiguously (i.e., not all line items classified as category 3, for example, will be grouped together). Due to Commission judgment, some line items were moved to "outlier" positions of greater or lesser importance than their category rank.

FOOTNOTES

P-1.... "Description of Findings: 1986 Health Insurance Coverage Survey," Committee for Counting the Medically Indigent, State Health Planning and Development Agency, December, 1986.

P-2.... Estimate developed by Oregon's Office of Medical Assistance Programs with Lewin/ICF, 1991.

P-3.... Oregon Revised Statutes (ORS) 414.036(4a)3.

1-1.... ORS 414.036 (4)1.

1-2.... Anne Beveridge, "International Health Care Systems: A Review of the National Health Care Campaign's Paper 'Paying More, Getting Less" Office of Health Policy, Department of Human Resources, State of Oregon, 1989.

1-3.... John Golenski and Stephen Blum, "Oregon Medicaid Priority-Setting Project," Conducted by Medical Research Foundation of Oregon, March 1989.

1-4.... Alaska Statutes (AS) 47.07.035.

1-5.... David West, "Campaigning for Health Care Reform," *Health/PAC Bulletin*, Summer 1990, pp. 12-15.

1-6.... K. Grumbach, "California Dreaming," *Health/PAC Bulletin*, Summer 1990, pp. 6-11.

1-7.... D.U. Himmelstein and S. Woolhandler, "Patchwork not Perestroika," *Health/PAC Bulletin*, Summer 1990, pp. 22-26.

1-8.... R. Restuccia, "The Universal Health Care Law in Action," *Health/PAC* Bulletin, Summer 1990, pp. 16-21.

1-9.... "An Introduction to State Health Insurance Program," Hawaii State Department of Health.

1-10... David Hadorn, "Health Care Effectiveness and Public Policy," November 23, 1988.

1-11... R.H. Brook, J.E. Ware, A. Davis-Avery, et. al., "Overview of Health Status Measures Fielded in Rand's Health Insurance Study," *Medical Care*, Vol. 17 (Supp.), pp. 1-131, 1979.

1-12... "Sickness Impact Profile," Department of Health Services, University of Washington, 1977.

1-13... Robert M. Kaplan and John P. Anderson, "A General Health Policy Model: Update and Applications," *HSR:Health Services Research* 23:2, June 1988.

1-14... Practice Management Information Corporation, *International Classification of Disease*, Ninth Revision, Third Edition, C.M., 1989.

1-15... American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition, Revised, Washington, D.C., 1987.

2-1... ORS 414.065 (4a)3.

2-2... Practice Management Information Corporation, op. cit.

2-3... American Psychiatric Association, op. cit.

2-4... American Medical Association, *Physicians' Current Procedural Terminology*, Fourth Edition, Chicago, Illinois.

2-5... Robert M. Kaplan and John P. Anderson, op. cit.

3-1.... ORS 291.371(1).

4-1.... ORS 414.036 (6)1.

4-2.... ORS 414.036 (6)4.

4-3... Adverse selection results when people needing more health care than average tend to choose a given health plan.

4-4.... American Medical Association, op. cit.

5-1.... ORS 414.036 (4a)3.

5-2.... Report to OMAP by Coopers & Lybrand, March 23, 1990.

5-3.... The AFDC program covers single parent families with children and two-parent families when the primary wage-earner is unemployed. Income limits are set at approximately 51% of the federal poverty level.

5-4... The GA program covers adults who do not qualify for any of the other programs and who are unable to work due to a medical disability for at least 60 days. The income limit for the GA program is set at 49% of the federal poverty level.

5-5... The PLM program covers pregnant women and children. Children are covered up to age 6 with the income limit set at 133% of the federal poverty level, and all children born after September 30, 1983 are covered with the income limit set at 100% of the federal poverty level. Pregnant women are covered with the come level set at 133% of the federal poverty level.

5-6... For Example: "Socioeconomic Characteristics of Medical Practice, 1989," American Medical Association Center for Health Policy Research.

OREGON HEALTH SERVICES COMMISSION

THE 1991 PRIORITIZATION OF HEALTH SERVICES

AN OVERVIEW

An increasing number of Oregonians are not receiving adequate health care.

Nearly one-fifth of the state's population -- up to 450,000 Oregonians -- have no health insurance. Another 230,000 are underinsured. The rising costs of health care and health insurance are pushing these numbers higher every year. Oregonians spent an estimated $6 billion dollars on health care in 1989, three times what they paid in state income taxes.

In 1989, the Oregon legislature passed a comprehensive program to address the problem. Composed of three inter-related laws, the Oregon Plan:

- expanded Medicaid to cover all Oregonians below the Federal Poverty Level, currently $928/month for a family of three
- mandated employment based coverage for full time workers and their dependents by 1994
- created an insurance pool for covering "high risk" Oregonians

The goal of the Oregon Plan is good health. The cornerstone of the Oregon Plan is a publicly defined, standard package of effective health care (Standard Benefit Package) offered to all Oregonians at an affordable price.

THE HEALTH SERVICES COMMISSION

Oregon acknowledges that all medical procedures are not equally valuable or effective. Therefore, in order to define an affordable, quality health care package, the state has to determine first which services are most beneficial. The Legislature created the Health Services Commission to rank all health care services according to their importance to the entire population. The Legislature will then use this prioritized list to determine the Standard Benefit Package.

The 11-member Commission began work in September, 1989. The five physicians, four consumers, public health nurse and social services worker undertook and completed a task which has never before been accomplished.

THE LIST

The commissioners produced a list of 709 items defined in condition/treatment pairs. They said a treatment's effectiveness is determined only when linked to a condition (diagnosis). They then assigned the pairs to 17 categories of care. After ordering the categories, Commissioners then ranked the pairs within the categories. Finally, they moved some specific pairs up or down the list, independent of their categories.[1]

Wanting to give the Legislature guidance in determining quality health care, Commissioners defined each category as:[2]

- "essential" (categories 1 - 9)
- "very important" (categories 10 - 13)
- "valuable to certain individuals" but significantly less likely to be cost-effective or to produce substantial long-term gain (categories 14 - 17)

"Essential" services include those which preserve life, maternity care, preventive care for children and adults, reproductive services, comfort care for the terminally ill. They are effective, contribute to quality of life, give good value for the dollar, and demonstrate community compassion for those who are terminally ill. They are responsive to what Oregonians said they valued most.

"Very important" services include treatment for non-fatal conditions where there is full or partial recovery and treatment which will improve quality of life.

Services which may be "valuable to certain individuals..." includes those for non-fatal conditions where treatment merely speeds recovery, infertility services, and those where treatment provides for little improvement in quality of life.

RECOMMENDATIONS

The Commission makes ten recommendations to the legislature.[3]

First, it recommends the Legislature use the prioritized list as the basis for determining the Standard Benefit Package.

It further recommends that generally, those services within the "essential" and most of the "very important" categories be included in the Standard Benefit Package.

And it recommends that mental health and chemical dependency services be integrated into the list by 1993. The Commission recognizes the inseparability of mind and body; the interaction between physical and mental functions. Oregonians said they consider these services an important need.

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[1] See attached - "The Prioritization Process"

[2] See attached - "Categories & Services"

[3] See attached "Recommendations to the Legislature"

HIGHLIGHTS

Commissioners say every person is entitled to a diagnosis as part of the Standard Benefit Package. Once that diagnosis is made, then coverage for a person's treatment is determined by its position on the list.

Necessary ancillary services, such as hospital services, prescription drugs and medical equipment and supplies, are part of each treatment.

Preventive care is ranked high on the list, especially for children.

Comfort care ranks high and includes medications and services to reduce pain, home health and hospice care for the terminally ill.

METHODOLOGY

Commissioners used a combination of scientific data and social values to develop their methodology and rank the 709 condition/treatment pairs. They used a number of tools to do this.

- research and expert testimony on the effectiveness of treatments
- a formula that considered cost and benefit of each treatment
- public values gleaned from 47 community meetings, 12 public hearings, and a 1001-person telephone survey
- categories that grouped services to reflect the Commissioners' sense of what was most important to Oregonians
- independent Commissioner judgment

Using the same methodology, a Commission subcommittee ranked mental health and chemical dependency services independently of physical medicine. The subcommittee then recommended integrating mental health/chemical dependency services into the prioritized list for implementation in 1993-95.

PRICING THE LIST

Coopers and Lybrand, as independent actuaries, determined the costs of providing the services to the Medicaid population under the Oregon Plan. They've given estimates on how much it will cost to provide 11 possible benefit packages, depending on how much of the list is included. The final estimate is for covering the entire list.[4]

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[4] See attached - "Estimated Costs to Cover Expanded Medicaid Population"
also see complete Coopers & Lybrand reports contained in Prioritization of Health Services, the complete report of the Health Services Commission

OREGON HEALTH SERVICES COMMISSION

THE PRIORITIZED LIST

CATEGORIES AND HEALTH CARE SERVICES

The Commission ranked 709 condition/treatment pairs under 17 categories of care. The condition/treatment pairs in "Category 1" generally will precede those in "Category 2" and so on down the list, although Commissioners did move some pairs up or down the list independent of their categories.

Commissioners then made recommendations to the Legislature of what general categories should be covered in its Standard Benefit Package. Generally, services in Categories 1-9 are considered "essential" and should be covered. Services in Categories 10-13 are considered "very important" and should be funded to the extent possible. Services in Categories 14-17 are considered "valuable to certain individuals but significantly less likely to be cost-effective or to produce long-term gain."

Every person is entitled to services necessary for a diagnosis.

(Following are the categories and some examples of services in each category)

ESSENTIAL

1. **Acute Fatal, treatment prevents death and allows full recovery:** appendectomy for appendicitis; non-surgical treatment for whooping cough; repair of deep, open wound in neck; non-surgical treatment for infection of the heart muscle (myocarditis)

2. **Maternity Care, including most newborn disorders:** obstetrical care for pregnancy; care of the newborn

3. **Acute Fatal, treatment prevents death but does not allow full recovery:** non-surgical treatment for stroke; all treatment for burns; treatment for severe head injuries

4. **Preventive Care for Children:** immunizations and well-child exams

5. **Chronic Fatal, treatment improves life span and quality of life:** non-surgical treatment for insulin dependent diabetes; medical and surgical treatment for treatable cancer of the uterus; medical treatment for asthma; drug therapy for HIV disease

6. **Reproductive Services, excludes maternity and infertility services:** birth control and sterilization

7. **Comfort Care:** pain management and hospice care for the end stages of diseases such as cancer and AIDS

OREGON HEALTH SERVICES COMMISSION

RECOMMENDATIONS TO THE LEGISLATURE

- Adopt this prioritized list of health services
- Fund a benefit package to include at least:
  - "essential" services
  - most "very important" services
- Integrate prioritized mental health and chemical dependency services in 1993-95
- Address the current gap in mental health/chemical dependency coverage for state-sponsored insurance pools
- Enact legislation allowing the Commission to technically revise the list more often than the mandated biennial review
- Fund further study and improvement to support prioritization process
- Consider including representation on the Commission from the mental health and chemical dependency fields
- Make an affordable Standard Benefit Package available to all Oregonians
- Continue to promote and develop health care cost containment and set practice guidelines for medical care
- Evaluate the impact on Oregonians of implementing the prioritized list of health services

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WG:JJ-11
4/28/91

APPENDIX A

OREGON BASIC HEALTH CARE ACT

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1) Senate Bill 27 (Chapter 835 Oregon Session Laws 1989)

2) Senate Bill 935 (Chapter 381 Oregon Session Laws 1989)

3) Senate Bill 534 (Chapter 838 Oregon Session Laws 1989)

F-Engrossed
Senate Bill 27

Ordered by the House June 13
Including Senate Amendments dated February 16, March 23, March 31
and April 5 and House Amendments dated May 9 and June 13

Sponsored by Senators KITZHABER, BRADBURY, BRENNEMAN, BUNN, CEASE, COHEN, DUKES, GRENSKY, HAMBY, HANNON, HOUCK, L. HILL, KINTIGH, OTTO, PHILLIPS, ROBERTS, SHOEMAKER, THORNE, TIMMS, TROW, Representatives CEASE, GERSHON, KATZ, KEISLING, KOTULSKI, PETERSON, VAN VLIET, Representative GILMOUR

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure.

Establishes program to provide health care to all persons under certain income levels through capitation system. Specifies that such program is contingent on obtaining necessary waivers and authorization for appropriation for second year of biennium.

Establishes Health Services Commission. Prescribes membership, terms and duties. Requires commission to establish Subcommittee on Mental Health Care **and Chemical Dependency**. Prescribes membership and duties. Requires Adult and Family Services Division to contract for prepaid managed care health services beginning July 1, 1990. Requires commission to prioritize services. Excludes certain services and medical assistance from priority setting. Requires commission to make initial [*recommendations*] **report** no later than March 1, 1990. Provides for reducing in order of priority covered benefits for entire covered population if revenues decline.

Appropriates moneys from General Fund to Emergency Board for fiscal year beginning July 1, 1990, for expenses of Act if federal waivers are obtained.

[*Appropriates moneys from General Fund to Executive Department for biennial expenses of commission.*]

Appropriates moneys from General Fund to Director of Department of Human Resources for administrative expenses of commission. Limits biennial expenditures from federal funds collected or received by director of department for administrative expenses of commission.

Limits biennial expenditures from fees, moneys or other revenues, including Miscellaneous Receipts, excluding federal funds, collected or received by Executive Department for administrative expenses of commission.

Appropriates moneys from General Fund to Adult and Family Services Division for biennial administrative expenses of Act. **Limits biennial expenditures from federal funds collected or received by division for administrative expenses of Act.**

Declares emergency, effective July 1, 1989.

A BILL FOR AN ACT

Relating to health services; creating new provisions; amending ORS 414.025, 414.036, 414.042 and 414.065; appropriating money; limiting expenditures; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. ORS 414.036 is amended to read:

414.036. (1) The Legislative Assembly finds that:

(a) Hundreds of thousands of Oregonians have no health insurance or other coverage and lack the income and resources needed to obtain health care;

(b) The number of [*medically needy*] persons **without access to health services** increases dramatically during periods of high unemployment;

(c) Without health coverage, [*the medically needy*] **persons who** lack access to health [*care and*] **services may** receive treatment, [*if at all,*] **but** through costly, inefficient, acute care; [*and*]

(d) The unpaid cost of health [*care*] **services** for [*the medically needy*] **such persons** is shifted

NOTE: Matter in **bold face** in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted.

to paying patients, driving up the cost of hospitalization and health insurance for all Oregonians; **and** [.]

(e) The state's medical assistance program is increasingly unable to fund the health care needs of low-income citizens.

(2) In order to provide access to health [*care*] **services** for those [*most*] in need, to contain rising health [*care*] **services** costs through appropriate incentives to providers, payers and consumers, **to reduce or eliminate cost shifting** and to promote the stability of the health [*care*] **services** delivery system and the health and well-being of all Oregonians, it is the policy of the State of Oregon to provide medical assistance to those in need [*and eligible*] **whose family income is below the federal poverty level and who are eligible** for [*benefits*] **services** under the [*program*] **programs** authorized by this chapter.

SECTION 2. As used in this Act, "health services" means at least so much of each of the following as are approved and funded by the Legislative Assembly:

(1) Provider services and supplies;

(2) Outpatient services;

(3) Inpatient hospital services; and

(4) Health promotion and disease prevention services.

SECTION 3. The following services are available to persons eligible for services under this Act but such services are not subject to subsection (1) of section 4a of this Act:

(1) Nursing facilities and home- and community-based waivered services funded through the Senior Services Division;

(2) Medical assistance for the aged, the blind and the disabled or medical care provided to children under ORS 418.001 to 418.034 and 418.187 to 418.970;

(3) Institutional, home- and community-based waivered services or Community Mental Health Program care for the mentally retarded or developmentally disabled, for the chronically mentally ill or emotionally disturbed and for the treatment of alcohol- and drug-dependent persons; and

(4) Services to children who are wards of the Children's Services Division by order of the juvenile court and services to children and families for health care or mental health care through the division.

SECTION 4. (1) The Health Services Commission is established, consisting of 11 members appointed by the Governor and confirmed by the Senate. Five members shall be physicians licensed to practice medicine in this state who have clinical expertise in the general areas of obstetrics, perinatal, pediatrics, adult medicine, geriatrics or public health. One of the physicians shall be a Doctor of Osteopathy. Other members shall include a public health nurse, a social services worker and four consumers of health care. In making the appointments, the Governor shall consult with professional and other interested organizations.

(2) Members of the Health Services Commission shall serve for a term of four years, at the pleasure of the Governor.

(3) Members shall receive no compensation for their services, but subject to any applicable state law, shall be allowed actual and necessary travel expenses incurred in the performance of their duties.

(4) The commission may establish such subcommittees of its members and other medical, economic or health services advisers as it determines to be necessary to assist the commission in the performance of its duties.

SECTION 4a. (1) The Health Services Commission shall consult with the Joint Legislative Committee on Health Care and conduct public hearings prior to making the report described in subsection (3) of this section. The commission shall solicit testimony and information from advocates for seniors; handicapped persons; mental health services consumers; low-income Oregonians; and providers of health care, including but not limited to physicians licensed to practice medicine, dentists, oral surgeons, chiropractors, naturopaths, hospitals, clinics, pharmacists, nurses and allied health professionals.

(2) In conjunction with the Joint Legislative Committee on Health Care, the commission shall actively solicit public involvement in a community meeting process to build a consensus on the values to be used to guide health resource allocation decisions.

(3) The commission shall report to the Governor a list of health services ranked by priority, from the most important to the least important, representing the comparative benefits of each service to the entire population to be served. The recommendation shall be accompanied by a report of an independent actuary retained for the commission to determine rates necessary to cover the costs of the services.

(4) The commission shall make its report by July 1 of the year preceding each regular session of the Legislative Assembly and shall submit a copy of its report to the Joint Legislative Committee on Health Care.

(5) The Joint Legislative Committee on Health Care shall determine whether or not to recommend funding of the Health Services Commission's report to the Legislative Assembly and shall advise the Governor of its recommendations. After considering the recommendations of the Joint Legislative Committee on Health Care, the Legislative Assembly shall fund the report to the extent that funds are available to do so.

SECTION 5. For the purpose of this Act, and for the 1989-1991 biennium only:

(1) The Health Services Commission shall make its report to the Governor and to the Joint Legislative Committee on Health Care no later than March 1, 1990.

(2) The committee shall make its recommendations to the Emergency Board.

(3) After consideration of the recommendations of the committee, the Emergency Board shall fund the report to the extent that funds are available to do so.

(4) The Joint Legislative Committee on Health Care and the Emergency Board are not authorized to alter the report of the Health Services Commission.

SECTION 6. Upon meeting the requirements of section 9 of this Act:

(1) Pursuant to rules adopted by the Adult and Family Services Division, the division shall execute prepaid managed care health services contracts for the health services funded pursuant to section 9 of this Act. The contract must require that all services are provided to the extent and scope of the Health Services Commission's report for each service provided under the contract. Such contracts are not subject to ORS 279.011 to 279.063. It is the intent of this Act that the state move toward utilizing full service managed care health service providers for providing health services under this Act. The division shall solicit qualified providers or plans to be reimbursed at rates which cover the costs of providing the covered services. Such contracts may be with hospitals and medical organizations, health maintenance organizations, managed health care plans and any other qualified public or private entities. The division shall not discriminate against any contractors which offer services within their providers' lawful scopes of practice.

(2) The initial contract period shall begin on or after July 1, 1990.

(3) Except for special circumstances recognized in rules of the division, all subsequent contracts shall be for one-year periods starting on July 1, 1991.

(4) In the event that there is an insufficient number of qualified entities to provide for prepaid managed health services contracts in certain areas of the state, the division may institute a fee-for-service case management system where possible or may continue a fee-for-service payment system for those areas that pay for the same services provided under the health services contracts for persons eligible for health services under this Act. In addition, the division may make other special arrangements as necessary to increase the interest of providers in participation in the state's managed care system, including but not limited to the provision of stop-loss insurance for providers wishing to limit the amount of risk they wish to underwrite.

(5) As provided in subsections (1) and (4) of this section, the aggregate expenditures by the Adult and Family Services Division for health services provided pursuant to this Act shall not exceed the total dollars appropriated for health services under this Act.

(6) Actions taken by providers, potential providers, contractors and bidders in specific accordance with this Act in forming consortiums or in otherwise entering into contracts to provide health care services shall be performed pursuant to state supervision and shall be considered to be conducted at the direction of this state, shall be considered to be lawful trade practices and shall not be considered to be the transaction of insurance for purposes of the Insurance Code.

(7) Health care providers contracting to provide services under this Act shall advise a patient of any service, treatment or test that is medically necessary but not covered under the contract if an ordinarily careful practitioner in the same or similar community would do so under the same or similar circumstances.

SECTION 7. The commission shall establish a Subcommittee on Mental Health Care and Chemical Dependency to assist the commission in determining priorities for mental health care and chemical dependency that shall be reported to the Sixty-sixth Legislative Assembly. The subcommittee shall include mental health and chemical dependency professionals who provide inpatient and outpatient mental health and chemical dependency care.

SECTION 8. (1) If insufficient resources are available during a contract period:

(a) The population of eligible persons determined by law shall not be reduced.

(b) The reimbursement rate for providers and plans established under the contractual agreement shall not be reduced.

(2) In the circumstances described in subsection (1) of this section, reimbursement shall be adjusted by reducing the health services for the eligible population by eliminating services in the order of priority recommended by the Health Services Commission, starting with the least important and progressing toward the most important.

(3) The division shall obtain the approval of the Legislative Assembly or Emergency Board, if the Legislative Assembly is not in session, before instituting the reductions. In addition, providers contracting to provide health services under this Act must be notified at least two weeks prior to any legislative consideration of such reductions. Any reductions made under this section shall take effect no sooner than 60 days following final legislative action approving the reductions.

SECTION 9. The prerequisites for implementation of this Act are:

(1) The Adult and Family Services Division shall obtain the necessary agreement from the Federal Government; and

(2) The Emergency Board must vote affirmatively to authorize the release of the appropriation

for the second year of the 1989-1991 biennium.

SECTION 10. Any health care provider or plan contracting to provide services to the eligible population under this Act shall not be subject to criminal prosecution, civil liability or professional disciplinary action for failing to provide a service which the Legislative Assembly has not funded or has eliminated from its funding pursuant to section 8 of this Act.

SECTION 11. Notwithstanding the term of office specified by section 4 of this Act, of the members first appointed to the commission:

(1) Two shall serve for terms ending July 1, 1990.

(2) Three shall serve for terms ending July 1, 1991.

(3) Three shall serve for terms ending July 1, 1992.

(4) Three shall serve for terms ending July 1, 1993.

SECTION 12. (1) In addition to and not in lieu of any other appropriation, there is appropriated to the Emergency Board for the fiscal year beginning July 1, 1990, out of the General Fund, the sum of $62,182,348, which may be expended for purposes of this Act if the agreement described in section 9 of this Act is given. The Emergency Board shall authorize expenditures of any or all of the amount appropriated by this section upon recommendation of the Joint Legislative Committee on Health Care.

(2) The amount of the appropriation in subsection (1) of this section is in lieu of the same amount in the appropriation of the Adult and Family Services Division for medical assistance in the second year of the biennium ending June 30, 1991.

(3) If all of the moneys referred to in subsection (1) of this section are not allocated by the Emergency Board prior to July 1, 1990, such moneys on that date become available for purposes of ORS 414.025 to 414.325 and 414.610 to 414.670.

(4) Nothing in this section prohibits the Emergency Board from authorizing expenditures of amounts greater than appropriations under this section for the purpose of this Act.

SECTION 13. In addition to and not in lieu of any other appropriation, there is appropriated to the Adult and Family Services Division, out of the General Fund, for the biennium beginning July 1, 1989, the sum of $523,567 for purposes of meeting the administrative expenses incurred by the division under this Act.

SECTION 14. In addition to and not in lieu of any other appropriation, there is appropriated to the Office of the Director of the Department of Human Resources, out of the General Fund, for the biennium beginning July 1, 1989, the sum of $173,780 for purposes of contracting with the Executive Department for administrative expenses of the Health Services Commission.

SECTION 15. Notwithstanding any other law, the amount of $347,560 is established for the biennium beginning July 1, 1989, as the maximum limit for the payment of expenses from fees, moneys or other revenues, including Miscellaneous Receipts, excluding federal funds, collected or received by the Executive Department for purposes of meeting the administrative expenses of the Health Services Commission.

SECTION 16. Notwithstanding any other law, the amount of $698,299 is established for the biennium beginning July 1, 1989, as the maximum limit for the payment of expenses from federal funds collected or received by the Adult and Family Services Division for the purposes of meeting the administrative expenses incurred by the division under this Act.

SECTION 17. Notwithstanding any other law, the amount of $173,780 is established for the biennium beginning July 1, 1989, as the maximum limit for the payment of expenses from federal

funds collected or received by the Office of the Director of the Department of Human Resources, for purposes of contracting with the Executive Department for administrative expenses of the Health Services Commission.

SECTION 18. Nothing in this Act is intended to limit the authority of the Legislative Assembly to authorize services for persons whose income exceeds 100 percent of the federal poverty level for whom federal medical assistance matching funds are available if state funds are available therefor.

SECTION 19. ORS 414.025 is amended to read:

414.025. As used in this chapter, unless the context or a specially applicable statutory definition requires otherwise:

(1) "Category of aid" means old-age assistance, aid to the blind, aid to the disabled, aid to dependent children or Supplemental Security Income payment of the Federal Government.

(2) "Categorically needy" means, insofar as funds are available for the category, a person who is a resident of this state and who:

(a) Is receiving a category of aid.

(b) Would be eligible for, but is not receiving a category of aid.

(c) Is in a medical facility and, if the person left such facility, would be eligible for a category of aid.

(d) Is under the age of 21 years and would be a dependent child under the program for aid to dependent children except for age and regular attendance in school or in a course of vocational or technical training.

(e) Is a caretaker relative named in ORS 418.035 (1)(c) who cares for a dependent child who would be a dependent child under the program for aid to dependent children except for age and regular attendance in school or in a course of vocational or technical training; or is the spouse of such caretaker relative and fulfills the requirements of ORS 418.035 (2).

(f) Is under the age of 21 years, is in a foster family home or licensed child-caring agency or institution under a purchase of care agreement and is one for whom a public agency of this state is assuming financial responsibility, in whole or in part.

(g) Is a spouse of an individual receiving a category of aid and who is living with the recipient of a category of aid, whose needs and income are taken into account in determining the cash needs of the recipient of a category of aid, and who is determined by the Adult and Family Services Division to be essential to the well-being of the recipient of a category of aid.

(h) Is a caretaker relative named in ORS 418.035 (1)(c) who cares for a dependent child receiving aid to dependent children, or a child who would be eligible to receive aid to dependent children except for duration of residence requirement; or is the spouse of such caretaker relative and fulfills the requirements of ORS 418.035 (2).

(i) Is under the age of 21 years, is in a youth care center and is one for whom a public agency of this state is assuming financial responsibility, in whole or in part.

(j) Is under the age of 21 years and is in an intermediate care facility which includes institutions for the mentally retarded; or is under the age of 22 years and is in a psychiatric hospital.

(k) Is under the age of 21 years and is in an independent living situation with all or part of the maintenance cost paid by Children's Services Division.

(L) Is a member of a family which received aid to dependent children in at least three of the six months immediately preceding the month in which such family became ineligible for such assistance because of increased hours of or increased income from employment. As long as the member

of the family is employed, such families will continue to be eligible for medical assistance for a period of four calendar months beginning with the month in which such family became ineligible for assistance because of increased hours of employment or increased earnings.

(m) Was receiving Title XIX benefits in the month of December 1973, and for that reason met all conditions of eligibility including financial eligibility for aid to the disabled or blind by criteria for blindness or disability and financial criteria established by the State of Oregon in effect on or before December 1973, had been determined to meet, and for subsequent months met all eligibility requirements.

(n) Is an essential spouse of an individual described in paragraph (m) of this subsection.

(o) Is an adopted person under 21 years of age for whom a public agency is assuming financial responsibility in whole or in part.

(p) Is an individual or is a member of a group who is required by federal law to be included in the state's medical assistance program in order for that program to qualify for federal funds.

(q) Is an individual or member of a group who, subject to the rules of the division and within available funds, may optionally be included in the state's medical assistance program under federal law and regulations concerning the availability of federal funds for the expenses of that individual or group.

(r) Is a pregnant woman who would be eligible for aid to families with dependent children including such aid based on the unemployment of a parent, whether or not the woman is eligible for cash assistance.

(s) Would be eligible for aid to families with dependent children pursuant to 42 U.S.C. 607 based upon the unemployment of a parent, whether or not the state provides cash assistance.

(t) Except as otherwise provided in this section and to the extent of available funds, is a pregnant woman or child for whom federal financial participation is available under Title XIX of the federal Social Security Act.

(u) Is not otherwise categorically needy and is not eligible for care under Title XVIII of the federal Social Security Act, but whose family income is less than the federal poverty level.

(3) "Essential spouse" means the husband or wife of a recipient of a category of aid who is needy, is living with the recipient and provides a service that otherwise would have to be provided by some other means.

(4) "Income" means income as defined in ORS 413.005 (3).

(5) "Medical assistance" means so much of the following medical and remedial care and services as may be prescribed by the Adult and Family Services Division according to the standards established pursuant to ORS 414.065, including payments made for services provided under an insurance or other contractual arrangement and money paid directly to the recipient for the purchase of medical care:

(a) Inpatient hospital services, other than services in an institution for mental diseases;

(b) Outpatient hospital services;

(c) Other laboratory and X-ray services;

(d) Skilled nursing facility services, other than services in an institution for mental diseases;

(e) Physicians' services, whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere;

(f) Medical care, or any other type of remedial care recognized under state law, furnished by

licensed practitioners within the scope of their practice as defined by state law;

(g) Home health care services;

(h) Private duty nursing services;

(i) Clinic services;

(j) Dental services;

(k) Physical therapy and related services;

(L) Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(m) Other diagnostic, screening, preventive and rehabilitative services;

(n) Inpatient hospital services, skilled nursing facility services and intermediate care facility services for individuals 65 years of age or over in an institution for mental diseases;

(o) Any other medical care, and any other type of remedial care recognized under state law;

(p) Periodic screening and diagnosis of individuals under the age of 21 years to ascertain their physical or mental defects, and such health care, treatment and other measures to correct or ameliorate defects and chronic conditions discovered thereby; and

(q) Inpatient hospital services for individuals under 22 years of age in an institution for mental diseases.

(6) "Medical assistance" includes any care or services for any individual who is a patient in a medical institution or any care or services for any individual who has attained 65 years of age or is under 22 years of age, and who is a patient in a private or public institution for mental diseases. **"Medical assistance" includes "health services" as defined in section 2 of this 1989 Act.** "Medical assistance" does not include care or services for an inmate in a nonmedical public institution.

(7) "Medically needy" means a person who is a resident of this state and who is considered eligible under federal law for medically needy assistance.

(8) "Resources" means resources as defined in ORS 413.005 (4).

SECTION 20. ORS 414.042 is amended to read:

414.042. (1) The need for and the amount of medical assistance to be made available **for each eligible group of recipients of medical assistance** shall be determined, in accordance with the rules of the Adult and Family Services Division, taking into account:

(a) The requirements and needs of the person, the spouse and other dependents;

(b) The income, resources and maintenance available to the person;

(c) The responsibility of the spouse, and, with respect to a person who is blind, or is permanently and totally disabled, or is under the age of 21 years, the responsibility of the parents; [*and*]

(d) The conditions existing in each case; **and** [.]

(e) Except for eligible groups of aged, blind and disabled, or children under ORS 418.001 to 418.034 and 418.187 to 418.970, the report of the Health Services Commission as funded by the Legislative Assembly.

(2) Such amounts of income and resources may be disregarded as the division may prescribe by rules, except that the division may not require any needy person over 65 years of age, as a condition of entering or remaining in a hospital, nursing home or other congregate care facility, to sell any real property normally used as such person's home. Any rule or regulation of the division inconsistent with this section is to that extent invalid. The amounts to be disregarded shall be within the limits required or permitted by federal law, rules or orders applicable thereto.

(3) In the determination of the amount of medical assistance available to a medically needy person, all income and resources available to the person in excess of the amounts prescribed in ORS 414.038, within limits prescribed by the division, shall be applied first to costs of needed medical and remedial care and services not available under the medical assistance program and then to the costs of benefits under the medical assistance program.

SECTION 21. ORS 414.065 is amended to read:

414.065. (1) With respect to medical and remedial care and services to be provided in medical assistance during any period, and within the limits of funds available therefor, the Adult and Family Services Division shall determine, subject to such revisions as it may make from time to time **and with respect to the "health services" defined in section 2 of this 1989 Act, subject to legislative funding in response to the report of the Health Services Commission**:

(a) The types and extent of medical and remedial care and services to be provided **to each eligible group of recipients of medical assistance**.

(b) Standards to be observed in the provision of medical and remedial care and services.

(c) The number of days of medical and remedial care and services toward the cost of which public assistance funds will be expended in the care of any person.

(d) Reasonable fees, charges and daily rates to which public assistance funds will be applied toward meeting the costs of providing medical and remedial care and services to an applicant or recipient.

(e) Reasonable fees for professional medical and dental services which may be based on usual and customary fees in the locality for similar services.

(2) The types and extent of medical and remedial care and services and the amounts to be paid in meeting the costs thereof, as determined and fixed by the division and within the limits of funds available therefor, shall be the total available for medical assistance and payments for such medical assistance shall be the total amounts from public assistance funds available to providers of medical and remedial care and services in meeting the costs thereof.

(3) Except for payments under a cost-sharing plan, payments made by the division for medical assistance shall constitute payment in full for all medical and remedial care and services for which such payments of medical assistance were made.

(4) Medical benefits, standards and limits established pursuant to paragraphs (a), (b) and (c) of subsection (1) of this section for the eligible medically needy may be less but shall not exceed medical benefits, standards and limits established for the eligible categorically needy, except that, in the case of a research and demonstration project entered into under ORS 411.135, medical benefits, standards and limits for the eligible medically needy may exceed those established for **specific eligible groups of** the categorically needy.

(5) Notwithstanding the provisions of this section, the division shall cause Type A hospitals, as defined in ORS 442.470, identified by the Office of Rural Health as rural hospitals to be reimbursed fully for the cost of covered services based on the Medicare determination of reasonable cost as derived from the Hospital and Hospital Health Care Complex Cost Report, referred to as the Medicare Report, provided by the hospital to a person entitled to receive medical assistance.

SECTION 22. This Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this Act takes effect July 1, 1989.

C-Engrossed
Senate Bill 935

Ordered by the House May 31
Including Senate Amendments dated April 6 and April 28 and House Amendments dated May 31

Sponsored by COMMITTEE ON HEALTH INSURANCE AND BIO-ETHICS

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure.

Requires Insurance Pool Governing Board to provide health care packages that are fair to all and report on its activities to Sixty-sixth Legislative Assembly. Requires distribution of notice regarding effect and operation of Act.

Revises eligibility and coverage of health insurance pool for small employers.

Specifies requirements for eligibility of employers. Prescribes requirements for coverage. Limits employe contribution for insurance to $15.

Creates Insurance Pool Fund. Requires **certain** employers not providing health insurance by 1994 to make monthly payments to fund. Provides formula for payments. Appropriates moneys in fund to Health Insurance Pool Governing Board for purposes of Act.

Prescribes schedule and phaseout for tax credit allowed to employer for providing health coverage. Requires board to report number of employes insured through Act on specified dates. Makes extension of higher tax credits and repeal of employer contribution contingent on specified number of insured employes. Prorates credit for nonresident employers. Allows board, after July 1, *[1990]* **1991**, to establish health insurance program without tax credit for larger businesses which are already providing health benefits.

Requires Oregon Health Council to monitor and evaluate health benefits available under program and effect of plans on health care costs. Revises membership of board and requires appointments to be made by October 1, 1989.

A BILL FOR AN ACT

Relating to health care; creating new provisions; amending ORS 316.096, 317.113, 653.725, 653.765 and 653.775; and appropriating money.

Be It Enacted by the People of the State of Oregon:

SECTION 1. It is the policy of the State of Oregon to provide health services to those in need. If Senate Bill 27 becomes law, services to Oregonians who do not have health insurance must include substantially similar medical services as those recommended by the Health Services Commission and funded by the appropriate legislative review agency, as defined in ORS 291.371, pursuant to chapter _____, Oregon Laws 1989 (Enrolled Senate Bill 27).

SECTION 2. (1) The Insurance Pool Governing Board shall provide packages of health services that are fair to consumers, providers and citizens of this state.

(2) The board shall:

(a) Examine the advantages and disadvantages of various alternatives for implementing a statewide pool; and

(b) After considering employe health benefit plans being provided by employers and the full priority list recommended by the Health Services Commission, the board shall determine benefit packages and other requirements that should be in place before implementing subsection (4) of section 4 of this Act.

(3) Report on its activities pursuant to this section to the Joint Legislative Committee on Health

NOTE: Matter in **bold face** in an amended section is new; matter *[italic and bracketed]* is existing law to be omitted.

Care.

SECTION 3. (1) The Insurance Pool Governing Board shall report to the Sixty-sixth Legislative Assembly by submitting copies of its report to the President of the Senate and the Speaker of the House of Representatives who may refer the report to appropriate standing committees.

(2) A preliminary version of the report, the contents of which is described in paragraphs (a) and (b) of subsection (2) of section 2 of this Act, is due by September 1, 1990, and the final report is due by January 1, 1991. The final report shall be submitted in the manner described in subsection (1) of this section.

SECTION 4. ORS 653.765 is amended to read:

653.765. (1) In order to be eligible to participate in the programs authorized by ORS 316.096, 317.113, 318.170 and 653.705 to 653.785, an employer shall:

[*(1)*] **(a)** Employ no more than 25 employes **who do not have health insurance as a spouse, dependent or otherwise.**

[*(2)*] **(b)** Have not contributed within the preceding two years to any **group health** insurance premium on behalf of an employe who is to be covered by the employer's contribution.

[*(3)*] **(c)** Make a [*minimum*] contribution to be set by the board toward the premium incurred on behalf of a covered employe.

[*(4)*] **(2)** An employer may elect to cover fewer than the total number of employes so long as its covered class includes all employes in the class.

(3) The Insurance Pool Governing Board may waive the provision of paragraph (a) of subsection (1) of this section if a sufficient number of the employes of the employer are eligible for medical assistance under ORS chapter 414 so that only 25 or fewer employes are eligible for coverage under this section.

(4) On and after July 1, 1991, with the approval of the Sixty-sixth Legislative Assembly, the board may establish health insurance programs for employers who employ more than 25 employes or for those employers employing 25 or fewer employes who have provided health insurance for the purposes of ORS 653.705 to 653.785 only, if the employer otherwise satisfies the requirements of this section.

(5) The board shall not discriminate against any contractors which offer services within their providers' lawful scopes of practice.

(6) Any contribution by an employer to a health insurance plan within the preceding two years solely for the benefit of the employer or the employer's dependents shall not be considered to disqualify the employer under paragraph (b) of subsection (1) of this section.

SECTION 5. ORS 653.775 is amended to read:

653.775. (1) Part I coverage [*shall focus on episodic acute care and recovery care for catastrophic illness or accident. The coverage*] applies to eligible covered employes only.

(2) The plan shall have a [*deductible and a high*] stop loss to insure that no employe is required to pay the costs of a major accident or illness, beyond the costs of the deductible **and other reasonable cost-sharing requirements** and that Part I coverage can be obtained at a low enough cost to insure accessibility.

(3) Subject to subsection (4) of this section, employers shall pay the premium of Part I coverage up to a maximum of $40 for each eligible covered employe per month.

(4) All covered eligible employes shall participate in and be covered by **at least** Part I coverage. An employer may require a minimum employe contribution of not to exceed 25 percent of the pre-

mium **or $15, whichever is the lesser,** for **only** Part I coverage described in this section.

(5) Part I coverage shall include at least those health care services described by section 1 of this 1989 Act.

(6) The amounts specified in this section apply only to those employers who qualify for tax credits under ORS 316.096, 317.113 or 318.170.

SECTION 5a. (1) The Governor shall direct a state agency that regularly distributes notices or report forms, including tax return forms, to persons who are or may be employers to give notice to such persons of the current and anticipated effect and operation of this Act.

(2) The content of the notice shall be prepared by the Insurance Pool Governing Board. The affected state agency shall use the text supplied by the board.

(3) The notice shall be printed at the board's expense and distributed at the agency's expense. The agency shall make its distribution not later than 120 days after the effective date of this Act.

SECTION 6. Section 7 of this Act is added to and made a part of ORS 653.705 to 653.785.

SECTION 7. (1) There is created the Insurance Pool Fund. All employers who have not provided employe and dependent health care benefits, including group health insurance, a self-funding entity and employe welfare benefit plan that provides health plan benefits, or participation under ORS 653.765, by January 1, 1994, shall make monthly payments to the fund equal to the contribution set by the board for each employe of the employer. The payments shall be based on a percentage of taxable payroll calculated to be equivalent to 75 percent of the cost of a basic health benefits package for each employe and at least 50 percent for dependent coverage. The Insurance Pool Fund shall be considered a state agency for purposes of ORS 293.240 and 293.245.

(2) The Insurance Pool Fund shall be continuously appropriated to the board for the purpose of providing access to adequate health care for employes of employers described in this section.

(3) An employer who is eligible under ORS 653.765 (1)(a) to (c) who obtain health benefits for employes by means other than through the pool shall notify the Insurance Pool Governing Board of the number of employes being provided health benefits by the employer.

(4) Upon application therefor by an employer who is otherwise subject to making the payments required under this section, the board may exempt the employer from such requirement due to hardship and fix the terms and conditions of the exemption. The board by rule shall establish procedures under which it reviews such applications. The denial of an exemption is appealable under ORS 183.484.

(5) If a person first becomes an employer after January 1, 1994, the person shall be allowed 18 months from the commencement of business as an employer before being required to make payments under this section. If the person obtains employe and dependent health benefit coverage during the 18-month period and meets the eligibility requirements of ORS 653.765, the person shall be eligible for a tax credit in the amount of $25 per month per eligible covered employe or 50 percent of the total amount paid by the person during the taxable year, whichever is less, for one year after such coverage is provided. In all other respects, ORS 316.096, 317.113 and 318.170 apply to the person to whom this subsection applies.

SECTION 8. ORS 316.096 is amended to read:

316.096. (1) A credit against the taxes otherwise due under this chapter shall be allowed to a resident employer for amounts paid during the taxable year for purposes of this section and ORS 317.113, 318.170 and 653.715 to 653.785 on behalf of an eligible employe as defined in ORS 653.705 to provide health insurance or care.

[(2) The amount of the credit allowed by subsection (1) of this section shall be $25 per month per eligible covered employe or 50 percent of the total amount paid by the employer during the taxable year, whichever is less, for the first two years of participation. In the third year, the credit shall be equal to 75 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. In the fourth year, the credit shall be equal to 50 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. In the fifth year, the credit shall be equal to 25 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. For the sixth and subsequent years, no credit shall be allowed.]

(2) The amount of the credit allowed by subsection (1) of this section shall end on December 31, 1993, and shall be equal to the dollar amount specified in the following table or 50 percent of the total amount paid by the employe during the taxable year, whichever is the lesser:

Year of Participation	Dollar Amount Per Covered Employe Per Month
1989	$25
1990	$25
1991	$18.75
1992	$12.50
1993	$6.25

(3) As used in this section "employer" means an employer carrying on a business, trade, occupation or profession in this state who is an employer within the meaning of ORS 653.705.

(4) If the credit allowed by this section is claimed, the amount of any deduction allowable under this chapter for expenses described in this section shall be reduced by the dollar amount of the credit. The election to claim the credit shall be made at the time of filing the tax return in accordance with rules adopted by the department.

(5) Any amount of expenses paid by an employer under this section and ORS 317.113, 318.170 and 653.715 to 653.785 shall not be included as income to the employe for purposes of this chapter. If such expenses have been included in arriving at federal taxable income of the employe, the amount included shall be subtracted in arriving at state taxable income under this chapter. As used in ORS 316.162, with respect to the employe, "wages" does not include expenses paid under this section and ORS 317.113, 318.170 and 653.715 to 653.785.

(6) A nonresident shall be allowed the credit computed in the same manner and subject to the same limitations as the credit allowed a resident by this section. However, the credit shall be prorated using the proportion provided in ORS 316.117.

(7) If a change in the taxable year of a taxpayer occurs as described in ORS 314.085, or if the department terminates the taxpayer's taxable year under ORS 314.440, the credit allowed by this section shall be prorated or computed in a manner consistent with ORS 314.085.

(8) If a change in the status of a taxpayer from resident to nonresident or from nonresident to resident occurs, the credit allowed by this section shall be determined in a manner consistent with ORS 316.117.

(9) Any tax credit otherwise allowable under this section which is not used by the taxpayer in

a particular year may not be carried forward and offset against the taxpayer's tax liability for the next succeeding tax year.

(10) If the taxpayer is a shareholder of an S corporation that has elected to take tax credit relief pursuant to ORS 317.113 (7), the credit shall be computed using the shareholder's pro rata share of the corporation's expenses described in this section. In all other respects, the allowance and effect of the tax credit shall apply to the corporation as otherwise provided by law.

SECTION 9. ORS 317.113 is amended to read:

317.113. (1) A credit against the taxes otherwise due under this chapter shall be allowed to an employer for amounts paid during the taxable year for purposes of ORS 316.096, 317.113, 318.170 and 653.715 to 653.785 on behalf of an eligible employe as defined in ORS 653.705 to provide care for a qualified individual.

[*(2) The amount of the credit allowed by subsection (1) of this section shall be $25 per month per eligible covered employe or 50 percent of the total amount paid by the employer during the taxable year, whichever is less, for the first two years of participation. In the third year, the credit shall be equal to 75 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. In the fourth year, the credit shall be equal to 50 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. In the fifth year, the credit shall be equal to 25 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. For the sixth and subsequent years, no credit shall be allowed.*]

(2) The amount of the credit allowed by subsection (1) of this section shall end on December 31, 1993, and shall be equal to the dollar amount specified in the following table or 50 percent of the total amount paid by the employe during the taxable year, whichever is the lesser:

Year of Participation	Dollar Amount Per Covered Employe Per Month
1989	$25
1990	$25
1991	$18.75
1992	$12.50
1993	$6.25

(3) As used in this section, "employer" means a taxpayer subject to the tax imposed by this chapter paying compensation in this state.

(4) If the credit allowed by this section is claimed, the amount of any deduction allowable under this chapter for expenses described in this section shall be reduced by the dollar amount of the credit. The election to claim the credit shall be made at the time of filing the tax return in accordance with rules adopted by the department.

(5) Any amount of expenses paid by an employer under ORS 316.096, 317.113, 318.170 and 653.715 to 653.785 shall not be included as income to the employe for purposes of the Personal Income Tax Act of 1969. If such expenses have been included in arriving at federal taxable income of the employe, the amount included shall be subtracted in arriving at state taxable income under the Personal Income Tax Act of 1969. As used in ORS 316.162, with respect to the employe, "wages"

does not include expenses paid under ORS 316.096, 317.113, 318.170 and 653.715 to 653.785.

(6) Any tax credit otherwise allowable under this section which is not used by the taxpayer in a particular year may not be carried forward and offset against the taxpayer's tax liability for the next succeeding tax year.

(7) If the taxpayer is an electing small business corporation as defined in section 1361 of the Internal Revenue Code, and the taxpayer elects to take tax credit relief, the election may be made on behalf of the corporation's shareholders. Each shareholder shall be entitled to take tax credit relief as provided in ORS 316.096, based on that shareholder's pro rata share of the expenses described in this section.

SECTION 10. Before January 1, 1992, the board shall report publicly on the number of employes provided health care benefits as described in section 7 of this Act on October 1, 1991, who did not receive such benefits before April 1, 1989. If the number exceeds 50,000, ORS 316.096 and 317.113 are further amended as provided in sections 11 and 12 of this Act, effective January 1, 1992. In determining the minimum number for purposes of this section, the Insurance Pool Governing Board shall include the number of employes who are covered by the pool or who were covered by the pool during the period and whose coverage was withdrawn from the pool but continued by means described in and which has been reported to the board under section 7 of this Act.

SECTION 11. ORS 316.096, as amended by section 8 of this Act, is further amended to read:

316.096. (1) A credit against the taxes otherwise due under this chapter shall be allowed to a resident employer for amounts paid during the taxable year for purposes of this section and ORS 317.113, 318.170 and 653.715 to 653.785 on behalf of an eligible employe as defined in ORS 653.705 to provide health insurance or care.

[*(2) The amount of the credit allowed by subsection (1) of this section shall be $25 per month per eligible covered employe or 50 percent of the total amount paid by the employer during the taxable year, whichever is less, for the first two years of participation ending December 31, 1990. In the third year, ending December 31, 1991, the credit shall be equal to 75 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. In the fourth year, ending December 31, 1992, the credit shall be equal to 50 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. In the fifth year, ending December 31, 1993, the credit shall be equal to 25 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. For the sixth and subsequent years, no credit shall be allowed.*]

(2) The amount of the credit allowed by subsection (1) of this section shall end on December 31, 1993, and shall be equal to the dollar amount specified in the following table or 50 percent of the total amount paid by the employe during the taxable year, whichever is the lesser:

Year of Participation	Dollar Amount Per Covered Employe Per Month
1989	$25
1990	$25
1991	$25
1992	$18.75
1993	$12.50

(3) As used in this section, "employer" means an employer carrying on a business, trade, occupation or profession in this state who is an employer within the meaning of ORS 653.705.

(4) If the credit allowed by this section is claimed, the amount of any deduction allowable under this chapter for expenses described in this section shall be reduced by the dollar amount of the credit. The election to claim the credit shall be made at the time of filing the tax return in accordance with rules adopted by the department.

(5) Any amount of expenses paid by an employer under this section and ORS 317.113, 318.170 and 653.715 to 653.785 shall not be included as income to the employe for purposes of this chapter. If such expenses have been included in arriving at federal taxable income of the employe, the amount included shall be subtracted in arriving at state taxable income under this chapter. As used in ORS 316.162, with respect to the employe, "wages" does not include expenses paid under this section and ORS 317.113, 318.170 and 653.715 to 653.785.

(6) A nonresident shall be allowed the credit computed in the same manner and subject to the same limitations as the credit allowed a resident by this section. However, the credit shall be prorated using the proportion provided in ORS 316.117.

(7) If a change in the taxable year of a taxpayer occurs as described in ORS 314.085, or if the department terminates the taxpayer's taxable year under ORS 314.440, the credit allowed by this section shall be prorated or computed in a manner consistent with ORS 314.085.

(8) If a change in the status of a taxpayer from resident to nonresident or from nonresident to resident occurs, the credit allowed by this section shall be determined in a manner consistent with ORS 316.117.

(9) Any tax credit otherwise allowable under this section which is not used by the taxpayer in a particular year may not be carried forward and offset against the taxpayer's tax liability for the next succeeding tax year.

(10) If the taxpayer is a shareholder of an S corporation that has elected to take tax credit relief pursuant to ORS 317.113 (7), the credit shall be computed using the shareholder's pro rata share of the corporation's expenses described in this section. In all other respects, the allowance and effect of the tax credit shall apply to the corporation as otherwise provided by law.

SECTION 12. ORS 317.113, as amended by section 9 of this Act, is further amended to read:

317.113. (1) A credit against the taxes otherwise due under this chapter shall be allowed to an employer for amounts paid during the taxable year for purposes of ORS 316.096, 317.113, 318.170 and 653.715 to 653.785 on behalf of an eligible employe as defined in ORS 653.705 to provide care for a qualified individual.

[*(2) The amount of the credit allowed by subsection (1) of this section shall be $25 per month per eligible covered employe or 50 percent of the total amount paid by the employer during the taxable year, whichever is less, for the first two years of participation ending December 31, 1990. In the third year, ending December 31, 1991, the credit shall be equal to 75 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. In the fourth year, ending December 31, 1992, the credit shall be equal to 50 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. In the fifth year, ending December 31, 1993, the credit shall be equal to 25 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. For the sixth and subsequent years, no credit shall be allowed.*]

(2) The amount of the credit allowed by subsection (1) of this section shall end on De-

cember 31, 1993, and shall be equal to the dollar amount specified in the following table or 50 percent of the total amount paid by the employe during the taxable year, whichever is the lesser:

Year of Participation	Dollar Amount Per Covered Employe Per Month
1989	$25
1990	$25
1991	$25
1992	$18.75
1993	$12.50

(3) As used in this section, "employer" means a taxpayer subject to the tax imposed by this chapter paying compensation in this state.

(4) If the credit allowed by this section is claimed, the amount of any deduction allowable under this chapter for expenses described in this section shall be reduced by the dollar amount of the credit. The election to claim the credit shall be made at the time of filing the tax return in accordance with rules adopted by the department.

(5) Any amount of expenses paid by an employer under ORS 316.096, 317.113, 318.170 and 653.715 to 653.785 shall not be included as income to the employe for purposes of the Personal Income Tax Act of 1969. If such expenses have been included in arriving at federal taxable income of the employe, the amount included shall be subtracted in arriving at state taxable income under the Personal Income Tax Act of 1969. As used in ORS 316.162, with respect to the employe, "wages" does not include expenses paid under ORS 316.096, 317.113, 318.170 and 653.715 to 653.785.

(6) Any tax credit otherwise allowable under this section which is not used by the taxpayer in a particular year may not be carried forward and offset against the taxpayer's tax liability for the next succeeding tax year.

(7) If the taxpayer is an electing small business corporation as defined in section 1361 of the Internal Revenue Code, and the taxpayer elects to take tax credit relief, the election may be made on behalf of the corporation's shareholders. Each shareholder shall be entitled to take tax credit relief as provided in ORS 316.096, based on that shareholder's pro rata share of the expenses described in this section.

SECTION 13. Before January 1, 1993, the board shall report publicly on the number of employes provided health care benefits as described in section 7 of this Act on October 1, 1992, who did not receive such benefits before April 1, 1989. If the number exceeds 100,000, ORS 316.096 and 317.113 are further amended as provided in sections 14 and 15 of this Act, effective January 1, 1993. In determining the minimum number for purposes of this section, the Insurance Pool Governing Board shall include the number of employes who are covered by the pool or who were covered by the pool during the period and whose coverage was withdrawn from the pool but continued by means described in and which has been reported to the board under section 7 of this Act.

SECTION 14. ORS 316.096, as amended by sections 8 and 11 of this Act, is further amended to read:

316.096. (1) A credit against the taxes otherwise due under this chapter shall be allowed to a

resident employer for amounts paid during the taxable year for purposes of this section and ORS 317.113, 318.170 and 653.715 to 653.785 on behalf of an eligible employe as defined in ORS 653.705 to provide health insurance or care.

[*(2) The amount of the credit allowed by subsection (1) of this section shall be $25 per month per eligible covered employe or 50 percent of the total amount paid by the employer during the taxable year, whichever is less, for the first three years of participation ending December 31, 1991. In the fourth year, ending December 31, 1992, the credit shall be equal to 75 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. In the fifth year, ending December 31, 1993, the credit shall be equal to 50 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. For the sixth and subsequent years, no credit shall be allowed.*]

(2) The amount of the credit allowed by subsection (1) of this section shall end on December 31, 1993, and shall be equal to the dollar amount specified in the following table or 50 percent of the total amount paid by the employe during the taxable year, whichever is the lesser:

Year of Participation	Dollar Amount Per Covered Employe Per Month
1989	$25
1990	$25
1991	$25
1992	$18.75
1993	$18.75

(3) As used in this section, "employer" means an employer carrying on a business, trade, occupation or profession in this state who is an employer within the meaning of ORS 653.705.

(4) If the credit allowed by this section is claimed, the amount of any deduction allowable under this chapter for expenses described in this section shall be reduced by the dollar amount of the credit. The election to claim the credit shall be made at the time of filing the tax return in accordance with rules adopted by the department.

(5) Any amount of expenses paid by an employer under this section and ORS 317.113, 318.170 and 653.715 to 653.785 shall not be included as income to the employe for purposes of this chapter. If such expenses have been included in arriving at federal taxable income of the employe, the amount included shall be subtracted in arriving at state taxable income under this chapter. As used in ORS 316.162, with respect to the employe, "wages" does not include expenses paid under this section and ORS 317.113, 318.170 and 653.715 to 653.785.

(6) A nonresident shall be allowed the credit computed in the same manner and subject to the same limitations as the credit allowed a resident by this section. However, the credit shall be prorated using the proportion provided in ORS 316.117.

(7) If a change in the taxable year of a taxpayer occurs as described in ORS 314.085, or if the department terminates the taxpayer's taxable year under ORS 314.440, the credit allowed by this section shall be prorated or computed in a manner consistent with ORS 314.085.

(8) If a change in the status of a taxpayer from resident to nonresident or from nonresident to

resident occurs, the credit allowed by this section shall be determined in a manner consistent with ORS 316.117.

(9) Any tax credit otherwise allowable under this section which is not used by the taxpayer in a particular year may not be carried forward and offset against the taxpayer's tax liability for the next succeeding tax year.

(10) If the taxpayer is a shareholder of an S corporation that has elected to take tax credit relief pursuant to ORS 317.113 (7), the credit shall be computed using the shareholder's pro rata share of the corporation's expenses described in this section. In all other respects, the allowance and effect of the tax credit shall apply to the corporation as otherwise provided by law.

SECTION 15. ORS 317.113, as amended by sections 9 and 12 of this Act, is further amended to read:

317.113. (1) A credit against the taxes otherwise due under this chapter shall be allowed to an employer for amounts paid during the taxable year for purposes of ORS 316.096, 317.113, 318.170 and 653.715 to 653.785 on behalf of an eligible employe as defined in ORS 653.705 to provide care for a qualified individual.

[*(2) The amount of the credit allowed by subsection (1) of this section shall be $25 per month per eligible covered employe or 50 percent of the total amount paid by the employer during the taxable year, whichever is less, for the first three years of participation ending December 31, 1991. In the fourth year, ending December 31, 1992, the credit shall be equal to 75 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. In the fifth year, ending December 31, 1993, the credit shall be equal to 50 percent of the lesser of $25 per month per employe or 50 percent of the total amount paid to the board. For the sixth and subsequent years, no credit shall be allowed.*]

(2) The amount of the credit allowed by subsection (1) of this section shall end on December 31, 1993, and shall be equal to the dollar amount specified in the following table or 50 percent of the total amount paid by the employe during the taxable year, whichever is the lesser:

Year of Participation	Dollar Amount Per Covered Employe Per Month
1989	$25
1990	$25
1991	$25
1992	$18.75
1993	$18.75

(3) As used in this section, "employer" means a taxpayer subject to the tax imposed by this chapter paying compensation in this state.

(4) If the credit allowed by this section is claimed, the amount of any deduction allowable under this chapter for expenses described in this section shall be reduced by the dollar amount of the credit. The election to claim the credit shall be made at the time of filing the tax return in accordance with rules adopted by the department.

(5) Any amount of expenses paid by an employer under ORS 316.096, 317.113, 318.170 and 653.715

to 653.785 shall not be included as income to the employe for purposes of the Personal Income Tax Act of 1969. If such expenses have been included in arriving at federal taxable income of the employe, the amount included shall be subtracted in arriving at state taxable income under the Personal Income Tax Act of 1969. As used in ORS 316.162, with respect to the employe, "wages" does not include expenses paid under ORS 316.096, 317.113, 318.170 and 653.715 to 653.785.

(6) Any tax credit otherwise allowable under this section which is not used by the taxpayer in a particular year may not be carried forward and offset against the taxpayer's tax liability for the next succeeding tax year.

(7) If the taxpayer is an electing small business corporation as defined in section 1361 of the Internal Revenue Code, and the taxpayer elects to take tax credit relief, the election may be made on behalf of the corporation's shareholders. Each shareholder shall be entitled to take tax credit relief as provided in ORS 316.096, based on that shareholder's pro rata share of the expenses described in this section.

SECTION 16. Before January 1, 1994, the board shall report publicly on the number of employes provided health care benefits as described in section 7 of this Act on October 1, 1993, who did not receive such benefits before April 1, 1989. If the number exceeds 150,000, section 7 of this Act is repealed, effective January 1, 1994. In determining the minimum number for purposes of this section, the Insurance Pool Governing Board shall include the number of employes who are covered by the pool or who were covered by the pool during the period and whose coverage was withdrawn from the pool but continued by means described in and which has been reported to the board under section 7 of this Act.

SECTION 16a. (1) The Oregon Health Council shall monitor and evaluate the adequacy and effectiveness of health benefits available under ORS 653.705 to 653.785 and the effect of the plans on health care costs.

(2) The Insurance Pool Governing Board shall supply the Oregon Health Council with data obtained by the board in implementing ORS 653.705 to 653.785.

SECTION 17. ORS 653.725 is amended to read:

653.725. (1) There is established an Insurance Pool Governing Board consisting of [*five*] **seven** voting members **six of whom shall be** appointed by the Governor [*and as a nonvoting member two employers add labor or the Consumer Advocate in the Department of Insurance and Finance*]. Of the members appointed by the Governor, two shall be employers **and one shall be an employe representing organized labor.** [*and*] At least two shall be knowledgeable about insurance but who are not officers or employes of a carrier and not consultants to a carrier or contractor. **The Director of the Department of Insurance and Finance shall appoint a consumer representative who shall serve as a voting member.**

(2) The term of office of each member is three years, but a voting member serves at the pleasure of the [*Governor*] **appointing authority**. Before the expiration of the term of a member, the [*Governor*] **appointing authority** shall appoint a successor whose term begins on July 1 next following. A member is eligible for reappointment. If there is a vacancy for any cause, the [*Governor*] **appointing authority** shall make an appointment to become immediately effective for the unexpired term.

(3) The appointing authority shall not allow any position on the board to remain vacant for more than 60 days after the vacancy occurs.

SECTION 18. The appointments required by ORS 653.725, as amended by section 17 of this Act,

and the filling of any vacancy existing on the effective date of this Act must be made by October 1, 1989.

B-Engrossed
Senate Bill 534

Ordered by the Senate June 21
Including Senate Amendments dated April 17 and June 21

Sponsored by COMMITTEE ON HEALTH INSURANCE AND BIO-ETHICS (at the request of Blue Cross/Blue Shield of Oregon; Capitol Health Care; Greater Oregon Health Service; Kaiser Permanente; Health Insurance Association of America; Klamath Medical Service Bureau; National Association, Multiple Sclerosis Society; Oregon Association of Hospitals; Oregon Chapter, American Diabetes Association; Oregon Health Underwriter's Association; Oregon Medical Association; Pacific Hospital Association; Physicians' Association of Clackamas County Health Plans; Rogue Valley Physicians Service; Sisters of Providence Health Plans in Oregon)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure.

Establishes Oregon Medical Insurance Pool Account in [*insurance fund*] **State Treasury.** [*Requires Department of Insurance and Finance*] **Creates Oregon Medical Insurance Pool Board to establish Oregon Medical Insurance Pool and** to adopt rules and policies for account. **Prescribes membership, duties and powers.** Appropriates moneys in account to [*department*] **board. Provides formula to determine each insurer's assessment.**

Appropriates moneys from General Fund to [*Insurance and Finance Fund*] **account for biennial expenses** to assist in obtaining major medical insurance coverage for high risk persons.

Declares emergency, effective July 1, 1989.

A BILL FOR AN ACT

Relating to the Oregon Medical Insurance Pool; creating new provisions; amending ORS 735.605, 735.610, 735.615, 735.620, 735.625, 735.630, 735.635, 735.640, 735.645 and 735.650 and section 19, chapter 838, Oregon Laws 1987; appropriating money; limiting expenditures; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. In addition to and not in lieu of any other appropriation, there is appropriated to the Oregon Medical Insurance Pool Account, out of the General Fund, for the biennium beginning July 1, 1989, the sum of $1 million to be used by the Oregon Medical Insurance Pool Board to be used with the other funds available to the board to carry out the provisions of ORS 735.600 to 735.650.

SECTION 2. There is established in the State Treasury, the Oregon Medical Insurance Pool Account, which shall consist of:

(1) Moneys appropriated to the account by the Legislative Assembly to obtain the coverage described in ORS 735.625.

(2) Interest earnings from the investment of moneys in the account.

(3) Assessments and other revenues collected or received by the Oregon Medical Insurance Pool Board.

SECTION 3. All moneys in the Oregon Medical Insurance Pool Account are continuously appropriated to the Oregon Medical Insurance Pool Board to carry out the provisions of ORS 735.600 to 735.650.

SECTION 4. (1) If the Oregon Medical Insurance Pool Board determines at any time that funds

NOTE: Matter in **bold face** in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted.

in the Oregon Medical Insurance Pool Account are or will become insufficient for payment of expenses of the pool in a timely manner, the board shall determine the amount of funds needed and shall impose and collect assessments against insurers, as provided in this section, in the amount of the funds determined to be needed.

(2) Each insurer's assessment shall be determined by multiplying the total amount to be assessed by a fraction, the numerator of which equals the number of Oregon insureds and certificate holders insured or reinsured by each insurer, and the denominator of which equals the total of all Oregon insureds and certificate holders insured or reinsured by all insurers, all determined as of the end of the prior calendar year.

(3) The board shall insure that each insured and certificate holder is counted only once with respect to any assessment. For that purpose, the board shall require each insurer that obtains reinsurance for its insureds and certificate holders to include in its count of insureds and certificate holders all insureds and certificate holders whose coverage is reinsured in whole or part. The board shall allow an insurer who is a reinsurer to exclude from its number of insureds those that have been counted by the primary insurer or the primary reinsurer for the purpose of determining its assessment under this subsection.

(4) Each insurer shall pay its assessment as required by the board.

(5) If assessments exceed the amounts actually needed, the excess shall be held and invested and, with the earnings and interest, used by the board to offset future net losses or to reduce pool premiums. For purposes of this subsection, future net losses include reserves for incurred but not reported claims.

(6) Each insurer's proportion of participation in the pool shall be determined by the board based on annual statements and other reports deemed necessary by the board and filed by the insurer with the board. The board may use any reasonable method of estimating the number of insureds and certificate holders of an insurer if the specific number is unknown. With respect to insurers that are reinsurers, the board may use any reasonable method of estimating the number of persons insured by each reinsurer.

(7) The board may abate or defer, in whole or in part, the assessment of an insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the insurer to fulfill the insurer's contractual obligations. In the event an assessment against an insurer is abated or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other insurers in a manner consistent with the basis for assessments set forth in this section. The insurer receiving the abatement or deferment shall remain liable to the board for the deficiency for four years.

(8) The board shall abate or defer assessments authorized by this section if the board determines that assessments cannot be made applicable to reinsurers.

SECTION 5. Sections 2 to 4 of this Act are added to and made a part of ORS 735.600 to 735.650.

SECTION 6. ORS 735.605 is amended to read:

735.605. As used in ORS [*317.080,*] 735.600 to 735.650[, *748.603 (2) and (3) and 750.055*]:

(1) "Benefits plan" means the coverages to be offered by the pool to eligible persons pursuant to ORS [*317.080,*] 735.600 to 735.650[, *748.603 (2) and (3) and 750.055*].

(2) "Board" means the [*board of directors of the pool*] **Oregon Medical Insurance Pool Board.**

(3) "Insured" means any individual resident of this state who is eligible to receive benefits from any insurer [*or self-insurance arrangement*].

(4) "Insurer" means:

(a) Any insurer as defined in ORS 731.106 or fraternal benefit society as defined in ORS [*748.103*] **748.106** required to have a certificate of authority to transact health insurance business in this state, and any health care service contractor as defined in ORS 750.005 (2), **issuing medical insurance in this state on or after September 27, 1987.**

(b) Any reinsurer reinsuring medical insurance in this state on or after September 27, 1987.

(c) To the extent consistent with federal law, any self-insurance arrangement covered by the Employe Retirement Income Security Act of 1974, as amended, that provides health care benefits in this state on or after September 27, 1987.

(d) All self-insurance arrangements not covered by the Employe Retirement Income Security Act of 1974, as amended, that provides health care benefits in this state on or after September 27, 1987.

(5) "Medical insurance" means any health insurance benefits payable on the basis of hospital, surgical or medical expenses incurred and any health care service contractor subscriber contract. Medical insurance does not include accident only, disability income, hospital confinement indemnity, dental or credit insurance, coverage issued as a supplement to liability insurance, **coverage issued as a supplement to Medicare,** insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(6) "Medicare" means coverage under both part A and part B of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq., as amended.

[*(7) "Member" means all insurers and self-insurance arrangements participating in the pool.*]

[*(8)*] **(7)** "Plan of operation" means the plan of operation of the pool, including articles, bylaws and operating rules, adopted by the board pursuant to ORS [*317.080,*] 735.600 to 735.650[*, 748.603 (2) and (3) and 750.055*].

[*(9)*] **(8)** "Pool" means the Oregon Medical Insurance Pool as created by ORS 735.610.

(9) "Reinsurer" means any insurer as defined in ORS 731.106 from whom any person providing medical insurance to Oregon insureds procures insurance for itself in the insurer, with respect to all or part of the medical insurance risk of the person.

(10) "Self-insurance arrangement" means any plan, program, contract or any other arrangement under which one or more employers, unions or other organizations provide health care services or benefits to their employes or members in this state, either directly or indirectly through a trust or third party administrator, unless the health care services or benefits are provided by an insurer **other than a self-insurance arrangement.**

SECTION 7. ORS 735.610 is amended to read:

735.610. (1) There is created a [*nonprofit entity*] **state agency** to be known as the Oregon Medical Insurance Pool **Board. The board shall establish the Oregon Medical Insurance Pool and otherwise carry out the responsibilities of the board under ORS 735.600 to 735.650.** [*The following shall be members of the pool:*]

[*(a) All insurers issuing medical insurance in this state on or after September 27, 1987;*]

[*(b) To the extent consistent with federal law, all self-insurance arrangements which are covered by the Employe Retirement Income Security Act of 1974, as amended, and which provide health care*

benefits in this state on or after September 27, 1987; and]

[(c) All self-insurance arrangements which are not covered by the Employe Retirement Income Security Act of 1974, as amended, and which provide health care benefits in this state on or after September 27, 1987, including but not limited to governmental and church plans.]

(2) **The board shall consist of nine individuals, eight of whom shall be appointed by the Governor.** *[The director shall, within 90 days after September 27, 1987, give notice to all insurers and, to the extent feasible, all self-insurance arrangements of the time and place for the initial organizational meetings of the pool. The pool members shall select the initial seven member board of directors. The selection of the board shall be subject to approval by the director.]* The Director **of the Department of Insurance and Finance** shall be a member of the *[pool]* **board** and shall also serve as the chair of the board or shall designate such chair. The board shall at all times, to the extent possible, include at least one representative of a domestic insurance company licensed to transact health insurance, one representative of a domestic not-for-profit health care service contractor, one representative of a health maintenance organization, **one representative of reinsurers** and *[one member]* **two members** of the general public who *[is]* **are** not associated with the medical profession, a hospital or an insurer.

[(3) If, within 60 days of the organizational meeting, the board is not selected, the director shall appoint the initial board and appoint an administering insurer.]

(3) The Governor may fill any vacancy on the board by appointment.

(4) The board shall submit to the director a plan of operation for the pool and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the pool. The director shall, after notice and hearing, approve the plan of operation provided the plan is determined to be suitable to assure the fair, reasonable and equitable administration of the pool. The plan of operation shall become effective upon approval in writing by the *[commissioner consistent with the date on which the coverage under ORS 317.080, 735.600 to 735.650, 748.603 (2) and (3) and 750.055 is required to be made available]* **director**. If the board fails to submit a suitable plan of operation within 180 days after the *[selection or appointment of the board]* **effective date of this Act**, or at any time thereafter fails to submit suitable amendments to the plan, the *[commissioner]* **director** shall, after notice and hearing, adopt such rules as are necessary or advisable to effectuate the provisions of ORS *[317.080,]* 735.600 to 735.650*[, 748.555, 748.603 (2) and (3) and 750.055]*. Such rules shall continue in force until modified by the director or superseded by a plan submitted by the board and approved by the director.

(5) In its plan, the board shall:

(a) Establish procedures for the handling and accounting of assets and moneys of the pool;

(b) Select an administering insurer or insurers in accordance with ORS *[317.080,]* 735.600 to 735.650*[, 748.603 (2) and (3) and 750.055 and establish procedures for filling vacancies on the board]*;

(c) Establish *[procedures for the selection, replacement, term of office and qualifications of the directors of the board and]* rules of procedures for the operation of the board; and

(d) Develop and implement a program to publicize the existence of the plan, the eligibility requirements and procedures for enrollment and to maintain public awareness of the plan.

(6) The *[pool]* **board** shall have the general powers and authority granted under the laws of this state to insurance companies with a certificate of authority to transact health insurance and the specific authority to:

(a) Enter into such contracts as are necessary or proper to carry out the provisions and pur-

poses of ORS [*317.080,*] 735.600 to 735.650[, *748.603 (2) and (3) and 750.055,*] including the authority[, *with the approval of the director,*] to enter into contracts with similar pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

(b) [*Sue or be sued, including taking any legal actions necessary or proper for recovery of*] **Recover** any assessments for, on behalf of, or against [*pool members*] **insurers**;

(c) Take such legal action as necessary to avoid the payment of improper claims against the pool or the coverage provided by or through the pool;

(d) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserves or formulas and perform any other actuarial function appropriate to the operation of the pool. Rates shall not be unreasonable in relation to the coverage provided, the risk experience and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim costs and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices;

(e) Issue policies of insurance in accordance with the requirements of ORS [*317.080,*] 735.600 to 735.650[, *748.603 (2) and (3) and 750.055*];

(f) Appoint from among [*members*] **insurers** appropriate [*legal,*] actuarial and other committees as necessary to provide technical assistance in the operation of the pool, policy and other contract design, and any other function within the authority of the [*pool*] **board**;

(g) [*Borrow money*] **Seek advances** to effect the purposes of the pool; [*. Any notes or other evidence of indebtedness of the pool not in default shall be legal investments for insurers and may be carried as admitted assets; and*]

(h) Establish rules, conditions and procedures for reinsuring risks under ORS [*317.080,*] 735.600 to 735.650; [*, 748.603 (2) and (3) and 750.055.*]

(i) Adopt rules for the purpose generally of carrying out ORS 735.600 to 735.650, as provided under ORS 183.310 to 183.550; and

(j) Employ such staff and consultants as may be necessary for the purpose of carrying out its responsibilities under ORS 735.600 to 735.650.

(7) Each member of the board is entitled to compensation and expenses as provided in ORS 292.495.

SECTION 8. Section 19, chapter 838, Oregon Laws 1987, is amended to read:

Sec. 19. The board may assess [*members of the pool*] **insurers** for organizational and initial operating expenses. The total assessment under this section may not exceed $150,000. The board shall determine each [*member's*] **insurer's** share of the total assessment in a reasonable manner. **Nothing in this section limits the amount of assessments that the board may otherwise impose under section 4 of this 1989 Act.**

SECTION 9. Notwithstanding any other law, the amount of $2 million is established for the biennium beginning July 1, 1989, as the maximum limit for payment of expenses from fees, moneys or other revenues, including Miscellaneous Receipts, excluding federal funds, collected or received by the Oregon Medical Insurance Pool Board for the purposes of this Act.

SECTION 10. The Governor shall appoint all members of the Oregon Medical Insurance Pool Board as soon as possible after the effective date of this Act. Until such time, members of the board on the effective date of this Act shall continue to serve as members of the board.

SECTION 11. ORS 735.615 is amended to read:

735.615. (1) Except as provided in subsection (3) of this section, any individual person who is a resident of this state shall be eligible for pool coverage if:

(a) An insurer, or an insurance company with a certificate of authority in any other state, has made an adverse underwriting decision, as defined in ORS 746.600 (1), on medical insurance for health reasons while the person was a resident;

(b) The person has a history of any medical or health conditions on the list adopted by the board under subsection (2) of this section; or

(c) The person is a spouse or dependent of a person described in this subsection.

(2) The board may adopt a list of medical or health conditions for which a person is eligible for pool coverage without applying for medical insurance pursuant to this section.

(3) A person is not eligible for coverage under [*the pool*] **ORS 735.600 to 735.650** if:

(a) The person is eligible for health care benefits under ORS chapter 414 or Medicare;

(b) The person has terminated coverage in the pool unless 12 months have lapsed since such termination;

(c) The [*pool*] **board** has paid out $1 million in benefits on behalf of the person;

(d) The person is an inmate of or a patient in a public institution named in ORS 179.321; or

(e) The person has, on the date of issue of coverage by the [*pool*] **board**, coverage under health insurance or a self-insurance arrangement which is substantially equivalent to coverage under ORS 735.625.

(4) A person applying for coverage [*under the pool*] shall establish initial eligibility by such evidence as the plan of operation shall require.

SECTION 12. ORS 735.620 is amended to read:

735.620. (1) The board shall select an insurer or insurers through a competitive bidding process to administer the [*pool*] **insurance program**. The board shall evaluate bids submitted based on criteria established by the board which shall include:

(a) The insurer's proven ability to handle individual medical insurance.

(b) The efficiency of the insurer's claim paying procedures.

(c) An estimate of total charges for administering the plan.

(d) The insurer's ability to administer the pool in a cost-effective manner.

(2)(a) The administering insurer shall serve for a period of three years subject to removal for cause.

(b) At least one year prior to the expiration of each three-year period of service by an administering insurer, the board shall invite all insurers, including the current administering insurer, to submit bids to serve as the administering insurer for the succeeding three-year period. Selection of the administering insurer for the succeeding period shall be made at least six months prior to the end of the current three-year period.

(3) The administering insurer shall:

(a) Perform all eligibility and administrative claims payment functions relating to the pool.

(b) Establish a premium billing procedure for collection of premiums from insured persons on a periodic basis as determined by the board.

(c) Perform all necessary functions to assure timely payment of benefits to covered persons under the pool including:

(A) Making available information relating to the proper manner of submitting a claim for benefits [*to the pool*] and distributing forms upon which submission shall be made.

(B) Evaluating the eligibility of each claim for payment [*by the pool*].

(d) Submit regular reports to the board regarding the operation of the pool. The frequency, content and form of the report shall be as determined by the board.

(e) Following the close of each calendar year, determine net written and earned premiums, the expense of administration and the paid and incurred losses for the year and report this information to the board [*and the division*] on a form as prescribed by the [*director*] **board.**

(f) Be paid as provided in the plan of operation for its expenses incurred in the performance of its services.

SECTION 13. ORS 735.625 is amended to read:

735.625. (1) The [*pool*] **board** shall offer major medical expense coverage to every eligible person.

(2) The coverage to be issued by the [*pool*] **board**, its schedule of benefits, exclusions and other limitations, shall be established through rules [*promulgated by the director*] **adopted by the board**, taking into consideration the advice and recommendations of the [*board and*] pool members. In the absence of such rules, the pool shall [*use*] **adopt by rule** the minimum benefits prescribed by section 6 (Alternative 1) of the Model Health Insurance Pooling Mechanism Act of the National Association of Insurance Commissioners (1984).

(3) In establishing the pool coverage, the [*director*] **board** shall take into consideration the levels of medical insurance provided in the state and medical economic factors as may be deemed appropriate and shall promulgate benefit levels, deductibles, coinsurance factors, exclusions and limitations determined to be generally reflective of, and commensurate with, medical insurance provided through a representative number of large employers in the state.

(4)(a) Premiums charged for coverages issued by the [*pool*] **board** may not be unreasonable in relation to the benefits provided, the risk experience and the reasonable expenses of providing the coverage.

(b) Separate schedules of premium rates based on age and geographical location may apply for individual risks.

(c) The [*pool*] **board** shall determine the standard risk rate by calculating the average individual rate charged by the five largest insurers offering coverages in the state comparable to the pool coverage. In the event five insurers do not offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Initial rates for pool coverage shall not be more than 150 percent of rates established as applicable for individual risks. [*All rates and rate schedules shall be submitted annually to the director for approval.*]

(d) The board[*, in consultation with the director,*] shall annually determine adjusted benefits and premiums. Such adjustments will be in keeping with the purposes of ORS [*317.080,*] 735.600 to 735.650[*, 748.603 (2) and (3) and 750.055*], subject to a limitation of keeping pool losses under one percent of the total of all medical insurance premiums, subscriber contract charges and 110 percent of all benefits paid by member self-insurance arrangements. [*All such adjusted benefits and premiums are subject to final approval by the director.*] The board may determine the total number of persons that may be enrolled for coverage [*by the pool*] at any time and may permit and prohibit enrollment in order to maintain the number authorized. Nothing in this paragraph authorizes the board to prohibit enrollment for any reason other than to control the number of persons in the pool.

(5)(a) Pool coverage shall exclude charges or expenses incurred during the first six months following the effective date of coverage as to any condition, if:

(A) The condition manifested itself within the six-month period immediately preceding the effective date of coverage in such a manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment; or

(B) Medical advice, care or treatment was recommended or received within the six-month period immediately preceding the effective date of coverage.

(b) The preexisting condition exclusions described in paragraph (a) of this subsection shall be waived to the extent to which similar exclusions have been satisfied under any prior health insurance coverage which was involuntarily terminated if the application for pool coverage is made not later than 60 days following the involuntary termination. In such a case, coverage in the pool shall be effective from the date on which such prior coverage was terminated. The board may assess an additional premium of up to 10 percent for coverage provided under the plan in this manner, notwithstanding the premium limitations stated in ORS [*317.080,*] 735.600 to 735.650[, *748.603 (2) and (3) and 750.055*].

(6)(a) Benefits otherwise payable under pool coverage shall be reduced by all amounts paid or payable through any other health insurance, or self-insurance arrangement, and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program except Medicaid.

(b) The [*pool*] **board** shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not for covered expenses. Benefits due from the pool may be reduced or refused as a setoff against any amount recoverable under this paragraph.

(7) Notwithstanding any other provision of law, no mandated benefit statutes apply to pool coverage under ORS [*317.080,*] 735.600 to 735.650, [*748.603 (2) and (3) and 750.055*].

(8) Pool coverage may be furnished through a health care service contractor or such alternative delivery system as will contain costs while maintaining quality of care.

SECTION 14. ORS 735.630 is amended to read:

735.630. Neither participation in the pool as members, the establishment of rates, forms or procedures, nor any other action taken in the performance of the powers and duties under ORS [*317.080,*] 735.600 to 735.650[, *748.603 (2) and (3) and 750.055*] shall be the basis of any legal action, criminal or civil liability or penalty against the [*pool*] **board**, any [*of its*] members, [*its board,*] the Director **of the Department of Insurance and Finance** or any of their agents or employes.

SECTION 15. ORS 735.635 is amended to read:

735.635. The pool established pursuant to ORS [*317.080,*] 735.600 to 735.650[, *748.603 (2) and (3) and 750.055*] shall be exempt from any and all taxes assessed by the State of Oregon.

SECTION 16. ORS 735.640 is amended to read:

735.640. After two years of operation of the pool, and every two years thereafter, the board shall conduct a study of the pool and adjust the plan of operation and benefits plan to reflect the findings of the study. The board may also recommend amendments to ORS [*317.080,*] 735.600 to 735.650[, *748.603 (2) and (3) and 750.055*] **and other statutes as necessary** to the Legislative Assembly to address the claims loss experience of the pool.

SECTION 17. ORS 735.645 is amended to read:

735.645. On and after the date the pool becomes operational [*as provided in ORS 317.080, 735.600 to 735.650, 748.603 (2) and (3) and 750.055*], every insurer [*or self-insurance arrangement*] shall include

a notice of the existence of the Oregon Medical Insurance Pool in any adverse underwriting decision on medical insurance, as defined in ORS 735.615 (1)(a), for reasons of the health of the applicant.

SECTION 18. ORS 735.650 is amended to read:

735.650. (1) The pool shall be subject to examination and regulation by the Director **of the Department of Insurance and Finance**.

(2) The following provisions of the Insurance Code shall apply to the pool to the extent applicable and not inconsistent with the express provisions of ORS [*317.080,*] 735.600 to 735.650[, *748.603 (2) and (3) and 750.055*]: ORS 731.004 to 731.022, 731.052 to 731.146, 731.162, [*731.204*] **731.216** to 731.328, 733.010 to 733.050, 733.080, 743.006, 743.009, 743.010, 743.018 to 743.028, 743.037 to 743.054, 743.060, 743.069, 743.078, 743.081, 743.084, 743.093, 743.096, 743.108, 743.117 to 743.135, 743.402 to 743.444, 743.447 to 743.480, 743.483 to 743.498, 744.005 to 744.215, 746.005 to 746.370, 746.600 to 746.690.

(3) For the purposes of this section only, the pool shall be deemed an insurer, pool coverage shall be deemed individual health insurance and pool coverage contracts shall be deemed policies.

SECTION 19. This Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this Act takes effect July 1, 1989.

APPENDIX B

COMMISSION AND SUBCOMMITTEE MEMBERSHIP

1) **Health Services Commission**

2) **Mental Health Care and Chemical Dependency Subcommittee**

Commissioner Profiles

The Health Services Commission was created by the Oregon Basic Health Services Act to define a list of health services and rank them according to their benefit to the entire population. Appointed in August of 1989 by Governor Neil Goldschmidt, the 11-member Commission is composed of physicians, consumer advocates, a social service worker and public health nurse.

Commissioners are serving staggered four-year terms and are mandated to review the prioritization of services every two years.

Alan Bates, 45, of Eagle Point, is a family physician in Central Point. He is a member of the American Osteopathic Association. Dr. Bates attended Central Washington State University and received his D.O. degree from Kansas City College of Osteo Medicine. His term expires in 1991.

Tina Castanares, 42, of Hood River, is a staff physician at La Clinica del Carino and health officer for Hood River County. Dr. Castanares received the Distinguished Service Award from the U.S. Public Health Service in 1983. She graduated from the University of California at Santa Cruz, and received her M.D. from the University of Southern California School of Medicine. Her term expires in 1993.

Donalda Dodson, 47, of Salem, is a public health manager with the Marion County Health Department and manages its clinic, family planning and refugee services. She is a member of Healthy Mothers/Healthy Babies and Early Intervention Coalitions. Ms. Dodson established the Family Planning Clinic for Marion County and is also active with the Marion County Teen Parent Program. She received her bachelor of science degree from the University of Oregon and her M.P.H. degree from the University of Washington. Her term expires in 1992.

Sharon Gary-Smith, 42, of Portland, is a local and national health activist and community organizer. She served as program director for the National Black Women's Health Project. Her firm, Consulting By Design, specializes in group facilitation, anti-racism and diversity training, and alliance-building. Ms. Gary-Smith was clinic director for Carolyn Downs Family Medical Center in Seattle. She attended Oregon State University. Her term expires in 1994.

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Bill Gregory, 56, of Glendale, is owner and president of Gregory Forest Products, Inc., a major employer in Douglas County. He is active in Oregon Health Decisions and a leader in providing comprehensive health care for employees and their families. Mr. Gregory received his bachelor of arts degree from the University of Washington and attended Harvard University Graduate School of Business Administration. His term expires in 1993.

Paul Kirk, 52, of Portland, is professor and chairman of the Department of Obstetrics and Gynecology at Oregon Health Sciences University (OHSU). He is a member of the boards of Washington County Head Start program and Healthy Mothers/Healthy Babies Coalition. Dr. Kirk's articles on the problems of high-risk pregnancy and maternal grieving are widely published. He sits on the Ethics and Humanities Task Force at OHSU and is a fellow at the Royal College of Obstetricians and Gynaecologists. Dr. Kirk received his bachelor of science and M.D. degrees from the University of London. His term expires in 1993.

Amy Klare, 27, of Salem, is the research education director for the Oregon AFL-CIO. She was press secretary for the Oregon Legislature from 1986-88. Ms. Klare currently serves on the executive boards of the Oregon Health Action Campaign, the Healthy Mothers/Healthy Babies Coalition, and the Oregon Health Sciences University's Center for Ethics - Consumer Advisory Committee. She received her bachelor of arts degree from Portland State University. Her term expires in 1991.

Harvey Klevit, 59, of Portland, is medical director of the Oregon Board of Medical Examiners. He practiced pediatrics and endocrinology for 24 years at Kaiser Permanente where he was chief of pediatrics and assistant regional medical director. He won the Distinguished Service Award from the Oregon Health Sciences University Alumni in 1983. He serves on the National Kaiser New Technologies Committee. Dr. Klevit is clinical professor of Pediatrics and Public Health at Oregon Health Sciences University and received his M.D. degree from Temple University. His term expires in 1994.

Yayoe Kuramitsu, 47, of Eugene, is director of the Medical Social Work Department at Sacred Heart General Hospital. Ms. Kuramitsu has been a medical social worker for 20 years and served on numerous community boards, and has worked in alcohol and drug treatment programs, the Eugene Community Development Committee, and as chair of the Home Health Advisory Board. She also serves on the Shanti in Oregon Board. Ms. Kuramitsu received her M.S.W. degree from Boston College School of Social Work in 1970. Her term expires in 1991.

Ellen C. Lowe, 60, of Portland, is associate director of Ecumenical Ministries of Oregon for legislative and governmental ministries. A long-time community and environmental activist, she served on the Salem City Council and Planning Commission, was president of the League of Oregon Cities and serves on the state Hunger Task Force. Ms. Lowe is a former secondary social studies teacher and university librarian. She received her bachelor of science degree from the University of Oregon in 1952. Her term expires in 1992.

Rick Wopat, 41, of Lebanon, is a private practice family physician. He is president of Western Oregon Independent Physicians Association and senior medical advisor to the Oregon Medical Professional Review Organization. He received a bachelors degree from Northwestern University, and M.D. from the University of Wisconsin, and did his residency at the University of Oregon Health Sciences University. He was named the "Oregon Family Physician of the Year" for 1990. His term expires in 1992.

Min Zidell, 65, of Portland, was owner of a gift shop from 1977 through 1988. She is active in the Cancer Patient Awareness Program as well as the Providence Hospital Medical Foundation. She retired from the Commission in 1990.

Mental Health Care and Chemical Dependency Subcommittee

Member Profiles

Donalda Dodson, of Salem, is one of eleven members of the Health Services Commission and chair of its Mental Health Care and Chemical Dependency Subcommittee. She is a nurse with the Marion County Health Department and manages its clinic, family planning and refugee services. Ms. Dodson has worked closely with drug and alcohol programs in Marion County. she has served on the state's Drug and Alcohol Task Force. A member of Healthy Mothers/Health Babies coalition, she chaired its perinatal substance abuse coalition. Ms. Dodson received her bachelor of science degree from the University of Oregon and her M.P.H. degree from the University of Washington.

Marion Fox, of Portland, is a former mental patient and leader of Recovery, Inc. A board member of the Mental Health Association of Oregon, she is also on the Mental Health Services Planning and Advisory Council. Ms. Fox plays the viola for the Oregon Symphony, Portland Opera Orchestra and west coast Chamber Orchestra. She was graduated from Marylhurst College with a bachelor's degree in music.

Muriel Goldman, of Portland, is a full time community volunteer focusing in the mental health, child welfare and juvenile justice arenas. She is on the board of the Mental Health Association of America and is immediate past president of the Mental Health Association of Oregon. She was recently appointed by Governor Roberts to the citizen position on the state Coordinating Council for Children and Families. Ms. Goldman received her bachelor's degree from the University of Chicago and has completed graduate work towards her master's degree in sociology.

Evan Kaeser, of Portland, is a past board member of Mind Empowered, Inc. He has written articles on criminal insanity, health care fraud and a monography on the rights of people with mental illness. Mr. Kaeser is an advocate for the rights of people with mental illness. He earned his bachelor's degree in political science from Colorado College and has completed graduate work in the areas of screenplays and film making. He retired from the Subcommittee in 1990.

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Robert King, of Portland, is director of the Clackamas County Community Mental Health Center. He is a member of the American Psychological Association of Oregon and the Association of Oregon Community Mental Health Program Directors. Mr. King has a doctorate in clinical psychology from the University of Oregon.

***Ray Lynch**, of Portland, was delegated to represent Gary Braden* and Neil McNaughton* who were unable to attend all subcommittee meetings. Mr. Lynch is a consultant for the Addiction Treatment Association, representing most private treatment centers in Oregon and southwest Washington. He is a recovering alcoholic with 14 years sobriety. Mr. Lynch is a former marketing director and board member of Serenity Family Treatment Centers. He is active in the St. Charles' Alcohol and Drug Team and the Substance Abuse Ministry of Portland Organizing Project.

Janet Mathews, of Aloha, is a psychiatric mental health nurse practitioner and assistant professor in the Department of Mental Health Nursing at Oregon Health Sciences University. She is a consultant at Metropolitan Family Services. Ms. Mathews is a doctoral student at Portland State University.

David Pollack, M.D., of West Linn, is medical director of Mental Health Services West, Inc. He is adjunct assistant professor of psychiatry at Oregon Health Sciences University and assistant director of its Public Psychiatry Training Program. Dr. Pollack attended Northwestern University, Oklahoma Health Sciences Center and received his psychiatry training from Oregon Health Sciences University.

Kathleen Savicki, L.C.S.W., of Salem, is director of Outpatient Services for Poyama Counseling Services. She is a member of the Oregon Chapter of the National Association for Social Workers and the Marion County Sex Abuse Treatment Network. Ms. Savicki has a master's degree from Smith College School for Social Work.

Ann Uhler, of Portland, is executive director of Comprehensive Option Drug Abusers. She is a member of the executive committee of the State Director's of Alcohol and Drug Abuse Association. Ms. Uhler has a master's degree in Human Development Counseling from Sangamon State University.

Judith Varner, of Turner, is executive director of Bridgeway Alcohol and Drug Outpatient Treatment, Salem. She is president of the Women's Commission on Alcohol and Drug Issues of Oregon. Ms. Varner has a bachelor's degree in psychology.

*Gary Braden, of Gresham, is executive director of Legacy Chemical Dependency Treatment Services and has been active in chemical dependency treatment for 17 years. He is treasurer of Addiction Treatment Association of Oregon. Mr. Braden received his doctorate in Counseling Psychology from Oregon State University.

*Neil McNaughton, of Springfield, is the executive director of Serenity Lane, Inc., a treatment center for alcohol and drug dependency. He is adjunct instructor at the University of Oregon Health Education Department. Mr. McNaughton is affiliated with the Academy of Certified Social Workers. He received his masters of social work from the University of Denver.

APPENDIX C

TELEPHONE SURVEY

1) Survey Overview

2) Calculation of Health-State Weights

3) Description of Functional Impairments and Symptoms

4) Health-State Weights

5) Survey Interpretation

6) Telephone Survey

SURVEY OVERVIEW

The Social Values Subcommittee recommended that a random sample survey of Oregonians be done to measure their reactions regarding health states described by symptoms and functional impairment modifiers.

The survey instrument adopted is a modification of Dr. Robert M. Kaplan's Quality of Well-Being (QWB) Scale*. Dr. Kaplan reviewed and approved modifications making the survey suitable for self-administration or telephone interviewing. The QWB Scale was chosen in preference to other measures of health status because:

1. It affords a single comprehensive measure of overall health related quality of life using dimensions of mortality, functional status and major symptomatology.
2. Field tests have shown the QWB Scale's ability to discriminate between and among health states.
3. It is simple enough to be manageable in a public survey.
4. It has been validated through use by the National Center for Health Statistics.

The results of the survey were converted to weighting factors which were applied to the outcomes data (see Appendix D) contributed by health care providers. The public's reaction to the symptoms and functional impairment modifiers is the bridge between the public preference for health states and the facts presented by the providers.

In February 1990, the Health Services Commission contracted with the Survey Research Center of Oregon State University to conduct the telephone survey**. The Survey Research Center's experience is that a sample of 800 is sufficiently large enough for Oregon's diversity attributable to region, age and race. However, because of the policy implications of the Health Services Commission survey, the Center increased the sample to 1,001.

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* Robert M. Kaplan and John P. Anderson, "A General Health Policy Model: Update and Applications," HSR:Health Services Research 23:2, June 1988

**The Survey Research Center contracted with Bardsley & Neidhart Inc. of Portland, Oregon to do the telephone interviews.

It was important to ensure that all regions of the state be polled. However, it was not necessary that the results from each region be generalized to that region since there is no intent to offer a Medicaid package which would vary from region to region. Random digit dialing was used to obtain equal probability samples in each region. The overall statewide sample was allocated to the regions in proportion to population. The following number of households in each region completed surveys:

Region*	Household
Portland Metropolitan Area	427
Mid-Willamette Valley	256
Southern Oregon	137
Coastal Counties	74
Columbia Basin	40
Central Oregon	34
Eastern Oregon	33
Total	1,001

The refusal rate (23.3 percent) was as high as the completion rate (23.3 percent) in this survey. This fact illustrates the sensitivity of the questions. The remainder (53.4 percent) of the 4,300 telephone numbers available represented those which had been disconnected, no answer, business/ government, midway termination of the survey, deaf/language barrier, answering machines, and numbers not tried.

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*The regions sampled are comprised of the following counties:

Portland Metropolitan Statistical Area: Multnomah, Washington, Clackamas, Yamhill
Mid-Willamette Valley: Marion, Polk, Benton, Linn, Lane
Southern Oregon: Josephine, Jackson, Douglas, Klamath, Lake
Coastal: Coos, Curry, Clatsop, Columbia, Tillamook, Lincoln
Columbia Basin: Hood River, Wasco, Sherman, Morrow, Gilliam, Umatilla
Central Oregon: Jefferson, Crook, Deschutes
Eastern Oregon: Wallowa, Union, Baker, Malheur, Grant, Wheeler, Harney

The sample compared quite well to Oregon's population of 2.7 million. This is true particularly in view of the fact that only households with telephones were surveyed. Adults 18 years old or older were selected at random from each household contacted. The selection mechanism was to interview only the one adult with the most recently celebrated birthday. This person's responses were subsequently weighted by the number of adults in the respondent's household. If this had not been done, the results would be biased toward small or single-person households. A demographic description of the weighted sample follows:

Category	Survey	Oregon Adults
Age in Years, Males		
18 - 39	42%	49%
40 - 54	37	24
55 - 64	9	11
65+	12	16
Age in Years, Females		
18 - 39	43%	45%
40 - 54	28	23
55 - 64	13	11
65+	16	21
Gender		
Male	40%	48%
Female	60	52%
Below Poverty Level	8%	11%
Ethnicity		
White	93.5%	92.0%
African-American	0.6	1.5
Hispanic	1.3	2.9
Other	4.6	3.6

Overall, women were over-sampled. Survey calls were made between the hours of 3 p.m. and 7 p.m. which would catch most people regardless of their work schedules. An explanation of the higher percentage of women sampled may be that more women are not employed outside the home than men.

Those households below the poverty level were under-sampled which probably is illustrative of the fact that only households with telephones were included in the survey.

Oregon's white population was somewhat over-sampled with African-Amercians and Hispanics somewhat under-sampled. This may also be attributable to the telephone factor. Questionnaires were administered to additional selected African-Americans to substantiate the responses with the telephone survey. The "other" ethnicity group comprises of a number of ethnic groups: American Indian, Asian, and people of mixed heritage.

CALCULATION OF HEALTH-STATE WEIGHTS

Best and Worst Health States

Each respondent was asked to give a score from 0 to 100 for each of the health states described in the survey. First they were asked to rate a situation where they had no health problems or restrictions on activity. This score for the best health situation became the basis against which all other health states would be measured. A worst health situation was then presented so that the respondent could establish their upper and lower bounds.

Functional Impairments*

The survey went on to ask for scores of health states involving different combinations of the six health limitations. Weights for the individual health limitations were calculated by taking the difference of the two scores corresponding to the questions that differed only in the presence of the limitation in question. This difference was then scaled to a range of 0 to 1 by the score given for the best health situation. The following example shows how the weight for needing help to eat or go to the bathroom (SAC1) would be calculated for one response.

100 -- Score given for best health situation
35 -- Score for SAC1 and PAC1
45 -- Score for PAC1 alone

Incremental score for SAC1: 35 - 45 = -10
Scaled weight for SAC1: -10 / 100 = -.100

This calculation was performed for each of the respondents who gave the three necessary scores. The average weight for the response total is -.106. This weight can be interpreted to mean that, on a scale of 0 to 1 where 0 is death and 1 is perfect health, the average Oregonian would give a score of .894 [1+(-.106)] to the health state of "needing help with self-care activities." If a person were in a health state involving only this limitation, their Quality of Well Being (QWB) score would be .894.

Symptoms*

Calculating weights for each symptom was more straight-forward since only one symptom was involved in each survey question. Symptom weights were calculated by scaling each respondent's score by his/her best health situation score and then averaging the weights given by all respondents. The following example shows the calculation of the weight for "pain in the back or joints" for one response.

95 -- Score given for best health situation
70 -- Score for pain in back or joints

Scaled weight for pain in back/joints: 70 - 95 / 100 = -.250

Again, this calculation was made for each respondent who completed these questions. The average weight for "pain in the back or joints" was determined to be -.253, for a QWB score of 1 + (-.253) = .747.

A person suffering from severe pain in the joints resulting in the need for help with self-care activities would therefore have a QWB score of 1 +(-.253) +(-.106) = .641.

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*See following pages for full descriptions of functional impairments and symptoms.

DESCRIPTION OF FUNCTIONAL IMPAIRMENTS AND SYMPTOMS

The survey questions are representative of the following functional impairments and symptoms including good or perfect health.

Functional Impairments

Mobility:

MOB1 ---In hospital, health related

MOB2 ---did not drive a car, health related; did not ride in a car as usual for age (younger than 15 years); **and/or**, did not use public transportation; or had or would have used more help than usual for age to use public transportation, health related

Physical Activity:

PAC1 ---In bed, chair or couch for most of or all of the day; **or** in wheelchair, did not move or control the movement of wheelchair without help from someone else, health related

PAC2 ---In wheelchair, moved or controlled movement of wheelchair without help from someone else, or had trouble or did not try to lift, stoop, bend over, or use stairs or inclines; **and/or**, limped, used a cane, crutches, or walker; **and/or**, had any other physical limitation in walking, or did not try to walk as far or as fast as others the same age are able, health related

Social Activity:

SAC1 ---Performed no major role activity **and** did not perform or had more help than usual in performance of one or more self-care activity, health related

SAC2 ---Limited in major or other role (recreational) activity, **or** performed no major role activity, but did perform self-care activity, health related

Major Symptoms

1) Loss of consciousness such as seizure (fits), fainting, or coma (out cold or knocked out)
2) Burn over large areas of face, body, arms or legs
3) Pain, bleeding, itching or discharge [drainage from sexual organs--does not include normal menstrual (monthly) bleeding]
4) Trouble learning, remembering, or thinking clearly
5) Any combination of one or more hands, feet, arms or legs either missing, deformed (crooked), paralyzed (unable to move), or broken--includes wearing artificial limbs or braces
6) Pain, stiffness, weakness, numbness, or other discomfort in chest, stomach (including hernia or rupture), side, neck, back, hips, or any joints or hands, feet, arms, or legs
7) Pain, burning, bleeding, itching, or other difficulty with rectum, bowel movements, or urination (passing water)
8) Sick or upset stomach, vomiting or loose bowel movement, with or without fever, chills, or aching all over
9) General tiredness, weakness, or weight loss
10) Coughing, wheezing, or shortness of breath, with or without fever, chills, or aching all over
11) Spells of feeling upset, being depressed or of crying
12) Headache, or dizziness, or ringing in ears, or spells of feeling hot, or nervous, or shaky
13) Burning or itching rash on large areas of face, body, arms, or legs
14) Trouble talking, such as lisp, stuttering, hoarseness, or being unable to speak
15) Pain or discomfort in one or both eyes (such as burning or itching) or any trouble seeing after correction
16) Overweight for age and height or skin defect of face, body, arms, or legs such as scars, pimples, warts, bruises, or changes in color
17) Pain in ear, tooth, jaw, throat, lips, tongue; several missing or crooked permanent teeth--includes wearing bridges or false teeth; stuffy runny nose; or any trouble hearing--includes wearing a hearing aid
18) Taking medication or staying on a prescribed diet for health
19) Wore eyeglasses or contact lenses
20) Has trouble falling asleep or staying asleep
21) Has trouble with sexual interest or performance
22) Is often worried
23) Has trouble with the use of drugs or alcohol

HEALTH-STATE WEIGHTS

Following are the survey results of Oregonians' reactions to queries regarding states of health.

The first column describes the functional impairment and symptoms describing an impaired health state. Column 2 shows the weights developed from Oregon's survey along with their corresponding standard errors in Column 3; and Column 4 allows comparison with Dr. Robert Kaplan's survey experience.

The minus signs in Columns 2 and 4 mean that perfect health (0) has been downgraded by the value shown to the end point of death (-1.0). NA in Column 4 signifies these items were not a part of Kaplan's work. The Mental Health and Chemical Dependency (MHCD) Subcommittee was particularly concerned that MHCD conditions be adequately addressed by the symptom list used in the survey and by the providers contributing outcomes data (see Appendix D). For that reason, the original symptom list was expanded.

#1 CONDITION	#2 OREGON WEIGHTS	#3 STANDARD* ERROR	#4 KAPLAN'S WEIGHTS
Functional Impairment:			
[MOB1] Hospital/Nursing Home	-.049	.0062	-.090
[MOB2] Unable to drive or use transportation	-.046	.0049	-.062
[PAC1] In bed or wheelchair controlled by someone else	-.560	.0113	-.077
[PAC2] Have used wheelchair/walker under your own control	-.373	.0108	-.060
[SAC1] Needed help going to the bathroom or eating	-.106	.0064	-.106
[SAC2] Limited in recreational activities	-.062	.0043	-.061
Symptoms:			
1. Loss of consciousness due to seizures, blackouts, or coma	-.114	.0077	-.407
2. Bad burn over large areas and pain.	-.372	.0117	-.387

(table continued)

#1 CONDITION		#2 OREGON WEIGHTS	#3 STANDARD* ERROR	#4 KAPLAN'S WEIGHTS
Symptoms: continued				
3.	Drainage from sexual organs	-.325	.0106	-.349
4.	Trouble learning, remembering	-.367	.0103	-.340
5.	Difficulty walking: broken leg	-.253	.0092	-.333
6.	Pain or weakness in back or joints	-.253	.0092	-.299
7.	Pain with urinating or bowel movement	-.299	.0095	-.292
8.	Stomach aches/vomiting/diarrhea	-.370	.0105	-.290
9.	A lot of tiredness or weakness	-.275	.0088	-.259
10.	Coughed/wheezed/trouble breathing	-.318	.0099	-.257
11.	Often felt depressed or upset	-.326	.0103	-.257
12.	Headaches or dizziness	-.305	.0097	-.244
13.	Itchy rash over large area of body	-.297	.0100	-.240
14.	Trouble talking	-.188	.0089	-.237
15.	Pain or discomfort in eyes or vision problems that corrective lens cannot fix	-.248	.0093	-.230
16.	Overweight or acne on the face	-.215	.0100	-.188
17.	Pain in ear or trouble hearing	-.217	.0090	-.170
18.	Prescribed medication or diet	-.123	.0080	-.144
19.	Wear glasses or contact lens	-.055	.0105	-.011
20.	Trouble falling asleep or staying asleep	-.248	.0099	NA
21.	Trouble with sexual performance	-.276	.0110	NA
22.	Unable to stop worrying	-.215	.0096	NA
23.	Trouble with the use of alcohol /drugs	-.455	.0129	NA

*Standard error of Oregon weights.

SURVEY INTERPRETATION

Most weights compared favorably with Kaplans' work. Those "Oregon" items which differ significantly are MOB1, PAC1, PAC2, and symptoms 1 and 19. A possible explanation may be that Kaplan's survey was done in an interview situation; Oregon's survey was conducted by telephone. This may allow a degree of misunderstanding on the part of the respondent.

It can be speculated that for symptom #1 (coma/loss of consciousness), people focused on what they might be most familiar with--fainting--and did not consider that to be a critical problem. Oregonians also seem to believe the impairment of physical activity (PAC1 and PAC2) is much more severe than the measures for mobility (MOB1 and MOB2) or social activity (SAC1 and SAC2). Further analysis is needed to suggest reasons for these differences. Other than functional impairments noted, alcohol and drug problems are thought of as being the situations which most adversely affect quality of life. The ability to learn and think follow in significance.

There was some ambiguity with two questions that were meant to arrive at the weight for symptom #5. The higher weight resulting from the two questions was used.

Experience was a significant factor in the responses for the following items:

4. Trouble learning, remembering or thinking clearly
10. Coughed, wheezed or had trouble breathing
18. Prescribed medication or diet for health reasons
19. Wear glasses or contact lens
21. Trouble with sexual performance

In each of the above situations, those who had experienced the problem did not feel it was as severe as those who had not experienced the problem. This response has been replicated in a number of studies.

At the end of the survey, respondents were asked questions concerning age, household income, ethnicity, and insurance:

Age The relationship of age to the responses given will need further analysis. However, older respondents tended to rank conditions as being more severe than the younger respondents.

Income There were no significant differences in responses between those below the federal poverty level and those above.

Ethnicity The percentage of minorities in Oregon is very small. Therefore our sample is too small from which to make generalizations. Over-sampling would be required to make generalizations on the correlation of response to ethnicity.

Insurance Of the 1,001 households completing the survey, 868 indicated they had insurance coverage (excluding Medicare, Medicaid and accident-only). Five households were not able to answer the insurance question. Household having no private insurance numbered 128. Of the 128 households, 80 had Medicaid cards.

The last question on the survey invites the respondents to make comments about their health or health care in Oregon. 488 comments were made by the 391 people (40 percent of total) responding to the last question. Following are those issues of greatest concern:

42% --- cost of both insurance and care
11% --- need for national health care or some other type of control of the industry
8% --- lack of insurance availability or access to care

The remaining responses were fairly evenly divided among the issues concerning: elderly, rights/entitlements, government program problems, and funding/financing. About 5 percent of the responses were "no complaints."

The survey did not require individuals to make trade-off decisions. The decision by the Commission was to obtain information regarding health values instead of condition-specific statements. There was a concern that the knowledge of specific conditions may vary significantly across respondents--this area may be of interest for future study.

REP: Phone No. _____

PAGE: Area No. _____

January 1990 OREGON STATE UNIVERSITY Final

"Hello, I'm _____. I'm calling from Oregon State University at Corvallis. First, I need to be sure I have dialed the right number. Is this (READ NUMBER)? "We would like to speak to the adult who has had the most recent birthday if he or she is at home now." (IF R IS NOT AT HOME ASK): "When would that person be home? (RECORD BELOW AND CALL BACK.)

(WHEN YOU HAVE CORRECT RESPONDENT, CONTINUE WITH): "As I said, I'm calling for Oregon State University at Corvallis. Our interview contains several interesting topices about how people feel about their health and how their health affects the quality of their lives. The information is important for it will help Oregon's Health Services Commission plan future health support programs for the state's citizens. All information that you give us is strictly confidential and the results are summarized for the state as a whole, not for any one person. Also, I want to assure you that the interview is voluntary, and if we should come to any question that you don't want to answer, just say so and we'll go on to the next question. If you have any questions after we have finished, we would be happy to have you call the study director at 737-3773 and he will answer them for you.

"Because people have different ideas about how health problems affect their happiness or satisfaction with life, we would like to ask how you feel.

"In the next few minutes, we will describe several health situations. We would like you to tell us how you feel about each one by giving it a score. If you feel the situation describes good health, give it a score of 100. If you feel it is as bad as death, give it a score of 0. If the situation is about halfway between death and good health, give it a score of 50. You can use any numbers from 0 to 100, such as 0, 7, 18, 39, 50, 63, 78, 89, 100, and so forth. Remember, you can use any number between 0 and 100.

"For each health situation, you should assume you would have no other problems than the ones described. Also, you should think of each health situation as permanent. Okay?

"The first description is the best health situation that you will be asked to rate; the second description is the worst. Here is the first one...

A. You can go anywhere, can move around freely wherever you are, have no restrictions on activity, and have no health problems. On a scale where 100 is good health and 0 is death what score would you give in this situation? . . . . SCORE _____
DK/NA. . 999

B. Now, here is the second. You have to stay at a hospital or nursing home, have to be in bed or in a wheelchair controlled by someone else, need help to eat or go to the bathroom, and have losses of consciousness from seizures, blackouts or coma. Again, on a scale of 0 to 100, what score would you give in this situation? . . . . . SCORE _____
DK/NA. . 999

C. Moving on to other situations, you have to stay at a hospital or nursing home, have to be in bed or in a wheelchair controlled by someone else, and need help to eat or go to the bathroom, but have no other health problems . . . . . SCORE _____
DK/NA. . 999

D. You can be taken anywhere, but have to be in bed or in a wheelchair controlled by someone else, need help to eat or go to the bathroom, but have no other health problems. . . . . SCORE _____
DK/NA. . 999

E. You can be taken anywhere, but have to be in bed or in a wheelchair controlled by someone else. Otherwise, you have no restrictions on activity and have no other health problems. . . . . SCORE _____
DK/NA. . 999

F. You cannot drive a car or use public transportation, you have to use a walker or wheelchair under your own control, and are limited in the recreational activities you may participate in. You have no other health problems. . . . . SCORE _____
DK/NA. . 999

G. You can be taken anywhere but you have to use a walker or a wheelchair under your own control, and are limited in the recreational activities you may perform, but have no other health problems .SCORE _____
DK/NA. . 999

H. You can be taken anywhere, but you have to use a walker or a wheelchair under your own control. Otherwise, you have no restrictions on activity and have no other health problems . . . . . SCORE _____
DK/NA. . 999

I. You can go anywhere and have no limitations or other activity, but wear glasses or contact lenses. . . . . SCORE _____
DK/NA. . 999

Before we continue, I'd like to remind you that we are asking you to rate each health situation on a scale of 0 to 100, where 0 is death and 100 is good health. You may use any number from 0 to 100 for your rating.

J. You can go anywhere and have no limitations on physical or other activity, but have pain or discomfort in your eyes or vision problems that corrective lenses can't fix. . . . . SCORE _____
DK/NA. . 999

K. You can go anywhere and have no limitations on physical or other activity, but have stomach aches, vomiting or diarrhea . . . . . SCORE _____
DK/NA. . 999

L. You can go anywhere and have no limitations on physical or other activity, but have trouble falling asleep or staying asleep. . . . . SCORE _____
DK/NA. . 999

M. You can go anywhere and have no limitations on physical or other activity, but have a bad burn over large areas of your body. . . . . SCORE _____
DK/NA. . 999

N. You can go anywhere and have no limitations on physical or other activity, but are on prescribed medicine or a prescribed diet for health reasons. . . . . SCORE _____
DK/NA. . 999

O. You can go anywhere and have no limitations on physical or other activity, but have drainage from your sexual organs and discomfort or pain. . . . . SCORE _____
DK/NA. . 999

P. You can go anywhere and have no limitations on physical or other activity, but have trouble with sexual interest or performance . . . . . SCORE _____
DK/NA. . 999

Q. You can go anywhere and have no limitations on physical or other activity, but have pain in your ear or trouble hearing. . . . . SCORE _____
DK/NA. . 999

R. You can go anywhere and have no limitations on physical or other activity, but have trouble learning, remembering or thinking clearly . . . . . SCORE _____
DK/NA. . 999

S. You can go anywhere. You have difficulty walking, but no other limitations on activity . . . SCORE _____
DK/NA. . 999

As we continue, please remember we are asking you to rate each health situation on a scale of 0 to 100, where 0 is death and 100 is good health. You may use any number form 0 to 100 in your ratings.

T. You can go anywhere. You have difficulty in walking because of a paralyzed or broken leg, but you have no other limitations on activity . . . SCORE _____
DK/NA. . 999

U. You can go anywhere and have no limitations on physical or other activity, but you have trouble talking, such as a lisp, stuttering or hoarseness . . . . . SCORE _____
DK/NA. . 999

V. You can go anywhere and have no limitations on physical or other activity, but you can't stop worrying . . . . . SCORE _____
DK/NA. . 999

W. You can go anywhere and have no limitations on physical or other activity, but you have a painful or weak condition of the back or joints . . SCORE _____
DK/NA. . 999

X. You can go anywhere and have no limitations on physical or other activity, but you have an itchy rash over large areas of your body. . . . . SCORE _____
DK/NA. . 999

Y. You can go anywhere and have no limitations on your physical or other activity, but you have pain while you are urinating or having a bowel movement. SCORE _____
DK/NA. . 999

Z1. You can go anywhere and have no limitations on physical activity, but you have trouble with the use of drugs or alcohol. . . . . SCORE _____
DK/NA. . 999

Z2. You can go anywhere and have no limitations on physical activity, but you have headaches or dizziness. . . . . SCORE _____
DK/NA. . 999

Z3. You can go anywhere and have no limitations on physical or other activity, but you experience a a lot of tiredness or weakness . . . . . SCORE _____
DK/NA. . 999

Z4. You can go anywhere and have no limitations on physical or other activity, but you are often depressed or upset . . . . . SCORE _____
DK/NA. . 999

Z5. You can go anywhere and have no limitations on physical or other activity, but you cough, wheeze or have trouble breathing . . . . . SCORE _____
DK/NA. . 999

Z6. You can go anywhere and have no limitations on physical or other activity, but are overweight or have acne on your face . . . . . SCORE _____
DK/NA. . 999

Thank you for your ratings. Next, I have here a list of medical conditions. As I read each one, will you please tell me if you have had or presently have the condition? **(INT: START WITH RED-CHECKED ITEM AND WORK YOUR WAY THROUGH ALL 30.)**

CONDITION	DK/NA	NO NOT HAD	YES HAD OR HAVE	YES, MONTH YEARS
1. You have been, at some time, unable to drive a car or use public transportation	1	2	3	____
2. You have used a walker or wheelchair under your own control	1	2	3	____
3. You have been limited in the recreational activities in which you participate.	1	2	3	____
4. You have experienced difficulty in walking because of a paralyzed or broken leg.	1	2	3	____
5. You have had stomach aches, vomiting or diarrhea.	1	2	3	____
6. You have had trouble falling asleep or staying asleep.	1	2	3	____
7. You have been overweight or have had acne on your face.	1	2	3	____
8. You have experienced pain in your ear or have had trouble hearing . . .	1	2	3	____
9. You have stayed in a hospital or in a nursing home	1	2	3	____
10. You have had trouble with the use of drugs or alcohol.	1	2	3	____
11. You have had drainage from your sexual organs and discomfort or pain. . . .	1	2	3	____

CONDITION	DK/NA	NO NOT HAD	YES HAD OR HAVE	YES, MONTH YEARS
12. You have had headaches or dizziness .	1	2	3	____
13. You have been in a bed or a wheelchair controlled by someone else.	1	2	3	____
14. You have often felt depressed or upset	1	2	3	____
15. You have had trouble learning, remembering or thinking clearly. . .	1	2	3	____
16. You have experienced pain while urinating or having a bowel movement	1	2	3	____
17. You have coughed, wheezed or had trouble breathing.	1	2	3	____
18. You have had pain or weakness in your back or joints	1	2	3	____
19. You have had an itchy rash over large areas or your body	1	2	3	____
20. You wear glasses or contact lenses. .	1	2	3	____
21. You have had trouble with sexual interest or performance.	1	2	3	____
22. You have had difficulty in walking. .	1	2	3	____
23. You have had trouble talking.	1	2	3	____
24. You have been unable to stop worrying	1	2	3	____
25. You have experienced pain or discomfort in your eyes or had vision problems that corrective lenses can't fix.	1	2	3	____
26. You have been on prescribed medicine or a prescribed diet for health reasons	1	2	3	____
27. You have had a bad burn over large areas of your body	1	2	3	____
28. You have experienced a lot of tiredness or weakness.	1	2	3	____

29. You have needed help in eating or going to the bathroom . . . . . 1 2 3 ____

30. You have had loss in consciousness due to seizures, blackouts or coma . 1 2 3 ____

Finally, a few questions about yourself. . .

31. Including yourself, how many persons are living in your immediate household?

NUMBER OF PERSONS _____
Refused 99

32. How many are 18 years or older?

NUMBER OF PERSONS _____
Refused 99

33. How many are under 18 years of age?

NUMBER OF PERSONS _____
Refused 99

34. We are interested in the level of health insurance coverage for Oregon families. Is anyone in your household presently covered by health insurance, that is, a health insurance plan which pays any part of a doctor or a hospital bill? Do not count Medicare, Medicaid or plans that pay only for accidents.

DK/NA 3
NO. 2
YES 1

→ 34a. How many adults and children in your household are covered by this type of health insurance plan?

NUMBER COVERED _____

34b. Are there <u>any</u> adults or children in your household who are <u>not</u> covered by this type of health insurance?

DK/NA 1
NO 2
YES 3

→ 34c. How many adults or children in your household are <u>not</u> covered by this type of health insurance?

NUMBER _____

35. Incidentally, do you or anyone in your household carry a Medicaid card, or not?

DK/NA. 1
NO 2
YES. 3

→ 35a. How many persons in your household are covered by Medicaid?

NUMBER COVERED_____

[INT: REFER TO Q 31 FOR THE TOTAL HH SIZE AND WRITE IT HERE. (____). THEN COMPARE THE INCOME LEVEL FOR THE HH SIZE IN THE TABLE BELOW AND ASK THE FOLLOWING QUESTION:]

36. By the way, is your total household income for 1989 above or below $_____?

HH SIZE	INCOME
1	$ 6,000
2	8,000
3	10,000
4	12,000
5	14,000
6	16,000
7	18,250
8	20,250
9	22,250
10	24,250

ABOVE. 1
SAME 2
BELOW. 3
DK/NA. 4

37. Thinking back over the past 12 months, was there any time when you or someone in your household should have seen a doctor but for some reason did not?

DK/NA 1
NO. 2
YES.. 3

→ 37a. What do you feel is the main reason this person or persons did not see a doctor when they should have? **(PROBE!)**

What else?

38. Would you please tell me in (or near) which town or city you live?

TOWN OR CITY _____
Refused 999

39. Which one of these best describes your racial or ethnic heritage -- white, black, American Indian, Oriental or Hispanic?

WHITE 1
BLACK 2
AMERICAN INDIAN . 3
ORIENTAL. 4
HISPANIC. 5
Refused 6

40. One final question. What was your age on your last birthday?

YEARS . . . _____
Refused . . 99

41. Is there anything else you would like to tell us about your health or about health care in Oregon?

(THANK YOU FOR YOUR COOPERATION!)

- -

(BY OBSERVATION):

42. R'S Sex?

MALE 1
FEMALE 2

Interviewer's Sig. _____ Date _____

APPENDIX D

OUTCOMES OF HEALTH SERVICES

---

1) **Cost-Benefit Ratio, Sample Calculation and Assumptions**

2) **Cost**

3) **Definition of health states**

4) **Duration of benefit**

5) **Impact of cost-benefit ratio on final prioritization**

6) **Data collection form and instructions to providers**

COST-BENEFIT RATIO

EVOLUTION

A cost-benefit ratio provides a measure for comparing health services based on outcome effectiveness in relation to cost. Early on in the process, the Commission decided that this tool would provide an objective comparison of the health services to be prioritized. The ratio evolved as the Commission began the process of data collection.

Initially a **benefit-cost** ratio included both cost of treatment and cost without treatment. A negative ratio occurred when the cost of a treatment was less than medical expenses incurred if no treatment were given. In the case of the **benefit-cost** ratio, the more negative the number the better the ratio, while the less positive the number the better the ratio.

In a **cost-benefit** (the reciprocal of benefit cost) ratio, the smaller the ratio, whether positive or negative in value, the more cost-effective the service. This change to the formula did not alter the ranking of services, but facilitated the computer sorting of services by ratio.

Other changes to the formula were proposed but not adopted. Those changes considered included the **discounting of future costs.** If costs were to be discounted in the case of prolonged treatment, the inflation of medical expenditures would also have to be included. Medical costs tend to increase faster than the inflation rate; therefore, the two terms would minimize the total effect.

Discounting future life-years was also not included in the final formula. The idea that a person may value a year of life more at one point of their lifetime than another is a controversial issue. This, plus the fact that no generally accepted discounting factor for human capital has been developed among those who agree with this principle, led to exclusion of this term.

Utility functions were not included in the formula because the Commission considered the policy of prioritization of health care to be essentially a risk-neutral situation. Consequently, preferences are not described for providing a benefit of one to ten people or providing a benefit of ten for one person and zero for the other nine.

CURRENT FORMULA

The most significant change to the formula which could have resulted in a different rank order of the list of health services was **the deletion of the without treatment costs** from the original formula. While the Commission felt that the net costs would have given more information than treatment costs alone, without treatment costs are not available.

The final formula, as shown below, remained a cost-benefit ratio:

$$B_n = \frac{c}{Y * \left[\sum_{i=1}^{5} (p_{i1} * QWB_{i1}) - \sum_{i=1}^{5} (p_{i2} * QWB_{i2}) \right]}$$

[With Treatment] [Without Treatment]

$$\text{with} \quad QWB_{ik} = 1 + \sum_{j=1}^{30} d_{ijk} w_j$$

where

B_n = the net benefit value ratio for the n^{th} condition/treatment pair to be ranked. This value will be used in determining the actual rankings of health services from highest(0) to lowest($-\infty$).

c = cost <u>with</u> treatment, including all medications and ancillary services as well as the cost of the primary procedure.

Y = the years for which the treatment can be expected to benefit the patient with this condition. This may be the remainder of the patient's lifetime or some shorter amount of time.

p_{i1} = the probability that the i^{th} outcome will occur five years hence <u>with</u> treatment.

d_{ijk} = an indicator variable denoting the presence (=1) or absence (=0) of the j^{th} health limitation (MOB, PAC or SAC) or chief complaint for the i^{th} outcome either <u>with</u> treatment (for k=1) or <u>without</u> treatment (for k=2).

w_j = the weight given by Oregonian's to the j^{th} health limitation or chief complaint ranging from 0=no significant effect to -1=death.

p_{i2} = the probability that the i^{th} outcome will occur five years hence <u>without</u> treatment.

SAMPLE CALCULATION

The ratio calculated for acute myocardial infarction uses:

1) information on the effectiveness of treating heart attacks

   Without treatment:

   --30% of those diagnosed as suffering from a heart attack can be expected to die within five years
   --30% will experience frequent chest pain
   --20% will often experience shortness of breath
   --20% can be expected to return to their former state of health within five years.

   With treatment:

   --10% will die because medical therapy given for this condition will fail to avert death
   --30% will still experience chest pain
   --30% will have residual shortness of breath
   --30% will return to a former state of health.

2) median age at onset of this diagnosis is 46 years (midpoint of middle-age cohort; see Data Collection Instrument)

3) the treated patient will benefit from this treatment for the remainder of his/her life; duration of benefit is

   $y = 75\text{-}46 = 29$ years

4) total treatment cost of $32,500 (midpoint of cost interval #11, see Cost)

The above information is used to calculate NET-BENEFIT.

With Treatment Quality of Well-Being (QWB):

The formula assigned an average QWB score on a scale of 0 to 1 to denote the health state of the patient who is given treatment. This benefit was calculated as a weighted sum of up to five defined outcomes, the weights being the likelihood that each outcome will occur. Each of the five possible outcomes were themselves given a QWB score calculated using the weights

Oregonians place on the health states being defined (see Appendix C). Death was defined to have a QWB score of 0, a return to a former health state was given a QWB score of 1 and a significant residual effect was some value less than 1. The with treatment QWB calculations for this example are as follows:

i	p_i1	QWB_i1	$p_i1 \times QWB_i1$
1	0.10	0	0.0000
2	0.30	0.747	0.2241
3	0.30	0.682	0.2046
4	0.30	1	0.3000
			0.7287

The p_i1's represent the probability that each of the four health states defined for the patient with treatment and the QWB_i1's are the QWB scores for each health state. The calculations for the QWB_i1's are not shown since it is easier to verbally describe their computation. The weights corresponding to the symptoms/limitations corresponding to the different health states defined by the providers were summed and added to 1. The weights for chest pain and shortness of breath are -0.253 and -0.318, respectively. This in turn gives QWB scores of 1 + (-0.253) = 0.747 and 1 + (-0.318) = 0.682 (see Appendix C for further explanation). The sum of the products of the probabilities and the QWB score of 0.7287 then represents the average QWB score of the patient receiving treatment.

Without treatment Quality of Well-Being (QWB):

i	p_i2	QWB_i2	$p_i2 \times QWB_i2$
1	0.30	0	0.0000
2	0.30	0.747	0.2241
3	0.20	0.682	0.1364
4	0.20	1	0.2000
			0.5605

The average QWB score without treatment of 0.5605 was calculated in the same manner as shown for the with treatment case above.

Net benefit:

The net benefit gives an indication of the benefit of the treatment in terms of the change in QWB score with treatment as opposed to without treatment. For this example the net benefit is:

$$0.7287 - 0.5605 = 0.1682$$

Cost-benefit ratio:

The cost-benefit ratio gives a relative means of comparing the health benefits received in relation to the money spent for different condition/treatment pairs. In this example it is:

$$32{,}500 / (29 \times 0.1682) = 6662.84$$

ASSUMPTIONS

The Health Services Commission recognized that in order to compare outcomes of different treatments, data collection required the standardization of certain definitions. The following assumptions were incorporated into those definitions:

1) An average patient

   Providers were requested to provide outcome information based on the "average patient." "Average patient" is a patient of an age (median age) likely to contract the condition presented for treatment. The outcome of treatment is that which most commonly results.

   The Commission's charge was to rank health services based on effectiveness and public values. This had to be done based on the value of the service across the broad spectrum of Oregon's population. The Commission understands that the value of a service may depend heavily on the age of recipient, comorbidities, or other factors unique to an individual.

2) Without treatment means absence of treatment.

   In order to measure the effectiveness of providing a service, the effects of not providing a service must be determined. Early in the process, the term

"proxy treatment" or "substitute treatment" was used. The conclusion was that there are very few treatments which can be substituted for others. Therefore, without treatment means absence of treatment. The outcomes of absence of treatment can be:

--- return to former health state

--- death

--- suffer from the effects of conditions which may be non-fatal but significantly decrease the quality of or length of life

3) Five year time frame for the assessment of condition/treatment outcomes

It was necessary to select a time frame in which outcomes would be measured because treatment effectiveness can be a function of time. The selection of a five-year time frame was based on the current medical practice of evaluating the success of cancer treatment at five years. An argument has been made that most services for the very old and very ill would not be greatly valued because the life expectancies of these people are often less than five years. This argument was negated by the use of median age and the application of the ranked categorization (see Appendix G).

4) Incidence of diagnosis was not factored into an overall effectiveness measure.

The Commissioners agreed early in the process of methodology development that if a condition could be effectively treated, an individual should not be denied treatment because the condition occurs infrequently. However, in the scrutinization of drafts of the prioritized list of health services, it was deemed unreasonable to rank a very rare condition above conditions which are easily treatable and occur on a relatively frequent basis. This realization and the community value of "benefits many" prompted the Commission to utilize incidence as a factor when moving "out-of-position" items to develop the final, prioritized list of health services.

5) Distribution of costs

A uniform distribution is assumed when costs are incurred over any extended period of time, although costs may accrue unevenly over time (i.e., high front-end or rear-end.) The total cost of treatment is correct in looking at costs over all stages of the disease, but yearly costs could not be broken out.

COST

Cost was defined as "charges" by the provider to the payor whether the payor be public or private. Original cost estimates were provided by Oregon Medical Assistance Programs (OMAP), and the dental, and the mental health and chemical dependency specialties. Because of the difficulty in pinpointing costs, a cost range was adopted with an average of the cost range used in the numerator of the cost-benefit ratio. Cost intervals are:

Interval #1	Less than		$ 250
#2	$ 251	to	500
#3	501	to	1,000
#4	1,001	to	2,000
#5	2,001	to	3,000
#6	3,001	to	5,000
#7	5,001	to	8,000
#8	8,001	to	12,000
#9	12,001	to	18,000
#10	18,001	to	25,000
#11	25,001	to	40,000
#12	40,001	to	100,000
#13	100,001	to	250,000
#14	250,001	and	over

Cost corresponds to costs incurred during the time benefit accrued. For example:

The cost of resetting a simple fracture of the leg (including drugs, cast, appliances, physician and outpatient charges, x-ray, and necessary physical therapy) is in cost interval #4. Costs are not likely to be incurred beyond the time the leg is rehabilitated (approximately six months). However, the benefit extends over the remaining lifetime of the patient.

A chronic condition such as insulin dependent diabetes is in cost interval #11. This represents the life-time costs of repetitive treatments consisting of office visits, drugs, and medical supplies. Benefits will extend over a shortened life span.

Not included are the costs to society, indirect costs to the individual, other non-medical expenses and costs of "without treatment." Included costs are

hospitalization, professional services, non-medical but prescribed services and ancillary services.

DEVELOPMENT OF COSTS

Originally, the intent was to use specific costs of treatments. This was adapted due to an expected range of possible costs and the insensitivity of the formula to minor variations in the cost. "Relative costs" were the important factor. That is, it was necessary only to know that one procedure was 100 times less expensive than another. The "costs" were used in a ratio which reflects relationship rather than a meaningful number.

Data on relative costs of service (diagnosis, procedure, follow-up, and ancillary services) and the period over which each cost was paid out was provided by Oregon Medical Assistance Programs' (OMAP) Medicaid Management Information System (MMIS). MMIS consisted of claims submitted for medically needy and Medicaid populations since July 1, 1985. The average client receives assistance for nine months. Therefore, the average costs of treatment (diagnosis, procedure, follow-up, and ancillary services) over a minimum of nine months was provided. In order for the costs to be accrued, recipients had to have been in the system at least nine months without an interruption of greater than two weeks during that period.

The claim data were grouped as follows:

- -- professional services
- -- ancillary services defined as laboratory, radiology, medical diagnosis and therapy
- -- outpatient hospital services which include emergency room
- -- hospital services defined as inpatient treatments
- -- drugs defined as all prescription or over-the-counter drugs paid for by Medicaid

Data was sorted according to primary ICD-9 code based on the professional billing date. All services rendered within certain time frames were considered part of that treatment unless another professional billing with a different primary ICD-9 was submitted during that time frame.

For inpatient and outpatient hospital services 11 hospitals representing over 70 percent of all Medicaid and medically needy admission had submitted claims to OMAP for the purpose of recording charges. For radiology and

laboratory, a window of three weeks was used to collect data around an office visit. For durable medical equipment and therapies, a window of three months post-professional visit was utilized. Drug therapy data varied from the billed charges for other services in that actual payment data was used. This was done due to the significant variation in charges by provider.

These costs were representative of payments made over all stages of a condition. Therefore, in the cases where costs were incurred over the entire time period in which the treatment was beneficial (e.g., chronic conditions, transplants, etc.), the average yearly cost was computed and multiplied by the duration of benefits for the total cost of that treatment. In the case of acute conditions or single episode treatments, costs referred to a single episode of the condition and therefore represented the total cost of treatment.

The problems of identifying costs proved to be:

1) **Costs are not gathered per diagnosis.** Providers do not collect cost information on the basis of condition/treatments or require diagnosis on all billings for ancillary services.

2) **Inaccurate coding.** Providers may only bill for a primary diagnosis. For example, if a patient is being treated for depression and in a subsequent visit requires medication for another diagnosis (e.g., poison oak), the office visit would be attributed to depression with the resultant medication tied to depression.

3) **Limitations of OMAP's MMIS data.** Thirty-seven (37) percent of AFDC recipients are in pre-paid programs. Coopers & Lybrand tested the data and found that the remaining charges were reflective of the population at large. There was also a concern that the number of claims submitted for some diagnoses may not be large enough for reliable information.

   Mental health and dental claims are not included in OMAP's database except for acute inpatient treatments. All outpatient mental health and chemical dependency therapies are handled at a clinic level and there is no known way of linking diagnosis and outpatient treatments. However, the mental health care and chemical dependency as well as dental providers were able to provide estimated cost data which include both public and private charges.

4) **Without treatment costs**

Due to the lack of available information about the costs of not treating, the Commission decided to eliminate without treatment costs from the formula. The Health Outcomes and the Mental Health Care and Chemical Dependency (MHCD) Subcommittee tested the formula by including and excluding various components of cost. The effects of these variations changed the order of the ranking of mental health and chemical dependency condition-treatment pairs. The cost-benefit ratio was tested in three configurations:

a) **including net cost:** The net cost (cost with treatment less cost without treatment) is divided by the product of net benefits (benefits with treatment less the benefits without treatment) and duration of treatment benefit. The health cost of providing services for exacerbated conditions which may develop in the absence of treatment defined cost of no treatment.

b) **excluding cost of no treatment:** The cost of treatment is divided by the product of net benefits (benefits with treatment less benefits without treatment) and the duration of treatment benefit.

c) **excluding all costs:** All costs are excluded. Net benefits (by which to rank) are the sole measure.

The three tests created lists which bore no resemblance to each other. The definition of cost had a crucial impact on the order in which condition and treatment pairs rank. Therefore, selected institutions and providers were approached to try to at least identify whether costs of withholding care were significant or would exceed the cost of care.

The thought was that when the cost of not providing care is more than the cost of treatment a method would be developed to account for that factor in the formula or in the adjustments the Commissioners would make to the draft prioritized list of health services.

This effort proved to be unsuccessful. Not all condition/treatment pairs were responded to and the measurement of cost of not treating was applied unevenly. The Commission confirmed its decision to exclude the cost of non-treatment from the cost-benefit ratio. The medical and indirect costs of non-treatment were considered in the value attribute of "value to society" (see Appendix G).

DEFINITION OF HEALTH STATES

Mortality

The probability that death (which includes suicide and accidental death) will be the result of treatment or no treatment.

Morbidity

Morbidities are significant residual effects comprised of symptoms and functional impairments. They may be conditions remaining because of the inability of the treatment to return the patient to their former health state or conditions created by the treatment itself.

Health professionals chose up to three scenarios to describe outcomes in addition to death and return to former health state. Each of these three scenarios were described by picking one chief complaint from a list of symptoms provided. Functional impairment modifiers, also chosen from a list provided, were incorporated as a means of indicating severity.

The list of symptoms and functional impairments which health service providers used to described outcomes with and without treatment was the same list used in the telephone survey described in Appendix C. The weights generated by the survey were used to represent the providers' fact judgments in the benefits portion of the cost-benefit ratio.

Return to Former State of Health

This described a return to the health state present before the onset of the condition being treated. A former state of health need not describe a state of perfect health.

DURATION OF BENEFIT

The duration of benefit is the length of time a treatment is effective. If the condition being evaluated does not reduce one's expected life span, the duration of benefit is the expected remaining years of life. However, some conditions shorten expected life span. In these cases the duration of benefit was modified to reflect the shorter life expectancy.

The median age at onset of diagnosis is necessary to determine the years of benefit for a lifetime duration. The Commission defined the age cohorts that appear in "Data Collection Instruction" in this appendix. When a specific year was not given for the median age, the midpoint of the age cohort given was used for calculation purposes.

For example, if the presentation of a certain non life-threatening condition occurs in young adulthood the duration of benefit is calculated as:

75 yrs.	Life expectancy
- 27 yrs.	Midpoint of young adulthood cohort
48 yrs.	Duration of benefit

The above example illustrates the calculation of duration of benefit for the majority of cases--both acute and chronic. There are only three cases where this method does not apply:

-- Self-limited condition. A duration of only 5 years is applied to residual effects. For the small percentage who may die, a lifetime benefit applies.

-- Shortened expected life span. In this case the duration of benefit is the number of years remaining of the shortened life expectancy. If, in the above example, the patient could expect to live 60 years instead of 75, the duration of benefit would be reduced to 33 years (60 - 27 years).

-- Treatment of specified duration. Some treatments may have to be repeated during a patient's lifetime. For example, it is expected that a hip replacement will last about 10 years.

DATA COLLECTION INSTRUMENT

Outcomes are the measure of effectiveness of a health service. The Commission identified the best source for expected outcomes for health services as the individual practitioner or specialist. Professional specialty organizations and individuals known to be proficient in their field provided data based on collective experience and training.

Following is a facsimile of the data collection instrument, list of functional impairments and symptoms, and instructions. The instructions and instrument were revised many times as work progressed and inconsistencies were identified. In fact, the accompanying instrument incorporates two data elements which were abandoned.

For each diagnosis and a given treatment the following information was requested:

1) ICD-9 (*International Classification of Disease*) or DSM-III-R (*Diagnostic and Statistical Manual of Mental Disorders*) codes for each diagnosis.

   ICD-9 and DSM-III-R codes are accepted as the standard by the health care community internationally. These reference codes classify conditions by system or cause of disease. Diagnostic-related groups (DRGs) were considered as a source of diagnosis identification. The Commission decided not to use them because they do not include outpatient therapies, are very broad and may include comorbidities.

   To reduce the final list of prioritized health services to a manageable number and preserve continua of care, providers were encouraged to group condition and treatment pairs. This was done when services provided for similar conditions had similar expected costs and benefits. Such a grouping is exemplified by open shaft fractures. This is also true for conditions which will follow a progression requiring certain treatment at the beginning but very often progressing to the point of additional, different therapy, as in the case of Chron's Disease.

2) CPT-4 (*Current Physician's Terminology*) or ADA (American Dental Association) codes for a given treatment of a diagnosis.

   CPT-4 codes were used because current insurance practices require physician services to be billed utilizing these codes. They are also currently in use by Medicaid in Oregon.

   All medical therapy was described by the range of CPT-4 codes 90000 through 99999. This was determined to be most representative of the costs of medical therapy and does not limit the physician in the practice of medicine.

3) Median age at onset of diagnosis.

   Providers were requested to provide a median age of condition onset in order to calculate the duration of the treatment benefits.

   The following age cohorts were defined to facilitate choice of median age by the providers. The concept of age cohorts was defined on the basis of differences in the types of illnesses likely to occur at a given age and the body's changing responses to treatment. The mid-point in the age range was used in the calculation of duration of benefit and quality adjusted life years.

Infancy under	1 year of age
Child	1 - 10
Adolescent	11 - 18
Young Adult	19 - 35
Middle-Aged Adult	36 - 55
Senior Adult	56 - 70
Elderly	over 70

4) Probability of administering the treatment designated for the diagnosis.

   The intent of gathering this information was to collect information that could potentially offer verification to consensus data collected. It had been hoped that for a given diagnosis and all possible treatments, the frequency of delivery of each of the possible treatments would be specified. However, as data collection progressed, it became clear that the information would be of little use. Many providers responded that if a

given treatment were indicated, it would be administered 100 percent of the time. It happens that there are few situations in which an array of equally suitable treatments are available for selection.

5) Expected duration of benefits from the treatment.

This is the length of time for which a treatment is effective. If the treatment would have a lifetime effect, this was indicated by "LT." An example of a lifetime effect would be setting a broken leg. Otherwise, the number of months or years of benefit or shortened life span was specified.

6) Outcome probabilities with and without treatment.

(NOTE: THE LIST OF SYMPTOMS AND FUNCTIONAL IMPAIRMENTS CAN BE FOUND IN APPENDIX C.)

Outcome probabilities measure the possibility than a person may die as a result of treatment, be "returned to former health state," or endure significant residual effects (morbidities) because of or in spite of treatment. Outcome probabilities are also specified for no treatment. These probabilities are added to equal 1 for a total picture of the condition/treatment outcomes which would include death, "return to former health state," and limping, being bedridden, and pain, etc. with treatment or without treatment.

Asymptomatic is shorthand for "return to former state of health." It is recognized that a former state of health may not be perfect health. It simply describes returning to the point at which the patient functioned before the onset of the condition evaluated.

Providers were asked to consider the effects of not treating. What is the probability a person would die or be asymptomatic? What are the probabilities of an individual being left with significant residual effects (morbidities) from not being treated? The constraint on estimating probabilities was that they had to equal 100 percent. Providers were given three opportunities to describe significant morbidities. In each of the three cases, one symptom could be selected and as many as three descriptors for functional impairment.

The same process was repeated for effects of treating: estimating probabilities of death, return to former health state, and morbidities not to exceed 100 percent and designating what the significant morbidities would be as a result of treatment.

In the final computations, "taking medication or staying on a prescribed diet" was discarded as a significant residual effect. Providers did not differentiate between medication which usually produces significant side-effects (e.g., immuno-suppressants) and medication which does not (e.g., aspirin).

7) Cost with and without treatment.

The majority of providers were unable to contribute exact cost information. Exceptions were in the areas of transplantation, dental care, and mental health and chemical dependency.

Cost with treatment represented the total cost of medical and ancillary treatments necessary to effect positive outcomes. Costs without treatment include those costs associated with not treating a condition. It does not include costs such as societal costs, funeral expenses, indirect or other non-medical care costs.

IMPACT OF COST-BENEFIT ON FINAL PRIORITIZATION

A correlation analysis was performed to indicate to what degree the variation of individual components of the formula affected the rankings. These variations may be due to measurement error in the survey, biased opinions in the fact judgments given by experts, or changes in the component values over time.

The cost-benefit ratio was shown to have a correlation of some significance on the final ranking; however, the cost-benefit components of net benefit and quality of life years (duration of benefit x net benefit) do appear to have a significant role in the rankings.

	Component	Correlation to rankings	Significance level
1.	Cost	-.037	.342
2.	Duration of Benefit	-.235	.0001
3.	Net Benefit	-.466	.0001
4.	Quality Adjusted Life Years	-.396	.0001
5.	Cost-Benefit Ratio	.100	.011

The only correlation not significant at the =.05 level is for cost, and therefore has no significant influence on the final rank. The three components duration of benefit, net benefit and quality adjusted life years had very high correlations ($p<.0001$) with the final ranks. The negative correlations indicate that the higher the value of the component, the higher the service will tend to be on the prioritized list. As a whole the cost-benefit ratio did have a significant correlation at the =.05 level but it was not nearly as strong as a relationship as that between the rank and the net-benefit alone. Note that the positive correlation between ratio and rank indicates that the more cost effective services will tend to be prioritized higher on the list. The strong correlation between net benefit and rank indicates its relative importance in the prioritization process in comparison to the cost-benefit ratio. (See Chapter 2 for discussion.)

This information is being requested to develop the expected outcomes of a given treatment. It is understood that some outcome data may be subjective in nature. A disease may be bimodal with significantly different outcomes occurring dependent on age of onset or vary according to the extent of the disease at the time of presentation (stage). If this is the case, please use two or more lines to define the condition. An attachment sheet accompanies this package to define the major categories to be evaluated. PLEASE THINK OF THE AVERAGE PATIENT THAT PRESENTS WITH THIS CONDITION, NOT THE EXTREMES. Any references or supporting documentation would be appreciated. Please contact the Commission staff at 378-6575 for any questions.

INSTRUCTIONS

ICD-9 Codes and Diagnosis

Please list both the ICD-9 code and a brief description. These may be grouped as much as possible.

CPT-4 and Procedure

Please list both the CPT-4 code used for treatment of this condition and a brief description. Group procedures that are similar in efficacy as much as possible. Please be prepared to identify any ancillary service (such as radiology, physical therapy) that may assist this procedure.

Median Age for this Treatment of the Condition

Please provide a median age for the this treatment of the condition. The cohort code listed on the attachment should be used if specific ages cannot be identified.

Probability that Treatment for the given Diagnosis will be Applied

Please provide your best estimate in percentages for the incidence of this treatment for the given condition.

Expected Duration of the Treatment Result

Please indicate the length of time that the treatment result will continue to be effective for the condition. If the beneficial effects persists for the future lifetime of the patient, indicate "LT".

Outcome Probability

Please provide your best estimation of the percent of the time that certain outcomes would occur five (5) years hence not given evaluated treatment and with treatment. The outcome expectations should not exceed 100% of the population for no treatment and with treatment.

The outcomes are:

1. Death
2. Residual Effects
3. Residual Effects
4. Residual Effects
5. Asymptomatic

The residual effects columns may be used to define health states intermediate to death and the return to prior health. Each column used must contain a single number designating the major symptom and may include up to three alpha codes, each one representing an impairment of physical or social activity and mobility. See attachments for major symptom and physical, social and mobility codes.

Cost

Please give your best estimate of the cost of the condition for the lifetime of the patient without the aforementioned treatment and with the treatment, if you are able.

THANK YOU FOR YOUR TIME AND INFORMATION

CODE	MAJOR SYMPTOM
1	Loss of consciousness such as seizure (fits), fainting, or coma (out cold or knocked out)
2	Burn over large ares of face, body, arms or legs
3	Pain, bleeding, itching, or discharge (drainage) from sexual organs - does not include normal menstrual (monthly) bleeding
4	Trouble learning, remembering, or thinking clearly
5	Any combination of one or more hands, feet, arms or legs either missing, deformed (crooked), paralyzed (unable to move), or broken - includes wearing artificial limbs or braces
6	Pain, stiffness, weakness, numbness, or other discomfort in chest, stomach (including hernia or rupture), side, neck, back, hips, or any joints or hands, feet, arms, or legs
7	Pain, burning, bleeding, itching, or other difficulty with rectum, bowel movements, or urination (passing water)
8	Sick or upset stomach, vomiting or loose bowel movement, with or without fever, chills, or aching all over
9	General tiredness, weakness, or weight loss
10	Coughing, wheezing, or shortness of breath, with or without fever, chills, or aching all over
11	Spells of feeling upset, being depressed or of crying
12	Headache, or dizziness, or ringing in ears, or spells of feeling hot, or nervous, or shaky
13	Burning or itching rash on large areas of face, body, arms, or legs
14	Trouble talking, such as lisp, stuttering, hoarseness, or being unable to speak
15	Pain or discomfort in one or both eyes (such as burning or itching) or any trouble seeing after correction
16	Overweight for age and height or skin defect of face, body, arms, or legs, such as scars, pimples, warts, bruises, or changes in color
17	Pain in ear, tooth, jaw, throat, lips, tongue; several missing or crooked permanent teeth - includes wearing bridges or false teeth; stuffy, runny nose; or any trouble hearing - includes wearing a hearing aid
18	Taking medication or staying on a prescribed diet for health
19	Wore eyeglasses or contact lenses
20	Asymptomic problem
21	Has trouble falling asleep or staying asleep
22	Has trouble with sexual interest or performance
23	Is often worried
24	Has trouble with the use of drugs or alcohol

*Revised from Robert M. Kaplan and John P. Anderson

CODE	CLASSIFICATION	MEDIAN AGE* (in years)
I	Infancy	under 1
C	Child	1 - 10
A	Adolescent	11 - 18
Y	Young Adult	19 - 35
M	Middle-Aged	36 - 55
S	Senior Adult	56 - 70
E	Elderly	over 70

*Age group at which the condition must frequently occurs.

CODE DEFINITIONS

MOBILITY SCALE (MOB)

MT Did not drive a car, health related; did not ride in a car as usual for age (younger than 15 yr), health related, **and/or** did not use public transportation, health related; **or** had or would have used more help than usual for age to use public transportation, health related

MH In hospital, health related

PHYSICAL ACTIVITY SCALE (PAC)

PW In wheelchair, moved or controlled movement of wheelchair without help from someone else; or had trouble or did not try to lift, stoop, bend over, or use stairs or inclines, health related; **and/or** limped, used a cane, crutches, or walker, health related; **and/or** had any other physical limitation in walking, or did not try to walk as far or as fast as others the same age are able, health related

PB In bed, chair or couch for most of or all of the day, health related; or in wheelchair, did not move or control the movement of wheelchair without help from someone else, health related

SOCIAL ACTIVITY SCALE (SAC)

SL Limited in major or other role activity, health related, or performed no major role activity, health related, but did perform self-care activities

SN Performed no major role activity, health related, **and** did not perform or had more help than usual in performance of one or more self-care activities, health related

APPENDIX E

PUBLIC HEARINGS

1) **Public Hearings Overview**

2) **Testimony by Topic and City**

PUBLIC HEARINGS OVERVIEW

Twelve (12) public hearings were held in Portland, Salem, Pendleton, Eugene, Bend, Coos Bay and Medford. The purpose was to accept testimony and information from advocates for seniors, handicapped persons, mental health services consumers, low income Oregonians, and providers of health services. Oregon Fair Share provided door to door canvasing to encourage attendance, supplied the media with public service announcements concerning meeting times and places, and posted flyers announcing meetings. Meeting announcements were also included with Medicaid card mailings from Oregon's Office of Medical Assistance Programs. The process was aided by the support of the Oregon Health Action Campaign which represents 72 grass roots organizations.

The number of people testifying to the Commission ranged from 13 in Coos Bay to 62 in a Portland hearing with a total of over 1,500 people attending.

Testimony generally was not useful in measuring treatment effectiveness objectively but was useful for understanding the general tone of public needs and concerns. The message was delivered that dental, preventive and mental health care and chemical dependency services should be a part of the health services available.

TESTIMONY BY TOPIC AND CITY

TOPIC	TOTAL	Medford 11/03/89	Pendleton 11/17/89	Portland 12/01/89	Salem 12/15/89	Eugene 01/12/90	Portland 01/26/90	Bend 02/09/90	Coos Bay 02/23/90
Preventive Medicine	38	6	7	4	6	3	7	1	4
MHCD Services	38	7	3	2	4	11	10	1	0
Dental Services	19	6	2	1	1	2	6	1	0
Vision Services	7	1	0	0	1	1	4	0	0
Hearing Services	5	1	1	0	2	1	0	0	0
Govt. Budgetary Concerns	24	4	1	2	1	7	6	2	1
Individual Budgetary Concerns	8	0	1	1	1	0	3	2	0
Prenatal Care	15	3	1	2	2	0	4	1	2
Transplant Services	13	2	0	4	1	1	2	2	1
Univ. Access/Nat'l Health Care	34	6	3	2	6	4	12	0	1
Basic Health Care Package	19	1	2	3	2	3	7	0	1
Alt. Health Care Provider	34	2	4	6	9	9	4	0	0
Experimental Procedure	3	0	0	1	1	1	0	0	0
Education	13	3	0	5	0	1	1	1	2
Nutrition	4	1	0	0	1	0	0	1	1
Eliminate Unnecessary Treatments	6	1	0	4	1	0	0	0	1

APPENDIX F

COMMUNITY MEETINGS

1) *Health Care in Common*, Report of the Oregon Health Decisions Community Meetings Process, April 1990

HEALTH CARE IN COMMON

REPORT OF THE OREGON HEALTH DECISIONS COMMUNITY MEETINGS PROCESS

Report to the Health Services Commission to Identify Public Values for Use in the Health Services Prioritization Process

April 1990

by

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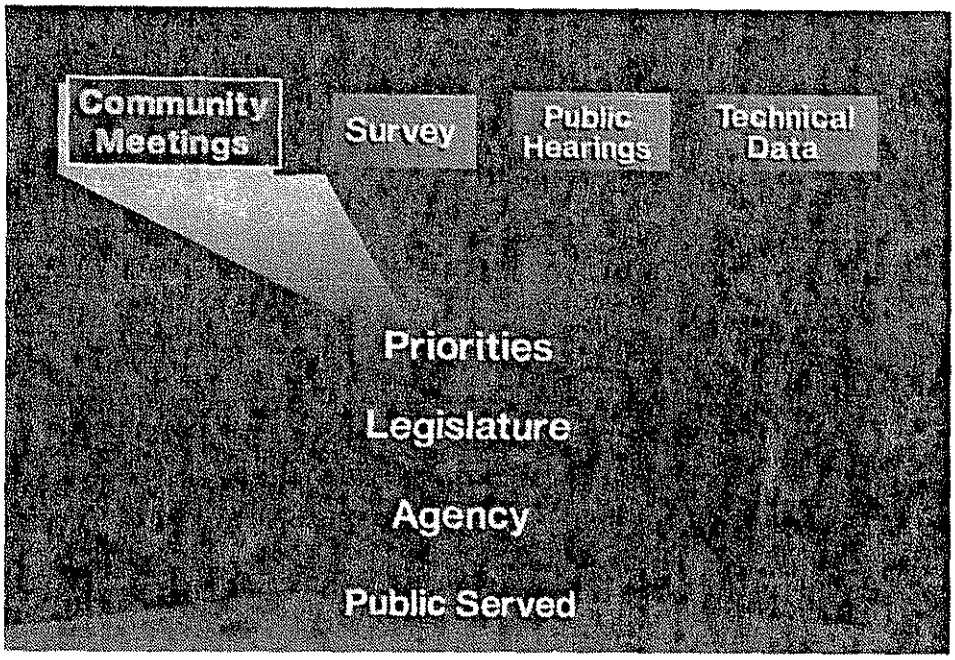
HEALTH CARE IN COMMON



REPORT OF THE OREGON HEALTH DECISIONS COMMUNITY MEETINGS PROCESS

APRIL 1990

Oregon Health Decisions

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Foreword

This report describes "community values about health care." But what are *community values*? How are community values *expressed*? How do community values fit into the Health Service Commission's process of setting priorities for health care services?

At the forty-seven community meetings from which this report derives, we defined values as the answer to the question, "Why is this health care service *important to us*?" Every attempt to answer that question led to an expression of values. The expression often started with an individual's point of view, but our question was always, "why is this important *to us as members of a community*?" By speaking out about our values to one another we discover whether we share some values, whether we have an unspoken consensus, whether we are in fact a community for whom some kinds of health care constitute a *common* good.

On the following pages, we summarize common themes that emerged at the community meetings. These common themes describe a consensus about what Oregonians think makes health care a valuable part of community life. The report necessarily involves interpretation and paraphrase, but we present it with the conviction that it is an authentic rendering of the many expressions of community values about health care our meeting facilitators heard and reported to us.

As individuals, we can trust our sense of priorities only when we have been able to examine our values in relation to the best factual information we can find about the things among which we have to choose. The best car, or best college, or best job is neither a purely factual judgment, nor, if we choose wisely, an arbitrary choice. Members of a community weighing their values about health care are like the individual trying to make a wise choice. The wisdom of a social choice, such as setting priorities for health care allocations, depends on thoughtfully combining reliable facts and authentic values.

This report provides the Health Services Commission with a *perspective* for testing the authenticity of the values that will "guide health resource allocation decisions." These expressions of *community values* complement the expressions of *individual values* which the Commission developed through its random survey of Oregonians and by taking testimony at the public hearings in 11 cities around the state. All of these expressions of values combined with factual information about health services will be the basis of the Commission's priorities.

With this report, therefore, we transmit the hopes and concerns of more than a thousand Oregonians who participated in the Oregon Health Decisions Community Meetings Process during January, February, and

March of 1990. We gathered in groups all over the state to explore the challenge and the promise implied in the fact that, as taxpayers and insurance subscribers, as providers and patients, as members of the Oregon community, we generate and hold the good of health care in common. This is what we citizens want to tell the Health Services Commission.

Executive Summary

The Health Services Commission requested Oregon Health Decisions to hold community meetings throughout the state of Oregon "to build consensus on the values to be used to guide health resource allocation decisions." A 29 member Project Advisory Committee was appointed to develop the slide show format and report forms and to best determine outreach strategies to ensure that a cross section of the general public attended the community meetings. Twenty-five volunteer facilitators, 24 volunteer coordinators and nine facilitator/coordinators were recruited from communities throughout the state to assist with this project. A training session was held in Portland for all facilitators and coordinators to familiarize them with the materials and the process of the community meetings.

Oregon Health Decisions scheduled fifty meetings throughout the state during January, February and March, 1990. Forty-seven meetings were actually conducted because weather conditions resulted in the cancellation of three meetings which were subsequently not rescheduled. In total, one thousand and forty eight (1,048) Oregonians gathered in community meetings across the state to express their values, essentially reflecting upon answers to the question, "why are certain health care services important to us?"

This report is a compilation of the values expressed at all of the health decisions community meetings held in Oregon. Some values were expressed more frequently than others. All are included in this report. What values do Oregonians want the Health Services Commission to use in guiding the process of prioritizing health care services? The following are values Oregonians indicated should be considered. (The frequency of discussion of each value is shown in parenthesis).

1. Prevention (very high-all community meetings)
2. Quality of Life (very high-all community meetings)
3. Cost Effectiveness (high-more than 3/4 of community meetings)
4. Ability to Function (moderately high-3/4 of community meetings)
5. Equity (moderately high-3/4 of community meetings)
6. Effectiveness of Treatment (medium high-more than 1/2 of community meetings)
7. Benefits Many (medium-1/2 of community meetings)
8. Mental Health and Chemical Dependency (medium-1/2 of community meetings)
9. Personal Choice (medium-1/2 of community meetings)
10. Community Compassion (medium low-less than 1/2 of community meetings

11. Impact on Society (medium low-less than 1/2 of community meetings)
12. Length of Life (medium low-less than 1/2 of community meetings)
13. Personal Responsibility (medium low-less than 1/2 of community meetings)

Each of these values reflects the comments, arguments, hopes and ideals of many individuals, and each is a synthesis formed of at least several approaches to the same general objective. It is the general objective for which the value has been named. It also bears reinforcing that the process as described does not allow for a "scientific" analysis of the values above. Our population base was not a random sample of Oregonians. The participants at these meetings were a self-selected group, many with a prior interest in health care. Hence the frequency with which each value was discussed is listed only to give a very rough quantitative idea of the importance of each value to the Oregonians at the community meetings. All opinions, if voiced by as few as a single participant, receive mention in this report. We hope that in their numbers, thoughtfulness and opinionated character, the participants in the community meetings addressed most of the issues important to most Oregonians.

While more than 1,000 Oregonians participated in the community meetings process, perhaps our chief concern has been the numbers of low income individuals, those directly impacted by Senate Bill 27, represented at the community meetings. The number of participants at each meeting ranged from 3 to 120, with an average of 20, and they reflected a variety of backgrounds. Nevertheless, demographic sheets filled out by participants reflect an imbalance with fully 90% of participants being insured while only 4.4% were Medicaid recipients and 9.4% were uninsured. Of interest, however is the fact that several individual meetings had much higher percentages in the latter two categories with no striking differences in values discussed. Notwithstanding this apparent concordance, outreach to low income individuals with an eye towards their inclusion in the community meetings process has been, and should continue to be, a high priority.

All of us who have been involved with this process will continue to support community meetings as a vehicle to involve the public in, and educate the public about important issues that affect all our lives. We will take with us lessons learned about what we did right this go around and what we can improve upon in the next.

The Process

On September 14, 1989, the Health Services Commission held its first meeting at the Kaiser Town Hall Auditorium. The eleven member Commission unanimously endorsed Oregon Health Decisions to carry out the charge of the Commission defined in Senate Bill 27 to "actively solicit public input through a community meetings process to build a consensus on the values to be used to guide health resource allocation decisions." Oregon Health Decisions recruited a full time project coordinator and half time project assistant for the Community Meetings Project.

A 29 member Project Advisory Committee was appointed representing citizen advocate groups, business, community, and professional organizations, and the Health Services Commission. The Advisory Committee met twice a month over a four month period. The Advisory Committee was divided into three subcommittees:

1) The Outreach Subcommittee was responsible for encouraging the public to attend and participate in the community meetings to generate broad representation from the citizens of the areas surrounding the communities in which the meetings were held.
2) The Slide Show and Format Subcommittee was responsible for developing and reviewing the content of the introductory slide show, information presented at the community meetings, and the format of the community meetings
3) The Report Forms Subcommittee was responsible for reviewing and developing the forms used to report the results of the community meetings.

The subcommittees held regular meetings in addition to the twice a month meetings of the whole Advisory Committee, and worked closely with the Social Values subcommittee of the Health Services Commission.

Oregon Health Decisions held training sessions in Portland on January 5th and 6th for the 25 volunteer facilitators, 24 volunteer coordinators, and nine volunteer facilitator/coordinators who were recruited from around the state. The facilitators conducted the local meetings and prepared the final reports of the meetings which they forwarded to Oregon Health Decisions. The coordinators were at the organizational end of the meetings and were responsible for outreach, publicity, and securing a meeting location. The project has absorbed over 5000 hours of volunteer time and energy. The great amount of volunteer assistance was critical to the success of the project and illustrates the strong sense of community prevalent in Oregonians.

The first set of community meetings were held in Multnomah and Washington counties on January 16, 1990 followed by a flurry of activity around the state over the next two months sometimes involving three or four meetings in different cities in a single evening. The meetings were scheduled to take place over a two hour period, but in many instances the discussions were so dynamic that the participants choose to go overtime. All of the meetings followed the same format to provide a measure of consistency in a setting where discussion had the opportunity to vary from community to community in terms of the values expressed by participants. The format was designed to ensure that there would be a consistent system to report the values of all the meetings to Oregon Health Decisions so they could be compiled into this final report, in turn, ensuring every community's values were indeed recorded and heard. The format consists of:

1. Informational materials handed out to participants
2. Introductions/settling in,with participants seated in tables of 6 to 10
3. Slide show presentation
4. Review of plan for the meeting
5. Questions and answers
6. Instructions to participants
7. Individual questionnaire completed in preparation for group discussion
8. Group discussion and completion of the group report form
9. Groups report results of the group consensus to whole meeting room and the results are recorded by the facilitator
10. Discussion of results and consensus of whole meeting
11. Participants encouraged to send in comments to Oregon Health Decisions
12. Meeting facilitator writes up report of community meeting and forwards to Oregon Health Decisions

VALUES

PREVENTION

Frequency of discussion: Very high (all community meetings)

Meaning:
Prevention includes the following--a health care service which prevents illness (e.g., immunizations, prenatal care), detects symptoms at an early stage (e.g., mammograms, cholesterol and blood pressure screenings) or prevents a problem from degenerating to a more severe state (e.g., drug and alcohol treatment, insulin for diabetics).

Value:
Participants felt prevention was valuable because it increases quality of life, is perceived to be highly cost effective, often works through education which is empowering to the individual, and because it can benefit large numbers of people.

Discussion:
This value was expressed at all of the community meetings and there was unanimous support for preventive services being prioritized high on the list. The reasons cited supporting the importance of preventive services came from underlying values that apply not only to prevention, but to other services as well. The most common reasons given by participants at the community meetings include such issues as:

1) **prevention is cost effective**
2) **it improves the quality of life**
3) **it is achievable**
4) **the results can ultimately be seen in a healthier community**
5) **it benefits many people**
6) **ultimately may save resources in the long run, i.e., long term benefit at low cost or even at a net savings.**

In general, participants felt that if people can avert illness and stay healthy it will influence the length and quality of their life in a positive way.

Prevention and education were often discussed as being mutually inclusive. Many Oregonians expressed that prevention through education not only teaches but empowers by promoting healthy habits in consumers. Specifically education concerning alcohol and drug abuse was frequently mentioned as an important preventive measure to curtail the increasing severity of this problem. Also, specific education programs regarding health

Prevention continued....

risks and positive behavior changes were seen as important components of prevention.

Other reasons less commonly mentioned by participants for making preventive services a high priority included that they promote wellness care, responsibility for oneself, and lessen dependence on others By achieving these goals the health of the whole community is ultimately improved. One group felt that incentive programs that promote health should be funded.

They offered the example that dental insurance might fully pay for preventive care every six months but only partially pay for restorative care due to preventable disease. Several communities discussed the importance of getting the young off to a healthy start which would mean funding good prenatal and postnatal care, immunizations, nutrition and health education from a young age. The strong support of preventive services tended to be based on the idea that prevention is related to overall health rather than illness, and that it looks beyond the "health care arena" to improve the overall health status of a community by incorporating such elements as education and quality of life. The community of Lebanon, Oregon may have said it best by stating that prevention encompasses essentially all values and the same underlying values that support other health services ultimately support preventive services.

QUALITY OF LIFE

Frequency of discussion: Very high (all community meetings)

Meaning:
Services which enhance Quality of Life are those which enhance a person's productivity and emotional well being, restore an individual's health, reduce pain and suffering, and allow one to function independently.

Value:
High quality of life was felt to be valuable because it increases emotional well being, reduces pain and suffering, and increases productivity, independence, and length of life.

Discussion:
The value, quality of life, initially led to discussions about who had the right to make decisions regarding one's quality of life. The Hillsboro community felt that quality of life was not a medical judgment. The Florence community reiterated this same point by stating that it is one's own perception that constitutes the definition of "quality of life" and the Medford community further echoed this sentiment by stating that "an individual defines quality of life for oneself, not the government or the service provider."

Given that "quality of life" is a difficult value to articulate, because it falls under the umbrella of subjective judgement, and hence must be an individual understanding, Oregonians found it difficult to define objective criteria for quality of life itself. **Services with the goal of enhancing a person's productivity and emotional well being, restoring an individual's health, reducing pain and suffering, and allowing one to function independently were seen as geared towards increasing quality of life.** The Roseburg community articulated the meaning of quality of life as the: "This is the 'will it fix what is wrong with me?' value...What quality of life is differs among individuals. It does not mean making a 55 year old feel like a teenager. It does not mean giving a knee operation to a person so he/she could run a marathon if he/she did not have chronic emphysema. It is making an average 55 year old feel like an average 55 year old."

Discussion of **quality of life almost inevitably became intertwined with that of length of life.** The majority of communities voiced their support for services that improve both quality and length of life, but if a service only prolongs life then its merit was not considered to be as strong. Optimally, treatments that give long term value are more important than treatments where benefits are short term. However, some communities expressed that even if a service improves quality of life for a short time, it may be worth it because that short life has value. However, this is different from

Quality of life continued...

simply prolonging life, or as some communities put it, prolonging death. It was generally agreed that measures that do not improve quality of life or do not allow one to die with dignity should not be given a high priority. Highest priority should be given to those services which provide long term quality of life. As the participants of the Oregon City community meeting stated "no prolongation if there is no quality of life."

The community of Klamath Falls added another dimension to the quality of life value by pointing out that it was important not to forget to consider the quality of life of the family impacted by a loved one's illness.

COST EFFECTIVENESS

Frequency of discussion: High (more than 3/4 of community meetings)

Meaning:
Cost effectiveness includes looking at the cost of a treatment through a cost/benefit ratio. Services that cost little and produce positive outcomes in the long run, have a low cost/benefit ratio and are highly cost effective.

Value:
Cost effectiveness was seen as valuable because it maximizes benefits while minimizing costs. That is, services are valuable that bring the greatest improvement for the amount of money, time, energy, etc., spent.

Discussion:
Cost effectiveness of a service was brought up frequently as a value that should guide the prioritization of health services with those services that are most cost effective holding a higher position on the list. However, many communities expressed concern that, although the cost of treatment, measured through a cost/benefit ratio, should be considered an important guiding criteria, cost should not be the most important determining measure. The Lebanon community mentioned that it is important to look at the issue of **saving money, not as a primary goal but as an end product,** particularly in relation to prevention.

This value **again returns to prevention** in that preventive services were mentioned as being cost effective, e.g.,"healthy people save money in the long run." Communities repeatedly stated that priority should be given to those treatments that cost little and produce positive outcomes in the long run (e.g. immunizations, prenatal care). Participants at the La Grande and Tillamook community meetings put it simply as "more bang for the buck" and stated that they were in favor of getting a good return on health care investments while they were not in favor of paying over and over again for a treatment if resources were limited and there was a very slight chance or no likelihood for cure. The dominant theme in discussion of this value was **to maximize dollar for dollar effectiveness towards provision of care.**

Participants at the meetings frequently voiced their frustration at the amount of money funnelled into bureaucratic administrative costs rather than into the provision of actual health care services.

ABILITY TO FUNCTION

Frequency of discussion: Moderately high (3/4 of the community meetings)

Meaning:
Ability to function includes emotional well being, productivity (not necessarily economic), independence, and restored quality of life.

Value:
Ability to function was felt to be valuable because it implies restoring a person to a preillness state (or as close as possible) and to independence.

Discussion:
Many Oregonians felt that a service's benefits can be measured by how successful an individual is at functioning in everyday tasks. This refers to treatment aimed at **restoring a person to preillness state (or as close as possible) and independence.** The criteria most often mentioned here was independence. Participants often favored giving high priority to services which will effectively restore a person's ability to function and communicate in society.

The "productivity" component of the "ability to function" value was controversial. Many participants at the community meetings expressed concern that reference to productivity not be misconstrued as economic productivity. Many people feared that this would bias against the poor, minorities and disabled. Productivity, by consensus, was defined as returning an individual back to society as a productive member in terms of fulfilling lives and being able to function independently.

EQUITY

Frequency of discussion: Moderately High (3/4 of community meetings)

Meanings:
Equity was felt to stem from a basic premise that no person should be excluded from receiving health care when they need it. This was often voiced as feeling that government should take more responsibility in the health care arena to work towards the assurance that everyone has equal access to an adequate level of health care.

Value:
Equity was felt to be valuable because it encompasses justice and humaneness in health care, by ensuring equal access to an adequate level of health care for everyone.

Discussion:
Although not all communities defined equity in the same way, the underlying values that came across were those of humaneness and justice. The more frequently mentioned facets of equity were a basic belief that health services should be available for everyone, and that when some go without, it impacts the whole society negatively. The Madras community strongly supported reprioritization at a macro level, i.e., the reallocation of resources, in total, at a state and national level. Many participants throughout the state expressed the concern that national priorities need reexamination with regard to, e.g., defense spending.

The participants at the St. Helens community meeting as well as numerous individuals at many other meetings voiced their support for a **national health insurance plan on the basis that such a plan would facilitate equity in health care delivery.** They voiced concern that the current system [public assistance] is dehumanizing and a national health insurance plan would equalize and humanize the system. The participants at the Eugene community meeting stressed universal access to health care as the only means of achieving equity. One table at the meeting in Multnomah county at the YWCA refused to play the "prioritization game" because they felt that prioritization itself was an issue of justice. The table leader, a person on public assistance, felt strongly that this entire process was unjust because it targeted the poor at this time, although he understood its potential for larger impact in the future.

Equity was also discussed in the context of age. The Florence and Roseburg communities voiced concern that advanced age should not be a reason for denying treatment. In The Dalles this point was reiterated by stating that age and productivity should not be factored into delivery of care. However, with the understanding that advanced age should not be factored in

Equity continued...

as a reason for denying treatment, emphasis to increase access to health care for children was strongly supported by the majority of communities.

The Hermiston community expressed concern that **health care should be equitable in relation to geographic distribution**, i.e., rural areas should not be forgotten. The Burns community indicated the importance of access to emergency or trauma treatment in remote or rural locations. In several communities the discussion of **access to treatment** also revolved around the availability of health care providers and advocated increasing reimbursement to physicians assistants and nurse practitioners in order to improve access in areas without physicians. Support for "low tech" over "high tech" services was often emphasized as a means of more equitably distributing resources.

EFFECTIVENESS OF TREATMENT

Frequency of discussion: Medium high (more than 1/2 of community meetings)

Meaning:
Effectiveness of treatment includes an indication of success rate which incorporates a cure rate, improvement in quality of life, and length of success, with priority going to long term success over short term success.

Value:
Effectiveness of treatment was felt to be valuable because it positively impacts cost effectiveness and quality of life.

Discussion:
The message from this value is, the higher the likelihood (%) of success from treatment, the higher its placement should be on the prioritized list of services. Services with high success rates should be available while services or procedures which have limited effectiveness should be placed lower on the list of priorities. Participants at the Salem community meeting suggested that there may be some drug and alcohol treatments that are more successful than others and expressed concern about funding those treatments that do not demonstrate acceptable success rates.

BENEFITS MANY

Frequency of discussion: Medium (1/2 of community meetings)

Meaning:
A service which benefits larger numbers of the population compared to other services is one which "benefits many."

Value:
Services which benefit many were felt to be valuable because they increase both the cost effectiveness and equity of health care.

Discussion:
This value is tied into cost-effectiveness, and hence into preventive services. The community of Klamath Falls stated that "available funds should be used for routine care that will help more [people], not on transplants or life support when funds are limited. The community of Fossil echoed this same sentiment by stating that "dollars spent on early intervention and maintenance will cover more people than last resort efforts." Many groups agreed that health services that benefit many with the dollars that are available should have higher priority than those which help only a few. The Dalles community questioned whether health care dollars should be put into premature babies if the **likelihood of a good quality of life or effectiveness of treatment** is questionable. Given such a scenario, participants at the meeting felt the dollars would be better spent on programs that would benefit many people. Some meeting participants pointed out that beneficial services are not limited to the patient but extend to the patient's family as well (e.g., a mother's illness and its impact on her children, husband, coworkers, etc.). Some specific services discussed by groups in this regard related to drug and alcohol abuse treatment and prevention such as early detection programs which provide long range benefits for many people.

MENTAL HEALTH AND CHEMICAL DEPENDENCY

Frequency of discussion: Medium (1/2 of community meetings)

Meaning:
Mental health and chemical dependency include education and awareness of alcohol and drugs, especially to populations such as pregnant women where impact on another life can be severely damaging. In addition, this includes services geared towards improving mental health and treatment for substance abusers.

Value:
Services that focus on mental health and chemical dependency were felt to be valuable because mental health is an important component of overall health, and because chemical dependency problems have a large negative impact on society as a whole.

Discussion:
Oregonians focussed discussion on the individual's responsibility in this area. Some communities felt that if a patient is not motivated it is a waste of resources to give treatment. They felt that patient dedication to achieving results should be factored into funding. A few communities suggested that there be a limit on repeat offenders and that recidivism be considered. However, it was also stated that the treatment programs themselves should be looked at in terms of appropriateness for the patient and community, follow up and rate of success. Some people suggested the need to work with the family and situation to increase the chance of a successful outcome. Communities questioned whether it was fair to treat a person without consideration to environmental factors that may lead to recidivism. Also, several participants favored giving special consideration to members who are critical to the family unit.

Communities frequently suggested that more dollars be put in promoting drug and alcohol awareness and education, especially into education about prenatal care. Several communities pointed out that services in this area have an **impact on all of society,** and considering this more money should be funnelled to these services.

The crux of this value is that mental health is as important as physical health according to many Oregonians. They favor a high prioritization for those mental health and chemical dependency programs that are effective.

PERSONAL CHOICE

Frequency of discussion: Medium (1/2 of community meetings)

Meaning:
Personal choice was thought generally to include autonomy and being an active participant in the decision making processes involved in one's own health care. In addition, personal choice meant having the right to choose the type of provider one goes to, whether traditional or nontraditional.

Value:
Personal choice was felt to be valuable because it preserves autonomy and human dignity.

Discussion:
The value of personal choice generated a lot of discussion, and generally speaking, there was rarely full consensus on this issue. Some groups thought of personal choice as a choice of providers while others interpreted it as being choice of treatment, and still others mentioned both freedoms.

The issue of choice of providers was relatively simple. Some people felt that they should have the right to choose the type of provider they go to, either traditional (e.g., medical doctors, dentists) or nontraditional (e.g., naturopaths or midwives). **The discussion that countered this pointed to the value of cost effectiveness.** Would it be cost effective to reimburse all providers so the consumer would have a choice? A participant at The Dalles community meeting pointed out that it could be cost effective if, for instance, one had the choice of going to a dentist or a dental hygienist for basic dental care and one chose the hygienist. Participants at the St. Helen's community meeting expressed their support of allowing individuals choice of providers but with the caveat that some sort of cost control be integrated into this.

Choice between treatment and no treatment was often discussed within the context of personal choice. Participants related this to one's autonomy and being an active participant in the decision making process for one's own treatment or nontreatment. Some participants pointed out that providers need to be sensitive towards providing treatment, realizing that what may be acceptable to one person may not be to another. A point of general agreement, and perhaps the essence of what is meant by personal choice, was that the patient and family should have the right to participate in decisions regarding treatment plans which would include ongoing and heroic measures. Otherwise stated, personal choice entails having the freedom to choose, and protection of the right of informed consent.

COMMUNITY COMPASSION

Frequency of discussion: Medium low (less than 1/2 of community meetings)

Meaning:
Community compassion includes a community concern for life, preserving the integrity of an individual and a family, and compassion for the vulnerable such as children and the elderly. Participants at the community meetings also referred to community compassion in the context of relieving pain and death with dignity (strong support for funding hospice care).

Value:
Community compassion was felt to be valuable because it encourages humaneness in caring, and a sense of community support.

Discussion:
This value addresses caring and humaneness. Community compassion was often described as preserving the integrity of a family or as compassion for the vulnerable in society, e.g., children should have a good start in life while the elderly should be allowed a dignified finish. In addition, participants at several community meetings described compassion as caring for the sick and for victims (i.e.,victims of auto accidents or on the job accidents). Groups frequently attributed community compassion to relieving pain for those with terminal illness. This is meant to include both physical and emotional components of relieving pain. Communities indicated that this would be **achievable through hospice and long term care with a heart.**

IMPACT ON SOCIETY

Frequency of discussion: Medium low (less than 1/2 of community meetings)

Meaning:
This value includes range of impact on society, i.e., positive to negative ratio, and consideration for societal needs and benefits.

Value:
Services with an impact on society were felt to be valuable because certain problems, if left untreated, such as infectious diseases, alcoholism, drug abuse, and child abuse, could have a very negative impact on society and thus affect not only the health of an individual, but the social structure of a community.

Discussion:
Those conditions that have a great ripple effect on society (e.g., child abuse, alcoholism) should be given priority over those that have more limited effects. This was sometimes considered to be different from "benefits many" in that serving a few often has a large impact on the community, whereas "benefits many" was often taken to mean many people receive a treatment or a service. Oregonians expressed that social impact, if high, may supersede cost effectiveness- -or should be factored into cost effectiveness. In addition to the examples above, many communities felt high priority should be given to those diseases which endanger others when left untreated (e.g., communicable diseases, including sexually transmitted diseases). Overall, Oregonians agree that consideration needs to be given to societal needs and benefits in prioritization.

LENGTH OF LIFE

Frequency of discussion: Medium low (less than 1/2 of community meetings)

Meaning:
Length of life includes treatments which extend life beyond what would otherwise occur without intervention.

Value:
Length of life is felt to be valuable when it incorporates the number of years of future functioning and quality of life.

Discussion:
This value addresses the number of years of future functioning. Treatment was viewed as valuable if it extended life beyond what would otherwise occur without treatment. The Lebanon community stated that length of life or extending life has value when quality of life and productivity (not economic) are factored in. However, simply extending life without consideration to quality of life or productivity was not considered valuable. This sentiment was shared by the majority of communities. However, half of the participants at the Hermiston community meeting indicated that "life has value in and of itself."

PERSONAL RESPONSIBILITY

Frequency of discussion: Medium low (less than 1/2 of community meetings)

Meaning:
Personal responsibility includes encouraging individuals to knowledgeably take responsibility for their health, and often implies a responsibility to educate health care consumers.

Value:
Personal responsibility was felt to be valuable because it encourages individual autonomy and control over one's own health and well being.

Discussion:
Communities strongly expressed that individual's should not be completely absolved of personal responsibility for their own health, especially if lifestyles are leading to bad health outcomes. There was considerable concern that this not be construed as "victim blaming", and participants clarified this by stressing that individuals that take responsibility are empowered to take charge and make decisions, potentially increasing the chance of a successful outcome from a service as well as increasing self esteem. It was widely believed that education can be used as a vehicle to increase personal responsibility. Many communities offered the example of someone receiving repeated drug or alcohol rehabilitation, and felt that there need to be limits. Some individuals expressed concern about public responsibility. They related this to the question of what we promote as a society (e.g., smoking, alcohol, and Madison Ave.).

Participants at the meeting at Emanuel Hospital in Portland conveyed a warning in referring to this value. They felt that people are sometimes blamed by society for recidivism when in fact they have not been to a truly appropriate program for their illness, situation, or ethnic background, or when they have not received appropriate follow-up. For example, the patient may not understand a procedure, treatment, or instructions due to a language or cultural barrier. Participants at the Emanuel meeting suggested promoting cultural sensitivity training in hospitals.

Other Comments

The purpose of this report is to convey values about health care services reached by group consensus in a community meeting setting. However, some individuals who attended these community meetings strongly voiced concern over two issues that were not frequently discussed and therefore consensus was not reached. In addition, these issues were often expressed as warnings rather than values. These two comments warrant some attention.

One table at the Eugene community meeting brought up the issue of reproductive rights. Participants at this table felt it was a moral responsibility of the Health Services Commission to address the issue of reproductive choice, especially considering the potentially far reaching applications of the health service priority list developed by the Health Services Commission.

In addition, some participants expressed concern about the lack of empirical health outcomes research and therefore lack of solid data about the effectiveness of existing treatments. Participants questioned how rational prioritizing could be accomplished without this information.

Evaluation and Suggestions

The primary goals of the community meetings were: 1) to ensure broad attendance by a cross section of the Oregon public to elicit values pertaining to why Oregonians find health care services important; 2) to attempt to ensure that the demographic characteristics of community meeting participants are representative of county demographics; and 3) to ensure that the target population of Senate Bill 27, those Oregonians below the federal poverty level, participate in community meetings.

The community meetings were successful in eliciting values Oregonians possess about why health care services are important, broadening the scope of information related to Oregon Health Care Legislation, and establishing a legacy of community involvement in an open process which will impact future health policy. Over 1000 Oregonians participated in the community meetings process and the number of people that attended each community meeting ranged from three to 120 with an average of about 20 people per meeting. Clearly, the number of participants per meeting was inconsistent, but the majority of comments received from participants of the community meetings were positive and people appreciated being provided an opportunity to voice their thoughts, opinions, and values in open dynamic discussions which were documented.

The community meetings were not successful in ensuring that meeting participants were representative of county demographics or in collecting values from Oregonians who are below the federal poverty level. Attendance at the community meetings was less than expected which is a common occurrence when public opinion is elicited through specially scheduled meetings rather than natural gatherings. Perhaps in the future we could increase participation by attempting to convey a single pressing issue to "grab" the citizenry[1]. The idea of coming to community meetings to discuss "values", is relatively intangible compared to a concrete purpose such as "freedom" or "access to health care for all." Senate Bill 27 is difficult to market in this light because of certain technicalities associated with it, e.g., the federal waiver needed to implement it.

Given these shortfalls, the community meetings were nevertheless accomplished on a very tight budget and time frame. Given unlimited resources, a method to encourage people to come to prearranged meetings such as the community meetings, would include a three step

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[1] Brian L. Hines, "Oregon and American Health Decisions, A guide for community action on bioethical issues," July, 1985.

phone calling process in addition to the normal routes of publicity such as flyers, newspaper, radio and television announcements. Organizers would call citizens a week before the meeting, the day before the meeting, and the day of the meeting. In addition, a solution for getting more input from low income individuals might include going directly to their homes to discuss health values with them or holding community meetings at prescheduled get togethers or usual gatherings of the target population (e.g., church services).[2]

Participants of the community meetings generally felt that the meetings were conducted well. However, several suggestions came into Oregon Health Decisions advising that it may be better to use the same pool of facilitators for all the meetings to ensure more consistency and uniformity. These suggestions often mentioned that having the same pool of facilitators at all the meetings might give more reliable results.

In addition, several participants were "put off" by the health care scenarios work sheet (see appendix A). Facilitators explained that the scenarios were strictly used to propel discussion and would not be collected or tabulated by Oregon Health Decisions. Nonetheless, many individuals found the worksheet disconcerting and asked that it be reevaluated.

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[2] Annette E. Kirby, "The Needs Assessment Process of Senate Bill 27: Analysis of Attendance at Community Meetings," March 1990.

Table 1: County Populations, Number of Participants at Community Meetings per County, Representativeness index of County Population Attending Community Meetings, and Number of Meetings held in each County.

County	County Population	# Attended Community Meetings	*Representativeness Index %	**SE	# of Community Meetings Held
Baker	15,700	8	64	.18	1
Benton	69,100	120	92	.04	1
Clackamas	262,200	14	74	.13	2
Clatsop	33,100	7	62	.19	1
Columbia	36,200	7	62	.19	1
Coos	61,000	8	64	.18	1
Crook	13,000	13	72	.14	1
Curry	17,100	11	70	.15	1
Deschutes	65,400	40	84	.08	1
Douglas	92,150	40	84	.08	1
Grant	8,050	12	72	.14	1
Harney	7,400	12	72	.14	1
Hood River	16,400	28	82	.09	2
Jackson	141,700	70	88	.06	1
Jefferson	12,200	25	80	.10	1
Josephine	64,000	37	84	.08	2
Klamath	58,630	22	78	.11	1
Lake	7,600	10	68	.16	1
Lane	273,700	49	86	.07	3
Lincoln	38,800	22	78	.11	1
Linn	89,900	39	84	.08	1
Malheur	26,900	21	78	.11	1
Marion	209,200	25	80	.10	1
Morrow	8,000	13	72	.14	1
Multnomah	561,800	132	92	.04	6
Sherman/Wasco	22,800	24	80	.10	1
Tillamook	21,400	12	72	.14	1
Umatilla	60,000	55	86	.07	3
Union	24,800	21	78	.11	1
Wallowa	7,420	9	66	.17	1
Washington	268,000	59	88	.06	2
Wheeler	1,350	11	70	.15	1
Yamhill	57,100	27	80	.10	1
TOTALS:	2,652,100	1003	96	.02	46

Please note that Sherman and Wasco Counties' meetings were combined, as well as both counties' population.

Meetings in Polk and Gilliam counties were cancelled and the Redmond meeting in Deschutes county was cancelled.

In addition, note that the meeting at Salishan is not included in these figures (45 participants attended the Salishan meeting for a total of 1048 participants).

*Representativeness Index-how adequate sample would be if unbiased.
** SE--Measure is based on standard error of a proportion of .5.

Table 2: Demographic Information Regarding Gender, Percentage of Workers in Mental Health and in Health Care fields, Insured, Uninsured, and Medicaid Recipients.

County	% Female	% Male	% Mental Health & Healthcare Workers	% Insured	% Uninsured	% Medicaid Recipients
Baker	37.5	62.5	50.0	87.5	12.5	12.5
Benton	65.7	34.3	48.5	95.9	4.0	11.1
Clackamas	78.6	21.4	57.1	71.4	28.6	7.1
Columbia	57.1	42.9	28.6	71.4	28.6	14.3
Coos	62.5	37.5	87.5	87.5	12.5	0.0
Crook	53.8	46.2	46.2	61.5	38.5	0.0
Curry	45.5	54.5	72.7	100.0	0.0	0.0
Deschutes	52.5	47.5	82.5	90.0	10.0	5.0
Douglas	40.0	60.0	57.5	90.0	10.0	2.5
Grant	75.0	25.0	33.3	83.3	16.7	8.3
Harney	75.0	25.0	50.0	100.0	0.0	0.0
Hood River	42.9	57.1	50.0	50.0	50.0	0.0
Jackson	63.0	37.0	42.6	87.0	13.0	5.6
Jefferson	52.0	48.0	60.0	100.0	0.0	4.0
Josephine	59.5	40.5	86.5	94.6	5.4	5.4
Lake	70.0	30.0	100.0	90.0	10.0	0.0
Lane	79.6	20.4	67.3	79.6	20.4	4.0
Lincoln	63.7	36.3	45.4	86.3	13.7	0.0
Linn	46.2	53.8	80.8	100.0	0.0	3.8
Malheur	85.7	14.3	42.9	100.0	0.0	0.0
Marion	68.0	32.0	84.0	100.0	0.0	0.0
Morrow	76.9	23.1	38.5	92.3	7.7	7.7
Multnomah	84.8	15.2	81.6	94.4	5.6	4.0
Sherman/Wasco	71.4	28.6	52.4	100.0	0.0	4.8
Tillamook	50.0	50.0	91.7	91.7	8.3	0.0
Umatilla	58.2	41.8	58.2	90.9	9.1	3.6
Union	61.9	38.1	71.4	100.0	0.0	0.0
Washington	58.2	41.8	50.9	94.5	5.5	3.6
Yamhill	74.1	25.9	74.1	96.3	3.7	0.0
Additional Meeting: Salishan	23.1	76.9	100.0	100.0	0.0	3.8
TOTAL: of 47 meetings	63.6	36.4	69.2	90.6	9.4	4.4

A small percentage of participants chose not to fill out demographic forms or filled them out incompletely.

Table 3: Demographic Information Regarding Age, Education, Ethnic Background, Annual Household Income, and Number of Persons in Household.

AGE: Percentage of Meeting Participants who were:

20 & Under	21-30	31-40	41-50	51-60	61-70	71-80	81-90
3%	10%	28%	28%	14%	11%	4%	1%

EDUCATION: Percentage of Meeting Participants who had last completed:

Elementary School	Some High School	High School	Some College	College Graduate
1%	2%	8%	22%	67%

ETHNIC BACKGROUND: Percentage of Meeting Participants who were:

Black	White	American Indian	Hispanic	Asian	Other
1%	93%	1%	3%	1%	Less than 1% (1-Middle East, 1-Slovak, & 1 European)

ANNUAL HOUSEHOLD INCOME: Percentage of Meeting Participants whose households take in:

Less than $5,000	$5,000-$9,999	$10,000-$14,999	$15,000-$19,999	$20,000-$24,999	$25,000-$34,999	$35,000-$49,999	$50,000 and up
5%	5%	6%	6%	9%	16%	19%	34%

NUMBER OF PEOPLE PER HOUSEHOLD: Percentage of Meeting Participants whose household has ____ people residing: .

1	2	3	4	5	6	7	8	9	10	11
18%	36%	17%	18%	7%	3%	-------Less than 1%-------				

A small percentage of participants chose not to fill out demographic forms or filled them out incompletely.

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Members are listed by major organizational affiliation.

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Linda Johnson	**--Harney**
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Appendix A
-Schedule
-Health Care Scenarios Worksheet
-Demographic form
-Additional Comments sheet

Oregon Health Priorities and Values
Community Meeting Project

Oregon Health Decisions thanks you for taking the time to attend this meeting and express your views on important health issues facing our state. The 1989 Oregon Legislature passed three new laws as part of their plan to make health insurance available to all Oregonians. These laws (Senate Bills 27, 935, 534) will allow many more Oregonians than before to receive health care. Although this means that many more people will be served, it also means that there may not be enough money to provide all the services that people may want. For this reason, the law requires that health services be ranked in order of importance. In order to do this the Health Services Commission has asked for your help in telling them what values are most important to you and society.

It won't be easy to compare and rank the many services and needs. To make sure that all opinions are explored and that there will be enough information from the public to help the Health Services Commission, they have asked that you participate in the group discussions tonight and fill out the questionnaires which we will be giving you later in the meeting.

The results of the questionnaires and the conclusions of the discussions will be given to the Health Services Commission, the Joint Committee on Health Care of the Oregon Legislature and other policy-makers.

SCHEDULE FOR THIS MEETING

7:00	30 min.	-Self introductions at tables -Welcome -Slide show -Demographic forms -Review of plan for the meeting
7:30	50 min	-Tables work on samples of health care categories and discuss values
8:20	10 min.	-Tables prepare highlights of their value discussions
8:30	30 min.	-Reports of table highlights to the whole community meeting
9:00		-Closing

HEALTH CARE SITUATIONS

Please read the following examples of health care situations. These are individual cases in which people need health services. They are listed to help start our thinking about why health services are important.

--A heavy user of crack cocaine wants help for drug addiction. Immediate treatment will help stop use. A month of intensive in-hospital treatment and outpatient treatment for a year will help stop the alcohol and drug use for the long term.

--A collapsed lung and internal bleeding have resulted from an accidental bullet wound through the chest. This person is conscious. Surgery to repair the lung and take care of the bleeding is likely to be successful; giving less treatment is likely to cause death or permanent damage.

--A person wishes to have a face-lift, saying that keeping the job absolutely depends on having a youthful appearance.

--A person has an advanced brain disease (Alzheimer's Disease). Normal communication and function are impossible. The person has just started vomiting from a blocked intestine. Surgery to remove part of the intestine could help. The outlook is only fair to poor because of chronic bad health and nutrition.

--A depressed parent of two preschool children is feeling hopeless, confused. The person is obsessed with thoughts of killing the children and him/herself. A week of hospital care and six months of outpatient treatment will allow the person to function as a parent and on the job.

--A child needs routine immunizations which include polio, diphtheria and whooping cough. Without immunizations the child may become ill and spread the disease to others. Sometimes these illnesses cause death.

--After 3 heart attacks, a patient is getting worse despite taking several medicines daily. An operation to put in a pacemaker would probably help the heart's rhythm but not the general condition of the heart. The day-to-day activities of the patient may improve.

--A severely mentally ill person is now unemployed and homeless. The person hears voices and feels threatened by "evil spirits." Regular treatment and medicine probably will help the person return to work and to a stable living situation.

SAMPLE HEALTH CARE CATEGORIES

Please classify the categories below as essential (1), very important (2), or important (3). Try to place three (3) categories in each classification. Your ranking should be based on your beliefs and values about which categories are most important for your community as a whole.

____ A. Treatment of conditions which are fatal and can't be cured. The treatment will not extend the person's life for more than five years.

____ B. Treatment of conditions where the health care is likely to extend life by more than two years or to improve the person's quality of life.

____ C. Treatment for alcoholism or drug addiction.

____ D. Treatment of sudden or ongoing conditions where the person is likely to get well. If the person does not receive care, the length or quality of their life will be reduced.

____ E. Treatment not likely to extend life or make any big improvement in quality of life.

____ F. Treatment of conditions where the health care is not likely to extend life by more than two years or to improve the quality of life.

____ G. Treatment provided in or out of the hospital for mental illness or emotional disturbance, which will restore the person's health.

____ H. Preventive care which definitely can prevent early death or a reduction in quality of life.

____ I. Treatment for chronic ongoing conditions where health care will improve quality of life for the person's remaining years.

Oregon Health Priorities and Values
Demographic Information

Oregon Health Decisions thanks you for taking the time to attend this meeting and express your views on important health issues facing our state. Please fill in the information below while you are waiting for the meeting to start. This will help the Health Services Commission interpret and appreciate the comments and opinions of your community. Individuals cannot be identified, so your responses are completely confidential.

(1) Where do you live? Name of City:_____ County:_____

(2) Age: _____

(3) Sex: Male_____ Female_____

(4) Do you work in the health care field? Yes____No____

(5) Do you work in the mental health field? Yes____No____

(6) Education (check highest level finished):
- ____Elementary school
- ____Some high school
- ____High school or vocational school graduate/diploma
- ____Some College
- ____College Graduate

(7) What is your ethnic background?
- ____Black
- ____White
- ____American Indian
- ____Hispanic
- ____Asian
- ____Other (please specify)_____

(8) Do you have health insurance? Yes____No____Not sure____

Do you have a Medicaid insurance card? Yes____No____Not sure____

(9) Annual household income?
- ____Less than $5,000
- ____$5,000 to $9,999
- ____$10,000 to $14,999
- ____$15,000 to $19,999
- ____$20,000 to $24,999
- ____$25,000 to $34,999
- ____$35,000 to $49,999
- ____$50,000 or more

(10) Number in household ____

Thank you!

We know that meetings such as this one get people to think about important issues. If you have thoughts about the values discussed or the meeting itself, please share them with us. We will pass your ideas on to the Health Services Commission.

If you would like a copy of the final report, let us know.

Please write down your thoughts and give them to the meeting facilitator or mail them to:

Romana Hasnain
Oregon Health Decisions
921 SW Washington, Suite 723
Portland, OR 97205

Appendix B
Slide show script

Following introductions at the tables, the meeting facilitator says:

"We have a very important task this evening. Before we get to work, it is important to understand why we are here."

INTRODUCTION BY FACILITATOR

Of all the industrialized nations in the world, there are only two which do not provide health care to all their citizens: the United States and South Africa.

The United States is now facing a crisis in health care. The crisis is forcing a change in the way the federal government, the states, and Americans view our health system.

There are over 37 million uninsured Americans and insurance rates are growing an average of 20% a year - twice the rate of inflation. Several states have started advancing proposals for universal access to health care. Oregon is at the forefront of those efforts.

You have been asked to attend this community meeting tonight along with hundreds of other Oregonians in 49 similar meetings around the state to participate in developing Oregon's plan for universal access to health care. Your time, your involvement, your willingness to come to this meeting is critical to the success of Oregon's plan. We thank you.

For the next 15 minutes, I will give an overview of the health crisis in Oregon and then focus in on our responsibility at this meeting. After that we will have 10 minutes for questions and answers. Please hold your questions until the slide show is over.

SLIDE 1:

There is a *Crisis in health Care. 400,000 Oregonians are uninsured. 280,0000 are workers and their dependents. 120,0000 are uninsured and living in poverty.*

SLIDE 2:

Oregonians, like all Americans, access health care in one of several ways.

Most people are provided insurance on the job. The group of people with private and job-based insurance is represented by the blue section on the graph.

Medicare is a federally funded insurance plan for those over 65. The Medicare population is represented by the green section of this graph.

Medicaid, is a health plan funded jointly by States and the federal government which provides health care to the poor. The Medicaid population is represented on this graph by the purple section.

SLIDE 3:

In order to get Medicaid in Oregon, a family can now make no more than 58% of the Federal Poverty Level. *The Federal Poverty Level* is the income the federal government feels is minimally necessary to sustain families of various sizes.

As you can see on this graph, for a family of 4 the federal poverty level is $12,000 gross income year or $1,000 a month. Thus currently in Oregon, a family who makes more than $6960 a year or $580 a month is ineligible for Medicaid.

SLIDE 4:

The problem is growing. Who Pays?

When people without health insurance get health care that they cannot pay for, someone else pays. Who is that someone else?

SLIDE 5:

That 'someone else' is everyone. Faced with an *increased demand for care without payments, hospitals now report that 20% of their costs are due to providing charity care to the uninsured.*

Hospitals and doctors raise their rates to cover the charity care they provide. This is part of what is called the "cost-shift".

SLIDE 6:

This slide shows the *cost-shift.* When people without health insurance incur hospital and medical bills they can't pay, bills for those who do pay, individuals and insurance companies, are increased.

SLIDE 7:

Employers say *'Not Fair'.*

84% of the private insurance is provided through employer group plans. Employers are being asked to pay the lions share of the cost shift. They can't afford it anymore.

SLIDE 8:

Employees say *'Not Fair'.*

Employees who are insured are being asked to contribute more and more toward their plans or to pick up the entire cost of insurance for their families.

SLIDE 9:

Understanding the problem.

The problem is enormous. But it is important to try to understand some of its components.

SLIDE 10:

Part of the problem is that *responsibility has not been defined.*. The health care system has been allowed to develop without effective coordination by the government, employees, and consumers. Many people say the United States does not have a health care system at all but a patch work method of sickness care.

SLIDE 11:

Another part of the problem is that *Public expectations exceed available resources.*

People assume health care is there whey they need it and that one should not be denied life saving treatments.

Providers are under pressure to offer the latest in modern technology, regardless of its effectiveness.

SLIDE 12:

A third part of the problem is that *Health care costs continue to outreach the economy. Health care costs (consume 12% of the Gross National Product) and are growing more than twice the rate of inflation.*

Right now, if we pool public and private moneys spent on health care, the United States spends $250 a month per person and the percentage of people without health insurance continues to grow.

SLIDE 13:

Oregon's Solution is to provide access to health care for all Oregonians.

Our solution is the first step in solving Oregon's health crisis. It is based on the principle that all people have a right to health care.

SLIDE 14:

Through an expanded Medicaid program, *the federal and state governments are planning to assume responsibility for those persons living at or below the Federal Poverty Level.*

As you will remember, Oregon now provides Medicaid to only those families at or below 58% of the FPL. The proposal to expand Medicaid is sometimes called SM 27. This proposal is one part of the *Oregon Solution* to the health care crisis.

SLIDE 15:

The second part of the *Oregon Solution* is that *Employers will assume responsibility for all permanent workers and their dependents.*

As you may recall, 280,000 uninsured Oregonians are workers and their dependents. This plan, SB 935, will provide them with health care.

SLIDE 16:

The third part of the *Oregon Solution* is that *employees will share in the responsibility for themselves and their dependents by paying a portion of their families' insurance premium.* This is also part of the SB 935 plan.

SLIDE 17:

A critical part of the Oregon Solution is the creation of The Oregon Health Services Commission whose job it is to set priorities for health services. Their prioritized list will be used to determine they types of health benefits Oregonians should have access to.

SLIDE 18:

This graph shows us how the Oregon plan lowers the numbers of uninsured.

Both the blue bar, Oregonians with private insurances, and the pink bar, Oregonians eligible for Medicaid will grow. The black bar, Oregonians without health insurance, will shrink.

The Oregon plan does not impact Medicare beneficiaries.

SLIDE 19:

This chart depicts what must happen before the Oregon health plan is implemented and how we, here at the community meeting, fit it.

SLIDE 20:

We are here to assist in the work of the Oregon Health Services Commission. They are soliciting information from a number sources.

health care experts will provide information and professional opinions about cost and effectiveness of health care services..

SLIDE 21:

Through Oregon Health Decisions community meetings and through a survey tool, *the public will provide community values to guide the priority setting process.*

The public is also involved in public hearings where people speak out about health benefits they feel are most important and the Commission's process. These public hearings are being held around the State.

SLIDE 22:

Repeat of Slide 19.

After the community hearings, the expert testimony, the survey tools, and the public hearings are completed or collected, the Health Services Commission will present its prioritized list of health services to the legislature.

The legislature will determine what level of funding the State can afford and this will determine the health services that will be made available to the new Medicaid population and the workers eligible for SB 935.

State agencies will make the plans available to the target populations. And the *public will be served.*

SLIDE 24:

This is *what we will do during this meeting.*

SLIDE 25:

We will make *individual judgements.*

SLIDE 26:

We will *develop community consensus on the values to be used in determining health benefits.*

SLIDE 27:

We will *make recommendations to the Health Services Commission.*

SLIDE 28:

Our job is to determine the values of our community. A health care value makes us ask why a health service is important to us.

Thank you again for taking the time to involve yourself in this process. We will soon get to work. Are there any questions about what you have just seen or heard?

APPENDIX G

RANKED CATEGORIZATION

---

1) Evolution of Ranked Categorization

2) Placement of Condition/Treatment Pairs in Categories

3) Ranking Process

4) Health Services Categories

5) Combination of Ranked Categorization and Commission Judgement

EVOLUTION OF RANKED CATEGORIZATION OF HEALTH SERVICES

The Commission decided to create an Alternative Methodology Subcommittee to work concurrently with the Health Outcomes Subcommittee in developing complementary approaches to the solution of prioritization of health services. The decision came after the initial review of the cost-benefit formula revealed that it did not appear to adequately reflect the community values expressed by Oregonians or the relative importance of life-saving treatments.

The Alternative Methodology Subcommittee revisited ideas for prioritization originally considered for guidance. Review of the Oregon Medicaid Priority-Setting Project and the Hadorn classification confirmed that those systems were inappropriate for Commission's objectives. Nevertheless, the classification ideation used by both was attractive. Categorization could be used in combination with the cost-benefit ratio or net-benefit calculation which could rank condition/treatment pairs within categories.

The Health Outcomes Subcommittee worked to refine the cost-benefit formula and validate the outcomes and cost data. Formula refinement consisted of sensitivity analyses done by varying formula components to test the effect on the ranking of a sample of condition/treatment pairs. Commission review, correction and affirmation by the providers of the information, and confirmation by outside authorities worked to validate the outcomes data. Cost data was checked with third-party payor organizations.

The Alternative Methodology Subcommittee chose to develop categories of two basic types. The first group was made up of unique types of care that had few, if any, defined condition/treatment pairs. These included preventive services, comfort care, preventive dentistry, maternity care and others. The second group included treatment of acute and chronic conditions divided on the basis of effect of treatment on both the quality of well-being and the potential morbidity of the condition (i.e., did the treatment prevent death and/or improve the quality of well-being). As a result, twenty-six (26) categories were developed initially but pared to seventeen (17).

CRITERIA FOR PLACEMENT IN CATEGORIES

Assignment to Categories

Placement of a condition/treatment pair in a category depended first on whether the condition was chronic or acute. The Commission's physicians decided which conditions are never completely cured and those for which treatment does cure. The Commission classified condition/treatment pairs as acute or chronic. This work was reviewed by the health care providers who had contributed data on treatment effectiveness.

Staff devised a computer algorithm to sort chronic and acute conditions into the previously defined health services categories by degrees of fatality and improvement in quality of life. Following is the definition of that algorithm: (Note: There are ten categories to which this algorithm applies. The number preceding each description is the category rank.)

#1 Acute fatal, prevents death, full recovery

- Acute condition
- Without treatment mortality is at least 1%
- Treatment reduces mortality by at least 25% at 5 years
- At least 90% of those surviving with treatment returned to former state of health OR with treatment quality of life (benefit) is at least 0.9

#3 Acute fatal, prevents death, without full recovery

- Acute condition
- Without treatment mortality is at least 1%
- Treatment reduces mortality by at least 25% at 5 years
- Less than 90% of those surviving with treatment returned to former state of health
- With treatment quality of life (benefit) is less than 0.9

#5 Chronic fatal, improves life span and quality of life

- Chronic condition
- Without treatment mortality is at least 1%
- Treatment reduces mortality rate by at least 25% at 5 years

#10 Acute nonfatal, return to previous health

- Acute condition
- Without treatment mortality is less than 1%
- Condition is not self-limiting
- With treatment quality of life (benefit) is at least 0.9
- Net-benefit is greater than 0.01

#11 Chronic nonfatal, one time treatment improves quality of life

- Chronic condition
- Without treatment mortality is less than 1% at 5 years
- Duration of benefit of treatment is the remaining lifetime
- Net-benefit is greater than 0.01

#12 Acute nonfatal, without return to previous health

- Acute condition
- Without treatment mortality is less than 1%
- Condition is not self-limiting
- With treatment quality of life (benefit) is less than 0.9
- Net-benefit is greater than 0.01

#13 Chronic nonfatal, repetitive treatment improves quality of life

- Chronic condition
- Without treatment mortality is less than 1% at 5 years
- Duration of benefit of treatment is short term
- Net-benefit is greater than 0.01

#14 Acute nonfatal, expedites recovery

- Acute condition
- Without treatment mortality is less than 1%
- Condition is self-limiting
- Net-benefit is greater than 0.01

#17 Fatal or nonfatal, minimal or no improvement in quality of life

Nonfatal:
- Without treatment mortality is less than 1% at 5 years
- Net-benefit is no greater than 0.01

Fatal:
- Without treatment mortality is at least 1%
- Treatment reduces mortality rate by less than 25% at 5 years
- Net-benefit is no greater than 0.01

The Commissioners reviewed the results of the algorithm and made changes based on their professional judgement.

CATEGORY RANKING PROCESS

The ranking process consisted of:

1) classifying community values to arrive at a manageable number of broad value-laden attributes
2) weighting of attributes
3) assigning a score to each category of health services
4) using a modified Delphi technique to achieve consensus
5) calculation of averaged, weighted scores for each health service category

1) Health Care Values

Oregon Health Decisions held meetings throughout Oregon to learn which health care values were seen as important by the communities. From these meetings, 13 health-related values emerged (see Appendix F) but were not quantified or ranked.

The 13 values were grouped by the Commission into three attributes which were used to rank the categories of health services. Some values appear in more than one attribute.

Value to Society:

Prevention
Benefits many
Impact on society
Quality of life
Personal responsibility
Cost effectiveness
Community compassion
Mental health and chemical dependency

Value to an Individual at Risk of Needing the Service:

Prevention
Quality of life
Ability to function
Length of life
Personal responsibility
Equity
Effectiveness of Treatment
Personal choice
Community compassion
Mental health and chemical dependency

Essential to Basic Health Care:

Prevention	Cost effectiveness
Benefits many	Impact on society
Quality of life	

2) Weighting of Attributes

Each Commissioner gave a relative weight from a total of 100 to the attributes of:

- -- value to society;
- -- value to an individual at risk of needing the service; and,
- -- essential to a basic health care package.

3) Scoring Categories of Health Services

The Commissioners scored each category three separate times: once on the basis of value to society; once on the basis of value to an individual at risk of needing the service; and, once on the basis of whether that category of service was essential to a basic health care package. Each time a Commissioner addressed a category, a number from 1 to 10 was assigned to each category.

> Example:
>
> A Commissioner might have assigned a 10 to infertility services based on "value to an individual;" a two based on "value to society;" and, a one based on "essential to a basic health care package."

The community values subsumed in each attribute were considered as each Commissioner individually assigned a score to each health service category. The following information expanded their understanding of the community values and included some information learned in public hearings:

Value to the society This attribute incorporated the public values that reflect the concerns of the community. It included the impact of social costs of institutionalization, incarceration, and damage to family structure as the result of non-coverage of treatment. This testimony also included the ripple effect

of chemical dependency, mental illness and child abuse as well as contagious diseases.

Essential to basic health care This attribute was a measure of how essential the category is to a health care plan. Basic or essential was defined as a level of health services below which it is felt no person should fall.

Value to the individual This attribute was utilized from the perspective of a person at risk for the need of a specific category of health services (e.g. maternity or fertility services from the perspective of a person who may have need of these services).

Testimony at public hearings stressed the individuals need to have some control over the health services that are available and how to efficiently use them.

4) Modified Delphi Technique

The Delphi method consisted of three steps: a) a report on where individual Commission scores and weighted scores fell within the total distribution, b) a Commission meeting to discuss considerations for making judgments, and c) an opportunity to adjust previously submitted individual values.

a) Report on Individual Responses: The distribution of Commission responses was developed for the 1 to 10 scores assigned to each health service category and the weighted scores which included the total of 0 to 100 points distributed among the three attributes. This report did not identify scores and weights by name of Commissioner. The results were used as a tool by the Commissioners to prepare questions or comments for discussion at the Commission meeting.
b) Commission Meeting: The Commissioners brought items for discussion developed as a result of the distribution report. Discussion focused on those items which had the largest amount of variation in responses.
c) Adjustments: After the meeting, each Commissioner had the opportunity to change any response that they previously submitted. There was no pressure to conform to the norm. Scores and weights were then used to obtain an average weighted score for each category.

5) Calculations

Staff applied the weights of the attributes to the 1 to 10 scoring. Then staff summed the weighted scores (11 scores--one score per Commissioner) for each category and averaged the result.

Example: Infertility services may have been weighted and scored as follows:

Value Perspective	Perspective Weight (100 total)	X	Category Score (1 - 10)	Total
Value to society	40		2	80
Value to individual	20		9	180
Essential to basic	40		2	80
One Commissioner's weighted score				340

For the same category of service, other Commissioner's weighted scores were 260, 180, 470, 260, 110, 200, 320, 360, 215, and 175. These add to 2890. This total divided by 11 results in an average weighted score of 263 for the category of infertility services.

The categories were ordered from the largest score (highest rank) to the lowest.

The process reduced to a simplified expression is:

$$\frac{\text{Perspective weight (0-100) x Service category (1-10)}}{\text{11 Commissioners}}$$

HEALTH SERVICE CATEGORIES

The following ranked list of health services categories is the result of category weights and Commission judgment. They are ranked from most important to least important. The groupings of condition/treatment pairs are acute or chronic and are further characterized by being fatal or non-fatal (e.g., chronic nonfatal, one-time treatment improves quality of life). Note that the examples cited in parenthesis are intended to be illustrative--not comprehensive.

1. **Acute Fatal,** treatment prevents death with full recovery: appendectomy for appendicitis; repair of deep, open wound in neck; medical therapy for myocarditis.
2. **Maternity Care,** including most disorders of the newborn: obstetrical care for pregnancy.
3. **Acute Fatal,** treatment prevents death without full recovery: surgical treatment for head injury with prolonged loss of consciousness; medical therapy for acute bacterial meningitis; reduction of an open fracture of a joint.
4. **Preventive Care for Children:** immunizations; medical therapy for streptococcal sore throat and scarlet fever--reduce disability, prevents spread; screening for specific problems such as vision or hearing difficulties or anemia.
5. **Chronic Fatal,** treatment improves life span and quality of life: medical therapy for Type I Diabetes Mellitus; medical and surgical treatment for treatable cancer of the uterus; medical therapy for asthma.
6. **Reproductive Services,** excludes maternity and infertility services: contraceptive management; vasectomy; tubal ligation.
7. **Comfort Care:** palliative therapy for conditions in which death is imminent.
8. **Preventive Dental Care,** adults and children: cleaning and fluoride applications.
9. **Proven Effective Preventive Care for Adults:** mammograms; blood pressure screening; medical therapy and chemoprophylaxis for primary tuberculosis.

10. **Acute Nonfatal,** treatment causes return to previous health state: medical therapy for acute thyroiditis; medical therapy for vaginitis; restorative dental service for dental caries.
11. **Chronic Nonfatal,** one-time treatment improves quality of life: hip replacement; laser surgery for diabetic retinopathy; medical therapy for rheumatic fever.
12. **Acute Nonfatal,** treatment without return to previous health state: relocation of dislocated elbow; arthroscopic repair of internal derangement of knee; repair of corneal laceration.
13. **Chronic Nonfatal,** repetitive treatment improves quality of life: medical therapy for chronic sinusitis; medical therapy for migraine; medical therapy for psoriasis.
14. **Acute Nonfatal,** treatment expedites recovery of self-limiting conditions: medical therapy for diaper rash; medical therapy for acute conjunctivitis; medical therapy for acute pharyngitis.
15. **Infertility Services:** medical therapy for anovulation; microsurgery for tubal disease; in-vitro fertilization.
16. **Less Effective Preventive Care for Adults:** dipstick urinalysis for hematuria in adults less than 60 years of age; sigmoidoscopy for persons less than 40 years of age; screening of non-pregnant adults for Type I Diabetes Mellitus.
17. **Fatal or Nonfatal,** treatment causes minimal or no improvement in quality of life: repair fingertip avulsion that does not include fingernail; medical therapy for gallstone without cholecystitis; medical therapy for viral warts.

The original list of health service categories contained 26 designations. Following are the nine categories not listed above and a description of their disposition:

-- Preventive care for nutritional deficiencies in children at risk with nutritional supplements was blended with category #4

The two following categories were blended into category #8, Preventive Dental Care:

- -- Preventive dental care for children (cleaning and fluoride applications)
- -- Preventive dental care for adults (cleaning and fluoride applications)

- Preventive care for nutritional deficiencies in adults at risk with nutritional supplements -- this category was determined to be either #14 (self-limiting) or a part of #9.

-- Vision and hearing screening for adults -- people will present to a health care provider with a complaint of trouble hearing or seeing. This would be considered part of the initial diagnosis. To routinely screen without any indication of a problem is not considered to be effective.

-- Health education for adults (smoking cessation, alcohol abuse, etc.) -- counseling and education activities are subsumed in categories #9 and #16.

-- Health and safety education (workplace for adults) -- this category was considered to be occupational health and safety and outside of the purview of the Commission.

-- Initial diagnostic screening of presenting problem -- the umbrella assumption under which health services are ranked is that everyone will be able to access diagnosis. Therefore, this category is not ranked but heads the list.

The two following categorizations were blended to create #17:

- -- Treatment of a fatal condition with improvement in life span with no improvement in quality of life

- -- Treatment of nonfatal conditions with minimal or no improvement in quality of life

COMBINATION OF RANKED CATEGORIZATION AND COMMISSION JUDGEMENT

A draft list of prioritized health services resulted from the ranked categorization of health services with net-benefit ranking within categories. The Commission used professional judgments and their interpretation of the community values to re-rank items on the draft list.

A correlation analysis was performed to indicate to what degree the variation of the components of the formula affected the rankings. The ranked categorization and net-benefit were the most significant factors.

The Commissioners used a "reasonableness" test when they adjusted the objectively ranked health services. The "reasonableness" standard was applied by evaluating the public health impact, cost of medical treatment, incidence of condition, effectiveness of treatment, social costs, and cost of non-treatment to determine a new ranking. The Commissioners also observed that it was not reasonable--logically or economically--to rank preventable or readily treatable conditions in relatively unfavorable positions. In other words, where severe or exacerbated conditions were ranked in a relatively favorable position compared to prevention of disease, disability or exacerbation, these occurrences were reversed.

APPENDIX H

MENTAL HEALTH CARE AND CHEMICAL DEPENDENCY

1) **Report to the Health Services Commission, including**

   --Ranked List of MHCD Health Services

   --Ranked Integrated List of Health Services

Prioritization of Mental Health Care and Chemical Dependency Services

A Report to the Health Services Commission

Mental Health Care and Chemical Dependency Subcommittee

1991

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MENTAL HEALTH CARE AND CHEMICAL DEPENDENCY SUBCOMMITTEE

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EXECUTIVE SUMMARY

The Mental Health Care and Chemical Dependency (MHCD) Subcommittee advocates for the integration of mental health and chemical dependency services in an overall prioritized list of health services and basic health care. This recommendation incorporates ancillary services, such as case management, necessary to the success of treatment. The subcommittee also recommends:

- . . . MHCD preventive services be implemented in 1992;
- . . . linked health care delivery systems;
- . . . basic MHCD health care extend to item 49 on the ranked MHCD list of health services;
- . . . MHCD representation on the Commission;
- . . . existing MHCD mandates be extended to the state-sponsored insurance pools until an integrated health services list is implemented in 1993-1995 -- pending legislative approval;
- . . . continuation of the MHCD Subcommittee;
- . . . continued study of the value of incorporating the effects of co-morbidity and indirect costs in the Commission's methodology ; and,
- . . . further study on the effectiveness of services for nicotine dependence, mental retardation, learning disabilities, profound developmental disabilities and paraphilias.

The subcommittee did the following in pursuit of the goal of prioritizing MHCD services: reviewed research literature; received expert testimony; reviewed the outcomes data provided by invited MHCD specialists; reviewed testimony presented to the Commission; and, identified values related to both the prioritization process and the health care delivery system.

Many MHCD professionals, advocates, and consumers expressed the hope that this prospective planning process would be a positive step towards developing a comprehensive health care system which serves all Oregonians who have mental health and chemical dependency needs.

The subcommittee recognizes that many MHCD professionals, consumers and advocacy groups opposed the prioritization of MHCD services and their inclusion in a body with other health services. There was concern that the hard-won gains in mandated insurance coverage as well as recent improvements in the public mental health system would be lost. However, the subcommittee members believed it imperative that they participate in the process or risk having these services excluded from a basic health care package. The goal was to participate in developing a methodology giving equitable consideration to MHCD concerns.

The recommendation of integration is based on the following facts:

1) The mind and body are inseparable and should be treated in an integrated manner. There is significant interaction between physical and mental function. Many medical/surgical conditions have psychological symptoms or may appear to be MHCD conditions. Many MHCD conditions are at least partially caused by genetic or other biological factors.
2) MHCD services are effective for most MHCD conditions. These services improve functioning, quality of well-being, and extend the life of affected individuals.
3) Effective MHCD care contributes to decreased utilization of other health services. Lack of or improper treatment of MHCD conditions may create or exacerbate other health problems and may interfere with the treatment of those problems.
4) The costs of timely and effective treatment of MHCD conditions are less than the health care costs of delayed treatment and are much less than the combined social and health care costs when treatment does not occur.
5) MHCD conditions are associated with attitudes, such as stigma and denial, which can cause providers and consumers to avoid or delay appropriate treatment.

An integrated list of health services means that preventive and early intervention services would be included in the 1993-95 implementation process. However, the subcommittee believes prevention to be critical to the quality of life, the Commission agreed and included it in the list of health services to be implemented in 1992.

An integrated list of health services connoting the inseparability of mind and body and from which resources are allocated requires linked health care delivery systems. The subcommittee recommends that planning for linkages

begin immediately and defines values to inform and guide the process. The integration of MHCD conditions and services into the overall prioritized list depends on these values being honored and incorporated into the system of services.

1) Consumer-centered system The delivery system must respond to cultural, ethnic, gender and other social factors. It must fit the consumers' needs for least restrictive treatment settings and least intrusive services rather than forcing consumers to accommodate the system's need for conformity and simplicity.
2) Access to services The system must be designed to facilitate ease of referral and consultation among mental health, chemical dependency and other health delivery systems. Regardless of the consumers' point of entry into the health care system, patients and providers must have access to the benefits of referral, on site MHCD service delivery, and consultation from MHCD providers.
3) Early identification and early intervention The assessment of all persons who seek health services should include attention to psychological and social factors. Early intervention includes case finding, outreach and prevention services.
4) Effective use of MHCD providers for assessment and treatment services All persons seeking MHCD services deserve accurate and appropriate diagnostic evaluation and treatment services performed by providers whose expertise is supported by training, credentials, and experience suited to the task.
5) Clinically relevant care management and quality assurance Care mangement criteria must be based primarily on clinical effectivness rather than cost. Assessment measures of outcomes of MHCD services need to be the same or comparable to those used to assess outcomes of other health services and should be relevant to the clinical and social factors involved in MHCD conditions.

MHCD services are an integral part of essential and very important health care. Included are prevention and early intervention and treatment for most life-threatening MHCD diagnoses. The subcommittee determined that conditions through stereotypy/habit disorders are essential or very important to basic health care. It will advocate with the Legislature to fund an integrated list of health services to at least this point. Meanwhile, the subcommittee recommends that the existing MHCD mandates be extended to be a part of the minimum coverage provided for participants in the Small

Business Insurance and Medically High-Risk Pools. At such time as the integrated health services list is implemented (probably in 1993-95), the funded portion of the integrated list, including MHCD services, must be legislated as the minimum health care package for the state-sponsored insurance pools.

The MHCD subcommittee expected the task of ranking MHCD services to be demanding and was not disappointed. As a result of this experience, the subcommittee recommends the addition of two MHCD representatives to the Commission to balance expertise.

The MHCD Subcommittee should be continued to investigate issues pertinent to MHCD and make recommendations to the Commission. Continuing work should include further study of the value of incorporating in future prioritization indirect costs, co-morbidity and the services for nicotine dependence, mental retardation, learning disabilities, profound developmental disabilities and paraphilias.

In addition to the prioritization of MHCD services, there were several other process gains.

-- Coalition building. Within the MHCD community, an alliance of providers, consumers and advocates was built. Although there is not a consensus on the methodology or the prioritization of services, there is a desire to create a better, comprehensive system which provides sufficient services to more people.

-- Outcomes. This has been an historic attempt to systematically and thoroughly review outcomes data regarding MHCD services. There are limitations both in the methodology and data for MHCD outcomes research. Similar limitations are evident in outcomes research for other health services.

-- Education. The process has informed others within the health care community and the Commission of the legitimacy and effectiveness of MHCD services. More parallels than divergences became evident in measuring outcomes of all health-related conditions.

-- Prospective planning. The prioritization process has been a first step in prospective planning. It is an example of a revolution in health care planning occurring nationwide which may lead to a national health care system. This process brought attention to the need to include MHCD services in such a health care system.

PREFACE

The purpose of this report is to explain the process of ranking mental health care and chemical dependency (MHCD) services from most beneficial to least beneficial and the values affecting that process.

This report addresses the rationale for integrating all health services into one list and delivery system issues. At its conclusion are recommendations with a list of prioritized MHCD services alone and a ranked list of health services including MHCD services.

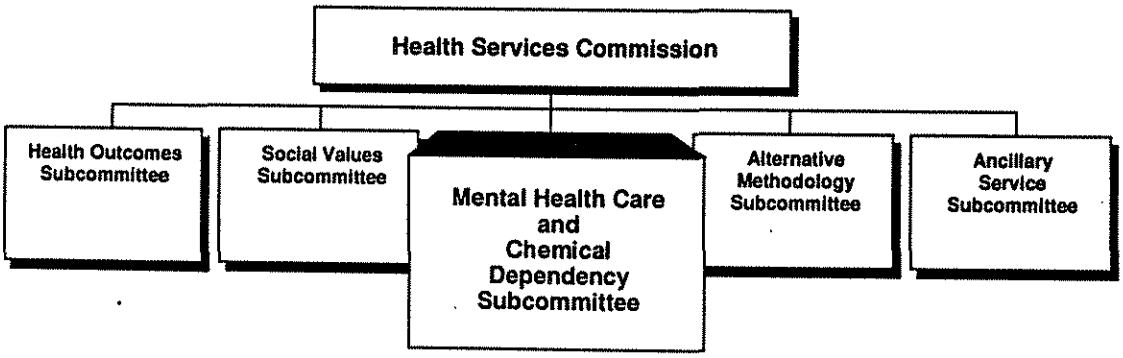
Subcommittee background

At the time Senate Bill (SB) 27 (see Appendix A) was drafted, there was substantial opposition to including MHCD services on a prioritized list with other health services. The potential loss of hard-won gains in mandated insurance coverage was of paramount concern. Another argument was that MHCD services could not be evaluated on an individual basis and that to do so would fragment the continuum of care (a series of services required for effective treatment of a diagnosis) making treatment ineffective. As a compromise, the Mental Health Care and Chemical Dependency Subcommittee was mandated by the legislation "to assist the commission in determining priorities for mental health care and chemical dependency . . . ." [P-1] The decision of if or how to prioritize MHCD services was left to the subcommittee.

Regardless of the subcommittee's approach to its charge, SB 27 did not call for the first prioritized list of health services to include MHCD services. The first list of services was to be reported in March 1990. The legislation required that a report on MHCD services be made during the 1991 Legislative session. As it happens, the necessary delays in the Commission's work resulted in both lists being reported in the 1991 session. However, implementation of the integrated list cannot occur until the 1993-95 biennium.

The Mental Health Care and Chemical Dependency Subcommittee is unique to the Commission because it is the only subcommittee specified in the legislation and has only one Commissioner as a formal part of its structure. (See Figure 1.)

Figure 1. Commission Organizational Chart



Chairperson Donalda Dodson solicited nominations for subcommittee membership from the MHCD community. The list of nominees was narrowed to 12 and forwarded for Commission approval. Subcommittee membership is evenly divided between representatives from mental health and chemical dependency and includes a mix of providers and consumers. (See Appendix B.)

Importance of providing MHCD services

The importance of providing adequate and effective services is demonstrated by statistics showing incidence of MHCD conditions.

National statistics Data on the lifetime prevalence of the three most common MHCD problems affecting adults are: [P-2,P-3]

1) Substance abuse = over 16 in every 100
2) Anxiety disorders = nearly 15 in every 100
3) Affective disorders = just over 8 in every 100

It is estimated that between 8 and 14 million children need mental health services. Projections indicate a continuing and perhaps a growing need of services for adolescents. [P-4] Not least of all, at least one in ten children in the United States is born into a chemically dependent family. Parental addiction causes long-lasting detrimental effects on the health and safety of these children. [P-5]

Oregon statistics An estimated 315,000 Oregonians have severe alcohol or drug problems. An additional 12 percent of the state's residents are directly affected by these problems. Substance abuse contributes to physical and mental illness, crime, violence and a myriad of social problems.

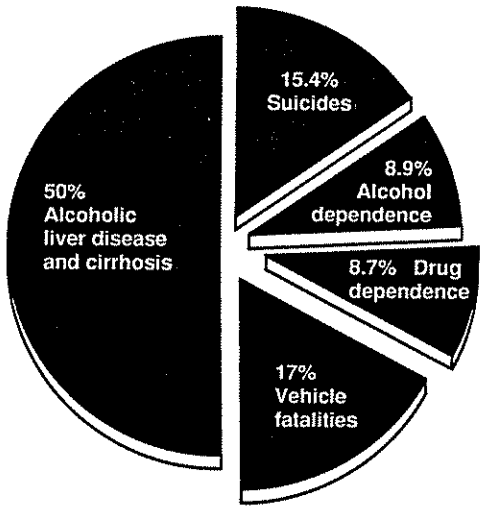
Babies born to mothers who use alcohol and other drugs are at greater risk of mental retardation, physical malformation and malfunction, and exposure to AIDS and other sexually transmitted diseases. In Oregon 1.8 percent (746) of mothers giving birth in 1989 reported using street drugs or controlled substances. Alcohol use was reported by 9 percent (3,710) of mothers giving birth during the same year. The costs of treating the manifestations of maternal alcohol and drug use in infants and the resultant educational and social problems are enormous.

One-fifth of marijuana users and one-tenth of cocaine users report that they started using the drug in the sixth grade or before. The following breakdown shows how many Oregon eighth graders have ever used alcohol or drugs:

4 in 5 ---- alcohol	1 in 11 ---- cocaine
1 in 4 ---- marijuana	1 in 10 ---- amphetamines

Among all Oregonians who died in 1986, one in 44 died from the direct effects of alcohol or drugs. (See Figure 2.) Half of these deaths were due to alcoholic liver disease and cirrhosis. Another 8.9 percent were attributed to alcohol dependence syndrome while 8.7 percent were caused by drug dependence or abuse and 15.4 percent were suicides. Motor vehicle fatalities since 1980 show about half of the victims, whether driver, passenger or pedestrian, had alcohol detected in their blood. [P-5]

Figure 2. Representation of Causes of Death Due to the Direct Effects of Alcohol or Drugs



Adults with serious mental illness [P-6] in Oregon numbered 40,269 in a 1988 estimate. Of those with a serious mental illness [P-7], 19,027 suffer from chronic mental illness and 21,242 have a severe mental illness. Services reached a little over half of those with chronic illness whereas the system serviced a little under half of those with severe mental illness. Chronic illness increased by 15 percent and severe illness increased by 12 percent when compared with a 1986 survey.

The National Institute of Mental Health estimates 11.8 percent of children and adolescents in the United States have mental or emotional disturbances. This means 80,995 of Oregon's children are in need of mental health services. Sixty-nine percent (55,886) are children with a moderate level of impaired social functioning who are "at risk" of developing mental or emotional disturbance. Of the remaining 25,109 children, who are seriously or severely disturbed, approximately 8,000 (30%) received state aid in 1987-89. [P-8]

CHAPTER 1

PREPARATORY WORK

Abstract *The Mental Health Care and Chemical Dependency (MHCD) Subcommittee's review of the scientific literature substantiated that treatment for mental illness, emotional disturbance, and chemical dependency is effective.*

The subcommittee adopted the Health Services Commission's methodology for ranking health services because it:

- *applies equally well to all health services and reasonably prioritizes MHCD services;*
- *allows inclusion of MHCD services in a basic health care package; and,*
- *meets the legislative mandate for a list of services from which a benefits package can be drawn and which can be expanded or contracted with changing economic conditions.*

The Mental Health Care and Chemical Dependency (MHCD) Subcommittee organized and began work in late October of 1989. Their purpose was to assist the Health Services Commission to determine priorities for MHCD services. At that time, the Commission's work was underway. The immediate question addressed by the subcommittee was whether to participate in the continuing development of the Commission's methodology or to develop a different approach. They decided to:

1) review treatment effectiveness data required for any ranking process that would adhere to the provisions of Senate Bill 27 (see Appendix A);
2) investigate other prioritization methods before making a final recommendation to adopt the Commission's method; and,
3) participate in the development of the Commission's prioritization technique by recommending modifications to accommodate inclusion of MHCD services.

OUTCOMES RESEARCH

There is agreement in the scientific literature that mental health care is effective, people with chemical dependency do recover, and that prevention and treatment reduce health care costs, crime, injuries, and death. These conclusions are drawn despite some research weaknesses.

Available outcomes information for most health treatments and services suffers from a lack of well-designed studies. Reasons for this are ethical and pragmatic. A researcher faces an ethical dilemma if treatment were to be withheld in order to create a control group. Pragmatic considerations include the size of the population necessary to conduct a scientific study; and, in some cases, requirement of a lifetime commitment to conduct the longitudinal studies required for chronic conditions such as schizophrenia. [1-1]

Mental illness

Hundreds of studies exist on the effectiveness of a wide variety of psychiatric services as well as several in-depth reviews of the literature. There is a weight of evidence that: [1-2]

-- Patients receiving mental health care show significant improvement n mood, personality and behavior.

-- The average therapy recipient tends to be better off than 80 percent of those who do not receive treatment.

In any six-month period, approximately 29.4 million adult Americans suffer from one or more mental disorders ranging from mild to serious. Therapeutic interventions are appropriate for these people. Improvement in behavior, personality, and general mood occurred when professional care was provided for a wide variety of disorders. These improvements led to a rise in the level of functioning.[1-3]

Chemical dependency

A consistent research result found in the literature is that the provision of some treatment for chemical dependency results in better outcomes than no treatment. [1-4,1-5] Chemical dependency, as used in this report, includes drugs and alcohol and as well as illness severity described as abuse or dependency.

Most treatments do not have proven measurable life-time impact on abstinence. In part, this is due to lack of measurement. Often program studies do not address dropout rates or measure long-term abstinence after discharge. However, it is clear a significant number of people do benefit from treatment when using abstinence as a yardstick, especially if treatment is combined with self-help groups such as Alcoholics or Narcotics Anonymous. People close to the client also benefit (e.g., family, friends, co-workers).

Beyond the important goal of complete abstinence, there are other measures of treatment success. Some programs are now beginning to measure other accomplishments including reduction in amounts consumed or frequency of abuse, improvement in family and personal relationships, positive changes in work-related behavior and decreased use of other health or medical care and social services. [1-6]

EXISTING PRIORITIZATION TECHNIQUES

The subcommittee looked for existing approaches for ranking health services, particularly MHCD services. Review found no evidence of a system for prioritizing MHCD services which would incorporate the criteria in the legislation: community consensus on values and comparative benefits of treatments. However, listed here are the systems which the Subcommittee reviewed.

-- In Oregon, the delivery of mental health services is prioritized in three (3) broad categories. The services considered to be most important are those for the most severely ill. The least important and consequently the first to be reduced are services in Priority 3 for those people "experiencing mental or emotional disturbances and for whom services would be beneficial but not necessary for them to function in everyday life." [1-7]

-- Alaska ranks twenty-two (22) categories of health services. Entire categories will be excluded from funding--beginning with category number one--should the cost of medical assistance exceed available resources. Mental health and substance dependency services are included throughout categories 13 through 16. [1-8]

-- National attention has focused on Washington [1-9], California [1-10], New York [1-11], Massachusetts [1-12] and Hawaii [1-13] because of their efforts to revise their health care systems. Most or all of their approaches to reorganization have severely limited or excluded MHCD services or coverage.

Prioritization of discrete services based on relative effectiveness--including public values--is not attempted by any system reviewed. Oregon incorporates cost containment by ranking the least effective services at the bottom of the list of health services where the legislature is least likely to fund items and utilizes capitated, managed care systems.

HEALTH SERVICES COMMISSION PRIORITIZATION TECHNIQUE

The subcommittee believed it imperative that they participate in and influence the Commission's process at its inception for the following reasons:

- The subcommittee could determine if reasonable prioritization of MHCD services would occur using the Commission methodology. Ranking of MHCD and other health services using the same system means that service necessity and effectiveness are measured using common criteria which could lead to an integrated list of health services. An integrated list could result in a rational distribution of resources aimed at serving the comprehensive health care needs of individuals.
- A Legislatively funded basic health care package may include MHCD services only if it is a part of the prioritized, integrated list of health services.
- The Small Business Insurance Pool was of particular concern. The pool is a self-insured entity created to provide insurance to those Oregonians employed by small businesses and not previously insured. The Pool is not

subject to Oregon law mandating provision of MHCD services. However, the content of the health benefit packages the pool offers are linked by law to the list of services developed by the Health Services Commission. The likelihood of the inclusion of MHCD services in the Small Business Insurance Pool's packages will be better if they are in the prioritized list of health services.

Final acceptance of the Commission's methodology depended upon its ability to accurately reflect the value of MHCD services when compared with one another and when compared with other health services.

The Health Services Commission prioritized health services using facts and values gathered from Oregon's residents and health care providers. First, categories of health services were ranked from most important to least important. Within the categories which comprise diagnoses and treatments, net-benefit ranks services and cost-benefit is a factor. This objective ranking process is modified by Commission judgment and Commission understanding of the public will. (Detail can be found in Chapter 2 and Appendices C, D, G, H.)

The subcommittee carefully scrutinized all of the variables included in or excluded from the cost-benefit ratio and net-benefit and the parameters for categorizing health services. Examination yielded a recognition by both the members of the Commission and the subcommittee that most weaknesses of the methodology were true for of all types of health services. The most important weaknesses are those of estimated data, omission of co-morbidity factors and indirect costs, and shortcomings in the measurement of quality of well-being.

Data for all health services were largely interpolated from research and based on providers' collective experience, education and judgement. This basis is consistent with the patient's acceptance of his or her provider's knowledge and best estimate for an appropriate course of treatment and its resulting outcomes. As outcomes research expands, verifiable data, including quality of life information, will grow.

Co-morbidity is not addressed. Therefore, the outcomes do not represent patients with co-existing medical problems which complicate the measurement of treatment effectiveness and add to the cost of treatment. Multiple physical, mental and chemical dependency conditions are common in MHCD clients.

Indirect Costs Omission of indirect costs from the cost-benefit ratio adversely and disproportionally affected MHCD services. Indirect costs are clearly much greater in magnitude for MHCD conditions than for other health problems. The sequelae of untreated MHCD conditions, such as educational failure, decreased productivity, crime, institutionalization and incarceration are enormous.

Quality of well-being incorporates measurement of impaired functionality in the areas of mobility, physical and social functioning. The social scale was most often used by MHCD professionals to describe morbidities associated with the treatment or lack of treatment for MHCD diagnoses. The social scale allows three levels of discrimination:

- no limitations in social functioning;
- limited performance of major or other activity (health related), or performed no major role activity (health related) but did perform self care; or,
- performed no major role activity (health related), and did not perform or had more help than usual in performance of one or more self-care activities (health related).

Thus, this scale allows only the broadest description of impairments associated with MHCD conditions and the assessment of their treatment outcomes.

Careful examination of the Commission's methodology concluded that it was the best available response to the task. Therefore, the subcommittee recommended including MHCD services in the Health Services Commission process because:

- The methodology can accommodate inclusion of MHCD services as part of a basic health care package.
- The evaluative criteria is the same for all and generally applies equally well.
- Community, public and individual values are incorporated.
- The process forces inspection of the effectiveness of treatments and procedures in terms of outcomes and segregates more effective services from less effective services.

CHAPTER 2

CONTRIBUTIONS TO PRIORITIZATION METHODOLOGY

Abstract *The Mental Health Care and Chemical Dependency Subcommittee contributed to each phase of the Health Services Commission's work. The Commission accepted the subcommittee's suggestions for modifications of the criteria for gathering social values and treatment effectiveness information to accommodate a broader spectrum of symptomology. Also accepted were contributions to the definition of categories of services, preventive care, and ancillary services.*

As a result of cooperation across health care disciplines and perspectives, a methodology reflecting the relative effectiveness and importance of treatment developed. The process includes three steps:

Step 1: *Rank 17 categories of services termed acute or chronic and further categorized by whether treatment would prevent death or improve quality of life.*

Step 2: *Rank condition/treatment pairs within their respective category of service according to net-benefit.*

Step 3: *Move items which are "out-of-position" on the basis of Commission judgement and public input.*

This process allows prioritization of services according to their effectiveness and the values of Oregonians in a systematic way.

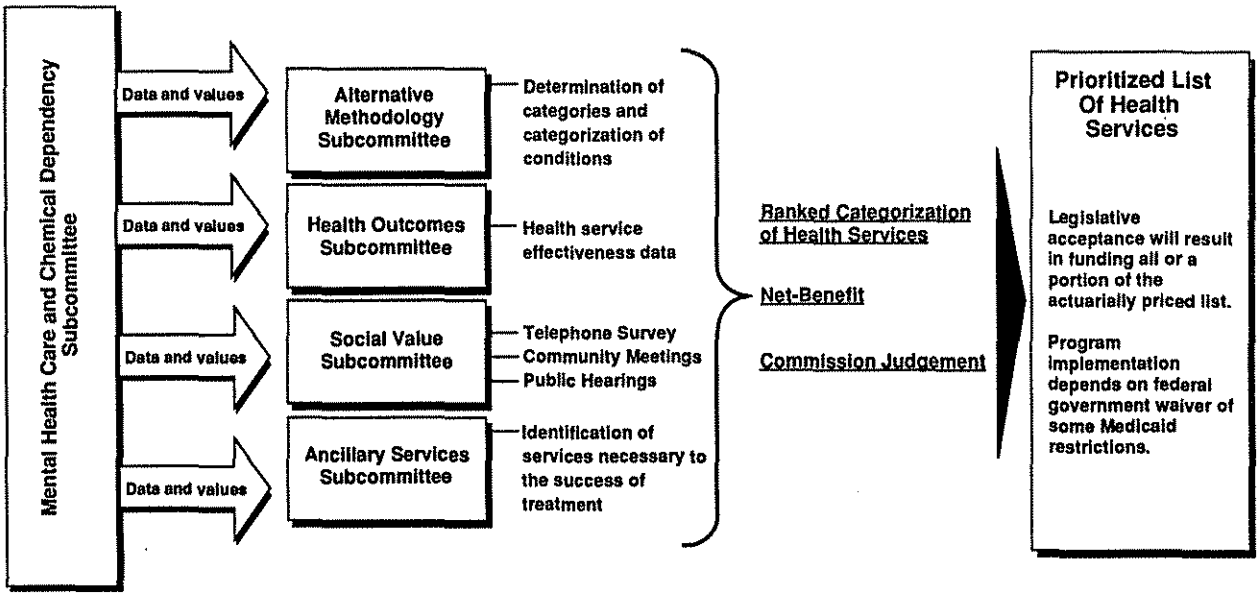
Senate Bill 27 (Appendix A) charged the Health Services Commission to develop "a list of health services ranked by priority from the most important to the least important...." [2-1] There were no established methods for ranking health services, so the Commission began to try possibilities with the idea of keeping those which worked and discarding those which did not.

The first method to be tried was cost-benefit with a quality of life component. Development of the components of the ratio was deceptively simple. Their complexity surfaced as work progressed and as modifications were made. After repeated testing, it was clear that a cost-benefit measure (as defined by the Commission) was not sufficient. At this point in the evolution of the methodology, a ranking system for categories of health services was developed and services were assigned to categories. The ranked categorization of health services resulted in a draft prioritized list which was a marked improvement over cost-benefit. However, the problem remained of how to rank services within their assigned categories.

In the final analysis, the ranked categorization of health services in conjunction with the net benefit component of the cost-benefit ratio defined the draft list of prioritized health services. Commission judgement played a significant role in refining the ranked list.

The Mental Health Care and Chemical Dependency (MHCD) Subcommittee participated in and influenced every phase of development of the Health Services Commission's prioritization methodology. (See Figure 3.)

Figure 3. MHCD Subcommittee Impact



The subcommittee's work resulted in a methodology which fairly integrates MHCD services into the spectrum of health services. Following are descriptions of the MHCD subcommittee's contributions to the premises on which the Commission built its methodology and then the methodology itself.

METHODOLOGICAL PREMISES

The Commission adopted as a foundation for its methodology:

1) a definition of health service which incorporates ancillary services;
2) an identification system for diagnoses and treatments;
3) the precept that all people with health-related complaints will have access to diagnosis;
4) the idea that effectiveness of service must be based on the "average" case; and,
5) prioritization of single or small groupings of health services rather than broad groupings of services.

Health service

The Commission adopted a definition of a health service which is applicable to MHCD services:

> A health service is an intervention related to a specific condition expected to maintain and/or restore an individual's health or well-being. Each health service listed is presumed to include all necessary ancillary and supportive services.

The detail pertinent to ancillary and supportive services is contained in Appendix I.

Condition/treatment pair

The MHCD subcommittee recommended use of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R)* as a source of MHCD condition identification. It is the common language of mental health clinicians and researchers for communicating about disorders and includes diagnostic labels for virtually all problems. [2-2]
CPT-4 codes (*Physicians' Current Procedural Terminology*) were used to identify care.[2-3]

For example:

Condition (Diagnosis)	Service (Treatment)
DSM-III-R: 295.32 Schizophrenia	CPT-4: 90844 Medical/psychotherapy

Diagnosis

The Commission began its task with the premise that everyone must receive diagnosis of their presenting condition. Subsequently, the health care provider may recommend treatment. Access to treatment is contingent upon the extent to which the Legislature funds the list of health services.

Effectiveness of service

Health service effectiveness plus its value to Oregon's residents are the criteria on which a service coupled with a diagnosis is evaluated. Effectiveness determined by net-benefit is based on the "average" case meaning presentation at a median age and a blend of outcomes probabilities. The premise was that if a treatment is very effective and necessary, an individual should have access to it--regardless of its frequency. However, as draft lists of health services developed, it became clear that conditions which are prevalent and treatable were often ranking less favorably than those conditions which occur infrequently. The Commissioners decided this was unreasonable and subsequently considered incidence in the movement of "out-of-position" items.

Adjustment of service level

The decision to rank condition/treatment pairs rather than broad groupings was a response to the floating revenue funding mechanism.

> If insufficient funds are available during a . . . . period, ...reimbursement shall be adjusted by reducing the health services for the eligible population by eliminating services in the order of priority recommended by the Health Services Commission, starting with the least important and progressing toward the most important. [2-4]

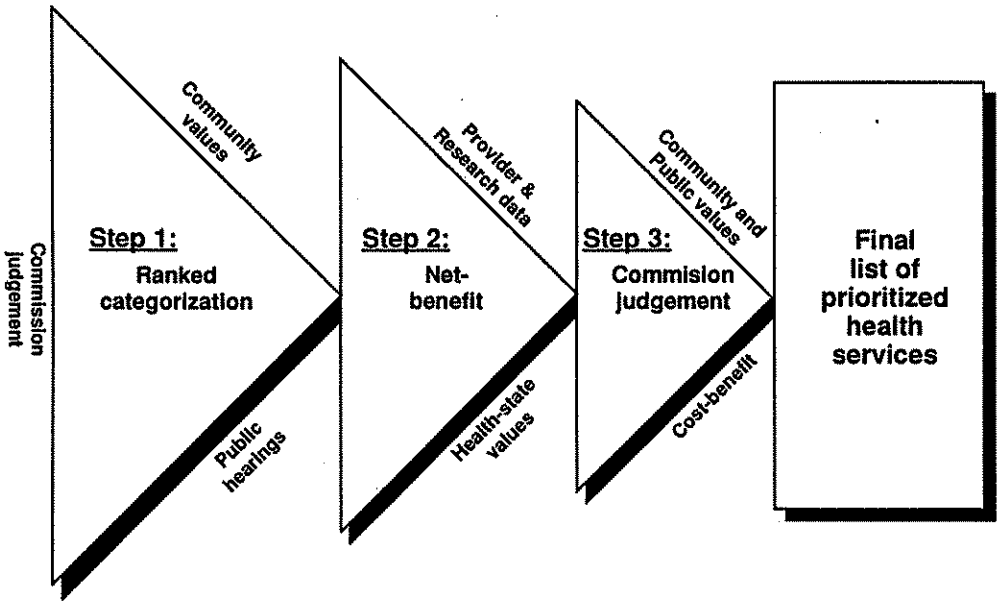
Evaluation of services must occur individually or in very small groups in order for the mechanism to work.

PRIORITIZATION: COMBINATION OF VALUES AND DATA

The law does not specify the methodology by which the Commission is to rank health services. It does dictate, however that a list of health services "representing the comparative benefits of each. . .[and]. . .a community meeting process to build a consensus on the values to be used to guide health resource allocation decisions" [2-5] were to be components of the methodology. With this understanding, the Commission decided that social values as well as treatment effectiveness data must be integral to the process.

Figure 4 is a description of the Commission methodology divided into three steps: 1) categorization and ranking of health service categories; 2) net-benefit; and 3) Commission judgement.

Figure 4. Three-Step Methodology



The following description of the prioritization methodology is a shortened version of chapter 2 in the Commission report with MHCD detail. A thorough report on the components of the methodology can be found in relevant appendices.

STEP 1: RANKED CATEGORIZATION OF SERVICES

Representatives of the MHCD Subcommittee were part of the Commission's Alternative Methodology Subcommittee. This subcommittee developed the ranked categorization of health services as the primary ranking tool in the Commission's methodology.

Seventeen (17) categories of health services were determined by the Commission. Most categories are either acute or chronic, fatal or non-fatal with treatment improving either quality or length of life. The categories are ranked from most to least important. A description of the categories and their ranking process can be found in Appendix G.

1. **Acute Fatal:** treatment prevents death with full recovery
2. **Maternity Care**
3. **Acute Fatal:** treatment prevents death without full recovery
4. **Preventive Care for Children**
5. **Chronic Fatal:** treatment improves life span and quality of life
6. **Reproductive Services:** (excludes maternity and infertility services)
7. **Comfort Care:** pallative therapy for conditions in which death is immine
8. **Preventive Dental Care**
9. **Proven Effective Preventive Care for Adults**
10. **Acute Nonfatal:** treatment causes return to previous health state
11. **Chronic Nonfatal:** one-time treatment improves quality of life
12. **Acute Nonfatal:** treatment without return to previous health state
13. **Chronic Nonfatal:** repetitive treatment improves quality of life
14. **Acute Nonfatal:** treatment expedites recovery of self-limiting conditions
15. **Infertility Services**
16. **Less Effective Preventive Care for Adults**
17. **Fatal or Nonfatal:** treatment causes minimal or no improvement in quality of life

Most MHCD services are in categories 1, 3 and 5. For example:

Category 1: major depressions, single episode; acute post-traumatic stress disorder and drug-induced deliriums.

Category 3: alcohol and drug abuse diagnoses.

Category 5: dysthymia, chronic post-traumatic stress disorder, alcohol and drug dependence, eating disorders, bipolar disorder, recurrent major depression, schizophrenia, conduct and personality disorders.

Social Values

The effectiveness of health services based on clinical evidence alone was not sufficient information on which to base prioritization. The community meetings (Appendix F) and public hearings (Appendix E) provided information used in the ranking of the categories of health services.

Community meetings The Health Services Commission hoped to obtain from the community meetings underlying health care values rather than health service or provider preference. For example, length of life exclusive of quality of life is not preferred according to the Oregon communities. In half of the meetings, however, the participants insisted that MHCD services be listed even though they are not "values."

> Services that focus on mental health and chemical dependency were felt to be valuable because mental health is an important component of overall health, and because chemical dependency problems have a large negative impact on society as a whole." [2-6]

The participants intended that these services include education and awareness which are hoped to prevent condition degeneration to a more severe state.

The Commission recognized the high indirect costs associated with not providing care for MHCD conditions. So, the MHCD "value" is incorporated in the attributes of "value to society" and "value to an individual." The community concerns about education and awareness are reflected in the screening and counseling services included in prevention for children and adults.

Public hearings Twelve (12) public hearings held in Portland, Salem, Pendleton, Eugene, Bend, Coos Bay and Medford provided a forum for testimony from advocates for seniors, handicapped persons, mental health services consumers, low income Oregonians, and providers of health services.

Testimony generally was not useful in measuring treatment effectiveness objectively but was useful for understanding the general tone of public needs and concerns. In part, the message delivered was that MHCD services should be a part of the health services available to all Oregonians.

STEP 2: NET-BENEFIT WITHIN CATEGORIES

Outcomes data collection

The Health Services Commission directed the MHCD subcommittee to collect clinically-based outcomes testimony from health care providers concurrent with the Commission collection process from other specialists. Clinicians, academicians, and researchers developed an outcomes product for mental health care. A team of alcohol and chemical dependency professionals reported outcomes using the same framework as the mental illness cohort of the report.

A condition (DSM-III-R) [2-7] and treatment pair comprises the unit measured for effectiveness. Similarity of severity, treatment costs and outcomes drove clumping of diagnostic groups as they did for other health conditions. For instance, age and the difficulty of treating specific addictions are the bases for grouping chemical dependency diagnoses. Evaluation of each MHCD condition included a continuum of care which could be expected for a typical course of therapy. A continuum of care includes locus of care (outpatient, day or residential facility, or inpatient hospital) and all necessary modalities and services (individual, family or group therapy; vocational training and occupational therapy; case management; medication and medication management).

The Oregon Psychiatric Association and membership of the Mental Health Care and Chemical Dependency Coalition [2-8] reacted to and modified the data. Cooperation precluded duplication of effort which would have occurred if each type of practitioner addressed the same diagnoses.

Net-benefit

Net-benefit established the initial prioritization in categories where condition/ treatment pairs exist. It is a number computed for each condition/treatment pair and is intended to represent the extent to which a person feels better or worse after having treatment or not.

The following information was specified as necessary to determine net-benefit:

- outcomes likely to result from treatment or without treatment for health-related conditions as specified by health care providers:
- mortality (death)

- return to former state of health
- morbidities (quality of life is represented by presence or lack of symptoms and functional impairments)
- quality of life (benefit) quantified by telephone survey responses so public attitudes and clinical findings could be blended.

Below is a simplified version of the net-benefit calculation used to establish the initial prioritization within service categories where condition/treatment pairs exist. It does not convey the complexities involved but does show the basic components and their relationship to one another (see Appendix D).

$$\text{Net-benefit} = \underbrace{[\text{outcomes} \times \text{probabilities}]}_{\textit{with treatment}} - \underbrace{[\text{outcomes} \times \text{probabilities}]}_{\textit{without treatment}}$$

The number is simply a measure of the relative magnitude of the benefits of one service to another. It does not appear on the list of prioritized services.

Benefits: Quality of Life

Detailed information regarding the content of the telephone survey, how results were calculated, and interpretation of the results is in Appendix C as well as a facsimile of the survey. Questions include demographics, whether a respondent experienced the health state, health insurance coverage, and general attitudes about health care in Oregon in addition to those directed at symptoms and functional impairment.

Health-State Values The basis of the survey is the Quality of Well-Being Scale developed by Dr. Robert M. Kaplan of the University of California at San Diego. [2-9] The survey instrument measures an individual's total health state or quality of well-being. A drawback of the instrument was that it did not adequately address MHCD problems. The Commission accepted the subcommittee's recommendation to modify the instrument's symptom list by including:

-- trouble falling asleep or staying asleep

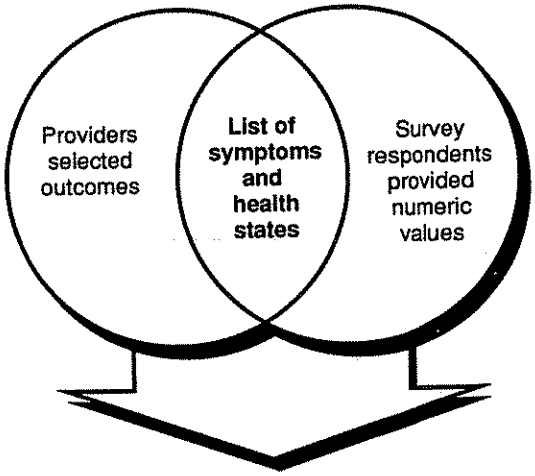
-- trouble with sexual interest or performance

-- is often worried

-- trouble with the use of drugs or alcohol

Survey respondents scored the severity of symptoms and functional impairments on a scale of 0 (death) to 100 (perfect health). The lower the score, the more serious the problem. The subcommittee suspected that the results of the survey may be skewed because of denial and stigma attached to MHCD. However, survey results showed Oregonians giving the lowest score to the symptom of "trouble with the use of alcohol and drugs" (58 out of 100). The next most severe symptom is "problems with learning and thinking clearly" (64 out of 100). Mental health clinicians relied heavily on this symptom to describe morbidity when quantifying outcomes.

Figure 5. Integration of Provider Outcomes and Survey.



STEP 3: COMMISSION JUDGMENTS

A draft list of prioritized health services resulted from the ranked categorization of health services with the net-benefit ranking within categories. The Commission used professional judgments and the values expressed by the public to re-rank "out-of-position" items on the draft list.

The Commissioners used a "reasonableness" test when they adjusted the objectively ranked health services. "Reasonableness" consisted of subjectively evaluating the public health impact, rarity of condition, effectiveness of treatment, indirect costs, and cost of non-treatment to determine a new ranking. The Commissioners also observed that it was not reasonable--logically or economically--to rank a service below a diagnosis which the service could prevent. These occurrences were rectified by moving a service above all diagnoses which it could prevent. The MHCD subcommittee used the same factors in re-ranking conditions within the MHCD specialties and when recommending the points within the list of health services at which MHCD services should be interleaved.

A cost-benefit ratio was developed for use in prioritization. In the final analysis it was a factor when the Commissioners applied the "reasonableness" test--as was cost by itself. However, the measure of net-benefit was second only to ranked categorization in terms of importance in the ranking of health services. Additional information regarding costs as they relate particularly to MHCD is found in Appendix D.

CHAPTER 3

BASIC HEALTH CARE ISSUES

Abstract *Mental health and chemical dependency (MHCD) services must be a part of basic health care which will be drawn from "essential" and "very important" health services as defined by the Health Services Commission for the following reasons:*

- *The inseparability of mind and body demand adoption of MHCD services as a part of a comprehensive approach to the promotion and maintenance of the total health of an individual.*
- *Appropriate provision of MHCD services decreases total health care costs.*
- *An integrated list of health services provides a common ground for rational allocation of health care resources for basic health care.*
- *The state-sponsored insurance pools are more likely to include MHCD services in their health care benefits packages if they are part of basic health care.*

The Commission defined basic health care as a minimum below which no person should fall. However, they were reluctant to draw a line on the list of health services stating that all services above the line are basic and all those below are not. The difficulty is that what is basic to one person may not be basic to the next. Therefore, the Commission decided to define categories of service as **essential, very important,** and **of value to certain individuals but significantly less likely to be cost-effective or to produce substantial long-term gain.** "Essential" comprises the first nine categories of health services; "very important" are categories 10 through 13; and, the final level is categories 14 through 17. (See Appendix G.)

This chapter describes reasons for including MHCD as a part of "essential" and "very important" health care which are likely to comprise the major portion of the legislatively-funded benefit package. Included are the psychological and physiological manifestations of MHCD problems, MHCD's economic impact on the bill for total health care, the pros and cons of presenting a list of MHCD services integrated with other health services, and the implications of the Small Business and Medically-High Risk insurance pools.

INSEPARABILITY OF MIND AND BODY

A human being is an organism of complex interactions. No emotional or somatic problem is a simple one-way street of linear cause and effect. It is a two-way street with many intersections. A condition may begin as a somatic problem but result in mental illness or chemical dependency; a MHCD condition may mask itself somatically. Recovery from an illness is affected by the patient's state of mind. Compliance with regimens of medication, exercise and other lifestyle change is dependant on an individual's attitude and the influence of a social support system.

A Rand study shows that patients with depressive disorders or depressive symptoms tend to have worse physical, social, and role functioning, worse perceived current health, and greater bodily pain than patients with no chronic conditions. In fact, poor functioning uniquely associated with depression is comparable with or worse than that associated with eight major chronic medical conditions (e.g., arthritis, diabetes, advanced coronary artery disease). [3-1]

Brain damage is just one of the consequences of alcohol dependency. It is not unusual for a variety of medical problems to occur: liver disease, malnutrition, heart damage and increased risk of mouth, throat, and liver cancer. The

health consequences caused by drugs depend on the drug of choice. In general, the user risks forming learning disabilities, respiratory problems, gastrointestinal disturbances, sleep disorders, hypertension, and malnutrition.

Alcohol and drug use causes serious problems in the user's family. Economic stress, divorce, and negative role modeling for children are prevalent. Intoxication, anxiety and depression can lead to self-destructive and violent behaviors such as accidental injuries, gunshot wounds, homicide and suicide. Chemical use by pregnant women affects both mother and child. Even moderate alcohol use may cause "fetal alcohol syndrome" in which babies may be born with mental retardation and physical malformations and malfunctions. Drug use by a pregnant woman may have similar effects. [3-2]

MEDICAL OFFSET

Medical offset is a term used to describe the decrease in medical utilization resulting from the provision of appropriate MHCD services. There are many studies showing significant savings when MHCD services are accurately diagnosed and treated. Although some studies suffer from limitations such as small study groups, inadequate comparison groups, short study periods, or surrogate measures for medical utilization [3-3], the overwhelming majority of studies demonstrate medical offset.

One of the best, most recent studies reflecting medical offset is applicable to both mental illness and chemical dependency. In 1985, McDonnell Douglas expanded and reorganized an employee-assistance program (EAP) with the proviso that program continuance would rely on a demonstrated return on investment. The findings were lower medical claims by employees and their families as well as a reduction in absenteeism and employee turnover. [3-4]

On average, families with a member receiving mental health treatment utilize total health care services and incur costs at a rate between 26 and 73 percent higher than similar families with no member receiving such treatment. [3-5, 3-6, 3-7] From another perspective, a study of the Aetna Federal Employees Health Benefit Program showed total health care costs dropping significantly following initiation of treatment. [3-8]

Several studies strongly suggest that treatment for alcohol abuse and alcoholism is frequently followed by a reduction in medical utilization and cost. A review of 22 studies shows an average decline of 46 percent. [3-9] An example is a Kaiser Permanente study conducted with treated and untreated alcoholic members. The overall costs of health care decreased for those who

completed treatment, but those who did not used more health care services -- a 70 percent increase. [3-10]

Health services which provide economic benefit due the prevention of disease and deterrence of exacerbation of conditions should be considered for a role in basic health care.

STATE-SPONSORED INSURANCE POOLS

Oregon's solution to the challenge of providing health care to Oregon's uninsured population comprises three components--government, business and labor. The government component of the solution is Senate Bill 27 which expands service to all people beneath the federal poverty level by using the prioritization mechanism. Business and labor collaborate in Senate Bill 935's (see Appendix A) effort to provide health insurance to employees and their dependents. The third part of the solution is establishment of a high-risk pool for those Oregonians whose existing health problems make them uninsurable.

The link among the three components of the Oregon solution to the health care access problem is that the funded portion of the Health Services Commission's priority list will be considered a benefit package. The Small Business Insurance Pool legislation states, "After considering . . .the full priority list recommended by the Health Services Commission, the board shall determine benefit packages . . . ." [3-11] This is interpreted to mean that, as a minimum, the work done by the Health Services Commission and funded by the Legislature will be adopted by the pool. The subcommittee also understands that the same package may be considered as a minimum, basic package for the high-risk pool.

The funded services will eventually serve as yardstick for standard, minimum health benefits by all employers whether they be public or private, small or large, self-insured or not.

AN INTEGRATED SERVICES LIST: Pros and Cons

The pros and cons of presenting an integrated list of health services to the Legislature were discussed by the subcommittee at length. It was agreed that an integrated list of services reflects a comprehensive approach to promotion and maintenance of the total health of an individual and advances inclusion of MHCD services in basic health care. The following list summarizes the other pros and cons.

Integration promotes:

-- validity of treating MHCD conditions on a par with other health conditions. This means that the impact of the condition(s) on an individual and the effectiveness of the corresponding treatment(s) is of equal importance with conditions and treatments corresponding to other health problems.

-- recognition of the similarity to private insurance mandates. The mandates cited in the insurance code [3-12] would probably be displaced by the content of the basic health care package.

-- positive response to the social and community values expressed in public hearings, community meetings, and the telephone survey. In all three venues people stressed that MHCD services are a priority for health and quality of well-being.

-- ability to expand or contract health service benefit packages according to available revenue. All health services are measured against common standards and blended coherently into one list. Two non-comparative lists of services would inhibit the Legislature's ability to rationally change the level of services as Oregon's economy fluctuates.

Integration may work against:

-- gains made in mental health along with the generally positive direction of mental health services. Mandates for minimum MHCD services may be dropped or undermined by the prioritization process.

-- the county delivery system and its present variability. A common list for different population needs may disrupt what now exists without providing a better system. A list of services is being built independently of a delivery system.

-- access. While new and/or more services may be offered, there may not be enough professionals to meet the demand. The estimated unserved population of seriously mentally ill [3-13] could overload the system.

There are both advantages and disadvantages to integrating MHCD services with other health services. However, the subcommittee concluded that if MHCD services are not part of an integrated list of health services, they have little chance of being considered part of basic health care.

CHAPTER 4

DELIVERY SYSTEM ISSUES

Abstract *Planning for a "linked" health care delivery system will support reasonable, comprehensive delivery of services. Linkages will facilitate provision for an individual's health and well-being in its entirety regardless of point of entry into the health care system.*

Other recommendations address accurate differential diagnoses and utilization review by qualified mental health and chemical dependency professionals to reduce inappropriate costs; treatment in the least restrictive and most natural setting to reduce costs and enhance client recovery; and involvement of the client's natural support system in the treatment plan to increase treatment effectiveness and sustain recovery.

The Mental Health Care and Chemical Dependency (MHCD) Subcommittee's charge does not include responsibility for recommendations on the MHCD delivery system or its relationship with the health care system at large. Nevertheless, the subcommittee believes it is incumbent upon them to do so given their recommendation of an integrated, prioritized list of health services.

Comprehensive biopsychosocial assessment and treatment must occur regardless of point of entry into the health care system. The subcommittee's recommendation to the Commission for integration of all health services is a step in that direction. Concern is high among mental health providers and consumers, and within the MHCD subcommittee, about the adequacy and availability of MHCD services within managed health care systems. An integrated list of health services does not mean total incorporation of MHCD services into managed health care systems. Rather, it requires thoughtful development of linkages among health service delivery systems.

Oregon's Office of Medical Assistance Programs (OMAP) is planning for the delivery of prioritized health services--with the exception of MHCD services--coupled with the Commission's deliberations. Implementation of MHCD services within a prioritized list must happen with the same sort of planning for linkages among health care systems.

CURRENT SYSTEM

Oregonians' access to adequate MHCD services varies widely on the basis of geography, income, and medical insurance coverage. The public mental health system serves the Medicaid population--among others (e.g., non-Medicaid eligibles who are children classified as Priority 1. [4-1] Oregonians with employer-provided health insurance have access to mandated minimum levels of care.

Oregon's insurance laws mandate MHCD coverage in all group insurance plans and managed health care systems, including federally qualified health maintenance organizations (HMOs). Mandates do not apply to individual policies, self-insured businesses (which comprise 40 percent of employers in Oregon), and specialty policies covering specific conditions (e.g., cancer, accidental injuries). A coalition of provider, business and insurance interests designed the mandates to ensure the provision of minimally adequate services and achieve cost containment. There are strict controls on access to and expenditures for expensive hospital-based services and provision for coverage of day and residential treatment and outpatient therapies.

Uninsured Oregonians face severe difficulties locating affordable MHCD services. In some communities, the public system is able to provide care for some of this population and there are very limited amounts of service available on a reduced fee basis through charitable organizations.

Public mental health services

The public mental health system reaches about half of Oregon's adults with serious and persistent illness and about one-third of its seriously emotionally disturbed children. Recent inclusion of MHCD screening as a part of the early periodic screening, diagnosis and treatment (EPSDT) for children should cause a reduction in the 80 percent of severely disturbed children who are not treated. [4-2]

A partnership of agencies, resources and programs comprises the public system. The Oregon Mental Health and Developmental Disability Services Division assumes the primary coordinating and administrative role in providing services.

The Division operates three psychiatric hospitals and contracts for community services with 32 Community Mental Health Programs (CMHPs). The county CMHPs either provide services directly or subcontract with private providers for service provision. Because community services are county-based, there are great variations in delivery and accessibility from county to county. Variations depend upon provider availability, level of need in the community, and contributions for services from the county tax base.

Public chemical dependency services

In 1987-88, public services for alcohol and chemical dependency reached over 39,000 persons. Those served represent 5 percent of the adults needing treatment for drug addiction and 17 percent of the adults needing treatment for alcoholism. Services for youths reach 8 percent of daily drug users and 42 percent of those drinking daily.

The Office of Alcohol and Drug Abuse Programs contracts for or directly supports and monitors 133 publicly-funded programs. In addition, 424 approved private programs offer services. Oregon State Hospital and state correctional facilities also provide treatment. [4-3]

Private MHCD services

Private providers include non-profit agencies, proprietary establishments and for-profit organizations. Over 320 private providers exist throughout the

system ranging from comprehensive community mental health centers and local psychiatric hospitals to smaller, more narrowly focused programs such as vocational rehabilitation agencies and residential programs. Most private providers subcontract with county CMHPs.

In addition, there are a number of MHCD practitioners in private practice who serve communities' need. Providers include licensed physicians, psychologists, social workers, and nurse practitioners and may be privately subsidized through third-party payments, donations or local church support.

RECOMMENDATIONS

The subcommittee's recommendation that MHCD services be included in a prioritized list of health services is a step toward reaching the following goals:

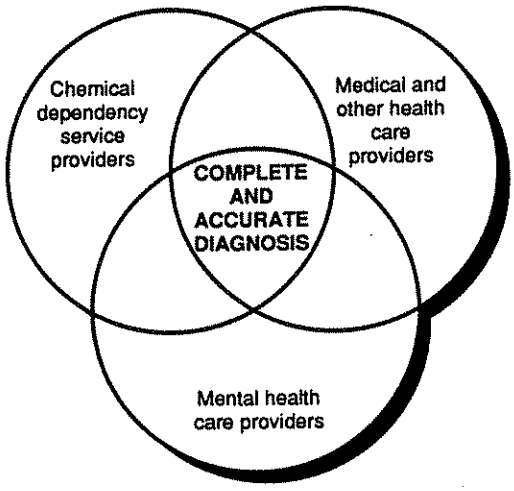
- -- expand the number of persons served and the adequacy of the services offered;
- -- build on current strengths in the MHCD delivery systems; and,
- -- forge new linkages between MHCD and health care providers.

The following objectives stem from these goals:

Cost containment Persons will receive treatment necessary to restore health and well-being when diagnosed with a condition for which health care providers will be reimbursed. Accurate differential diagnosis and appropriate treatment planning are the keys to cost containment in such a system. Utilization review must be done by qualified mental health professionals using criteria made available to providers in advance, as current Oregon law requires. The focus must be on the diagnosis justifying treatment, the clinical relevance of the treatment plan, and the effectiveness of the intervention in restoring well-being or preventing worsening of the condition.

Linked delivery systems "Linked" systems connote a fluidity in service delivery (See Figure 6). An individual must receive a complete and accurate diagnosis and access the services needed regardless of how or where that individual enters the health care system. If an individual is diagnosed by an internist as having cirrhosis of the liver (secondary to alcohol abuse), referral of that individual must be made to a MHCD professional. Treating the cirrhosis and ignoring the potential cause is not serving the individual's best interests or effecting the desired outcome. The same is true of MHCD professionals treating an eating disorder and ignoring the physical manifestations of that problem.

Figure 6. Linked Health Care Delivery System



Locus of treatment An adequate MHCD service system requires a continuum of care ranging from case management and outpatient therapy through day and residential programs and hospitalization. Oregon's Office of Health Policy developed model criteria for determining the appropriate level of care in the least restrictive and most natural treatment setting effective in meeting the needs of the MHCD patient. The alternative to timely and accessible case management, crisis intervention and outpatient treatment is expensive hospital-based care.

Systems approach Interventions which focus on the client's natural support system increase the effectiveness of treatment and sustain recovery. Involvement, education and support of family members can address the intrafamilial effects of MHCD conditions, dynamics contributing to the severity of illness, and the intergenerational transmission of many disorders.

Case management Effective treatment of certain MHCD conditions, especially those which are chronic, requires a comprehensive approach. This includes the complex function of case management. To be effective, a case manager serves in a clinical role and is central to assessment and treatment planning in collaboration with other clinical personnel (e.g., psychologists,

psychiatrists). In addition, a case manager links and connects clients with services necessary to preserve independence and well-being (e.g., financial, health care, housing, legal).

The system must be designed to facilitate ease of referral and consultation among mental health, chemical dependency and other health care providers. This will require:

-- **Education.** Health care providers must learn about the inseparability of mental and physical health and be aware of the range of providers and variety of expertise and treatment effectiveness. Education must eliminate the stigma associated with mental health problems and chemical dependency. Stigma can result in the denial of the presence of a condition by both the client and the health care provider. As a result, treatment is delayed.

-- **Planning.** Linkages require thoughtful planning and policy development between the public and private sectors and among the current public purveyors of services and funding such as Oregon Medical Assistance Programs, Office of Alcohol and Drug Programs, Mental Health and Developmental Disability Services Division, CMHPs, and managed health care organizations. Senate Bills 27 and 935 mandate delivery of services through existing managed health care systems where they are available, with fee-for-service arrangements in rural areas where they are not. This multiplicity of delivery systems will require adapting the linkage mechanisms to the needs of each community.

-- **Availability of Consultation.** MHCD consultation to primary care providers, for example, would extend expertise to them not only in the realm of diagnostic expertise but also in the provision of care.

CHAPTER 5

RECOMMENDATIONS

Abstract *The Mental Health Care and Chemical Dependency (MHCD) Sub-committee recommends:*

- *MHCD services be included in an integrated, prioritized list of health services;*
- *MHCD preventive services be included in the Commission's definition of preventive care for implementation in 1992;*
- *basic health care include the first 49 items on the MHCD ranked list;*
- *development of linked health care delivery systems for effective delivery of MHCD and other health care services;*
- *Commission membership include two representatives from MHCD;*
- *Legislate the minimum health benefits packages of the Small Business Insurance (SBIP) and Medically High-Risk Insurance (MHRP) Pools;*
- *the MHCD Subcommittee be continued;*
- *continued study of incorporating the cost of non-treatment, including indirect costs, and co-morbidity into the prioritization methodology; and,*
- *services for nicotine dependence, mental retardation, learning disabilities, profound developmental disabilities and paraphilias be suspended from the ranked list pending further consideration.*

The Mental Health Care and Chemical Dependency (MHCD) Subcommittee values, above all, the creation of an improved system which will serve more people. Senate Bill 27 legislates that more people in Oregon shall have access to health care. The following recommendations serve to enable and enhance comprehensive provision of that health care.

1) **An integrated, prioritized list of health services.** The endorsement of an integrated, prioritized list of health services is based on the acceptability of the Commission's methodology and the basic health care needs of Oregonians. The methodology used to measure the effectiveness of health services uses common assessment criteria and applies equally well to MHCD and other health services. And, testimony heard from the public, values cited in community meetings, and the seriousness Oregonians attach to MHCD conditions attest that MHCD services are requisite to basic health care. MHCD services must be included in the integrated list of health services to be considered as part of the legislatively-funded basic benefit package.

   The integrated list promotes distribution of health care resources from a common prioritized list. It also serves to emphasize the importance of multi-axial assessment, prevention and early intervention, and exclusion of treatments with limited effectiveness from basic health care.

   Assessment and early intervention and prevention for the MHCD needs of children rank in the top fifth of the list. It is an investment which will pay future dividends by reducing the costs of future MHCD services and other health care, incarceration, premature death, social services (e.g., housing, welfare), and nonproductive citizens.

   Diagnoses ranked in the top half of the list are characterized as those for which treatment can prevent death. The major mental illnesses rank high because of the incidence of suicide associated with disorders such as major depressions. Chemical dependency is near the top of the list because of its epidemic proportion, death due to suicide and accidents, and the cost to society.

   Near the bottom of the list are those diagnoses which are less prevalent and for which treatment has limited effectiveness. These diagnoses tend to be categorized as nonfatal acute or nonfatal chronic. The least treatable personality disorders, impulse disorders and severe conduct disorders are examples of conditions for which treatments are less effective.

2) **MHCD preventive services implemented in 1992** The subcommittee drew on research, professional experience and the work of the Office of Alcohol and Drug Programs and the Mental Health and Developmental Disability Services to develop a list of preventive services. Services are specified for all age groups and span screening for developmental disabilities in young children to watching for the effects of polypharmacy in older Oregonians.

   An integrated list of health services means that preventive services would be included in the 1993-95 implementation process. However, the subcommittee believes prevention to be so critical to quality of life that they requested and the Commission accept their recommendation to include it in the list of health services to be implemented in 1992.

3) **Basic health care includes the first 49 items on the MHCD ranked list** This chapter includes a ranked list of MHCD services exclusive of other health services. The subcommittee developed the ranking and reviewed it with MHCD professionals outside the subcommittee. As a result, the subcommittee determined that conditions through stereotypy/habit disorders are **essential** or **very important** to basic health care. The subcommittee will advocate with the Legislature to fund an integrated list of health services to at least this point.

4) **Linked health care delivery systems** Complete and accurate diagnosis and access to needed services depends on system indifference to the "how or where" of entry. System linkages must encourage movement among and between providers and systems in order to provide comprehensive, cost-effective, quality care. System linkages respect the inseparability of mental and physical health and the variety of expertise which can be employed to effect positive treatment outcomes.

   Provision of a basic benefits package consisting primarily of "essential" and "very important" health care drawn from an integrated list of health services can begin in the 1993-95 biennium. The administrators of health, mental health and chemical dependency systems must begin at once to thoughtfully plan and develop policy to modify existing service provision and administrative mechanisms.

5) **Expand the Commission to include representatives from each of the MHCD specialties** The Health Services Commission must include professionals from each of these specialties in order to balance expertise. Examination of prioritization methodology and assessment of treatment effectiveness of MHCD conditions can best be done through representation on the Commission.

6) **Legislate the minimum health benefits packages of the Small Business Insurance (SBIP) and Medically High-Risk Insurance (MHRP) Pools.** The SBIP health care benefits packages, by law, must include "substantially similar medical services as those recommended by the Health Services Commission" [5-1] and funded by the Legislature. However, the first list of services to be considered by the Legislature does not include MHCD services. For that reason, the subcommittee recommends that the existing MHCD mandates be extended to the pools until such time as an integrated health services list can be implemented.

   Also, the Commission's work is not legislatively tied to the MHRP. As a result, adequate MHCD services may not be available to pool participants.

   - The pools are self-insured; hence, they are not covered by Oregon law which requires inclusion of MHCD services in health benefits packages.
   - An interpretation of the SBIP law may be that if the Legislature does not fund any part of the Health Services Commission's prioritized list, inclusion of the Commission's work in Pool packages is not required.
   - "Substantially similar," as included in SBIP's enabling legislation (Senate Bill 935), could exclude MHCD services.
   - If the federal government fails to authorize implementation of the ranked list of health services, the link between the SBIP and the Commission's work could be abrogated.

   The MHCD Subcommittee recommends that the Legislature tie the minimum health care benefits packages of the SBIP and the MHRP to those of the basic health care package funded by the Legislature--including MHCD services.

7) **Continue the MHCD Subcommittee.** The subcommittee will continue to investigate and recommend solutions for prioritization problems. This is an effective research tool which enables the Commission to efficiently draw upon a wide variety of expertise and a range of public and private providers.

8) **Continue study of the value of incorporating the cost of non-treatment, including indirect costs, and co-morbidity in future prioritization.** The health care system cannot cure social ills associated with lack of adequate housing and education. However, prioritization of health care services can directly take into consideration the indirect costs of not providing health

care (e.g., inadequate treatment of chemical dependency leading to incarceration). Society pays in one way or another for not making available needed services. It is time to assess the interaction of various social needs on the total cost to society.

Co-morbidity has a significant impact on the effectiveness of treatment. This factor is missing from the Commission's prioritization methodology. The subcommittee believes that quantification of co-morbidity and indirect costs may enhance the effectiveness of the net-benefit and cost-benefit measues.

9) **Hold harmless services for nicotine dependence, mental retardation, learning disabilities, profound developmental disabilities and paraphilias.** The subcommittee understands that extensive research is being conducted by the federal government on the effectiveness of smoking cessation programs. Results are expected within the next two years. At that time, there will be enough evidence to rank the dependence and its associated treatment(s).

The subcommittee did not address developmental disabilities and recommends programs associated with these conditions continue as before. People with developmental disabilities may contract mental health and physical health conditions which are on the prioritized list. But, educational services associated with developmental disabilities are not. The subcommittee must carefully consider the implications of ranking "treatment" effectiveness and whether retardation and developmental disabilities by themselves are medically treatable or respond to psychotherapy.

The subcommittee recognizes the high indirect costs associated with a diagnosis such as pedophilia but does not have information which indicates that current treatment is generally effective. Further research is recommended to determine effectiveness of highly individuated treatments as well as collaboration with systems such as the Children's Services Division and Department of Corrections to make recommendations.

The subcommittee's recommendations are congruent with the health care goals cited by various planning entities. The linked delivery systems offering an integrated, prioritized list of health services ranking prevention and early intervention near the top of the list is particularly supportive of some of these goals. For instance:

- *Oregon Benchmarks* include measures of progress towards increasing and enhancing those things important to Oregon's people, their quality of life and the state's economy. Access to health care must be increased as well as the numbers of drug-free babies and drug-free teens to improve Oregon's livability. [5-2]

- The Oregon Health 2000 Project insists on the reduction of the rate of death due to drug and alcohol use [5-3] which supports goals of Oregon's Office of Alcohol and Drug Abuse Programs to prevent the harmful effects of dependency and abuse. [5-4]

- The subcommittee's recommendations and values correspond with Oregon's Mental Health and Developmental Disabilities Services Division goals--in particular: a consumer-centered mental health system; continuity of service through case management; timely delivery of services in natural settings; a one-tier system of services; and, a skilled and stable mental health work force. [5-5]

FOOTNOTES

P-1... Oregon Revised Statutes (ORS) 414.036(7).

P-2... Archives of General Psychiatry, "One-month Prevalence of Mental Disorders in the United States," November 1988, pp 961.

P-3... National Association of Private Psychiatric Hospitals, *In Perspective: Alcohol and Drug Abuse Hospitalization*, November 1989.

P-4... National Association of Private Psychiatric Hospitals, *In Perspective: Child and Adolescent Psychiatric Hospitalization*, November 1989.

P-5... Jan Bays, "Substance Abuse and Child Abuse: Impact of Addiction on the Child," *Pediatric Clinics of North America*, Vol.37, No. 4, August 1990, pp 881-904.

P-6... Report of the Oregon Health 2000 Project, *Health Objectives for the Year 2000*, Oregon Health Division, Department of Human Resources, State of Oregon, 1989.

P-7... The term "serious mental illness" as used by the Mental Health and Developmental Disability Services Division includes both severe and chronic mental illness. Chronic mental illness must be a diagnosis of schizophrenia, major affective or paranoid disorders or other severe mental illness. It also is defined as impaired role functioning including problems in at least two of the following areas: fulfilling social role, daily living skills and social acceptability. A severe illness is a psychotic disorder or other mental disorder of comparable severity.

P-8... Mental Health Division, *Developing Mental Health Services in Oregon 1989-1995*, Department of Human Resources, State of Oregon, 1989, p 114.

1-1... L. Sechrest and M. Hannah, "The Critical Importance of Nonexperimental Data" from *AHCPR Conference Proceedings: Research Methodology: Strengthening Causal Interpretations of Nonexperimental Data*, U.S. Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research, May 1990.

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1-3... American Academy of Child Psychiatry, "Child Psychiatric Treatment: The Case for Insurance Coverage," Working Draft, May 11, 1986.

1-4... J.B. Bixler and J. Hathaway, "Research Findings as to the Effectiveness of Alcoholism Treatment by Type and Setting," date unavailable.

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1-8... Alaska Statutes (AS) 47.07.035.

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1-10.. K. Grumbach, "California Dreaming," *Health/PAC Bulletin*, Summer 1990, pp 6-11.

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1-12.. R. Restuccia, "The Universal Health Care Law in Action," *Health/PAC Bulletin*, Summer 1990, pp 16-21.

1-13.. Hawaii State Department of Health, "An Introduction to State Health Insurance Program," 1990.

2-1... ORS 414.036(4a)3.

2-2... American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition-Revised, Washington D.C., 1987.

2-3... American Medical Association, *Physicians' Current Procedural Terminology*, Fourth Edition, Chicago, Illinois, 1990.

2-4... ORS 414.036(8)1,2.

2-5... ORS 414.036(4a)2.

2-6... *Health Care in Common*, Report of the Oregon Health Decisions Community Meetings Process, April 1990.

2-7... American Psychiatric Association, op. cit.

2-8... Membership of the Coalition includes Oregon Psychological Association, National Association of Social Workers, Oregon Counseling Association, Oregon Consumer Network, Oregon Community Mental Health Providers Association, Alcohol and Drug Program Directors Association of Oregon, Oregon Division of Marriage and Family Therapists, Mind Empowered, Inc., Addictions Treatment Association, Oregon Association of Community Mental Health Program Directors, Mental Health Association of Oregon, and Oregon Psychiatric Association.

2-9... Robert M. Kaplan and John P. Anderson, "A General Health Policy Model: Update and Applications," *HSR:Health Services Research* 23:2, June 1988.

3-1... Kenneth B. Wells, Anita Stewart, Audrey Burnam, et al., "The Functioning and Well-being of Depressed Patients: Results from the Medical Outcomes Study," *Journal of the American Medical Association*, Vol. 262, August 18, 1989, pp 914-919.

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3-3... K. Jones and T. Vischi. "Summary of Impact of Alcoholism Treatment on Medical Care Utilization and Cost," U.S. Department of Health, Education and Welfare, Public Health Service; Alcohol, Drug Abuse and Mental Health Administration, 1979.

3-4... McDonnell Douglas Corporation, "Employee Assistance Program Financial Offset Study, 1985-1988." Quoted with permission of Dan C. Smith, Director, EAP, McDonnell Douglas Corp.

3-5... N. Cummings, M. Pallack, H. Dorken and C. Henke, "Impact of Psychological Intervention on Health Care Utilization and Cost," Draft Report to the Health Care Finance Administration on the Hawaii research projects (No. 11-C-93844/9) Spring 1990.

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3-8... National Institute of Mental Health, No. 5, July 5, 1986, op. cit.

3-9... N. Cummings, et al., op. cit.

3-10.. Addictions Treatment Association, "The Costs and Benefits of Mandated Chemical Dependency Treatment in Oregon," April 1989.

3-11.. ORS 291.371(2)1b.

3-12.. ORS 743.

3-13.. Mental Health and Developmental Disability Services Division, *Developing Mental Health Services in Oregon 1989-1995, Document II: Incorporating Progress as of September 30, 1989*, Department of Human Resources, State of Oregon, 1990, pp 39 and 106.

4-1... Priority 1 -- 18 or older: At immediate risk of hospitalization; in need of continuing services to avoid hospitalization; or, pose a hazard to the health and safety of themselves or others.

Under the age of 18: at immediate risk of psychiatric hospitalization or removal from the home; exhibit behavior which indicates a high risk of developing disturbances of a severe or persistent nature; or, severely mentally or emotionally disturbed.

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of
INTEGRATED LIST

MHCD ITEMS FROM 3/27/91 INTEGRATED LIST

Line	Diagnosis
76	RUMINATION DISORDER OF INFANCY
99	DELIRIUM: AMPHETAMINE, COCAINE, OR OTHER PSYCHOACTIVE SUBSTANCE
108	MAJOR DEPRESSION, SINGLE EPISODE WITH PSYCHOTIC FEATURES
109	MAJOR DEPRESSION; SINGLE EPISODE, SEVERE, WITHOUT PSYCHOTIC FEATURES
125	BRIEF REACTIVE PSYCHOSIS
131	ALCOHOL WITHDRAWAL DELIRIUM; ALCOHOL HALLUCINOSIS; UNCOMPLICATED ALCOHOL WITHDRAWAL; WITHDRAWAL FROM AMPHETAMINES, COCAINE, OPIOID, SEDATIVES, HYPNOTICS, ETC.
132	ACUTE POST-TRAUMATIC STRESS DISORDER
150	MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE: MODERATE, IN FULL OR PARTIAL REMISSION AND UNSPECIFIED; DEPRESSIVE DISORDER NOS
151	MAJOR DEPRESSION: MILD
152	YOUTH ABUSE OF: HALLUCINOGEN, OPIOID, COCAINE, AMPHETAMINE OR SIMILARLY ACTING SYMPATHOMIMETIC, INHALANT, PCP, PSYCHOACTIVE NOS, ALCOHOL, CANNABIS, SEDATIVES, HYPNOTIC OR ANXIOLYTICS
153	YOUTH DEPENDENCE ON: HALLUCINOGEN, OPIOID, COCAINE, AMPHETAMINE OR SIMILARLY ACTING SYMPATHOMIMETIC, INHALANT, PCP, PSYCHOACTIVE NOS, ALCOHOL, CANNABIS, SEDATIVES, HYPNOTICS OR ANXIOLYTICS
161	ADULT ABUSE OF: HALLUCINOGEN, OPIOID, COCAINE, AMPHETAMINE OR SIMILARLY ACTING SYMPATHOMIMETIC, INHALANT, PCP, PSYCHOACTIVE NOS, ALCOHOL, CANNABIS, SEDATIVES, HYPNOTICS OR ANXIOLYTICS
162	ADULT DEPENDENCE ON: HALLUCINOGEN, OPIOID, COCAINE, AMPHETAMINE OR SIMILARLY ACTING SYMPATHOMIMETIC, INHALANT, PCP, PSYCHOACTIVE NOS, ALCOHOL, CANNABIS, SEDATIVES, HYPNOTICS OR ANXIOLYTICS
163	ACUTE DELUSIONAL MOOD ANXIETY, PERSONALITY, PERCEPTION AND ORGANIC MENTAL DISORDER CAUSED BY DRUGS; INTOXICATION
165	ATTENTION DEFICIT DISORDERS WITH HYPERACTIVITY OR UNDIFFERENTIATED
166	ANOREXIA NERVOSA
171	REACTIVE ATTACHMENT DISORDER OF INFANCY OR EARLY CHILDHOOD
173	BIPOLAR DISORDERS: MANIC, DEPRESSED, MIXED: MILD, IN PARTIAL OR FULL REMISSION, OR UNSPECIFIED
174	MAJOR DEPRESSION, RECURRENT, SEVERE WITHOUT PSYCHOTIC FEATURES
175	MAJOR DEPRESSION, RECURRENT: MODERATE, UNSPECIFIED WITH PSYCHOTIC FEATURES

MHCD ITEMS FROM 3/27/91 INTEGRATED LIST

Line	Diagnosis
176	MAJOR DEPRESSION, RECURRENT: SEVERE WITH PSYCHOTIC FEATURES
179	MODERATE BIPOLAR DISORDERS: MANIC, DEPRESSIVE, MIXED
185	BIPOLAR DISORDER, SEVERE WITH PSYCHOTIC FEATURES: MANIC, DEPRESSED, MIXED
186	BIPOLAR DISORDER, DISORDER, SEVERE WITHOUT PSYCHOTIC FEATURES: MANIC, DEPRESSIVE, MIXED
187	SCHIZOPHRENIC DISORDERS
226	CHRONIC POST-TRAUMATIC STRESS SYNDROME
227	EATING DISORDER NOS
228	BULIMIA NERVOSA
241	DYSTHYMIA
244	CONDUCT DISORDER, MILD/MODERATE: SOLITARY AGGRESSIVE, GROUP TYPE, UNDIFFERENTIATED
289	PSYCHOLOGICAL FACTORS AFFECTING PHYSICAL CONDITION (EG. ASTHMA, CHRONIC GI CONDITIONS, HYPERTENSION)
347	ANXIETY DISORDER, UNSPECIFIED GENERALIZED ANXIETY DISORDER
348	PANIC DISORDER WITH AND WITHOUT AGORAPHOBIA
349	DISSOCIATIVE DISORDERS: DEPERSONALIZATION DISORDER; MULTIPLE PERSONALITY DISORDER; DISSOCIATIVE DISORDER NOS; PSYCHOGENIC AMNESIA; PSYCHOGENIC FUGUE
350	AVOIDANT DISORDER OF CHILDHOOD OR ADOLESCENCE; ELECTIVE MUTISM
351	SEPARATION ANXIETY DISORDER
352	ADJUSTMENT DISORDERS
353	CONVERSION DISORDER, CHILD
354	TOURETTE'S DISORDER AND TIC DISORDERS
384	PARANOID (DELUSIONAL) DISORDER
385	SCHIZOTYPAL PERSONALITY DISORDERS
386	BORDERLINE PERSONALITY DISORDER
424	OVERANXIOUS DISORDER
425	SIMPLE PHOBIA

MHCD ITEMS FROM 3/27/91 INTEGRATED LIST

Line	Diagnosis
426	SOCIAL PHOBIA
427	OBSESSIVE-COMPULSIVE DISORDERS
457	FUNCTIONAL ENCOPRESIS
473	SEXUAL DYSFUNCTION
480	STEREOTYPY/HABIT DISORDER
489	CONDUCT DISORDER, SEVERE
502	OPPOSITIONAL DEFIANT DISORDER
508	CONVERSION DISORDER, ADULT
572	PERSONALITY DISORDERS EXCLUDING BORDERLINE, SCHIZOTYPAL AND ANTI-SOCIAL
620	FACTITIOUS DISORDER WITH PHYSICAL SYMPTOMS, NOS
621	FACTITIOUS DISORDER WITH PSYCHOLOGICAL SYMPTOMS
622	GENDER IDENTIFICATION DISORDER
623	AGORAPHOBIA WITHOUT HISTORY OF PANIC DISORDER
631	CHRONIC DELUSIONAL MOOD ANXIETY, PERSONALITY, PERCEPTION AND ORGANIC MENTAL DISORDER CAUSED BY DRUGS
632	HYPOCHONDRIASIS; SOMATOFORM DISORDER; NOS AND UNDIFFERENTIATED
633	SOMATIZATION DISORDER; SOMATOFORM PAIN DISORDER
714	IMPULSE DISORDERS
760	ANTI-SOCIAL PERSONALITY DISORDER
761	TRANSSEXUALISM
762	IDENTITY DISORDER
763	PICA

Diagnosis: PNEUMOCOCCAL PNEUMONIA, OTHER BACTERIAL PNEUMONIA, BRONCHOPNEUMONIA, INFLUENZA WITH PNEUMONIA
Treatment: MEDICAL THERAPY
ICD-9: 020.3-.5,022.1,073,466,481-483,485-486,487.1
CPT: 90000-99999
Line: 1 Category: 1

Diagnosis: TUBERCULOSIS
Treatment: MEDICAL THERAPY
ICD-9: 010-012
CPT: 90000-99999
Line: 2 Category: 5

Diagnosis: PERITONITIS
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 567
CPT: 90000-99999
Line: 3 Category: 1

Diagnosis: FOREIGN BODY IN PHARYNX, LARYNX, TRACHEA, BRONCHUS & ESOPHAGUS
Treatment: REMOVAL OF FOREIGN BODY
ICD-9: 933.0-.1,934.0-.1,935.1
CPT: 31635
Line: 4 Category: 1

Diagnosis: APPENDICITIS
Treatment: APPENDECTOMY
ICD-9: 540-543
CPT: 44950,44900,44960
Line: 5 Category: 1

Diagnosis: RUPTURED INTESTINE
Treatment: REPAIR
ICD-9: 569.3
CPT: 44600-10
Line: 6 Category: 1

Diagnosis: HERNIA WITH OBSTRUCTION AND/OR GANGRENE
Treatment: REPAIR
ICD-9: 550.0-.1,551-552
CPT: 39502-41,43330-31,43885,44050,44346,49500-611,51500,55540
Line: 7 Category: 1

Diagnosis: CROUP SYNDROME, ACUTE LARYNGOTRACHEITIS
Treatment: MEDICAL THERAPY, INTUBATION, TRACHEOTOMY
ICD-9: 464.0-.4
CPT: 90000-99999,31500
Line: 8 Category: 1

Diagnosis: ACUTE ORBITAL CELLULITIS
Treatment: MEDICAL THERAPY
ICD-9: 376.0
CPT: 90000-99999
Line: 9 Category: 1

Diagnosis: ECTOPIC PREGNANCY
Treatment: SURGERY
ICD-9: 633
CPT: 58700,58720,58770,58980,59135
Line: 10 Category: 1

Diagnosis: INJURY TO MAJOR BLOOD VESSELS OF UPPER EXTREMITY
Treatment: LIGATION
ICD-9: 903
CPT: 37618
Line: 11 Category: 1

Diagnosis: RUPTURED SPLEEN
Treatment: REPAIR/SPLENECTOMY/INCISION
ICD-9: 865.04
CPT: 38100,49000,38115
Line: 12 Category: 1

Diagnosis: ACUTE PELVIC INFLAMMATORY DISEASE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 614.0,614.3,614.5,615.0
CPT: 11043,58150,58805,58925,58980,90000-99999
Line: 13 Category: 1

Diagnosis: ACUTE PYELONEPHRITIS, RENAL & PERINEPHRIC ABSCESS
Treatment: MEDICAL AND SURGICAL THERAPY
ICD-9: 590.1-.2
CPT: 50200,90000-99999
Line: 14 Category: 1

Diagnosis: ANAPHYLACTIC SHOCK DUE TO FOOD, DRUG OR OTHER NON-VEMOMOUS SOURCE
Treatment: MEDICAL THERAPY
ICD-9: 995.0,995.2
CPT: 90000-99999
Line: 15 Category: 1

Diagnosis: GALLSTONE WITH CHOLECYSTITIS AND OTHER DISORDERS OF BILE DUCT
Treatment: CHOLECYSTECTOMY
ICD-9: 574.0-.1,574.3-.4,575.0-.5,576.1-.3
CPT: 47420-60,47480-90,47500-605
Line: 16 Category: 1

Diagnosis: RESPIRATORY OBSTRUCTION
Treatment: REPAIR OF CHOANAL ATRESIA
ICD-9: 748.0
CPT: 30540
Line: 17 Category: 2

Diagnosis: LOW BIRTH WEIGHT (1,250 GM AND OVER)
Treatment: MEDICAL THERAPY
ICD-9: 765.15-.19,769
CPT: 90000-99999
Line: 18 Category: 2

Diagnosis: SYPHILIS
Treatment: MEDICAL THERAPY
ICD-9: 090-097
CPT: 90000-99999
Line: 19 Category: 5

Diagnosis: HEMOLYTIC DISEASE DUE TO ISOIMMUNIZATION, LATE ANEMIA DUE TO ISOIMMUNIZATION, AND FETAL AND NEONATAL JAUNDICE
Treatment: MEDICAL THERAPY
ICD-9: 773.0-.2,773.4-.5,774.0-.4,774.6-.7
CPT: 90000-99999
Line: 20 Category: 2

Diagnosis: POLYCYTHEMIA NEONATORUM, SYMPTOMATIC
Treatment: MEDICAL THERAPY
ICD-9: 776.4
CPT: 36450,90000-99999
Line: 21 Category: 2

Diagnosis: PREGNANCY
Treatment: OBSTETRICAL CARE
ICD-9: 622.5,640-676,760-763,768,V22-V28,V30-V39
CPT: 59000-59899,57700
Line: 22 Category: 2

Diagnosis: SYNDROME OF "INFANT OF A DIABETIC MOTHER" AND NEONATAL HYPOGLYCEMIA
Treatment: MEDICAL THERAPY
ICD-9: 775.0,775.6
CPT: 36510,36660,90000-99999
Line: 23 Category: 2

Diagnosis: OMPHALITIS OF THE NEWBORN AND NEONATAL INFECTIVE MASTITIS
Treatment: MEDICAL THERAPY
ICD-9: 771.4-.5
CPT: 90000-99999
Line: 24 Category: 2

Diagnosis: GALACTOSEMIA
Treatment: MEDICAL THERAPY
ICD-9: 271.1,774.5
CPT: 90000-99999
Line: 25 Category: 2

Diagnosis: HYPOGLYCEMIC COMA; HYPOGLYCEMIA
Treatment: MEDICAL THERAPY
ICD-9: 251.0-251.2
CPT: 90000-99999
Line: 26 Category: 3

Diagnosis: WHOOPING COUGH
Treatment: MEDICAL THERAPY
ICD-9: 032-033
CPT: 90000-99999
Line: 27 Category: 1

Diagnosis: PHENYLKETONURIA (PKU)
Treatment: MEDICAL THERAPY
ICD-9: 270.1
CPT: 90000-99999
Line: 28 Category: 4

Diagnosis: CONGENITAL HYPOTHYROIDISM
Treatment: MEDICAL THERAPY
ICD-9: 243
CPT: 90000-99999
Line: 29 Category: 4

Diagnosis: ACUTE OSTEOMYELITIS
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 730.0
CPT: 90000-99999
Line: 30 Category: 1

Diagnosis: DEEP OPEN WOUND OF NECK, INCLUDING LARYNX; FRACTURE OF LARYNX OR TRACHEA, OPEN
Treatment: REPAIR
ICD-9: 874,807.6
CPT: 12001-12007,13131-50
Line: 31 Category: 1

Diagnosis: DISEASES OF PHARNYX INCLUDING RETROPHARYNGEAL ABSCESS
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 478.21-.22,478.24
CPT: 42700-42999,90000-99999
Line: 32 Category: 1

Diagnosis: PNEUMOTHORAX AND HEMOTHORAX
Treatment: TUBE THORACOSTOMY/THORACTOMY, MEDICAL THERAPY
ICD-9: 512,860.2
CPT: 90000-99999,32020,32100
Line: 33 Category: 1

Diagnosis: HYPOTENSION
Treatment: MEDICAL THERAPY
ICD-9: 458
CPT: 90000-99999
Line: 34 Category: 1

Diagnosis: FRACTURE OF SHAFT OF BONE, OPEN
Treatment: REDUCTION
ICD-9: 812.3,813.3,813.9,818.1,821.1,823.3,823.9
CPT: 24500-15,25500-25575,25610-25620,27500-06,27750-58,27800-04
Line: 35 Category: 1

Diagnosis: PYOGENIC ARTHRITIS
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 711
CPT: 24000,25040,26070-80,27030,27310,27610,29843,29871-72,29894,90000-99999
Line: 36 Category: 1

Diagnosis: INTESTINAL OBSTRUCTION W/O MENTION OF HERNIA
Treatment: EXCISION
ICD-9: 560.0,560.2,560.8-.9
CPT: 44005,44110-30,44140-44
Line: 37 Category: 1

Diagnosis: PATENT DUCTUS ARTERIOSUS
Treatment: LIGATION
ICD-9: 747.0
CPT: 33820-22
Line: 38 Category: 2

Diagnosis: HEMATOLOGICAL DISORDERS OF FETUS AND NEWBORN
Treatment: MEDICAL THERAPY
ICD-9: 776.0-.1,776.3
CPT: 90000-99999
Line: 39 Category: 2

Diagnosis: CONDITIONS INVOLVING THE TEMPERATURE REGULATION OF NEWBORNS
Treatment: MEDICAL THERAPY
ICD-9: 778.2-.4
CPT: 90000-99999
Line: 40 Category: 2

Diagnosis: BIRTH TRAUMA FOR BABY
Treatment: MEDICAL THERAPY
ICD-9: 767
CPT: 90000-99999
Line: 41 Category: 2

Diagnosis: HYPOCALCEMIA, HYPOMAGNESEMIA AND OTHER ENDOCRINE AND METABOLIC DISTURBANCES SPECIFIC TO THE FETUS AND NEWBORN
Treatment: MEDICAL THERAPY
ICD-9: 775.4-.5,775.7-.9
CPT: 36510,36660,90000-99999
Line: 42 Category: 2

Diagnosis: PERINATAL DISORDERS OF DIGESTIVE SYSTEM
Treatment: MEDICAL THERAPY
ICD-9: 777.1-.4
CPT: 90000-99999
Line: 43 Category: 2

Diagnosis: ANEMIA OF PREMATURITY OR TRANSIENT NEONATAL NEUTROPENIA
Treatment: MEDICAL THERAPY
ICD-9: 776.6-.9
CPT: 90000-99999
Line: 44 Category: 2

Diagnosis: ACUTE BACTERIAL MENINGITIS
Treatment: MEDICAL THERAPY
ICD-9: 024,027.0,036,320
CPT: 90000-99999
Line: 45 Category: 3

Diagnosis: HYPOTHERMIA
Treatment: MEDICAL THERAPY
ICD-9: 991.6
CPT: 90000-99999
Line: 46 Category: 3

Diagnosis: BURN, PARTIAL THICKNESS WITHOUT VITAL SITE, 10-30% OF BODY SURFACE
Treatment: FREE SKIN GRAFT, MEDICAL THERAPY
ICD-9: 941.26-.27,.36-.37,942.20-.24,.29-.34,.39,943.2-.3,944.20-.24,.26-.34,.36-.38,945.20-.21,.23-.31,.33-.39,946.2-.3,948,949.2-.3
CPT: 15000-15121,16000-16035,90000-99999
Line: 47 Category: 3

* THIS LIST IS SUBJECT TO REVISION UNTIL SUBMITTED TO THE LEGISLATURE

Diagnosis: ACUTE MYOCARDIAL INFARCTION
Treatment: MEDICAL THERAPY
ICD-9: 410
CPT: 90000-99999
Line: 48 Category: 3

Diagnosis: ACUTE PULMONARY HEART DISEASE AND PULMONARY EMBOLI
Treatment: MEDICAL THERAPY
ICD-9: 415
CPT: 90000-99999
Line: 49 Category: 3

Diagnosis: THYROTOXICOSIS WITH OR WITHOUT GOITER, ENDOCRINE EXOPHTHALMOS; CHRONIC THYROIDITIS
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 242,245.1-.9,246.8,376.2
CPT: 60245,67440,67599-67622,90000-99999
Line: 50 Category: 5

Diagnosis: LIFE-THREATENING ARRYTHMIAS
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 427.1,427.4-.5,746.86,996.01
CPT: 33200-33208,33212,33820,90000-99999
Line: 51 Category: 3

Diagnosis: FRACTURE OF RIBS AND STERNUM, OPEN
Treatment: STABILIZE
ICD-9: 807.1,807.3
CPT: 21805,21810,21825
Line: 52 Category: 1

Diagnosis: FATAL RICKETTSIAL AND OTHER ARTHROPOD-BORNE DISEASES
Treatment: MEDICAL THERAPY
ICD-9: 080-083,085.0,085.5,085.9
CPT: 90000-99999
Line: 53 Category: 1

Diagnosis: POISONING BY INGESTION AND INJECTION
Treatment: MEDICAL THERAPY
ICD-9: 960.2-.5,961.0,.3-.9,962.0,.2-.8,963.0,.2-.9,964.5,.7-.8,965.5-.7,966,968.0,968.5-.7,969.6,970.1,971.0-.2,972.3,972.6,972.8,974.0-.4,974.7,975.0-.1,975.7,977.0,978-985
CPT: 43235-47,90000-99999
Line: 54 Category: 1

Diagnosis: PERITONSILLAR ABSCESS
Treatment: INCISION AND DRAINAGE OF ABSCESS, MEDICAL THERAPY
ICD-9: 475
CPT: 42700,90000-99999
Line: 55 Category: 1

Diagnosis: RUPTURE BLADDER, NONTRAUMATIC
Treatment: CYSTORRHAPHY SUTURE
ICD-9: 596.6
CPT: 51860-51865
Line: 56 Category: 1

Diagnosis: FRACTURE OF FACE BONES, OPEN
Treatment: REPAIR OF MAND
ICD-9: 802.1,802.3,802.5,802.7,802.9
CPT: 21455,21461,21462,21360,21365,21385,21421
Line: 57 Category: 1

Diagnosis: LIFE-THREATENING EPISTAXIS
Treatment: SEPTOPLASTY/REPAIR/CONTROL HEMORRHAGE
ICD-9: 784.7
CPT: 30520-30999
Line: 58 Category: 1

Diagnosis: ACUTE MASTOIDITIS
Treatment: MASTOIDECTOMY, MEDICAL THERAPY
ICD-9: 383.0
CPT: 69601-46,69670,90000-99999
Line: 59 Category: 1

Diagnosis: ACQUIRED DEFORMITY OF HEAD AND COMPOUND/DEPRESSED FRACTURES OF SKULL
Treatment: CRANIOTOMY/CRANIECTOMY
ICD-9: 738.0-.1,800,803,804
CPT: 61304-576
Line: 60 Category: 1

Diagnosis: DISLOCATION OF ELBOW, HAND, ANKLE, FOOT, CLAVICLE AND SHOULDER, OPEN
Treatment: RELOCATION
ICD-9: 831.04,831.1,832.1,833.1,834.1,837.1,838.1
CPT: 23520-52,23650-80,24600-35,25660-95,26641-715,27840-48
Line: 61 Category: 1

Diagnosis: SEPTICEMIA
Treatment: MEDICAL THERAPY
ICD-9: 002,003.1,004.9,020.0-.2,020.8-.9,021,022.3,024,027,036.2,038,054.5,098.89,771.8,998.5,999.3
CPT: 90000-99999
Line: 62 Category: 1

Diagnosis: ERYSIPELAS
Treatment: MEDICAL THERAPY
ICD-9: 035
CPT: 90000-99999
Line: 63 Category: 1

Diagnosis: STEVENS-JOHNSON SYNDROME
Treatment: MEDICAL THERAPY
ICD-9: 695.1
CPT: 90000-99999,11100-11101
Line: 64 Category: 1

Diagnosis: DISORDERS OF BILE DUCT
Treatment: EXCISION, REPAIR
ICD-9: 576.4-.9
CPT: 47420-60,47500-999
Line: 65 Category: 1

Diagnosis: RUPTURE LIVER
Treatment: SUTURE/REPAIR
ICD-9: 864.04
CPT: 47350,47360
Line: 66 Category: 1

Diagnosis: RESPIRATORY FAILURE
Treatment: MEDICAL THERAPY
ICD-9: 518.81
CPT: 31600,90000-99999
Line: 67 Category: 1

Diagnosis: LUNG CONTUSION OR LACERATION
Treatment: MEDICAL THERAPY
ICD-9: 861.21,861.31
CPT: 90000-99999
Line: 68 Category: 1

Diagnosis: TRANSPLACENTAL HEMORRHAGE
Treatment: MEDICAL THERAPY
ICD-9: 772.0,772.3-.4,776.5
CPT: 90000-99999
Line: 69 Category: 2

Diagnosis: NEONATAL THYROTOXICOSIS
Treatment: MEDICAL THERAPY
ICD-9: 775.3
CPT: 90000-99999
Line: 70 Category: 2

Diagnosis: DRUG REACTIONS & INTOXICATIONS SPECIFIC TO NEWBORN
Treatment: MEDICAL THERAPY
ICD-9: 779.4
CPT: 90000-99999
Line: 71 Category: 2

Diagnosis: NEONATAL MYASTHENIA GRAVIS
Treatment: MEDICAL THERAPY
ICD-9: 775.2
CPT: 90000-99999
Line: 72 Category: 2

Diagnosis: CLEFT PALATE WTH AIRWAY OBSTRUCTION, PIERRE ROBIN DEFORMITY
Treatment: LIP-TONGUE SUTURE, MEDICAL THERAPY
ICD-9: 749.0,519.8
CPT: 41510,90000-99999
Line: 73 Category: 2

Diagnosis: LOW BIRTH WEIGHT (1,000-1,249 GM)
Treatment: MEDICAL THERAPY
ICD-9: 765.14,769
CPT: 90000-99999
Line: 74 Category: 2

Diagnosis: DRUG WITHDRAWAL SYNDROME IN NEWBORN
Treatment: MEDICAL THERAPY
ICD-9: 779.5
CPT: 90000-99999
Line: 75 Category: 2

[Diagnosis: RUMINATION DISORDER OF INFANCY
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 307.53
CPT: 90220,90800-90899
Line: 76 Category: 1]

Diagnosis: TOXIC EFFECT OF GASES, FUMES, AND VAPORS REQUIRING HYPERBARIC OXYGEN
Treatment: HYPERBARIC OXYGEN
ICD-9: 986-987
CPT: 99180-99182
Line: 77 Category: 3

Diagnosis: PHLEBITIS & THROMBOPHLEBITIS, DEEP
Treatment: LIGATION AND DIVISION, MEDICAL THERAPY
ICD-9: 451.0-.2,451.8
CPT: 11042,37720,37721,37735,37785,90000-99999
Line: 78 Category: 3

Diagnosis: DISLOCATION KNEE & HIP, OPEN
Treatment: RELOCATION
ICD-9: 835.1,836.4,836.6
CPT: 27250-55,27550-27557
Line: 79 Category: 3

Diagnosis: EMPYEMA AND ABSCESS OF LUNG
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 510,513.0
CPT: 90000-99999,31622,32000-32100
Line: 80 Category: 3

Diagnosis: CERVICAL VERTEBRAL DISLOCATIONS, OPEN OR CLOSED; OTHER VERTEBRAL DISLOCATIONS, OPEN
Treatment: REPAIR/RECONSTRUCTION
ICD-9: 839.0-.1,839.3,839.5,839.7
CPT: 22315,22325-22327,22505,22590-22650,22840-22855
Line: 81 Category: 3

Diagnosis: OPEN FRACTURE OF EPIPHYSIS OF LOWER EXTREMITIES
Treatment: REDUCTION
ICD-9: 820.11,821.32
CPT: 27516-27519
Line: 82 Category: 3

Diagnosis: SPINAL CORD INJURY WITHOUT EVIDENCE OF VERTEBRAL INJURY
Treatment: MEDICAL THERAPY
ICD-9: 952
CPT: 90000-99999
Line: 83 Category: 3

Diagnosis: ASPIRATION PNEUMONIA
Treatment: MEDICAL THERAPY
ICD-9: 507
CPT: 90000-99999,31645,31500
Line: 84 Category: 3

Diagnosis: ACUTE INFLAMMATION OF THE HEART DUE TO RHEUMATIC FEVER
Treatment: MEDICAL THERAPY
ICD-9: 391,392.0
CPT: 90000-99999
Line: 85 Category: 3

Diagnosis: FRACTURE AND OTHER INJURY OF CERVICAL VERTEBRA
Treatment: CERVICAL LAMENINECTOMY, MEDICAL THERAPY
ICD-9: 806.0-806.1,805.0-805.1,952.0
CPT: 63250,63265,63270,63275,63280,63285,63001,63015,63020,63035-40,63045,63048,63075-76,63081-82,63300,63304,63170-72,63180-82,63194,63196,63198,90000-99999
Line: 86 Category: 3

Diagnosis: FRACTURE OF HIP, CLOSED
Treatment: REDUCTION
ICD-9: 820.00,820.02-.09,820.2,820.8
CPT: 27230-27232,27235-27240,27242-27248
Line: 87 Category: 3

Diagnosis: SUBARACHNOID AND INTERCEREBRAL HEMORRHAGE/HEMATOMA
Treatment: BURR HOLES, CRANIECTOMY/CRANIOTOMY
ICD-9: 430-432,852-853
CPT: 61120-61151,61314-61315,61522-61712
Line: 88 Category: 3

Diagnosis: ACUTE PANCREATITIS
Treatment: MEDICAL THERAPY
ICD-9: 577.0
CPT: 90000-99999
Line: 89 Category: 3

Diagnosis: HYDATIDIFORM MOLE
Treatment: D & C, HYSTERECTOMY
ICD-9: 630
CPT: 58120,58150-200
Line: 90 Category: 1

Diagnosis: THROMBOCYTOPENIA
Treatment: MEDICAL THERAPY
ICD-9: 287
CPT: 90000-99999
Line: 91 Category: 1

Diagnosis: TOXIC EFFECT OF VENOM
Treatment: MEDICAL THERAPY
ICD-9: 989.5
CPT: 90000-99999
Line: 92 Category: 1

Diagnosis: CANCRUM ORIS
Treatment: MEDICAL THERAPY
ICD-9: 528.1
CPT: 90000-99999
Line: 93 Category: 1

Diagnosis: CANDIDIASIS OF LUNG, DISSEMINATED CANDIDIASIS, CANDIDAL ENDOCARDITIS AND MENINGITIS
Treatment: MEDICAL THERAPY
ICD-9: 112.4-.5,112.81,112.83
CPT: 90000-99999
Line: 94 Category: 1

Diagnosis: MYOCARDITIS, PERICARDITIS AND ENDOCARDITIS
Treatment: MEDICAL THERAPY
ICD-9: 420-423
CPT: 90000-99999
Line: 95 Category: 1

Diagnosis: RUPTURE OF ESOPHAGUS
Treatment: SURGERY
ICD-9: 530.4
CPT: 43100-01,43110-43235,43330-31
Line: 96 Category: 1

Diagnosis: TOXIC EPIDERMAL NECROLYSIS AND STAPHYLOCOCCAL SCALDED SKIN SYNDROME
Treatment: MEDICAL THERAPY
ICD-9: 695.1
CPT: 90000-99999,11100-11101
Line: 97 Category: 1

Diagnosis: CHOLERA, RAT-BITE FEVER AND TOXIC EFFECTS OF MUSHROOMS, FISH, BERRIES, ETC.
Treatment: MEDICAL THERAPY
ICD-9: 001,026,988
CPT: 90000-99999
Line: 98 Category: 1

Diagnosis: DELIRIUM: AMPHETAMINE, COCAINE, OR OTHER PSYCHOACTIVE SUBSTANCE
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 292.81,293.00
CPT: 90220,90800-90899
Line: 99 Category: 1

Diagnosis: INJURY TO BLOOD VESSELS OF THE THORACIC CAVITY
Treatment: REPAIR
ICD-9: 901
CPT: 37616
Line: 100 Category: 1

Diagnosis: NECROTIZING ENTEROCOLITIS IN FETUS OR NEWBORN AND PERINATAL INTESTINAL PERFORATION
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 777.5-.6
CPT: 36510,36660,90000-99999
Line: 101 Category: 2

Diagnosis: DISSEMINATED INTRAVASCULAR COAGULATION
Treatment: MEDICAL THERAPY
ICD-9: 286.6,776.2
CPT: 90000-99999
Line: 102 Category: 2

Diagnosis: BIRTH ASPHYXIA IN LIVEBORN INFANT
Treatment: MEDICAL THERAPY
ICD-9: 768.5-.9
CPT: 90000-99999
Line: 103 Category: 2

Diagnosis: CEREBRAL DEPRESSION, COMA, & OTHER ABNORMAL CEREBRAL SIGNS OF NEWBORN
Treatment: MEDICAL THERAPY
ICD-9: 779.2
CPT: 36510,36660,90000-99999
Line: 104 Category: 2

Diagnosis: TORSION OF OVARY
Treatment: OOPHERECTOMY, OVARIAN CYSTECTOMY
ICD-9: 620.5
CPT: 58925,58940-43,59120-26
Line: 105 Category: 1

Diagnosis: SPONTANEOUS ABORTION COMPLICATED BY INFECTION AND/OR HEMORRHAGE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 634.0-.1
CPT: 59820-21,90000-99999
Line: 106 Category: 1

Diagnosis: OTHER RESPIRATORY CONDITIONS OF FETUS AND NEWBORN
Treatment: MEDICAL THERAPY
ICD-9: 770.0-.6,770.8-.9
CPT: 90000-99999
Line: 107 Category: 2

Diagnosis: MAJOR DEPRESSION, SINGLE EPISODE WITH PSYCHOTIC FEATURES
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 296.24
CPT: 90220,90800-90899
Line: 108 Category: 1

Diagnosis: MAJOR DEPRESSION; SINGLE EPISODE, SEVERE, WITHOUT PSYCHOTIC FEATURES
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 296.23
CPT: 90220,90800-90899
Line: 109 Category: 1

Diagnosis: OTHER NONINFECTIOUS GASTROENTERITIS AND COLITIS
Treatment: MEDICAL THERAPY
ICD-9: 558
CPT: 90000-99999
Line: 110 Category: 3

Diagnosis: UNSPECIFIED DISEASES DUE TO MYCOBACTERIA, ACTINOMYCOTIC INFECTIONS, AND TOXOPLASMOSIS
Treatment: MEDICAL THERAPY
ICD-9: 031.9,039,130
CPT: 90000-99999
Line: 111 Category: 3

Diagnosis: BOTULISM
Treatment: MEDICAL THERAPY
ICD-9: 005.1
CPT: 90000-99999
Line: 112 Category: 3

Diagnosis: FRACTURE OF JOINT, OPEN
Treatment: REDUCTION
ICD-9: 810.1,811.1,812.1,812.5,813.1,813.5,820.10,820.12-.19,820.3,820.9,821.30-.31,821.33-.39,822.1,823.1,824.1,.3,.5,.7,.9,825.1,.3,826.1,828.1,814.1,815.1,816.1,817.1,819.1
CPT: 23500-15,23570-630,24530-88,24650-85,25600-50,26600-15,26720-85,27230-48,27[illegible]8-14,27520-40,27764-66,27780-92,27808-23,28400-530
Line: 113 Category: 3

Diagnosis: ABSCESS OF INTESTINE
Treatment: DRAIN ABSCESS, MEDICAL THERAPY
ICD-9: 569.5
CPT: 90000-99999,45355,45386,45310-45315
Line: 114 Category: 3

Diagnosis: ADULT RESPIRATORY DISTRESS SYNDROME
Treatment: MEDICAL THERAPY
ICD-9: 518.4-.5
CPT: 90000-99999
Line: 115 Category: 3

Diagnosis: HERPETIC ENCEPHALITIS
Treatment: MEDICAL THERAPY
ICD-9: 054.3
CPT: 90000-99999
Line: 116 Category: 3

Diagnosis: ARTHROPOD-BORNE VIRAL DISEASES
Treatment: MEDICAL THERAPY
ICD-9: 060-066
CPT: 90000-99999
Line: 117 Category: 3

Diagnosis: BURN, PARTIAL THICKNESS WITH VITAL SITE; FULL THICKNESS WITH VITAL SITE, LESS THAN 10% OF BODY SURFACE
Treatment: FREE SKIN GRAFT, MEDICAL THERAPY
ICD-9: 941.20-25,.28-.35,.38-.39,942.25,.35,944.25,.35,945.22,.32,946.2-.3,948,949.2-.3
CPT: 15000-15121,16000-16035,90000-99999
Line: 118 Category: 3

Diagnosis: FRACTURE OF PELVIS, OPEN AND CLOSED
Treatment: REDUCTION
ICD-9: 808
CPT: 27210-27225
Line: 119 Category: 3

Diagnosis: BURN FULL THICKNESS GREATER THAN 10% OF BODY SURFACE
Treatment: FREE SKIN GRAFT, MEDICAL THERAPY
ICD-9: 940,941.30-.35,941.4-.5,942.35,.4-.5,943.4-.5,944.35,.4-.5,945.32,.4-.5,946.3-.5,947,948.11-.19,.21-.29,.31-.39,.41-.49,.51-.59,.61-.69,.71-.79,.81-.89,.91-.99,949.4-.5
CPT: 15000-15121,16000-16035,90000-99999
Line: 120 Category: 3

Diagnosis: SUBACUTE MENINGITIS (EG. TUBERCULOSIS, CRYPTOCOCCOSIS)
Treatment: MEDICAL THERAPY
ICD-9: 013,054.72,117.5,117.9,123.1,130.8,321-322
CPT: 90000-99999
Line: 121 Category: 3

Diagnosis: CRUSH INJURIES: TRUNK, UPPER LIMBS, LOWER LIMB INCLUDING BLOOD VESSELS
Treatment: SURGICAL TX
ICD-9: 900,902,926.11-.12,927.03,927.2-.9,927.10,928,925,927.00,927.01
CPT: 24495,25020,25023,27600-27602,29105-29131,29240-29280,29345-29440,29520-29580,37615-18
Line: 122 Category: 3

Diagnosis: ACUTE GLOMERULONEPHRITITS AND OTHER ACUTE RENAL FAILURE
Treatment: MEDICAL THERAPY INCLUDING DIALYSIS
ICD-9: 580.0,580.8-.9,584
CPT: 90000-99999
Line: 123 Category: 3

Diagnosis: ACCIDENTS INVOLVING EXPOSURE TO NATURAL ELEMENTS (EG. LIGHTNING STRIKE, HEATSTROKE)
Treatment: MEDICAL THERAPY
ICD-9: 991.0-.5,992.0,993.2,994.0-.1,994.4-.9
CPT: 90000-99999
Line: 124 Category: 1

[Diagnosis: BRIEF REACTIVE PSYCHOSIS
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 297.3,298.80,298.90
CPT: 90220,90800-90899
Line: 125 Category: 1]

Diagnosis: DISSECTING OR RUPTURED ANEURYSM
Treatment: SURGICAL TREATMENT
ICD-9: 441.0-.1,441.3,441.5
CPT: 33860-77,35081-103,35301-11,35331-51,35450-515,35526-31,35536-52,35560-63,35601-16,35626-46,35651,35663
Line: 126 Category: 1

Diagnosis: ARTERIAL EMBOLISM/THROMBOSIS: ABDOMINAL AORTA, THORACIC AORTA
Treatment: SURGICAL TREATMENT
ICD-9: 444.0-.1,.8
CPT: 35536-51
Line: 127 Category: 3

Diagnosis: LOW BIRTH WEIGHT (750-999 GM)
Treatment: MEDICAL THERAPY
ICD-9: 765.13,769
CPT: 90000-99999
Line: 128 Category: 2

Diagnosis: CONGENITAL ANOMALIES OF DIGESTIVE SYSTEM EXCLUDING NECROSIS
Treatment: MEDICAL AND SURGICAL THERAPY
ICD-9: 751
CPT: 44050,45100,45120-21,46070,46080
Line: 129 Category: 2

Diagnosis: CONVULSIONS AND OTHER CEREBRAL IRRITABILITY IN NEWBORN
Treatment: MEDICAL THERAPY
ICD-9: 779.0-.1
CPT: 90000-99999
Line: 130 Category: 2

Diagnosis: ALCOHOL WITHDRAWAL DELIRIUM; ALCOHOL HALLUCINOSIS; UNCOMPLICATED ALCOHOL WITHDRAWAL; WITHDRAWAL FROM AMPHETAMINES, COCAINE, OPIOID, SEDATIVES, HYPNOTICS, ETC.
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 291.00,291.30,291.80
CPT: 90220,90800-90899
Line: 131 Category: 1

Diagnosis: ACUTE POST-TRAUMATIC STRESS DISORDER
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 309.89
CPT: 90220,90800-90899
Line: 132 Category: 1

Diagnosis: ACUTE NECROSIS OF LIVER
Treatment: MEDICAL THERAPY
ICD-9: 570
CPT: 90000-99999
Line: 133 Category: 3

Diagnosis: COCCIDIOIDOMYCOSIS, HISTOPLASMOSIS, BLASTOMYCOTIC INFECTION, OPPORTUNISTIC AND OTHER MYCOSES
Treatment: MEDICAL THERAPY
ICD-9: 114-118
CPT: 90000-99999
Line: 134 Category: 3

Diagnosis: INTRASPINAL AND INTRACRANIAL ABSCESS
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 324
CPT: 63172-63173,63266-63273,90000-99999
Line: 135 Category: 3

Diagnosis: ANEURYSM OF PULMONARY ARTERY
Treatment: EMBOLECTOMY
ICD-9: 417.1
CPT: 33910-33915
Line: 136 Category: 3

Diagnosis: FLAIL CHEST
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 807.4
CPT: 21800-25,90000-99999
Line: 137 Category: 3

Diagnosis: HEAD INJURY: HEMATOMA/EDEMA W/ MODERATE/PROLONGED LOSS OF CONSCIOUSNESS
Treatment: SURGICAL TREATMENT
ICD-9: 851.03,851.13,851.83,851.93,851.43,851.53
CPT: 61108,61314-15,62140-41
Line: 138 Category: 3

Diagnosis: RUPTURE OF PAPILLARY MUSCLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 429.5-.6
CPT: 33542,90000-99999
Line: 139 Category: 3

Diagnosis: ANAEROBIC INFECTIONS REQUIRING HYPERBARIC OXYGEN
Treatment: HYPERBARIC OXYGEN
ICD-9: 611.3,639.0,639.6,670.2,670.4,673.0,709.3,729.4,785.4,958.0,996.52,996.6-.7,998.8,999.1
CPT: 99180-99182
Line: 140 Category: 3

Diagnosis: TRAUMATIC AMPUTATION OF ARM(S) & HAND(S) (COMPLETE)(PARTIAL) W & W/O COMPLICATION
Treatment: REIMPLANT/AMPUTATE
ICD-9: 887.0-.3,887.5-.7
CPT: 20802,20804,20805,20806,23900,23920,23921,24900,24920,24925,24930,24931,24935,24940,25900-9
Line: 141 Category: 3

Diagnosis: ACUTE VASCULAR INSUFFICIENCY OF INTESTINE
Treatment: COLECTOMY
ICD-9: 557.0
CPT: 44140,44125,44141,44143,34151,34421,34451
Line: 142 Category: 3

Diagnosis: BURN, PARTIAL THICKNESS GREATER THAN 30% OF BODY SURFACE
Treatment: FREE SKIN GRAFT, MEDICAL THERAPY
ICD-9: 941.26-.27,942.20-.24,.29,943.2,944.20-.24,.26-.28,945.20-.21,.23-.29,946.2,948.30,.40,.50,.60,.70,.80,.90,949.2
CPT: 15000-15121,90200,16000-16035,90000-99999
Line: 143 Category: 3

Diagnosis: ACUTE GLOMERULONEPHRITIS: WITH LESION OF RAPIDLY PROGRESSIVE GLOMERULONEPHRITIS
Treatment: MEDICAL THERAPY INCLUDING DIALYSIS
ICD-9: 580.4
CPT: 90000-99999
Line: 144 Category: 3

Diagnosis: IRON DEFICIENCY ANEMIA AND OTHER NUTRITIONAL DEFICIENCIES
Treatment: MEDICAL THERAPY
ICD-9: 260-268,269.0-.3,280
CPT: 90000-99999
Line: 145 Category: 5

Diagnosis: TETANUS NEONATORUM
Treatment: MEDICAL THERAPY
ICD-9: 771.3
CPT: 90000-99999
Line: 146 Category: 2

Diagnosis: TRAUMATIC AMPUTATION OF LEG(S) (COMPLETE)(PARTIAL) W/ & W/O COMPLICATION
Treatment: REIMPLANT/AMPUTATE
ICD-9: 897.0-.3,897.6-.7
CPT: 20832,20834,27290-27598,27880-27889,27880-84,27886-89
Line: 147 Category: 3

Diagnosis: TRAUMATIC AMPUTATION OF FOOT/FEET (COMPLETE)(PARTIAL) W/ & W/O COMPLICATION
Treatment: REIMPLANT/AMPUTATE
ICD-9: 896,897.6-.7
CPT: 20838,20840,28800-28805
Line: 148 Category: 3

Diagnosis: PREVENTIVE SERVICES, CHILDREN
Treatment: MEDICAL THERAPY
ICD-9: V01-V06,V20-V21,V40-V41,V60,V62.3-.4,V70.0,V77,V79
CPT: 90000-99999
Line: 149 Category: 4

Diagnosis: MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE: MODERATE, IN FULL OR PARTIAL REMISSION AND UNSPECIFIED; DEPRESSIVE DISORDER NOS
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 296.22,311.00,296.25,296.26,296.20
CPT: 90220,90800-90899
Line: 150 Category: 1

Diagnosis: MAJOR DEPRESSION: MILD
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 296.21,296.31
CPT: 90220,90800-90899
Line: 151 Category: 1

Diagnosis: YOUTH ABUSE OF: HALLUCINOGEN, OPIOID, COCAINE, AMPHETAMINE OR SIMILARLY ACTING SYMPATHOMIMETIC, INHALANT, PCP, PSYCHOACTIVE NOS, ALCOHOL, CANNABIS, SEDATIVE, HYPNOTIC OR ANXIOLYTICS
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 305.00,305.20,305.30,305.40,305.50,305.60,305.70
CPT: 90220,90800-90899
Line: 152 Category: 3

Diagnosis: YOUTH DEPENDENCE ON: HALLUCINOGEN, OPIOID, COCAINE, AMPHETAMINE OR SIMILARLY ACTING SYMPATHOMIMETIC, INHALANT, PCP, PSYCHOACTIVE NOS, ALCOHOL, CANNABIS, SEDATIVES, HYPNOTICS OR ANXIOLYTICS
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 303.90,304.30,304.00,304.10,304.20,304.40,304.50,304.60,304.90
CPT: 90220,90800-90899
Line: 153 Category: 5

Diagnosis: STREPTOCOCCAL SORE THROAT AND SCARLET FEVER
Treatment: MEDICAL THERAPY
ICD-9: 034
CPT: 90000-99999
Line: 154 Category: 9

Diagnosis: RHEUMATIC FEVER
Treatment: MEDICAL THERAPY
ICD-9: 390
CPT: 90000-99999
Line: 155 Category: 10

Diagnosis: CONGENITAL ANOMALIES OF UPPER ALIMENTARY TRACT, EXCLUDING TONGUE
Treatment: MEDICAL AND SURGICAL THERAPY
ICD-9: 750.2-.9
CPT: 43300-52,90000-99999
Line: 156 Category: 2

Diagnosis: HYPERTENSION AND HYPERTENSIVE DISEASE
Treatment: MEDICAL THERAPY
ICD-9: 401,402.01
CPT: 90000-99999
Line: 157 Category: 5

Diagnosis: HYPERTENSIVE HEART AND RENAL DISEASE
Treatment: MEDICAL THERAPY
ICD-9: 404
CPT: 90000-99999
Line: 158 Category: 5

Diagnosis: ACUTE AND SUBACUTE ISCHEMIC HEART DISEASE
Treatment: SURGICAL TREATMENT
ICD-9: 411.1,996.03
CPT: 92950-93799,33510-16
Line: 159 Category: 3

Diagnosis: DIABETES MELLITUS, TYPE I
Treatment: MEDICAL THERAPY
ICD-9: 250.01,250.1-250.3,250.6,251.3,775.1
CPT: 90000-99999
Line: 160 Category: 5

Diagnosis: ADULT ABUSE OF: HALLUCINOGEN, OPIOID, COCAINE, AMPHETAMINE OR SIMILARLY ACTING SYMPATHOMIMETIC, INHALA
PCP, PSYCHOACTIVE NOS, ALCOHOL, CANNABIS, SEDATIVES, HYPNOTICS OR ANXIOLYTICS
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 305.00,305.20,305.30,305.40,305.50,305.60,305.70
CPT: 90220,90800-90899
Line: 161 Category: 3

Diagnosis: ADULT DEPENDENCE ON: HALLUCINOGEN, OPIOID, COCAINE, AMPHETAMINE OR SIMILARLY ACTING SYMPATHOMIMETIC,
INHALANT, PCP, PSYCHOACTIVE NOS, ALCOHOL, CANNABIS, SEDATIVES, HYPNOTICS OR ANXIOLYTICS
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 303.90,304.30,304.00,304.10,304.20,304.40,304.50,304.60,304.90
CPT: 90220,90800-90899
Line: 162 Category: 5

Diagnosis: ACUTE DELUSIONAL MOOD ANXIETY, PERSONALITY, PERCEPTION AND ORGANIC MENTAL DISORDER CAUSED BY DRUGS;
INTOXICATION
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 292.11,292.12,292.89,292.90,303.00,305.40,305.50,305.60,305.70,305.90,291.40
CPT: 90220,90800-90899
Line: 163 Category: 3

Diagnosis: ASTHMA
Treatment: MEDICAL THERAPY
ICD-9: 493
CPT: 90000-99999
Line: 164 Category: 5

Diagnosis: ATTENTION DEFICIT DISORDERS WITH HYPERACTIVITY OR UNDIFFERENTIATED
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 314.00,314.01
CPT: 90220,90800-90899
Line: 165 Category: 5

Diagnosis: ANOREXIA NERVOSA
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 307.10
CPT: 90220,90800-90899
Line: 166 Category: 5

Diagnosis: ULCERS, GASTRITIS AND DUODENITIS
Treatment: MEDICAL THERAPY
ICD-9: 531-535
CPT: 90000-99999
Line: 167 Category: 5

Diagnosis: NON-INSULIN DEPENDENT DIABETES
Treatment: MEDICAL THERAPY
ICD-9: 250.00
CPT: 90000-99999
Line: 168 Category: 5

Diagnosis: ACQUIRED HYPOTHYROIDISM, DYSHORMONOGENIC GOITER
Treatment: MEDICAL THERAPY
ICD-9: 244,246.1
CPT: 90000-99999
Line: 169 Category: 5

Diagnosis: CALCULUS OF BILE DUCT WITH OTHER CHOLECYSTITIS
Treatment: MEDICAL THERAPY
ICD-9: 574.4
CPT: 90000-99999
Line: 170 Category: 5

Diagnosis: REACTIVE ATTACHMENT DISORDER OF INFANCY OR EARLY CHILDHOOD
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 313.89
CPT: 90220,90800-90899
Line: 171 Category: 14

Diagnosis: PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
Treatment: MEDICAL THERAPY
ICD-9: 992.91,994.2-.3,995.5,995.81,V61.21
CPT: 90000-99999
Line: 172 Category: 1

Diagnosis: BIPOLAR DISORDERS: MANIC, DEPRESSED, MIXED: MILD, IN PARTIAL OR FULL REMISSION, OR UNSPECIFIED
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 296.41,296.51,296.61,296.40,296.45,296.46,296.50,296.55,296.56
CPT: 90220,90800-90899
Line: 173 Category: 5

Diagnosis: MAJOR DEPRESSION, RECURRENT, SEVERE WITHOUT PSYCHOTIC FEATURES
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 296.33,296.32,296.36
CPT: 90220,90800-90899
Line: 174 Category: 5

Diagnosis: MAJOR DEPRESSION, RECURRENT: MODERATE, UNSPECIFIED WITH PSYCHOTIC FEATURES
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 296.32,296.30,296.35,296.36
CPT: 90220,90800-90899
Line: 175 Category: 5

Diagnosis: MAJOR DEPRESSION, RECURRENT: SEVERE WITH PSYCHOTIC FEATURES
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 296.34
CPT: 90220,90800-90899
Line: 176 Category: 5

Diagnosis: GONOCOCCAL INFECTION OF EYE
Treatment: MEDICAL THERAPY
ICD-9: 098.4
CPT: 90000-99999
Line: 177 Category: 10

Diagnosis: HIV DISEASE
Treatment: MEDICAL THERAPY
ICD-9: 042.9,043.9,044.9
CPT: 90000-99999
Line: 178 Category: 5

Diagnosis: MODERATE BIPOLAR DISORDERS: MANIC, DEPRESSIVE, MIXED
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 296.42,296.52,296.62
CPT: 90220,90800-90899
Line: 179 Category: 5

Diagnosis: EPILEPSY
Treatment: MEDICAL THERAPY
ICD-9: 345.1,345.9
CPT: 90000-99999
Line: 180 Category: 5

Diagnosis: HEREDITARY HEMOLYTIC ANEMIAS (EG. SICKLE CELL)
Treatment: MEDICAL THERAPY
ICD-9: 282
CPT: 90000-99999
Line: 181 Category: 5

Diagnosis: STERILIZATION
Treatment: VASECTOMY
ICD-9: V25.2
CPT: 55250
Line: 182 Category: 6

Diagnosis: STERILIZATION
Treatment: TUBAL LIGATION
ICD-9: V25.2
CPT: 58600-11
Line: 183 Category: 6

Diagnosis: BIRTH CONTROL
Treatment: CONTRACEPTION MANAGEMENT
ICD-9: V25.0-.1,V25.4-.9
CPT: 90000-99999
Line: 184 Category: 6

Diagnosis: BIPOLAR DISORDER, SEVERE WITH PSYCHOTIC FEATURES: MANIC, DEPRESSED, MIXED
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 296.44,296.54,296.64
CPT: 90220,90800-90899
Line: 185 Category: 5

Diagnosis: BIPOLAR DISORDER, DISORDER, SEVERE WITHOUT PSYCHOTIC FEATURES: MANIC, DEPRESSIVE, MIXED
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 296.43,296.53,296.60,296.63,296.66,296.70
CPT: 90220,90800-90899
Line: 186 Category: 5

Diagnosis: SCHIZOPHRENIC DISORDERS
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 295.10-.95
CPT: 90220,90800-90899
Line: 187 Category: 5

Diagnosis: IMMINENT DEATH REGARDLESS OF DIAGNOSIS
Treatment: COMFORT CARE
ICD-9: 0
CPT: 90000-99999
Line: 188 Category: 7

Diagnosis: DENTAL SERVICES (EG. INFECTIONS)
Treatment: RESTORATIVE DENTAL SERVICE
ICD-9: 0
CPT: 00415,00501,01550,02910,02920,02940,03110,03120,03220,03310,03320,03330,03340,03350,05410-1,05420,05510,05951,06930,07110,07210,07440-1,07510,07520,07910-12,07990,09110
Line: 189 Category: 10

Diagnosis: PREVENTIVE DENTAL SERVICES
Treatment: CLEANING AND FLOURIDE
ICD-9: V72.2
CPT: 00502,00999,01201,01203,01330,01351,05931-5,05952-3,05956-7,05982,05986,07260,07490,07940-9,07955,09610
Line: 190 Category: 8

Diagnosis: PREVENTIVE SERVICES FOR ADULTS WITH PROVEN EFFECTIVENESS
Treatment: MEDICAL THERAPY
ICD-9: V01-V07,V10-V19,V41,V60-V65,V70.0,V70.9,V71,V72.0-.3,V72.8-.9,V73-V82
CPT: 90000-99999
Line: 191 Category: 9

Diagnosis: CANCER OF CERVIX, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 180
CPT: 57452-54,57500,90000-99999
Line: 192 Category: 5

Diagnosis: GONOCOCCAL INFECTIONS AND OTHER VENEREAL DISEASES
Treatment: MEDICAL THERAPY
ICD-9: 098,099.0-099.2,099.4-099.9
CPT: 90000-99999
Line: 193 Category: 10

Diagnosis: DYSPLASIA OF CERVIX AND CERVICAL CARCINOMA IN SITU
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 078.1,233.1,622.0-.2,623.0-.1,623.4,623.7,795.0
CPT: 56501,57061-105,57150,57180,57400,57454,57511-20,90000-99999
Line: 194 Category: 5

Diagnosis: CANCER OF BREAST, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 174-175,198.2,233.0,238.3,239.2
CPT: 19160-240,90000-99999
Line: 195 Category: 5

Diagnosis: UNDESCENDED TESTICLE
Treatment: ORCHIECTOMY, REPAIR
ICD-9: 752.5
CPT: 54520-54565,54300-440
Line: 196 Category: 5

Diagnosis: CANCER OF TESTIS, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 186,236.4
CPT: 54530-35,38564,38780,90000-99999
Line: 197 Category: 5

Diagnosis: COARCTATION OF THE AORTA
Treatment: SURGICAL/EXCISION
ICD-9: 747.10
CPT: 33840-33851
Line: 198 Category: 5

Diagnosis: PYODERMA
Treatment: MEDICAL THERAPY
ICD-9: 686.0-.1
CPT: 90000-99999
Line: 199 Category: 3

Diagnosis: ANGINA PECTORIS; OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 412-414,996.03
CPT: 33510-33516,92950-93799,90000-99999
Line: 200 Category: 5

Diagnosis: CANCER OF ENDOCRINE SYSTEM, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 164.0,193-194,198.7,234.8,237.0-.4,239.7
CPT: 21632,32095-100,32480-90,32480-525,90000-99999
Line: 201 Category: 5

Diagnosis: CANCER OF OVARY, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 183.0,198.6,236.2
CPT: 58951,90000-99999
Line: 202 Category: 5

Diagnosis: ADDISON'S DISEASE
Treatment: MEDICAL THERAPY
ICD-9: 255.4,255.5
CPT: 90000-99999
Line: 203 Category: 5

Diagnosis: CONSTITUTIONAL APLASTIC ANEMIA
Treatment: MEDICAL THERAPY
ICD-9: 284.0
CPT: 90000-99999
Line: 204 Category: 5

Diagnosis: CORONARY ARTERY ANOMALY
Treatment: ANOMALOUS CORONARY ARTERY LIGATION
ICD-9: 746.85
CPT: 33502
Line: 205 Category: 2

Diagnosis: CONGENITAL ANOMALIES OF URINARY SYSTEM
Treatment: RECONSTRUCTION
ICD-9: 753.0-.1,753.3-.9
CPT: 55899
Line: 206 Category: 5

Diagnosis: TOTAL ANOMALOUS PULMONARY VENOUS CONNECTION
Treatment: COMPLETE REPAIR
ICD-9: 747.41
CPT: 33730
Line: 207 Category: 2

Diagnosis: ULCERS, GI HEMORRHAGE
Treatment: HEMIGASTRECTOMY
ICD-9: 531-534,578
CPT: 43610-35,43641,43825,43840
Line: 208 Category: 5

Diagnosis: CANCER OF UTERUS, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 179,182,236.0
CPT: 57452-54,57500,58210,58120,58150-285,58951,90000-99999
Line: 209 Category: 5

Diagnosis: COAGULATION DEFECTS
Treatment: MEDICAL THERAPY
ICD-9: 286.0-.5,.7-.9
CPT: 90000-99999
Line: 210 Category: 5

Diagnosis: COMMON TRUNCUS
Treatment: TOTAL REPAIR/REPLANT ARTE
ICD-9: 745.0
CPT: 33786,33788
Line: 211 Category: 5

Diagnosis: HODGKIN'S DISEASE
Treatment: CHEMOTHERAPY, RADIATION THERAPY
ICD-9: 201
CPT: 90000-99999
Line: 212 Category: 5

Diagnosis: CONGENITAL STENOSIS AND INSUFFICIENCY OF AORTIC VALVE
Treatment: SURGICAL VALVE REPLACEMENT
ICD-9: 746.3-.4
CPT: 33405-33417
Line: 213 Category: 5

Diagnosis: ACQUIRED HEMOLYTIC ANEMIAS
Treatment: MEDICAL THERAPY
ICD-9: 283
CPT: 90000-99999
Line: 214 Category: 5

Diagnosis: BULBUS CORDIS ANOMALIES & ANOMALIES OF CARDIAC SEPTAL CLOSURE: DOUBLE OUTLET RIGHT VENTRICLE
Treatment: SHUNT
ICD-9: 745.11
CPT: 33750-33766
Line: 215 Category: 2

Diagnosis: CONGENITAL PULMONARY VALVE ATRESIA
Treatment: SHUNT
ICD-9: 746.01
CPT: 33750-33766
Line: 216 Category: 5

Diagnosis: NON-DISSECTING ANEURYSM WITHOUT RUPTURE
Treatment: SURGICAL TREATMENT
ICD-9: 441.2,441.4,441.9,442
CPT: 33860-77,35081-103,35301-11,35331-51,35450-515,35526-31,35536-52,35560-63,35601-16,35626-46,35651,35663
Line: 217 Category: 5

Diagnosis: PITUITARY DISORDERS: PANHYPOPITUITARISM, IATROGENIC AND OTHER
Treatment: MEDICAL THERAPY
ICD-9: 253.2,253.4,253.7,253.8
CPT: 90000-99999
Line: 218 Category: 5

Diagnosis: OTHER AND UNSPECIFIED TYPE ENDOCARDIAL CUSHION DEFECTS
Treatment: REPAIR ATRIOVENTRICULAR
ICD-9: 745.60,745.69,745.8,745.9
CPT: 33670
Line: 219 Category: 5

Diagnosis: INTERRUPTED AORTIC ARCH
Treatment: TRANSVERSE ARCH GRAFT
ICD-9: 747.11
CPT: 33870
Line: 220 Category: 2

Diagnosis: HEREDITARY FRUCTOSE INTOLERANCE, INTEST. DISACCHARIDASE AND OTHER DEFICIENCIES
Treatment: MEDICAL THERAPY
ICD-9: 271.2-.9
CPT: 90000-99999
Line: 221 Category: 5

Diagnosis: CONGENITAL TRICUSPID ATRESIA AND STENOSIS
Treatment: REPAIR
ICD-9: 746.1
CPT: 33649
Line: 222 Category: 5

Diagnosis: DISEASES AND DISORDERS OF AORTIC VALVE
Treatment: AV REPLACEMENT, VALVULOPLASTY
ICD-9: 395,424.1,996.02
CPT: 33400,33411
Line: 223 Category: 5

Diagnosis: CONGENITAL MITRAL VALVE STENOSIS
Treatment: MITRAL VALUE REPLACEMENT
ICD-9: 746.5
CPT: 33420-33430
Line: 224 Category: 2

Diagnosis: DISEASES OF MITRAL VALVE
Treatment: VALVULOPLASTY, MV REPLACE
ICD-9: 394,424.0,996.02
CPT: 33430,33425
Line: 225 Category: 5

Diagnosis: CHRONIC POST-TRAUMATIC STRESS SYNDROME
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 309.89
CPT: 90220,90800-90899
Line: 226 Category: 5

Diagnosis: EATING DISORDER NOS
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 307.50
CPT: 90220,90800-90899
Line: 227 Category: 5

Diagnosis: BULIMIA NERVOSA
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 307.51
CPT: 90220,90800-90899
Line: 228 Category: 5

Diagnosis: ADRENOGENITAL DISORDERS
Treatment: MEDICAL THERAPY
ICD-9: 255.2
CPT: 90000-99999,50700
Line: 229 Category: 5

Diagnosis: CANCER OF VAGINA, VULVA AND OTHER FEMALE GENITAL ORGANS, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 181,183.2-.9,184,236.1,236.3
CPT: 58200,90000-99999
Line: 230 Category: 5

Diagnosis: CANCER OF URINARY SYSTEM, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 188-189,198.0-.1,233.7,236.7,236.9,239.4
CPT: 50220-90,50650-60,51530,51550-97,53220,90000-99999
Line: 231 Category: 5

Diagnosis: CANCER OF EYE & ORBIT, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 190,234.0,238.8
CPT: 65101-05,90000-99999
Line: 232 Category: 5

Diagnosis: CANCER OF SOFT TISSUE, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 164.1,171,238.1
CPT: 21555-57,21925-35,23075-77,24075-77,25075-77,26115-17,27047-49,27075-79,27327-29,27615-19,28043-46,90000-99999
Line: 233 Category: 5

Diagnosis: ARTERIAL ANEURYSM OF NECK
Treatment: REPAIR
ICD-9: 442.81-.82
CPT: 35321,35355-81,35516-21,35533,35556-58,35565-87,35621,35650-61,35665-71
Line: 234 Category: 5

Diagnosis: HODGKIN'S DISEASE
Treatment: BONE MARROW TRANSPLANT (5-6 LOCI MATCH)
ICD-9: 201
CPT: 38230-41
Line: 235 Category: 5

Diagnosis: TETRALOGY OF FALLOT (TOF)
Treatment: TOTAL REPAIR TETRALOGY
ICD-9: 745.2
CPT: 33692-33696
Line: 236 Category: 5

Diagnosis: COMPLETE , CORRECTED AND OTHER TGA
Treatment: TRANSPOSITION OF VESSELS
ICD-9: 745.10,745.12,745.19
CPT: 33782-33784
Line: 237 Category: 2

Diagnosis: CONGENITAL CYSTIC LUNG - MILD AND MODERATE
Treatment: LUNG RESECTION
ICD-9: 748.4
CPT: 32500
Line: 238 Category: 5

Diagnosis: CHRONIC HEPATITIS
Treatment: MEDICAL THERAPY
ICD-9: 571.4,571.8-.9
CPT: 90000-99999
Line: 239 Category: 5

Diagnosis: OTHER SPECIFIED APLASTIC ANEMIAS
Treatment: BONE MARROW TRANSPLANT (5-6 LOCI MATCH)
ICD-9: 284.8
CPT: 38240
Line: 240 Category: 5

[Diagnosis: DYSTHYMIA
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 300.4
CPT: 90220,90800-90899
Line: 241 Category: 5]

Diagnosis: CANCER OF PENIS AND OTHER MALE GENITAL ORGAN, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 187,233.5
CPT: 54120-35,90000-99999
Line: 242 Category: 5

Diagnosis: BENIGN NEOPLASM OF THE BRAIN
Treatment: CRANIOTOMY/CRANIECTOMY
ICD-9: 225.0
CPT: 61304-61576
Line: 243 Category: 5

[Diagnosis: CONDUCT DISORDER, MILD/MODERATE: SOLITARY AGGRESSIVE, GROUP TYPE, UNDIFFERENTIATED
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 312.00,312.20,312.90
CPT: 90220,90800-90899
Line: 244 Category: 5]

Diagnosis: INFECTIOUS SKIN CONDITIONS
Treatment: MEDICAL THERAPY
ICD-9: 526.4,706.2,757.32,757.39,757.9
CPT: 10000-61,10141,11000,11100-446,17000-105,20000-05,21030,21044,21501,23030,23040,23930-31,25028-31,26010-30,26990-91,27301,27603-04,28001,40800-05,41800,90000-99999
Line: 245 Category: 5

Diagnosis: HEARING LOSS - AGE 3 OR UNDER
Treatment: MEDICAL THERAPY
ICD-9: 388-389
CPT: 90000-99999
Line: 246 Category: 4

Diagnosis: URETERAL CALCULUS
Treatment: CYSTOURETH. W/FRAG & SCOP, MEDICAL THERAPY
ICD-9: 592.1
CPT: 50951-80,52320,52325,52332,52335,90000-99999
Line: 247 Category: 5

Diagnosis: BENIGN CEREBRAL CYSTS
Treatment: DRAINAGE
ICD-9: 348.0,349.2
CPT: 61120-61152,61314-61315,61522-61524,61680-61712
Line: 248 Category: 5

Diagnosis: CANCER OF BONES, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 170,198.5,238.0,239.2
CPT: 23900,24900-31,25900-31,26910-52,27290,27590-98,27880-89,28800-25,60252-54,60500-605,90000-99999
Line: 249 Category: 5

Diagnosis: AMEBIASIS
Treatment: MEDICAL THERAPY
ICD-9: 006.0-.1,006.9
CPT: 90000-99999
Line: 250 Category: 10

Diagnosis: LIVER ABSCESS AND SEQUELAE OF CHRONIC LIVER DISEASE
Treatment: MEDICAL THERAPY
ICD-9: 572.0-.2
CPT: 90000-99999
Line: 251 Category: 5

Diagnosis: PEMPHIGUS, PEMPHIGOID; BENIGN MUCOUS MEMBRANCE PEMPHIGOID, OTHER AND UNSPECIFIED BULLOUS DERMATOSES
Treatment: MEDICAL THERAPY
ICD-9: 694.4-.9
CPT: 90000-99999
Line: 252 Category: 5

Diagnosis: INTESTINAL MALABSORPTION
Treatment: MEDICAL THERAPY
ICD-9: 579
CPT: 90000-99999
Line: 253 Category: 5

Diagnosis: ACROMEGALY & GIGANTISM, OTHER & UNSPEC. ANTERIOR PITUITARY HYPERFUNCT., BENIGN NEOP. THYROID GLANDS & OTHER ENDOCRINE GLANDS
Treatment: MEDICAL THERAPY
ICD-9: 253.0,253.1,253.6,253.9,226,227.0-.1,227.4-.9
CPT: 90000-99999
Line: 254 Category: 5

Diagnosis: MALIGNANT MELANOMA OF SKIN, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 172,238.2,239.2
CPT: 11600-46,19200-29,19272,21555-7,21632,21925-35,23075-7,24075-7,25075-7,26115-7,27047-9,27075-9,27327-9,27615-9,28043-6,38500-780,51575-95,54135,55842-45,90000-99999
Line: 255 Category: 5

Diagnosis: PARALYTIC ILEUS
Treatment: MEDICAL THERAPY
ICD-9: 560.1
CPT: 90000-99999
Line: 256 Category: 5

Diagnosis: URETERAL STRICTURE OR OBSTRUCTION
Treatment: OPEN RESECTION, PERC. NEPHROSTOL., NEPHROLITHOTOMY, LITHOTRIPSY
ICD-9: 593.3-.4
CPT: 50060-81,50700-16,50590
Line: 257 Category: 5

Diagnosis: TREATABLE DEMENTIA
Treatment: MEDICAL THERAPY
ICD-9: 291.2,290.40,292.82,293.9,294.8
CPT: 90000-99999
Line: 258 Category: 5

Diagnosis: CHRONIC OSTEOMYELITIS
Treatment: INCISION & DRAINAGE
ICD-9: 730.1-.2
CPT: 23035,23170-82,23189,23935,24134-24147,25035,25145-25151,26034,26230-36,26992,27303,27075-79,27070-1,27607,28005,27360,27640-1,28120-4
Line: 259 Category: 5

Diagnosis: CHRONIC PYELONEPHRITIS
Treatment: MEDICAL THERAPY
ICD-9: 590.0
CPT: 90000-99999
Line: 260 Category: 5

Diagnosis: TORSION OF TESTIS
Treatment: ORCHIECTOMY, REPAIR
ICD-9: 608.2
CPT: 54520-54560
Line: 261 Category: 10

Diagnosis: LEUKOPLAKIA OF CERVIX, DYSTROPHY OF VULVA
Treatment: MEDICAL THERAPY
ICD-9: 622.2,624.0
CPT: 90000-99999
Line: 262 Category: 5

Diagnosis: CANCER OF LUNG, BRONCHUS, PLEURA, TRACHEA, MEDIASTINUM & OTHER RESPIRATORY ORGANS, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 162-163,164.2-.9,165,195.1,197.0,197.2-.3,231.1-.2,235.7-.8
CPT: 31785-86,32095-100,32480-90,32440-50,90000-99999
Line: 263 Category: 5

Diagnosis: ACUTE LYMPHOCYTIC LEUKEMIA (CHILD)
Treatment: CHEMOTHERAPY, RADIATION THERAPY
ICD-9: 204.0
CPT: 90000-99999
Line: 264 Category: 5

Diagnosis: DISORDERS OF AMINO-ACID TRANSPORT AND METABOLISM (NON PKU)
Treatment: MEDICAL THERAPY
ICD-9: 270.0,270.2-270.9
CPT: 90000-99999
Line: 265 Category: 5

Diagnosis: PNEUMOCYSTIS CARINII PNEUMONIA
Treatment: MEDICAL THERAPY
ICD-9: 136.3
CPT: 90000-99999
Line: 266 Category: 5

Diagnosis: NON-HODGKIN'S LYMPHOMAS
Treatment: CHEMOTHERAPY, RADIATION THERAPY
ICD-9: 200,202.0-.2,202.8-.9
CPT: 90000-99999
Line: 267 Category: 5

Diagnosis: CANCER OF STOMACH, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 151,230.2,235.2
CPT: 43630-38,44100-25,44140-47,44625,45111,45550,46938,90000-99999
Line: 268 Category: 5

Diagnosis: DISORDERS OF THYROCALCITONIN SECRETION
Treatment: THYROIDECTOMY
ICD-9: 246.0
CPT: 60240
Line: 269 Category: 5

Diagnosis: AORTIC PULMONARY FISTULA
Treatment: REPAIR SINUS OF VALSALVA
ICD-9: 417.0
CPT: 33702-33710
Line: 270 Category: 5

Diagnosis: POLYARTERITIS NODOSA AND ALLIED CONDITIONS
Treatment: MEDICAL THERAPY
ICD-9: 446.0,446.4,446.6-.7
CPT: 90000-99999
Line: 271 Category: 5

Diagnosis: MYELOID, MONOCYTIC, ACUTE LYMPHOCYTIC AND OTHER SPECIFIED LEUKEMIAS
Treatment: BONE MARROW TRANSPLANT (5-6 LOCI MATCH)
ICD-9: 204.0,205-207
CPT: 38230-41
Line: 272 Category: 5

Diagnosis: CANCER OF COLON, RECTUM, SMALL INTESTINE AND ANUS, TREATABLE
Treatment: HEMICOLECTOMY, RECTUM RESECTION
ICD-9: 152-154,197.5,230.3-.4,235.5
CPT: 44140-47,45111,45550
Line: 273 Category: 5

Diagnosis: CARDIOMYOPATHY, HYPERTROPHIC MUSCLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 425
CPT: 33999,43030,43130-36,90000-99999
Line: 274 Category: 5

Diagnosis: PERNICOUS ANEMIA
Treatment: MEDICAL THERAPY
ICD-9: 281
CPT: 90000-99999
Line: 275 Category: 5

Diagnosis: CYSTIC FIBROSIS
Treatment: MEDICAL THERAPY
ICD-9: 277.0
CPT: 90000-99999
Line: 276 Category: 5

Diagnosis: AGRANULOCYTOSIS
Treatment: BONE MARROW TRANSPLANTATION (5-6 LOCI MATCH)
ICD-9: 288.0
CPT: 38240
Line: 277 Category: 5

Diagnosis: ATRIAL SEPTAL DEFECT, SECUNDUM
Treatment: REPAIR SEPTAL DEFECT
ICD-9: 745.5
CPT: 33640-33643
Line: 278 Category: 5

Diagnosis: ATRIAL SEPTAL DEFECT, PRIMUM
Treatment: REPAIR SEPTAL DEFECT
ICD-9: 745.61
CPT: 33640
Line: 279 Category: 5

Diagnosis: STROKE
Treatment: MEDICAL THERAPY
ICD-9: 434,436
CPT: 90000-99999
Line: 280 Category: 3

Diagnosis: GANGRENE; ATHEROSCLEROSIS OF ARTERIES OF EXTREMITIES, DIABETES MELLITUS W/PERIPHERAL CIRC DISORDER, CHRONIC UCLER OF SKIN, GAS GANGRENE, OTHER PERIPHERAL VASCULAR DISEASE
Treatment: AMPUTATION
ICD-9: 785.4,440.2,250.7,707.0,040.0,443.0
CPT: 28800-25,27880-89,27590-98,27290-95,26910-52,25900-31,24900-40,23900-21,23930,25020-28,26025-30,26990-91,27301,27305,27600-03,28001-03
Line: 281 Category: 5

Diagnosis: BUDD-CHIARI SYNDROME, AND OTHER VENOUS EMBOLISM AND THROMBOSIS
Treatment: THROMBECTOMY/LIGATION
ICD-9: 453
CPT: 37160,37500,34401
Line: 282 Category: 5

* THIS LIST IS SUBJECT TO REVISION UNTIL SUBMITTED TO THE LEGISLATURE

Diagnosis: OPPORTUNISTIC INFECTIONS IN IMMUNO-COMPROMISED HOSTS
Treatment: MEDICAL THERAPY
ICD-9: 003.9,007.2,007.7,031.9,039,042.0-.2,042.9,043.0-.2,043.9,044.0-.2,044.9,047.9,053-054,078.5,110,111.1,112.0,115,117.5,118,130,136.3,173,285.9,287.5,298.9,323.9,336.9,357
CPT: 90000-99999
Line: 283 Category: 5

Diagnosis: VENTRICULAR SEPTAL DEFECT
Treatment: CLOSURE
ICD-9: 745.4,745.7
CPT: 33681-33688
Line: 284 Category: 5

Diagnosis: CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 173,198.2
CPT: 11600-46,19200-29,19272,21555-7,21632,21925-35,23075-7,24075-7,25075-7,26115-7,27047-9,27075-9,27327-9,27615-9,28043-6,38500-780,51575-95,54135,55842-45,90000-99999
Line: 285 Category: 5

Diagnosis: CANCER OF PROSTATE GLAND, TREATABLE
Treatment: PROSTATECTOMY, RETROPERITONEAL NODE DISSECTION
ICD-9: 185,233.4,236.5
CPT: 38564,38780,55810-21
Line: 286 Category: 5

Diagnosis: HEART FAILURE
Treatment: MEDICAL THERAPY
ICD-9: 428
CPT: 90000-99999
Line: 287 Category: 5

Diagnosis: APLASTIC ANEMIAS DUE TO DISEASE OR TREATMENT
Treatment: MEDICAL THERAPY
ICD-9: 284.8
CPT: 90000-99999
Line: 288 Category: 5

Diagnosis: PSYCHOLOGICAL FACTORS AFFECTING PHYSICAL CONDITION (EG. ASTHMA, CHRONIC GI CONDITIONS, HYPERTENSION)
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 316.00
CPT: 90220,90800-90899
Line: 289 Category: 5

Diagnosis: ULCERATION OF INTESTINE
Treatment: COLECTOMY, ENTEROSTOMY
ICD-9: 569.82
CPT: 44150-60,44300-16
Line: 290 Category: 5

Diagnosis: CANCER OF RETROPERITONEUM, PERITONEUM, OMENTUM & MESENTARY, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 158,197.6,197.8,235.5
CPT: 21044-45,30117-18,30500,40810-16,41116,41135,41150-55,42104-20,42842-45,42880,90000-99999
Line: 291 Category: 5

Diagnosis: EBSTEIN'S ANOMALY
Treatment: REPAIR SEPTAL DEFECT
ICD-9: 746.2
CPT: 33640-33647
Line: 292 Category: 5

Diagnosis: DISEASES OF WHITE BLOOD CELLS
Treatment: MEDICAL THERAPY
ICD-9: 288.1-.9
CPT: 90000-99999
Line: 293 Category: 5

Diagnosis: CANCER OF ORAL CAVITY, PHARYNX, NOSE AND LARYNX, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 140-149,160-163,231.0,235.0-.1,235.6
CPT: 40530,41130,41110-14,90000-99999
Line: 294 Category: 5

Diagnosis: BENIGN NEOPLASM OF ISLETS OF LANGERHANS
Treatment: EXCISION OF TUMOR
ICD-9: 211.7
CPT: 60699
Line: 295 Category: 5

Diagnosis: PREMALIGNANT LESIONS AND CARCINOMA IN SITU OF SKIN
Treatment: DESTRUCT/EXCISION/MEDICAL THERAPY
ICD-9: 232,702
CPT: 17000-17102,11600-11646,67405-13,67450,69100,69110-20,69300,90000-99999
Line: 296 Category: 5

Diagnosis: ADRENAL OR CUTANEOUS HEMORRHAGE OF FETUS OR NEONATE
Treatment: MEDICAL THERAPY
ICD-9: 772.5-.9
CPT: 90000-99999
Line: 297 Category: 2

Diagnosis: SIALOADENITIS, ABSCESS, FISTULA OF SALIVARY GLANDS
Treatment: SURGERY
ICD-9: 527.2-.4
CPT: 42305,42325,42330,42340,42408,42410,42440-42507,42509,42600,42665,40810-40816,42650,42655
Line: 298 Category: 5

Diagnosis: HYDROPS FETALIS
Treatment: MEDICAL THERAPY
ICD-9: 778.0,773.3
CPT: 90000-99999
Line: 299 Category: 2

Diagnosis: LIPIDOSES AND OTHER DISORDERS OF METABOLISM
Treatment: MEDICAL THERAPY
ICD-9: 272,277.1,277.5,277.9,330.1
CPT: 90000-99999
Line: 300 Category: 5

Diagnosis: LEUKOPLAKIA OF ORAL MUCOSA, INCLUDING TONGUE
Treatment: INCIS/EXCIS TONGUE, BIOPSY
ICD-9: 528.6
CPT: 41000-41599
Line: 301 Category: 5

Diagnosis: MALARIA AND RELAPSING FEVER
Treatment: MEDICAL THERAPY
ICD-9: 084,087
CPT: 90000-99999
Line: 302 Category: 1

Diagnosis: REGIONAL ENTERITIS, IDIOPATHIC PROCTOCOLITIS
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 555,556
CPT: 90000-99999,49000,44110
Line: 303 Category: 5

Diagnosis: CONGENITAL PULMONARY VALVE STENOSIS
Treatment: SURGICAL PULM. VALVE
ICD-9: 746.02
CPT: 33470-33471
Line: 304 Category: 2

Diagnosis: URETERAL FISTULA (INTESTINAL)
Treatment: NEPHROSTOMY
ICD-9: 593.82
CPT: 50951-50980,50040-50045, 50395-50398,50686-50688,50930
Line: 305 Category: 5

Diagnosis: DISORDERS OF ARTERIES, VISCERAL
Treatment: BYPASS GRAFT
ICD-9: 447.0,447.2-.9
CPT: 35501-15,35526-31,35536-51,35560-63,35601-16,35626-46,35663
Line: 306 Category: 5

Diagnosis: DISEASES OF ENDOCARDIUM
Treatment: MEDICAL THERAPY
ICD-9: 424
CPT: 90000-99999
Line: 307 Category: 5

Diagnosis: CHRONIC LEUKEMIAS
Treatment: CHEMOTHERAPY, RADIATION THERAPY
ICD-9: 202.4,203.1,204.1-.9,205.1-.9,206.1-.9,207.1-.8,208.1-.9
CPT: 90000-99999
Line: 308 Category: 5

Diagnosis: CYSTICERCOSIS, OTHER CESTODE INFECTION, TRICHINOSIS
Treatment: MEDICAL THERAPY
ICD-9: 123.1-.9,124
CPT: 90000-99999
Line: 309 Category: 5

Diagnosis: LEPTOSPIROSIS
Treatment: MEDICAL THERAPY
ICD-9: 100
CPT: 90000-99999
Line: 310 Category: 1

Diagnosis: ENCEPHALOCELE; CONGENITAL HYDROCEPHALUS
Treatment: SHUNT
ICD-9: 742.0,742.3
CPT: 62180-62258
Line: 311 Category: 2

Diagnosis: ANAL AND RECTAL POLYP
Treatment: EXCISION OF POLYP
ICD-9: 569.0
CPT: 45310,45333,45170
Line: 312 Category: 5

Diagnosis: BENIGN NEOPLASMS OF DIGESTIVE SYSTEM
Treatment: SURGICAL TREATMENT
ICD-9: 211.0-.6,211.8-.9
CPT: 43202,43600,44100,45310,46610
Line: 313 Category: 11

Diagnosis: DIABETES INSIPIDUS
Treatment: MEDICAL THERAPY
ICD-9: 253.5
CPT: 90000-99999
Line: 314 Category: 5

Diagnosis: DISORDERS OF PLASMA PROTEIN METABOLISM
Treatment: MEDICAL THERAPY
ICD-9: 273
CPT: 90000-99999
Line: 315 Category: 5

Diagnosis: CUSHING'S SYNDROME; HYPERALDOSTERONISM, OTHER CORTICOADRENAL OVERACTIVITY, MEDULLOADRENAL HYPERFUNCTION
Treatment: MEDICAL THERAPY/ADRENALECTOMY
ICD-9: 255.0,255.1,255.3,255.6
CPT: 90000-99999,60540,61546
Line: 316 Category: 5

Diagnosis: GUILLAIN-BARRE SYNDROME
Treatment: MEDICAL THERAPY
ICD-9: 357.00
CPT: 90000-99999
Line: 317 Category: 3

Diagnosis: LEUKOPLAKIA OF ORAL MUCOSA, INCLUDING TONGUE
Treatment: MEDICAL THERAPY
ICD-9: 528.6
CPT: 90000-99999
Line: 318 Category: 5

Diagnosis: HEREDITARY ANGIONEUROTIC EDEMA
Treatment: MEDICAL THERAPY
ICD-9: 277.6
CPT: 90000-99999
Line: 319 Category: 5

Diagnosis: METASTATIC INFECTIONS WITH LOCALIZED SITES
Treatment: MEDICAL THERAPY
ICD-9: 003.2,006.3-.9,014-018,022.1
CPT: 90000-99999
Line: 320 Category: 5

Diagnosis: CHRONIC RESPIRATORY DISEASE ARISING IN THE NEONATAL PERIOD
Treatment: MEDICAL THERAPY
ICD-9: 770.7
CPT: 90000-99999
Line: 321 Category: 5

Diagnosis: NON LIFE-THREATENING ARRYTHMIAS
Treatment: MEDICAL THERAPY, PACEMAKER
ICD-9: 426,427.3,427.6,996.01
CPT: 33212,90000-99999
Line: 322 Category: 5

Diagnosis: LYMPHOID LEUKEMIA
Treatment: BONE MARROW TRANSPLANT (5-6 LOCI MATCH)
ICD-9: 204
CPT: 38240
Line: 323 Category: 5

Diagnosis: SYSTEMIC LUPUS ERYTHEMATOSUS, OTHER DIFFUSE DISEASES OF CONNECTIVE TISSUE
Treatment: MEDICAL THERAPY
ICD-9: 710.0,710.8,710.9
CPT: 90000-99999
Line: 324 Category: 5

Diagnosis: HYPOPLASIA AND DYPLASIA OF LUNG
Treatment: MEDICAL THERAPY
ICD-9: 748.5
CPT: 90000-99999
Line: 325 Category: 2

Diagnosis: PORTAL VEIN THROMBOSIS
Treatment: SHUNT
ICD-9: 452
CPT: 37140,49425
Line: 326 Category: 5

Diagnosis: TETANUS
Treatment: MEDICAL THERAPY
ICD-9: 037
CPT: 90000-99999
Line: 327 Category: 1

Diagnosis: VESICOURETERAL REFLUX
Treatment: MEDICAL THERAPY, REIMPLANTATION
ICD-9: 593.7
CPT: 90000-99999
Line: 328 Category: 5

Diagnosis: CONGENITAL HYDRONEPHROSIS
Treatment: NEPHRECTOMY/REPAIR
ICD-9: 753.2
CPT: 50230,50400-504
Line: 329 Category: 5

Diagnosis: DISORDERS OF PARATHYROID GLAND; BENIGN NEOPLASM OF PARATHYROID GLAND
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 227.1,252
CPT: 60500-05,90000-99999
Line: 330 Category: 5

Diagnosis: PULMONARY FIBROSIS
Treatment: MEDICAL THERAPY
ICD-9: 515-517
CPT: 90000-99999
Line: 331 Category: 5

Diagnosis: INTRACEREBRAL HEMORRHAGE
Treatment: MEDICAL THERAPY
ICD-9: 431
CPT: 90000-99999
Line: 332 Category: 3

Diagnosis: COARCTATION OF THE AORTA
Treatment: BALLOON DILATION - VALVE REPLACEMENT
ICD-9: 747.10
CPT: 33405-33417
Line: 333 Category: 5

Diagnosis: LEPROSY
Treatment: MEDICAL THERAPY
ICD-9: 030
CPT: 90000-99999
Line: 334 Category: 5

Diagnosis: CHRONIC OBSTRUCTIVE PULMONARY DISEASE
Treatment: MEDICAL THERAPY
ICD-9: 492,496
CPT: 90000-99999
Line: 335 Category: 5

Diagnosis: CONSTITUTIONAL APLASTIC ANEMIAS
Treatment: BONE MARROW TRANSPLANT (5-6 LOCI MATCH)
ICD-9: 284.0
CPT: 38240
Line: 336 Category: 5

Diagnosis: ACUTE LYMPHOCYTIC LEUKEMIAS (ADULT) AND MULTIPLE MYELOMA
Treatment: CHEMOTHERAPY, RADIATION THERAPY
ICD-9: 204.0,203.0,203.8
CPT: 90000-99999
Line: 337 Category: 5

Diagnosis: DISORDERS RELATING TO LONG GESTATION AND HIGH BIRTHWEIGHT
Treatment: MEDICAL THERAPY
ICD-9: 766
CPT: 90000-99999
Line: 338 Category: 2

Diagnosis: NEPHROTIC SYNDROME AND OTHER CHRONIC RENAL FAILURE
Treatment: MEDICAL THERAPY INCLUDING DIALYSIS
ICD-9: 581.0-581.2,581.8-.9,582,585,587-589
CPT: 90000-99999
Line: 339 Category: 5

Diagnosis: ACUTE NON-LYMPHOCYTIC LEUKEMIAS
Treatment: BONE MARROW TRANSPLANT (5-6 LOCI MATCH)
ICD-9: 205.0,206.0,207.0,208.0
CPT: 38230-41
Line: 340 Category: 5

Diagnosis: END STAGE RENAL DISEASE
Treatment: RENAL TRANSPLANT
ICD-9: 250.4,583.8-.9
CPT: 50360
Line: 341 Category: 5

Diagnosis: OTHER ANEURYSM OF ARTERY, PERIPHERAL
Treatment: SURGICAL TREATMENT
ICD-9: 442.0,442.3,442.9
CPT: 24900-31,25900-31,26910-52,27080,27590-98,27880-89,28800-25,37609,64510-20,64802-18,35001-03,35011,35013-21,35141-62
Line: 342 Category: 5

Diagnosis: DISORDERS MINERAL METABOLISM
Treatment: MEDICAL THERAPY
ICD-9: 275
CPT: 90000-99999
Line: 343 Category: 5

Diagnosis: NEONATAL CONJUNCTIVITIS, DACRYOCYTITIS AND CANDIDA INFECTION
Treatment: MEDICAL THERAPY
ICD-9: 771.6-.7
CPT: 90000-99999
Line: 344 Category: 2

Diagnosis: ESOPHAGEAL VARICES
Treatment: MEDICAL THERAPY/SHUNT/SCLEROTHERAPY
ICD-9: 456.0-.2
CPT: 90000-99999,37145,37160,37181,38100,43400
Line: 345 Category: 5

Diagnosis: CHRONIC PANCREATITIS
Treatment: MEDICAL THERAPY
ICD-9: 577.1
CPT: 90000-99999
Line: 346 Category: 5

Diagnosis: ANXIETY DISORDER, UNSPECIFIED; GENERALIZED ANXIETY DISORDER
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 300.00,300.02
CPT: 90220,90800-90899
Line: 347 Category: 5

Diagnosis: PANIC DISORDER WITH AND WITHOUT AGORAPHOBIA
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 300.21,300.01
CPT: 90220,90800-90899
Line: 348 Category: 5

Diagnosis: DISSOCIATIVE DISORDERS: DEPERSONALIZATION DISORDER; MULTIPLE PERSONALITY DISORDER; DISSOCIATIVE DISO NOS; PSYCHOGENIC AMNESIA; PSYCHOGENIC FUGUE
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 300.60,300.14,300.15,300.12,300.13
CPT: 90220,90800-90899
Line: 349 Category: 5

Diagnosis: AVOIDANT DISORDER OF CHILDHOOD OR ADOLESCENCE; ELECTIVE MUTISM
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 313.21,313.23
CPT: 90220,90800-90899
Line: 350 Category: 10

Diagnosis: SEPARATION ANXIETY DISORDER
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 309.21
CPT: 90220,90800-90899
Line: 351 Category: 10

Diagnosis: ADJUSTMENT DISORDERS
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 309.00,309.23,309.24,309.28,309.30,309.40,309.82,309.83,309.90
CPT: 90220,90800-90899
Line: 352 Category: 10

* THIS LIST IS SUBJECT TO REVISION UNTIL SUBMITTED TO THE LEGISLATURE

Diagnosis: CONVERSION DISORDER, CHILD
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 300.11
CPT: 90220,90800-90899
Line: 353 Category: 10

Diagnosis: TOURETTE'S DISORDER AND TIC DISORDERS
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 307.20-.23,307.00
CPT: 90220,90800-90899
Line: 354 Category: 13

Diagnosis: HYPERPLASIA OF PROSTATE
Treatment: TRANSURETH. RESECTION, MEDICAL THERAPY
ICD-9: 600
CPT: 52601,90000-99999
Line: 355 Category: 11

Diagnosis: END STAGE RENAL DISEASE
Treatment: MEDICAL THERAPY INCLUDING DIALYSIS
ICD-9: 250.4,583.8-.9
CPT: 90000-99999
Line: 356 Category: 5

Diagnosis: GIANT CELL ARTERITIS, KAWASAKI DISEASE, HYPERSENSITIVITY VASCULITIS
Treatment: MEDICAL THERAPY
ICD-9: 446.1-.2,446.5
CPT: 90000-99999
Line: 357 Category: 3

Diagnosis: DERMATOMYOSITIS, POLYMYOSITIS
Treatment: MEDICAL THERAPY
ICD-9: 710.3,710.4
CPT: 90000-99999
Line: 358 Category: 5

Diagnosis: SYSTEMIC SCLEROSIS
Treatment: MEDICAL THERAPY
ICD-9: 710.1
CPT: 90000-99999
Line: 359 Category: 5

Diagnosis: UNWANTED PREGNANCY
Treatment: ABORTION
ICD-9: 635-639,779.6
CPT: 59105-06,59840-52
Line: 360 Category: 6

Diagnosis: COMMON VENTRICLE
Treatment: TOTAL REPAIR TETRALOGY
ICD-9: 745.3
CPT: 33692-33696
Line: 361 Category: 5

Diagnosis: HERPES ZOSTER & HERPES SIMPLEX W/OPHTHALMIC COMPLICATIONS
Treatment: MEDICAL THERAPY
ICD-9: 053.2,054.4
CPT: 90000-99999
Line: 362 Category: 10

Diagnosis: HYPHEMA
Treatment: REMOVAL OF BLOOD CLOT
ICD-9: 364.41
CPT: 65815,65930
Line: 363 Category: 10

Diagnosis: PENETRATING WOUND OF ORBIT
Treatment: SURGICAL TREATMENT
ICD-9: 870.3,870.8,870.9
CPT: 67400-50
Line: 364 Category: 12

Diagnosis: PURULENT ENDOPHTHALMITIS
Treatment: VITRECTOMY
ICD-9: 360.0
CPT: 67005-67036
Line: 365 Category: 12

Diagnosis: PRIMARY AND OTHER ANGLE-CLOSURE GLAUCOMA
Treatment: IRIDECTOMY, LASER SURGERY
ICD-9: 365.20,365.22
CPT: 66761,66505,66625-66630
Line: 366 Category: 10

Diagnosis: GLAUCOMA ASSOCIATED WITH DISORDERS OF THE LENS
Treatment: EXTRACTION OF CATARACT
ICD-9: 365.5,360.19
CPT: 66920-66984
Line: 367 Category: 11

Diagnosis: PRIMARY AND OPEN ANGLE GLAUCOMA
Treatment: TRABECULECTOMY
ICD-9: 365.10-365.11
CPT: 66170
Line: 368 Category: 11

Diagnosis: GLAUCOMA: BORDERLINE, OPEN-ANGLE, CORTICOSTEROID-INDUCED, ASSOC. W/CONGENTIAL ANOMALIES, DYSTROPHIES & SYSTEMIC SYNDROMES, ASSOC. W/DISORDER OF THE LENS, ASSOC. W/OTHER OCULAR DISORDERS, OTHER & UNSPECIFIED
Treatment: MEDICAL THERAPY
ICD-9: 365.0-365.1,365.3-365.9
CPT: 90000-99999
Line: 369 Category: 13

Diagnosis: DEGENERATION OF MACULA AND POSTERIOR POLE
Treatment: VITRECTOMY, LASER SURGERY
ICD-9: 362.5
CPT: 67038,67210
Line: 370 Category: 11

Diagnosis: VITREOUS HEMORRHAGE
Treatment: VITRECTOMY
ICD-9: 379.23
CPT: 67036
Line: 371 Category: 12

Diagnosis: PRIMARY AND OTHER OPEN-ANGLE GLAUCOMA
Treatment: LASER TRABECULOPLASTY
ICD-9: 365.10-365.11
CPT: 65855
Line: 372 Category: 11

Diagnosis: PRIMARY AND OTHER OPEN-ANGLE GLAUCOMA
Treatment: CYCLOCRYOTHERAPY
ICD-9: 365.10-365.11
CPT: 66720-66721
Line: 373 Category: 11

Diagnosis: CATARACT
Treatment: EXTRACTION OF CATARACT
ICD-9: 366.0-.3
CPT: 66920-84
Line: 374 Category: 11

Diagnosis: RETINAL DETACHMENT WITH RETINAL DEFECT
Treatment: VITRECTOMY
ICD-9: 361.0
CPT: 67036-67112
Line: 375 Category: 12

Diagnosis: OPEN WOUND OF EYEBALL
Treatment: CORNEAL LACERATION REPAIR
ICD-9: 871
CPT: 65280-65285
Line: 376 Category: 12

Diagnosis: CHRONIC INFLAMMATORY DISORDER OF ORBIT
Treatment: MEDICAL THERAPY
ICD-9: 376.1
CPT: 90000-99999
Line: 377 Category: 13

Diagnosis: AFTER CATARACT
Treatment: DISCISSION, LENS CAPSULE
ICD-9: 366.5
CPT: 66800-66821
Line: 378 Category: 11

Diagnosis: ACUTE, SUBACUTE, CHRONIC AND OTHER CERTAIN TYPES OF IRIDOCYCLITIS
Treatment: MEDICAL THERAPY
ICD-9: 364.0-.3
CPT: 90000-99999
Line: 379 Category: 13

Diagnosis: DIABETIC AND OTHER RETINOPATHY
Treatment: LASER SURGERY
ICD-9: 250.5,362.0-362.2
CPT: 67210,67228
Line: 380 Category: 11

Diagnosis: RETROLENTAL FIBROPLASIA
Treatment: CRYOSURGERY
ICD-9: 362.21
CPT: 67101-67122
Line: 381 Category: 11

Diagnosis: APHAKIA AND OTHER DISORDERS OF LENS
Treatment: INTRAOCULAR LENS
ICD-9: 379.3
CPT: 66985
Line: 382 Category: 11

Diagnosis: EXOTROPIA
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 378
CPT: 67311-67335,90000-99999
Line: 383 Category: 11

Diagnosis: PARANOID (DELUSIONAL) DISORDER
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 297.10
CPT: 90220,90800-90899
Line: 384 Category: 5

Diagnosis: SCHIZOTYPAL PERSONALITY DISORDERS
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 301.22
CPT: 90220,90800-90899
Line: 385 Category: 5

Diagnosis: BORDERLINE PERSONALITY DISORDER
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 301.83
CPT: 90220,90800-90899
Line: 386 Category: 5

Diagnosis: BENIGN NEOPLASM OF PITUITARY GLAND
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 227.3
CPT: 61546-48,90000-99999
Line: 387 Category: 5

Diagnosis: TRAUMATIC AMPUTATION OF THUMB OR OTHER FINGER (COMPLETE)(PARTIAL) W/ & W/O COMPLICATION
Treatment: REIMPLANT/AMPUTATE
ICD-9: 385-386
CPT: 20812-28,26910-52
Line: 388 Category: 12

Diagnosis: OPEN WOUNDS
Treatment: REPAIR
ICD-9: 872.0-.1,872.62-.69,872.7-.9,878.4-.9,880.00,880.10,880.13,880.20,880.23,881.00,881.02,881.10,881.12,881.20,881.22,883,884.2,890-891,892.2,893,894.2
CPT: 12001-13300,15000-15510,15540-15550,15580-15625,15650-15720,15710-15770,56800,69440,69666,69667
Line: 389 Category: 10

Diagnosis: ABCESSES AND CYSTS OF BARTHOLIN'S GLAND AND VULVA
Treatment: INCISION AND DRAINAGE, MEDICAL THERAPY
ICD-9: 616.2-.9
CPT: 90000-99999,56400,56420,56440,56501,56600
Line: 390 Category: 10

Diagnosis: PILONIDAL CYST WITH ABSCESS
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 685.0
CPT: 10080-81,11770-72,90000-99999
Line: 391 Category: 14

Diagnosis: ACUTE THYROIDITIS
Treatment: MEDICAL THERAPY
ICD-9: 245.0
CPT: 90000-99999
Line: 392 Category: 10

Diagnosis: ACUTE OTITIS MEDIA
Treatment: MEDICAL THERAPY
ICD-9: 381.0-.4,381.8-.9,382.0,382.4,382.9
CPT: 90000-99999
Line: 393 Category: 10

Diagnosis: CHRONIC OTITIS MEDIA
Treatment: PE TUBES/T & A/TYMPANOPLASTY
ICD-9: 381.5-.7,382.1-.3
CPT: 69400-69410,42820,69631-69633
Line: 394 Category: 11

Diagnosis: ACUTE SINUSITIS
Treatment: MEDICAL THERAPY
ICD-9: 461
CPT: 90000-99999
Line: 395 Category: 1

Diagnosis: SPINA BIFIDA, DORSAL REGION
Treatment: MEDICAL THERAPY
ICD-9: 741.02
CPT: 90000-99999
Line: 396 Category: 2

Diagnosis: EDEMA AND OTHER CONDITIONS INVOLVING THE INTEGUMENT OF THE FETUS AND NEWBORN
Treatment: MEDICAL THERAPY
ICD-9: 778.5-.9
CPT: 90000-99999
Line: 397 Category: 2

Diagnosis: SEVERELY LOW BIRTH WEIGHT (500-749 GM)
Treatment: MEDICAL THERAPY
ICD-9: 765.12
CPT: 90000-99999
Line: 398 Category: 2

Diagnosis: CONGENITAL RUBELLA AND OTHER CONGENITAL INFECTIOUS DISEASES
Treatment: MEDICAL THERAPY
ICD-9: 771.0-.2
CPT: 90000-99999
Line: 399 Category: 2

Diagnosis: FEEDING PROBLEMS IN NEWBORN
Treatment: MEDICAL THERAPY
ICD-9: 779.3
CPT: 90000-99999
Line: 400 Category: 2

Diagnosis: DYSTONIA (UNCONTROLLABLE)
Treatment: MEDICAL THERAPY
ICD-9: 333
CPT: 90000-99999
Line: 401 Category: 5

Diagnosis: MULTIPLE VALVULAR DISEASE
Treatment: SURGICAL TREATMENT
ICD-9: 396-397
CPT: 33450-74,33480-92
Line: 402 Category: 5

Diagnosis: BILIARY ATRESIA
Treatment: LIVER TRANSPLANT
ICD-9: 751.61
CPT: 47135
Line: 403 Category: 5

Diagnosis: CIRRHOSIS OF LIVER OR BILIARY TRACT WITHOUT MENTION OF ALCOHOL
Treatment: LIVER TRANSPLANT
ICD-9: 571.5-.6
CPT: 47135
Line: 404 Category: 5

Diagnosis: CHRONIC PULMONARY HEART DISEASE, OTHER DISEASES OF PULMONARY CIRCULATION, ACUTE & SUBACUTE ENDOCARDITIS, ACUTE MYOCARDITIS, CARDIOMYOPATHY, OTHER CONG. ANOMALIES OF HEART AND CIRC. SYSTEM
Treatment: CARDIAC TRANSPLANT
ICD-9: 416-417,421-422,425,746-747
CPT: 33945
Line: 405 Category: 5

Diagnosis: ACUTE AND SUBACUTE NECROSIS OF LIVER
Treatment: LIVER TRANSPLANT
ICD-9: 570
CPT: 47135
Line: 406 Category: 3

Diagnosis: DIVERTICULITIS OF COLON
Treatment: COLON RESECTION
ICD-9: 562.1
CPT: 44140,44141,44143,44144,44145,44147
Line: 407 Category: 3

Diagnosis: CYST AND PSEUDOCYST OF PANCREAS
Treatment: DRAINAGE OF PANCREATIC CYST
ICD-9: 577.2
CPT: 48100-45,48151,48180,48500-40
Line: 408 Category: 5

Diagnosis: CANCER OF BRAIN AND NERVOUS SYSTEM, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 191-192,198.3-.4,237.5-.9,239.6
CPT: 63275-90,64774-818,90000-99999
Line: 409 Category: 5

Diagnosis: ATHEROSCLEROSIS, VISCERAL
Treatment: SURGICAL TREATMENT
ICD-9: 440.0-.1
CPT: 35501-15,35526-31,35536-51,35560-63,35601-16,35626-46,35663
Line: 410 Category: 5

Diagnosis: HYPERSOMNIA W/SLEEP APNEA
Treatment: MEDICAL THERAPY, TRACHEOTOMY
ICD-9: 780.53,347
CPT: 90000-99999,31600-10
Line: 411 Category: 5

Diagnosis: DISLOCATION KNEE & HIP, CLOSED
Treatment: RELOCATION
ICD-9: 835.0,836.3,836.5,718.35-.36
CPT: 27250-55,27550-27557
Line: 412 Category: 12

Diagnosis: DISLOCATION OF ELBOW, HAND, ANKLE, FOOT, CLAVICLE AND SHOULDER, CLOSED
Treatment: RELOCATION
ICD-9: 831.0,832.0,833.0,834.0,837.0,838.0,718.30-.34,718.36-.39
CPT: 23520-52,23650-80,24600-24635,25660-95,26641-715,27840-48,
Line: 413 Category: 12

Diagnosis: TRACHOMA
Treatment: MEDICAL THERAPY
ICD-9: 076
CPT: 90000-99999
Line: 414 Category: 10

Diagnosis: CLEFT LIP, CONGENITAL FISTULA OF LIP
Treatment: LIP EXCISION AND REPAIR
ICD-9: 749.1,750.25
CPT: 40650-720
Line: 415 Category: 11

Diagnosis: CLEFT PALATE
Treatment: REPAIR & PALATOPLASTY
ICD-9: 749.0
CPT: 42200-26,42235-81
Line: 416 Category: 11

Diagnosis: CLEFT PALATE WITH CLEFT LIP
Treatment: EXCISION & REPAIR VESTIBULE OF MOUTH
ICD-9: 749.2
CPT: 40800-40899
Line: 417 Category: 11

Diagnosis: CLOSED FRACTURE OF EPIPHYSIS OF LOWER EXTREMITIES
Treatment: REDUCTION
ICD-9: 820.01,821.22
CPT: 27516-27519
Line: 418 Category: 12

Diagnosis: FRACTURE OF SHAFT OF BONE, CLOSED
Treatment: REDUCTION
ICD-9: 812.2,813.2,813.8,818.0,821.0,823.2,823.8
CPT: 24500-15,25500-25575,25610-25620,27500-06,27750-58,27800-04,
Line: 419 Category: 10

Diagnosis: PARAPLEGIA, QUADRIPLEGIA
Treatment: MEDICAL THERAPY AND REHABILITATION
ICD-9: 343,344.0-.1
CPT: 90000-99999
Line: 420 Category: 13

Diagnosis: PARKINSON'S DISEASE
Treatment: MEDICAL THERAPY
ICD-9: 332
CPT: 90000-99999
Line: 421 Category: 13

Diagnosis: MULTIPLE SCLEROSIS AND OTHER DEMYELINATING DISEASES OF CENTRAL NERVOUS SYSTEM
Treatment: MEDICAL THERAPY AND REHABILITATION
ICD-9: 340-341,334
CPT: 90000-99999
Line: 422 Category: 5

Diagnosis: CEREBRAL PALSY
Treatment: MEDICAL THERAPY
ICD-9: 343.0-.3,.9,344.1,741.9,335.21,335.11,335.0
CPT: 90000-99999
Line: 423 Category: 13

Diagnosis: OVERANXIOUS DISORDER
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 313.00
CPT: 90220,90800-90899
Line: 424 Category: 10

Diagnosis: SIMPLE PHOBIA
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 300.29
CPT: 90220,90800-90899
Line: 425 Category: 11

Diagnosis: SOCIAL PHOBIA
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 300.23
CPT: 90220,90800-90899
Line: 426 Category: 11

Diagnosis: OBSESSIVE-COMPULSIVE DISORDERS
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 300.30
CPT: 90220,90800-90899
Line: 427 Category: 13

Diagnosis: SUPERFICIAL INJURIES WITH INFECTION
Treatment: MEDICAL THERAPY
ICD-9: 910.1,.3,.5,.7,.9,911.1,.3,.5,.7,.9,912.1,.3,.5,.7,.9,913.1,.3,.5,.7,.9,914.1,.3,.5,.7,.9,915.1,.3,.5,.7,.9,
916.1,.3,.5,.7,.9,917.1,.3,.5,.7,.9,919.1,.3,.5,.7,.9
CPT: 90000-99999
Line: 428 Category: 10

Diagnosis: LYME DISEASE
Treatment: MEDICAL THERAPY
ICD-9: 088
CPT: 90000-99999
Line: 429 Category: 13

Diagnosis: CHRONIC ULCER OF SKIN
Treatment: MEDICAL THERAPY
ICD-9: 707
CPT: 90000-99999,11000-44,15920-99
Line: 430 Category: 13

Diagnosis: CELLULITIS, NON-ORBITAL
Treatment: MEDICAL THERAPY
ICD-9: 527.3,566,597.0,607.2,608.4,611.0,616.0,681-682,686.8
CPT: 90000-99999
Line: 431 Category: 10

Diagnosis: ABSCESS OF BURSA OR TENDON
Treatment: INCISION AND DRAINAGE
ICD-9: 727.89
CPT: 27301,26990,26034,23930,23030,28001,27603
Line: 432 Category: 10

Diagnosis: ABSCESS OF PROSTATE
Treatment: TURP DRAIN ABSCESS
ICD-9: 601.2
CPT: 52601
Line: 433 Category: 10

Diagnosis: INFECTIVE OTITIS EXTERNA
Treatment: MEDICAL THERAPY
ICD-9: 380.1-.2,054.73,112.82
CPT: 90000-99999
Line: 434 Category: 14

Diagnosis: CHRONIC OTITIS MEDIA
Treatment: MEDICAL THERAPY
ICD-9: 381.5-.7,382.1-.3
CPT: 90000-99999
Line: 435 Category: 13

Diagnosis: DENTAL SERVICES (EG. DENTAL CARIES, FRACTURED TOOTH)
Treatment: RESTORATIVE DENTAL SERVICE
ICD-9: 0
CPT: 01110-20,02110-61,02210,02330-35,02930-2,02951,02970-80,03410-50,04910,05983-5,07120-30,07220-50,07285-6,07430-1,07450-65,07530-50,07981,09210-40,09310,09410-40
Line: 436 Category: 10

Diagnosis: RHEUMATOID ARTHRITIS, OSTEOARTHRITIS, AND ASEPTIC NECROSIS OF BONE
Treatment: ARTHROPLASTY
ICD-9: 714.0,714.3,715.1-.3,715.9,733.4
CPT: 27437-27454,27457,27580 ,23470-23472,23800-23802,27284-27286,27122-27132,27700-27703,27870-27871,24360-24366,24800-24802,26516-26536
Line: 437 Category: 11

Diagnosis: RHEUMATOID ARTHRITIS AND OTHER INFLAMMATORY POLYARTHROPATHIES
Treatment: MEDICAL THERAPY
ICD-9: 714
CPT: 90000-99999
Line: 438 Category: 13

Diagnosis: GOUT
Treatment: MEDICAL THERAPY
ICD-9: 274
CPT: 90000-99999
Line: 439 Category: 13

Diagnosis: CRYSTAL ARTHROPATHIES
Treatment: MEDICAL THERAPY
ICD-9: 712
CPT: 90000-99999
Line: 440 Category: 13

Diagnosis: SYMPATHETIC UVEITIS AND DEGENERATIVE DISORDERS AND CONDITIONS
Treatment: ENUCLEATION
ICD-9: 360.11,360.2,360.4
CPT: 65105
Line: 441 Category: 12

Diagnosis: DISLOCATIONS OF NON-CERVICAL VERTEBRA, CLOSED
Treatment: REPAIR/RECONSTRUCTION
ICD-9: 839.2,839.4,839.6
CPT: 22315,22325-22327,22505,22590-22650,22840-22855
Line: 442 Category: 12

Diagnosis: LUMBAR SPINAL STENOSIS
Treatment: LAMINECTOMY/LAMINOTOMY
ICD-9: 344.6
CPT: 63005,63017,63031,63042,63047
Line: 443 Category: 11

Diagnosis: FISTULA INVOLVING FEMALE GENITAL TRACT
Treatment: CLOSURE OF FISTULA
ICD-9: 619
CPT: 57300,57310,57320,51900-51920,50930,46715,44660
Line: 444 Category: 11

Diagnosis: HYMEN AND VAGINAL SEPTUM
Treatment: HYMENECTOMY
ICD-9: 623.2-.3,752.40,752.42
CPT: 56700-20
Line: 445 Category: 11

Diagnosis: RECTAL PROLAPSE
Treatment: PARTIAL COLECTOMY
ICD-9: 569.1
CPT: 44140-44
Line: 446 Category: 11

Diagnosis: CONGENITAL ABSENCE OF VAGINA
Treatment: ARTIFICIAL VAGINA
ICD-9: 752.49
CPT: 57291-57292
Line: 447 Category: 11

Diagnosis: PLEURISY
Treatment: MEDICAL THERAPY
ICD-9: 511
CPT: 90000-99999,32000
Line: 448 Category: 10

Diagnosis: HYPOSPADIAS AND EPISPADIAS
Treatment: REPAIR
ICD-9: 752.6
CPT: 54300-440
Line: 449 Category: 11

Diagnosis: FRACTURE OF VERTEBRAL COLUMN WITH SPINAL CORD INJURY, SACRUM AND COCCYX
Treatment: LAMINECTOMY
ICD-9: 806.6-806.9
CPT: 61720-61793
Line: 450 Category: 10

Diagnosis: LOWER EXTREMITY: COMPARTMENT SYNDROME
Treatment: DECOMPRESSION
ICD-9: 958.8
CPT: 27600-02
Line: 451 Category: 3

Diagnosis: OCCLUSION AND STENOSIS OF PRECEREBRAL ARTERIES
Treatment: THROMBOENDARTERECTOMY
ICD-9: 433
CPT: 35301
Line: 452 Category: 11

Diagnosis: ATHEROSCLEROSIS, PERIPHERAL
Treatment: SURGICAL TREATMENT
ICD-9: 440.2-.9,444.2
CPT: 35516-21,35533,35556-58,35565-87,35621,35650-61,35665-71,37609,64510-20,64802-18
Line: 453 Category: 11

Diagnosis: DISPLACEMENT OF CERVICAL INTERVERTEBRAL DISC WITHOUT MYELOPATHY
Treatment: CERVICAL LAMENINECTOMY, MEDICAL THERAPY
ICD-9: 722.0,722.2
CPT: 63250,63265,63270,63275,63280,63285,63001,63015,63020,63035-40,63045,63048,63075-76,63081-82,63300,63304,63170-72,63180-82,63194,63196,63198,90000-99999
Line: 454 Category: 11

Diagnosis: FRACTURE OF JOINT, CLOSED (EXCEPT HIP)
Treatment: REDUCTION
ICD-9: 810.0,811.0,812.0,.4,813.0,813.4,814.0,815.0,816.0,817.0,819.0,821.20-.21,821.23-.29,,822.0,823.0,824.0,.2,.4,.6,.8,825.0,.2,826.0,828.0
CPT: 23500-23515,23570-23630,24530-88,24650-52,25600-50,26600-15,26720-85,27508-14,27520-40,27760-62,27780-92,27808-23,28400-530
Line: 455 Category: 12

Diagnosis: CALCULUS OF BLADDER OR KIDNEY
Treatment: OPEN RESECTION, PERC. NEPHROSTOL., NEPHROLITHOTOMY, LITHOTRIPSY
ICD-9: 592.0,594.1
CPT: 50060-81,50700-16,50590
Line: 456 Category: 11

[Diagnosis: FUNCTIONAL ENCOPRESIS
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 307.70
CPT: 90220,90800-90899
Line: 457 Category: 14]

Diagnosis: ANAL FISTULA
Treatment: FISTULECTOMY
ICD-9: 565.1
CPT: 46270-85,46000-30
Line: 458 Category: 10

Diagnosis: RESIDUAL FOREIGN BODY IN SOFT TISSUE
Treatment: REMOVAL
ICD-9: 729.6
CPT: 28190,28192
Line: 459 Category: 10

Diagnosis: GLYCOGENOSIS
Treatment: MEDICAL THERAPY
ICD-9: 271.0
CPT: 90000-99999
Line: 460 Category: 5

Diagnosis: MALUNION & NONUNION OF FRACTURE
Treatment: SURGICAL TX
ICD-9: 733.8
CPT: 24410,24430-35,23840-85,25400-25440,27165-27170,27470-27472,27720-25,28320-22,24400
Line: 461 Category: 11

Diagnosis: OSTEOPOROSIS
Treatment: MEDICAL THERAPY
ICD-9: 733.0
CPT: 90000-99999
Line: 462 Category: 13

Diagnosis: OPHTHALMIC INJURY: LACRIMAL SYSTEM LACERATION
Treatment: CLOSURE
ICD-9: 870.2
CPT: 68760
Line: 463 Category: 17

Diagnosis: DISORDERS OF REFRACTION AND ACCOMMODATION
Treatment: MEDICAL THERAPY
ICD-9: 367
CPT: 90000-99999
Line: 464 Category: 13

Diagnosis: VINCENT'S DISEASE
Treatment: MEDICAL THERAPY
ICD-9: 101
CPT: 90000-99999
Line: 465 Category: 1

Diagnosis: URETHERITIS
Treatment: MEDICAL THERAPY
ICD-9: 597
CPT: 90000-99999
Line: 466 Category: 10

Diagnosis: TRICHOMONAL URETHRITIS, TRICHOMONAL PROSTATITIS
Treatment: MEDICAL THERAPY
ICD-9: 131.02,131.03,131.8,131.9
CPT: 90000-99999
Line: 467 Category: 10

Diagnosis: UTERINE LEIOMYOMA
Treatment: TOTAL HYSTERECTOMY OR MYOMECTOMY
ICD-9: 218-219
CPT: 58140-50
Line: 468 Category: 11

Diagnosis: REDUCTION DEFORMITY OF LOWER LIMB
Treatment: EPIPHYSEAL,OSTEOPLASTY
ICD-9: 755.3
CPT: 27475-27485,27466-27468,27730-27742,27715
Line: 469 Category: 11

Diagnosis: MIGRAINE
Treatment: MEDICAL THERAPY
ICD-9: 346
CPT: 90000-99999
Line: 470 Category: 13

Diagnosis: ANAL FISSURE
Treatment: FISSURECTOMY
ICD-9: 565.0
CPT: 46200
Line: 471 Category: 10

Diagnosis: STRESS INCONTINENCE, FEMALE
Treatment: URETHROPEXY/PESSARY
ICD-9: 625.6
CPT: 51840-41,57160
Line: 472 Category: 11

[Diagnosis: SEXUAL DYSFUNCTION
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 302.70-.76,302.79
CPT: 90220,90800-90899
Line: 473 Category: 14]

Diagnosis: BODY INFESTATIONS (EG. LICE, SCABIES)
Treatment: MEDICAL THERAPY
ICD-9: 132-134
CPT: 90000-99999
Line: 474 Category: 14

Diagnosis: SIALOLITHIASIS, MUCOCELE, DISTURBANCE OF SALIVARY SECRETION, OTHER AND UNSPECIFIED DISEASES OF SALIVARY GLANDS
Treatment: SURGERY
ICD-9: 527.5-527.9
CPT: 42305,42325,42330,42340,42408,42410,42440-42507,42509,42600,42665,40810-40816,42650,42655
Line: 475 Category: 11

Diagnosis: ANOMALIES OF EXTERNAL EAR W/ IMPAIRMENT OF HEARING
Treatment: RECONSTRUCT OF EAR CANAL
ICD-9: 744.0
CPT: 69320
Line: 476 Category: 11

Diagnosis: CERVICITIS, ENDOCERVICITIS, HEMATOMA OF VULVA, OVARIAN CYSTS AND NONINFLAMMATORY DISORDERS OF THE VAGINA
Treatment: MEDICAL THERAPY
ICD-9: 616.0,620.0-.2,620.9,622.3-.4,622.6-.7,623.6,623.8-.9,624.5,626.7
CPT: 90000-99999
Line: 477 Category: 10

Diagnosis: BENIGN NEOPLASM OF KIDNEY
Treatment: MEDICAL THERAPY
ICD-9: 223.1
CPT: 90000-99999
Line: 478 Category: 11

Diagnosis: NONINFLAMMATORY DISORDERS OF CERVIX
Treatment: MEDICAL THERAPY
ICD-9: 622.4-.9,624.2,624.5-.9
CPT: 90000-99999
Line: 479 Category: 11

[Diagnosis: STEREOTYPY/HABIT DISORDER
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 307.30
CPT: 90220,90800-90899
Line: 480 Category: 13]

Diagnosis: CEREBRAL PALSY
Treatment: REPAIR/RECONSTRUCTION
ICD-9: 343.0-.3,343.9,344.1,741.9,335.21,335.11,335.0
CPT: 27097-122,27140-85,27315,27320,27390-400,27605-06,27685-92,28010-11,28030,28130,28220-36,28240,28705-60,27306-07,28300-13
Line: 481 Category: 11

* THIS LIST IS SUBJECT TO REVISION UNTIL SUBMITTED TO THE LEGISLATURE

Diagnosis: HYPOPLASTIC LEFT HEART SYNDROME
Treatment: NORWOOD PROCEDURE
ICD-9: 746.7
CPT: 33480-33485
Line: 482 Category: 2

Diagnosis: OTHER SPECIFIED ANOMALIES OF HEART
Treatment: APICAL-AORTIC CONDUIT
ICD-9: 746.8
CPT: 33404
Line: 483 Category: 5

Diagnosis: UTERINE PROLAPSE
Treatment: SURGICAL REPAIR
ICD-9: 618
CPT: 57160,58150,58260-85
Line: 484 Category: 11

Diagnosis: SHIGELLOSIS, GIARDIASIS, INTESTINAL HELMINTHIASIS
Treatment: MEDICAL THERAPY
ICD-9: 004,007.1,120-122,123.0,125-129
CPT: 90000-99999
Line: 485 Category: 10

Diagnosis: CORNEAL ULCER
Treatment: MEDICAL THERAPY
ICD-9: 370.0
CPT: 90000-99999,65286
Line: 486 Category: 10

Diagnosis: CARPAL TUNNEL SYNDROME, GANGLION
Treatment: SURGICAL TREATMENT
ICD-9: 354.0,354.2,728.6
CPT: 26035-60,26120-80,26440-597,26820-63,27095-7,27100-22,27140-85,27306-7,27448-55,27466-8,27475-85,27715,27730-42,64702-4,64718-27,64774-83,64788-95,64850-7,64872-999
Line: 487 Category: 11

Diagnosis: DEFORMITIES OF UPPER BODY & LIMBS
Treatment: REPAIR/REVISION/RECONSTRUCTION/RELOCATION/FASCIECTOMY
ICD-9: 354.0,354.2,718.25,718.35,732.1-.3,736.06,736.21-.22,736.3-.5,736.8
CPT: 26035-60,26120-80,26440-597,26820-63,27095-7,27100-22,27140-85,27306-7,27448-55,27466-8,27475-85,27715,27730-42,64702-4,64718-27,64774-83,64788-95,64850-7,64872-999
Line: 488 Category: 11

Diagnosis: CONDUCT DISORDER, SEVERE
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 312.00,312.20,312.90
CPT: 90220,90800-90899
Line: 489 Category: 5

Diagnosis: MENSTRUAL BLEEDING DISORDERS
Treatment: MEDICAL THERAPY
ICD-9: 626.2-.6,626.8,627.0
CPT: 90000-99999
Line: 490 Category: 10

Diagnosis: RUPTURE OF SYNOVIUM
Treatment: REMOVAL OF BAKER'S CYST
ICD-9: 727.51
CPT: 27435
Line: 491 Category: 11

Diagnosis: DEFORMITIES OF FOOT
Treatment: FASCIOTOMY/INC/REPAIR/ART
ICD-9: 727.1,736.73,700,736.74,736.71,754.71,754.69,755.67,735.0-.2,735.4-.9,732.5,355.6,355.5
CPT: 28008,28010,28035,28050-28092,28110-28119,28126-28160,28220-28238,28240-28360,28705-28760,29425
Line: 492 Category: 11

Diagnosis: FOREIGN BODY IN UTERUS, VULVA AND VAGINA
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 939.1-.2
CPT: 57410,58120,90000-99999
Line: 493 Category: 10

Diagnosis: VAGINITIS
Treatment: MEDICAL THERAPY
ICD-9: 112.1,131.00-.01,131.09,623.5,625.1
CPT: 57150,90000-99999
Line: 494 Category: 10

Diagnosis: PRIAPISM, ORCHITIS, EPIDIDYMITIS, SEMINAL VESICULITIS, FOREIGN BODY IN PENIS, URETHERAL STRICTURE
Treatment: MEDICAL THERAPY, REMOVAL OF FOREIGN BODY, DILATION
ICD-9: 595.0,598,604,607.3,608.0,939.9
CPT: 54115,54154,54700-861,90000-99999
Line: 495 Category: 10

Diagnosis: BENIGN NEOPLASM OF EXTERNAL FEMALE GENITAL ORGANS
Treatment: BIOPSY/EXCISION
ICD-9: 221.1-221.9
CPT: 56440,56501,56600,57105,57135
Line: 496 Category: 11

Diagnosis: BALANOPOSTHITIS AND OTHER DISORDERS OF PENIS
Treatment: MEDICAL THERAPY
ICD-9: 607.1,607.8
CPT: 90000-99999
Line: 497 Category: 10

Diagnosis: NONINFLAMMATORY DISORDERS AND BENIGN NEOPLASMS OF OVARY AND FALLOPIAN TUBES
Treatment: SALPINGECTOMY, OOPHORECTOMY
ICD-9: 620.4,620.8,220,221.0
CPT: 58700-58720,58940
Line: 498 Category: 11

Diagnosis: FOREIGN BODY IN CONJUNCTIVAL SAC
Treatment: REMOVAL CONJ FOREIGN BODY
ICD-9: 930.1
CPT: 65205
Line: 499 Category: 10

Diagnosis: BONE SPUR
Treatment: OSTECTOMY
ICD-9: 726.91
CPT: 28119,28899
Line: 500 Category: 11

Diagnosis: BELL'S PALSY, EXPOSURE KERATOCONJUNCTIVITIS
Treatment: TARSORRHAPHY
ICD-9: 351.0,370.34
CPT: 67880
Line: 501 Category: 10

[Diagnosis: OPPOSITIONAL DEFIANT DISORDER
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 313.81
CPT: 90220,90800-90899
Line: 502 Category: 10]

Diagnosis: CHRONIC SINUSITIS, NASAL POLYP, BENIGN NEOPLASM OF NASAL CAVITIES, MIDDLE EAR & ACCESSORY SINUSES
Treatment: NASAL ANTRAL WINDOWS, RECONSTRUCTION
ICD-9: 473.9,471.9,212.0
CPT: 31032,31201,31020,30425,30520
Line: 503 Category: 11

Diagnosis: CYST OF THYROID
Treatment: SURGERY - EXCISION
ICD-9: 246.2
CPT: 60200,60100
Line: 504 Category: 11

Diagnosis: ORBITAL CYST
Treatment: ORBITOTOMY
ICD-9: 376.81
CPT: 67400-67450
Line: 505 Category: 11

Diagnosis: OTOSCLEROSIS
Treatment: STAPEDECTOMY
ICD-9: 387
CPT: 69650-62
Line: 506 Category: 11

Diagnosis: FOREIGN BODY: ACCIDENTLY LEFT DURING A PROCEDURE, GRANULOMA OF MUSCLE, GRANULOMA OF SKIN & SUBCUTANEOUS TISSUE
Treatment: REMOVAL OF FOREIGN BODY
ICD-9: 998.4,728.82,709.4
CPT: 22330,22331,24200,24201,25248,20520,20525,27086,27087,27372,28190,28192,28193
Line: 507 Category: 11

Diagnosis: CONVERSION DISORDER, ADULT
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 300.11
CPT: 90220,90800-90899
Line: 508 Category: 11

Diagnosis: HYPERTROPHY OF BREAST
Treatment: SUBCUTANEOUS TOTAL MASTECTOMY, BREAST REDUCTION
ICD-9: 611.1
CPT: 19140,19318
Line: 509 Category: 11

Diagnosis: OBSTRUCTION OF NASOLACRIMAL DUCT, NEONATAL
Treatment: PROBING NASOLACRIMAL DUCT
ICD-9: 375.55
CPT: 68825-68830
Line: 510 Category: 11

Diagnosis: THROMBOSED AND COMPLICATED HEMORRHOIDS
Treatment: HEMORRHOIDECTOMY, INCISION
ICD-9: 455.1-.2,455.4-.5,455.7-.8
CPT: 46083,46250-62,46320
Line: 511 Category: 11

Diagnosis: STENOSIS OF NASOLACRIMAL DUCT (ACQUIRED)
Treatment: DACRYOCYSTORHINOSTOMY
ICD-9: 375.4,375.56
CPT: 68720-68750
Line: 512 Category: 11

Diagnosis: URETHRAL FISTULA
Treatment: EXCISION, MEDICAL THERAPY
ICD-9: 599.1
CPT: 50650-50660,90000-99999
Line: 513 Category: 11

Diagnosis: ENDOMETRIOSIS
Treatment: MEDICAL AND SURGICAL TREATMENT WITHOUT HYSTERECTOMY
ICD-9: 617
CPT: 58145-50,58984,90000-99999
Line: 514 Category: 13

Diagnosis: PTOSIS (ACQUIRED) WITH VISION IMPAIRMENT
Treatment: PTOSIS REPAIR
ICD-9: 374.3
CPT: 15823,67904
Line: 515 Category: 11

Diagnosis: ENTROPION AND TRICHIASIS OF EYELID; ECTROPION; BENIGN NEOPLASM OF EYELID
Treatment: ECTROPION/ENTROPION REP.
ICD-9: 216.1,374.0-374.1
CPT: 17340,67700-67850,67880,67914-67924
Line: 516 Category: 11

Diagnosis: BENIGN NEOPLASM BONE & ARTICULAR CARTILAGE, OTHER BENIGN NEOPLASM OF CONNECTIVE AND OTHER SOFT TISSUE
Treatment: BIOPSY-EXCISION
ICD-9: 213,215,225.3-.4
CPT: 21920-21935,23065-23077,23140-23156,23100-23101,24065-24077,25120-25136,25170,26100-26117,26200-15,26250-62,27040-49,27065-7,27075-9,27323-9
Line: 517 Category: 11

Diagnosis: FOREIGN BODY IN EAR & NOSE
Treatment: REMOVAL OF FOREIGN BODY
ICD-9: 931-932
CPT: 69200-69205,30300-20
Line: 518 Category: 10

Diagnosis: PTERYGIUM
Treatment: EXCISION OR TRANSPOSITION OF PTERYGIUM W/O GRAFT
ICD-9: 372.4
CPT: 65420
Line: 519 Category: 11

Diagnosis: OPEN WOUND OF EAR DRUM
Treatment: TYMPANOPLASTY
ICD-9: 872.61
CPT: 69610-43
Line: 520 Category: 10

Diagnosis: ENOPHTHALMOS
Treatment: ORBITAL IMPLANT
ICD-9: 376.50
CPT: 67550
Line: 521 Category: 11

Diagnosis: HEARING LOSS - OVER AGE OF THREE
Treatment: MEDICAL THERAPY
ICD-9: 388-389
CPT: 90000-99999
Line: 522 Category: 11

Diagnosis: PARALYSIS OF VOCAL CORDS OR LARYNX, OTHER DISEASES OF LARYNX
Treatment: INC/EXC/ENDO/SINUS/LARYNX
ICD-9: 478.3,478.7
CPT: 31300-31579,31580-31605
Line: 523 Category: 11

Diagnosis: DENTAL CARIES (PERIAPICAL INFECTION)
Treatment: SURGERY
ICD-9: 521.0
CPT: 41899
Line: 524 Category: 11

Diagnosis: IMPACTED TEETH
Treatment: SURGERY
ICD-9: 520.6,524.3-.4
CPT: 41899
Line: 525 Category: 11

Diagnosis: RECURRENT EROSION OF THE CORNEA
Treatment: CORNEAL TATTOO, REMOVAL OF CORNEAL EPITHELIUM; WITH OR WITHOUT CHEMOCAUTERIZATION
ICD-9: 371.42
CPT: 65600,65435
Line: 526 Category: 11

Diagnosis: CHRONIC SINUSITIS, NASAL POLYPS, OTHER DISORDERS OF NASAL CAVITY AND SINUSES
Treatment: INCISION, EXCISION NASAL CAVITY, NASAL ATRAL WINDOWS
ICD-9: 471,473,478.1
CPT: 30000-31299
Line: 527 Category: 11

Diagnosis: OSTEOARTHRITIS AND ALLIED DISORDERS
Treatment: MEDICAL THERAPY
ICD-9: 715
CPT: 90000-99999
Line: 528 Category: 13

Diagnosis: DEVIATED NASAL SEPTUM, ACQUIRED DEFORMITY OF NOSE, OTHER DISEASES OF UPPER RESPIRATORY TRACT
Treatment: EXC CYST/RHINECTOMY/PROS/
ICD-9: 470,738.0,478.0,478.2-.9
CPT: 30124-30320,30410,30420
Line: 529 Category: 11

Diagnosis: ADHESIVE CAPSULITIS OF SHOULDER, ARTICULAR CARTILAGE DISORDER OF SHOULDER, PERIOSTITIS OF SHOULDER
Treatment: REPAIR/RECONSTRUCTION
ICD-9: 718.01,726.0,726.2,730.31
CPT: 29815-29825,23410-23420,23440-23466,23107-23125,23190,23000,23020
Line: 530 Category: 11

Diagnosis: MENOPAUSAL MANAGEMENT
Treatment: MEDICAL THERAPY
ICD-9: 627.2-.9
CPT: 90000-99999
Line: 531 Category: 9

Diagnosis: EQUINUS DEFORMITY OF FOOT, ACQUIRED
Treatment: ARTHROTOMY
ICD-9: 736.72
CPT: 27612
Line: 532 Category: 11

Diagnosis: CYSTS OF ORAL SOFT TISSUES
Treatment: MEDICAL THERAPY
ICD-9: 528.4
CPT: 90000-99999
Line: 533 Category: 11

Diagnosis: STOMATITIS, CELLULITIS AND ABSCESS OF ORAL SOFT TISSUE, AND DISEASES OF LIPS
Treatment: MEDICAL THERAPY
ICD-9: 528.0,528.3,528.5
CPT: 90000-99999
Line: 534 Category: 10

Diagnosis: OTHER SPECIFIED CONDITIONS OF THE TONGUE
Treatment: EXCISION, BIOPSY
ICD-9: 529.8
CPT: 41100,41105,41110,41112-41114,41599
Line: 535 Category: 11

Diagnosis: SPECIFIC DISORDERS OF THE TEETH AND SUPPORTING STRUCTURES
Treatment: EXCISION DENTO. STRUCTURE
ICD-9: 525.8
CPT: 41822,41823,41830,41874,41825-41827,41828,42299,41899,40899,17999
Line: 536 Category: 11

Diagnosis: PARAPLEGIA
Treatment: SURGICAL PREVENTION OF CONTRACTURES
ICD-9: 344.1
CPT: 27003
Line: 537 Category: 11

Diagnosis: PERIPHERAL ENTHESOPATHIES
Treatment: SURGICAL TREATMENT
ICD-9: 726.30-.32,726.4-.6,726.70,726.8,726.90
CPT: 29105,29125-29131,24105,27060-27062,29240,29260,29270,29280,29345,29355,29365,29405-50,20550,20600-10,29345,29355,29365
Line: 538 Category: 11

Diagnosis: CHRONIC DISEASE OF TONSILS AND ADENOIDS
Treatment: TONSILLECTOMY AND ADENOIDECTOMY
ICD-9: 474
CPT: 42820-36
Line: 539 Category: 11

Diagnosis: GANGLION OF TENDON OR JOINT
Treatment: EXCISION
ICD-9: 727.4
CPT: 28090
Line: 540 Category: 11

* THIS LIST IS SUBJECT TO REVISION UNTIL SUBMITTED TO THE LEGISLATURE

Diagnosis: KERTOCONJUNCTIVITIS SICCA, NOT SPECIFIED AS SJOGREN'S
Treatment: PUNCTAL OCCLUSION,TARSORRHAPHY
ICD-9: 370.33
CPT: 68760,67880
Line: 541 Category: 11

Diagnosis: PARAPLEGIA
Treatment: ARTHRODESIS
ICD-9: 344.1
CPT: 27870
Line: 542 Category: 11

Diagnosis: OVARIAN CYST
Treatment: OOPHERECTOMY
ICD-9: 256.1,256.4
CPT: 58940
Line: 543 Category: 12

Diagnosis: HISTIOCYTOSIS
Treatment: MEDICAL THERAPY
ICD-9: 277.8
CPT: 90000-99999
Line: 544 Category: 5

Diagnosis: CANCER OF ESOPHAGUS, TREATABLE
Treatment: MEDICAL AND SURGICAL THERAPY
ICD-9: 150,195.2,230.1
CPT: 47600-20,47710,43100-43120,43340-41,44140-47,45111,45550,90000-99999
Line: 545 Category: 5

Diagnosis: OCCUPATIONAL LUNG DISEASES
Treatment: MEDICAL THERAPY
ICD-9: 500-505
CPT: 90000-99999
Line: 546 Category: 5

Diagnosis: LESION OF PLANTAR NERVE
Treatment: MEDICAL THERAPY, EXCISION
ICD-9: 355.6
CPT: 28080,90000-99999
Line: 547 Category: 11

Diagnosis: NONTOXIC NODULAR GOITER
Treatment: THYROIDECTOMY
ICD-9: 241
CPT: 60245,60220
Line: 548 Category: 11

Diagnosis: HERNIA WITHOUT OBSTRUCTION OR GANGRENE
Treatment: REPAIR
ICD-9: 550.9,553
CPT: 39502-41,43330-31,43885,44050,44346,49500-611,51500,55540
Line: 549 Category: 11

Diagnosis: BENIGN NEOPLASM OF RESPIRATORY AND INTRATHORACIC ORGANS
Treatment: LOBECTOMY, MEDICAL THERAPY
ICD-9: 212
CPT: 90000-99999,60220-60225
Line: 550 Category: 11

Diagnosis: MUSCULAR DYSTROPHY
Treatment: MEDICAL THERAPY
ICD-9: 359
CPT: 90000-99999
Line: 551 Category: 5

Diagnosis: TRANSIENT CEREBRAL ISCHEMIA
Treatment: MEDICAL THERAPY
ICD-9: 435
CPT: 90000-99999
Line: 552 Category: 10

Diagnosis: PERITONEAL ADHESION
Treatment: SURGICAL TREATMENT
ICD-9: 568
CPT: 44005
Line: 553 Category: 1

Diagnosis: ALCOHOLIC FATTY LIVER OR ALCOHOLIC HEPATITIS
Treatment: MEDICAL THERAPY
ICD-9: 571.0-.1
CPT: 90000-99999
Line: 554 Category: 5

Diagnosis: SPINA BIFIDA WITH HYDROCEPHALUS
Treatment: MEDICAL THERAPY
ICD-9: 741.0
CPT: 90000-999999,63706
Line: 555 Category: 5

Diagnosis: OTHER DEFICIENCIES OF CIRCULATING ENZYMES (ALPHA 1-ANTITRYPSIN DEFICIENCY)
Treatment: MEDICAL THERAPY
ICD-9: 277.6
CPT: 90000-99999
Line: 556 Category: 5

Diagnosis: DIABETES MELLITUS WITH END STAGE RENAL DISEASE
Treatment: PANCREAS/KIDNEY TRANSPLNT
ICD-9: 250.4
CPT: 50389
Line: 557 Category: 5

Diagnosis: CANCER OF GALLBLADDER AND OTHER BILIARY, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 156,197.8,230.8
CPT: 47600-20,47710,90000-99999
Line: 558 Category: 5

Diagnosis: ACUTE POLIOMYELITIS
Treatment: MEDICAL THERAPY
ICD-9: 045
CPT: 90000-99999
Line: 559 Category: 3

Diagnosis: PITUITARY DWARFISM
Treatment: MEDICAL THERAPY
ICD-9: 253.3
CPT: 90000-99999
Line: 560 Category: 13

Diagnosis: UNSPECIFIED POLYNEUROPATHY
Treatment: MEDICAL THERAPY
ICD-9: 357.9
CPT: 90000-99999
Line: 561 Category: 3

Diagnosis: HEREDITARY HEMORRHAGIC TELANGEICTASIA
Treatment: EXCISION
ICD-9: 448.0
CPT: 11400-11426
Line: 562 Category: 5

Diagnosis: DISEASES OF THYMUS GLAND
Treatment: MEDICAL THERAPY
ICD-9: 254
CPT: 90000-99999
Line: 563 Category: 5

Diagnosis: CEREBRAL DEGENERATIONS USUALLY MANIFEST IN CHILDHOOD
Treatment: MEDICAL THERAPY
ICD-9: 330
CPT: 90000-99999
Line: 564 Category: 5

Diagnosis: CHRONIC RHEUMATIC PERICARDITIS, RHEUMATIC MYOCARDITIS
Treatment: MEDICAL THERAPY
ICD-9: 393,398.0
CPT: 90000-99999
Line: 565 Category: 5

Diagnosis: CANCER OF LIVER, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 155,197.7,235.3
CPT: 43630-38,48150,44131,47120-30,47600-20,47710,90000-99999
Line: 566 Category: 5

Diagnosis: ACUTE NON-LYMPHOCYTIC LEUKEMIAS
Treatment: CHEMOTHERAPY
ICD-9: 205.0,206.0,207.0,208.0
CPT: 90000-99999
Line: 567 Category: 5

Diagnosis: MULTIPLE MYELOMA AND CHRONIC LEUKEMIAS
Treatment: BONE MARROW TRANSPLANT (5-6 LOCI MATCH)
ICD-9: 202.4,203,205.1-.9,206.1-.9,207.1-.8,208.1-.9
CPT: 38230-41
Line: 568 Category: 5

Diagnosis: MALIGNANT NEOPLASM OF OTHER ENDOCRINE GLANDS AND RELATED STRUCTURES, TREATABLE
Treatment: BONE MARROW RESCUE AND TRANSPLANT
ICD-9: 194
CPT: 38240,38230
Line: 569 Category: 5

Diagnosis: ANOMALIES OF GALLBLADDER, BILE DUCTS, AND LIVER
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 751.6
CPT: 90000-99999,47400-47999
Line: 570 Category: 5

Diagnosis: CANCER OF PANCREAS, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 157,230.9
CPT: 31370-82,42410-26,90000-99999
Line: 571 Category: 5

Diagnosis: PERSONALITY DISORDERS EXCLUDING BORDERLINE, SCHIZOTYPAL AND ANTI-SOCIAL
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 301.00,301.20,301.40,301.50,301.60,307.81-.82,301.84,301.90
CPT: 90220,90800-90899
Line: 572 Category: 5

Diagnosis: PARASITIC INFESTATION OF EYELID
Treatment: MEDICAL THERAPY
ICD-9: 373.6
CPT: 90000-99999
Line: 573 Category: 10

Diagnosis: ATELECTASIS (COLLAPSE OF LUNG)
Treatment: MEDICAL THERAPY
ICD-9: 518.0-.1
CPT: 90000-99999,31645
Line: 574 Category: 10

Diagnosis: HEMORRHAGE AND INFARCTION OF THYROID
Treatment: MEDICAL THERAPY
ICD-9: 246.3
CPT: 90000-99999
Line: 575 Category: 10

Diagnosis: RETINAL TEAR
Treatment: LASER PROPHYLAXIS
ICD-9: 361.30
CPT: 67141-67145
Line: 576 Category: 10

Diagnosis: SPONTANEOUS AND MISSED ABORTION
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 631-632,634.2-.9
CPT: 59820-21,90000-99999
Line: 577 Category: 10

Diagnosis: INFLAMMATION OF LACRIMAL PASSAGES
Treatment: MEDICAL THERAPY
ICD-9: 375.0,375.
CPT: 90000-99999
Line: 578 Category: 10

Diagnosis: MINOR BURNS
Treatment: MEDICAL THERAPY
ICD-9: 941.0-.1,942.0-.1,943.0-.1,944.0-.1,945.0-.1,946.0-.1,948.00,.10,.20,.30,.40,.50,.60,.70,.80,.90,949.0-.1
CPT: 16000-16035,90000-99999
Line: 579 Category: 10

Diagnosis: ALLERGIC RHINITIS AND CONJUNCTIVITIS
Treatment: MEDICAL THERAPY
ICD-9: 477,471,472,372.00-.14
CPT: 90000-99999
Line: 580 Category: 13

Diagnosis: ATOPIC DERMATITIS
Treatment: MEDICAL THERAPY
ICD-9: 691.8
CPT: 90000-99999,11100
Line: 581 Category: 13

Diagnosis: CORNEAL ULCER
Treatment: CONJUNCTIVAL FLAP
ICD-9: 370.0
CPT: 68360
Line: 582 Category: 10

Diagnosis: HYPERESTROGENISM
Treatment: HYSTERECTOMY, MEDICAL THERAPY
ICD-9: 256.0
CPT: 58120,58150,90000-99999
Line: 583 Category: 10

Diagnosis: PELVIC PAIN SYNDROME
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 614.1-.2,614.4,614.6-.9,615.1-.9,625.0-.2,625.4-.5,625.8-.9
CPT: 11043,58150,58805,58925,58980,90000-99999
Line: 584 Category: 13

Diagnosis: RETAINED DENTAL ROOT
Treatment: EXCISION DENTO. STRUCTURE
ICD-9: 525.3
CPT: 41822,41823,41830,41874,41825-41827,41828,42299,41899,40899,17999
Line: 585 Category: 10

Diagnosis: KERATITIS: CORNEAL ULCER, SUPERFICIAL W/O CONJUNCTIVITIS, OTHER AND UNSPEC. KERATOCONJUNCTIVITIS, INTERSTITIAL & DEEP, CORNEAL NEOVASCULARIZATION
Treatment: KERATOPLASTY
ICD-9: 370.0,371.0-371.1,371.23,371.4-371.6
CPT: 65730,65920,66985
Line: 586 Category: 10

Diagnosis: FRACTURE OF FACIAL BONES, CLOSED
Treatment: SURGERY
ICD-9: 802.0,802.2,802.4,802.6,802.8
CPT: 41421-22,21470
Line: 587 Category: 10

Diagnosis: TRANSIENT NEPHROTIC SYNDROME WITH LESION OF MINIMAL CHANGE GLOMERULONEPHRITIS
Treatment: MEDICAL THERAPY
ICD-9: 581.3
CPT: 90000-99999
Line: 588 Category: 10

Diagnosis: TONGUE TIE AND OTHER ANOMALIES OF TONGUE
Treatment: FRENOTOMY, TONGUE TIE
ICD-9: 750.0-.1
CPT: 40819,41115
Line: 589 Category: 11

Diagnosis: BRANCHIAL CLEFT CYST
Treatment: EXCISION
ICD-9: 744.42
CPT: 42810,42815
Line: 590 Category: 11

Diagnosis: ATROPHY OF EDENTULOUS ALVEOLAR RIDGE
Treatment: VESTIBULOPLASTY, GRAFTS, IMPLANTS
ICD-9: 525.2
CPT: 40840,40842,40845,15999,20902,15350,15510,21210,21215,21244-50
Line: 591 Category: 11

Diagnosis: SPINE DEFORMITIES
Treatment: ARTHRODESIS/REPAIR/RECONSTRUCTION
ICD-9: 754.2,268.1,756.14,737.0,756.19,737.11-.12,356.1,731.0,252.0,737.30-.31,737.33-.39,724.3
CPT: 22800-22812,22820,22840-22899,22210-22230,22590-22650,22554-22585,29010-29035
Line: 592 Category: 11

Diagnosis: BENIGN NEOPLASM OF MALE GENITAL ORGANS: TESTIS, PROSTATE, EPIDIDYMIS
Treatment: MEDICAL THERAPY
ICD-9: 222.0,222.2,222.3,222.8, 222.9
CPT: 90000-99999
Line: 593 Category: 11

Diagnosis: DISORDERS OF BLADDER
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 596.0-.5,596.7-.9
CPT: 90000-99999,51800-45,51880-980
Line: 594 Category: 11

Diagnosis: HYPERTELORISM OF ORBIT
Treatment: ORBITOTOMY
ICD-9: 376.41
CPT: 67400
Line: 595 Category: 11

Diagnosis: DENTAL SERVICES (EG. TOOTH LOSS)
Treatment: RESTORATIVE DENTAL SERVICE
ICD-9: 0
CPT: 01510-25,04240-60,04345,05110-40,05213-4,05860,05911-21,05954-5,05949,07270,07310-20,07560,07610-80,07710-80,07950,09630
Line: 596 Category: 12

Diagnosis: DENTAL SERVICES (EG. MALPOSITIONED TOOTH)
Treatment: RESTORATIVE DENTAL SERVICE
ICD-9: 0
CPT: 02960,05211-2,05520,05610,05630-60,05710-21,05750-61,06212,06242,06792,06972-80,07271,07280-1,07290,07340-50,07470-80,07810-50,07860-80,07920,07960-80,079823,079914
Line: 597 Category: 11

Diagnosis: DENTAL SERVICES (EG. INSUFFICIENT ROOM TO RESTORE TOOTH)
Treatment: RESTORATIVE DENTAL SERVICE
ICD-9: 0
CPT: 03950,04210-1,04320-1,05620,05730-41,05810-05850,06211,06241,06520-40,06752,06780,06970
Line: 598 Category: 11

Diagnosis: UNSPECIFIED DISEASE OF HARD TISSUES OF TEETH (AVULSION)
Treatment: INTERDENTAL WIRING
ICD-9: 525.9
CPT: 21497
Line: 599 Category: 12

Diagnosis: RETAINED INTRAOCULAR FOREIGN BODY, MAGNETIC & NONMAGNETIC
Treatment: FOREIGN BODY REMOVAL
ICD-9: 360.5-360.6
CPT: 65230,65260-65265
Line: 600 Category: 12

Diagnosis: INTERNAL DERANGEMENT OF KNEE
Treatment: ARTHROSCOPIC REPAIR
ICD-9: 717.1-.3,717.40,717.42-.49
CPT: 29870-89,27403-29
Line: 601 Category: 12

Diagnosis: CLOSED FRACTURE OF EPIPHYSIS OF UPPER EXTREMITIES
Treatment: REDUCTION
ICD-9: 812.09,812.44,813.43
CPT: 25600-20
Line: 602 Category: 12

Diagnosis: CONGENITAL DISLOCATION OF HIP; COXA VARA & VALGA, CONGENITAL
Treatment: REPAIR/RECONSTRUCTION
ICD-9: 754.3,755.62,755.61
CPT: 27179,27181,27185
Line: 603 Category: 12

Diagnosis: MECHANICAL AND OTHER COMPLICATION OF INTERNAL ORTHOPEDIC AND PROSTHETIC DEVICE, IMPLANT AND GRAFT; IMPLANT OR GRAFT; INFECTION & INFLAMMATORY REACTION DUE TO INTERNAL PROSTHETIC DEVICE
Treatment: TREATMENT, ARTHROPLASTY
ICD-9: 996.4,996.77,996.66
CPT: 27485-27488,27265,27266,27134,27137,27138
Line: 604 Category: 12

Diagnosis: DISORDERS OF SHOULDER
Treatment: REPAIR/RECONSTRUCTION
ICD-9: 727.61,726.10,840.4
CPT: 29815-29825,23410-23420,23440-23466,23107-23125,23190,23000,23020
Line: 605 Category: 12

Diagnosis: CONGENITAL DISLOCATION OF KNEE, GENU VARUM (ACQ'D), CONGENITAL BOWING OF FEMUR, TIBIA & FIBULA; GENU VALGUM (ACQ'D), GENU RECURVATUM (ACQ'D), CONG. GENU RECURV LONG BONES OF LEGS, CONGENITAL DEFORMITIES OF KNEE
Treatment: OSTEOTOMY
ICD-9: 736.42,754.40-.43,755.64
CPT: 27455,27448-27450
Line: 606 Category: 12

Diagnosis: CONGENITAL DEFORMITIES OF KNEE
Treatment: ARTHROSCOPIC REPAIR
ICD-9: 755.64
CPT: 29870-89,27403-29
Line: 607 Category: 13

Diagnosis: UNSPECIFIED RETINAL VASCULAR OCCLUSION; CENTRAL RETINAL VEIN OCCLUSION, VENOUS TRIBUTARY (BRANCH) OCCLUSION
Treatment: LASER SURGERY
ICD-9: 362.30,362.35,362.36
CPT: 67228
Line: 608 Category: 12

Diagnosis: EXFOLIATION OF TEETH DUE TO SYSTEMIC CAUSES
Treatment: EXCISION DENTO. STRUCTURE
ICD-9: 525.0
CPT: 41822,41823,41830,41874,41825-41827,41828,42299,41899,40899,17999
Line: 609 Category: 12

Diagnosis: INJURY TO PERIPHERAL NERVE(S) OF SHOULDER GIRDLE AND UPPER LIMB
Treatment: SURGICAL REPAIR OF DISTAL NERVE(S)
ICD-9: 955
CPT: 64830,64787,64732-72,64716-21,64830-76,64702,64722,64726
Line: 610 Category: 12

Diagnosis: RUBEOSIS IRIDIS
Treatment: LASER SURGERY
ICD-9: 364.42
CPT: 67228,66720-66721
Line: 611 Category: 12

Diagnosis: TRAUMATIC AMPUTATION OF TOE (COMPLETE)(PARTIAL) W/ & W/O COMPLICATION
Treatment: REIMPLANT/AMPUTATE
ICD-9: 895
CPT: 20838-40,28810-25
Line: 612 Category: 12

Diagnosis: PERIPHERAL NERVE INJURY
Treatment: NEUROPLASTY
ICD-9: 953.4-.9,957.9,955.1-.6,955.9,956,353.0-.4,354.1,354.9,355.0,350.2,355.6,355.8
CPT: 64702-64727,64413-64450,64774-64792
Line: 613 Category: 12

Diagnosis: DISORDERS OF SWEAT GLANDS
Treatment: MEDICAL THERAPY
ICD-9: 705.0,705.81,705.89,705.9,780.8
CPT: 90000-99999
Line: 614 Category: 13

Diagnosis: CHONDROMALACIA
Treatment: MEDICAL THERAPY
ICD-9: 733.92
CPT: 90000-99999
Line: 615 Category: 13

Diagnosis: EPIPHYSEAL ARREST
Treatment: MEDICAL THERAPY
ICD-9: 733.91
CPT: 90000-99999
Line: 616 Category: 13

Diagnosis: DIAPHYSITIS
Treatment: MEDICAL THERAPY
ICD-9: 733.99
CPT: 90000-99999
Line: 617 Category: 13

Diagnosis: FRACTURES OF RIBS AND STERNUM, CLOSED
Treatment: MEDICAL THERAPY
ICD-9: 807.0,807.2
CPT: 90000-99999
Line: 618 Category: 10

Diagnosis: FRACTURE OF ONE OR MORE PHALANGES OF FOOT
Treatment: SET
ICD-9: 826
CPT: 29425,28470,28480,28505,28550
Line: 619 Category: 10

Diagnosis: FACTITIOUS DISORDER WITH PHYSICAL SYMPTOMS, NOS
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 300.19,301.51
CPT: 90220,90800-90899
Line: 620 Category: 5

Diagnosis: FACTITIOUS DISORDER WITH PSYCHOLOGICAL SYMPTOMS
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 300.16
CPT: 90220,90800-90899
Line: 621 Category: 5

Diagnosis: GENDER IDENTIFICATION DISORDER
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 302.60,302.85
CPT: 90220,90800-90899
Line: 622 Category: 11

Diagnosis: AGORAPHOBIA WITHOUT HISTORY OF PANIC DISORDER
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 300.22
CPT: 90220,90800-90899
Line: 623 Category: 12

Diagnosis: BRACHIAL PLEXUS LESIONS
Treatment: MEDICAL THERAPY
ICD-9: 353.0
CPT: 90000-99999
Line: 624 Category: 13

Diagnosis: CHRONIC SINUSITIS
Treatment: MEDICAL THERAPY
ICD-9: 473
CPT: 90000-99999
Line: 625 Category: 13

Diagnosis: LUMBAGO; THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS, UNSPECIFIED; POST-LAMINECTOMY SYNDROME
Treatment: MEDICAL THERAPY
ICD-9: 724.2,724.4,722.8
CPT: 90000-99999
Line: 626 Category: 13

Diagnosis: DYSMENORRHEA
Treatment: MEDICAL THERAPY
ICD-9: 625.3
CPT: 90000-99999
Line: 627 Category: 13

Diagnosis: TIBIAL BURSITIS, OSTEOCHONDROPATHIES AND CONGENITAL DEFORMITIES OF KNEE
Treatment: MEDICAL THERAPY
ICD-9: 726.62,726.69,732.4,732.7,755.64
CPT: 90000-99999
Line: 628 Category: 13

Diagnosis: EPICONDYLITIS AND RADIAL STYLOID TENOSYNOVITIS
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 726.31-.32,727.04
CPT: 26035-60,26120-80,26440-597,26820-63,27095-7,27100-22,27140-85,27306-7,27448-55,27466-8,27475-85,27715,27730-42,64702-4,64718-27,64774-95,64850-7,64872-999,90000-99999
Line: 629 Category: 13

Diagnosis: POLYMYALGIA RHEUMATICA
Treatment: MEDICAL THERAPY
ICD-9: 725
CPT: 90000-99999
Line: 630 Category: 13

Diagnosis: CHRONIC DELUSIONAL MOOD ANXIETY, PERSONALITY, PERCEPTION AND ORGANIC MENTAL DISORDER CAUSED BY DRUGS
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 292.11-.12,292.82-.84,292.89-.90,293.81-.83,310.10
CPT: 90220,90800-90899
Line: 631 Category: 13

Diagnosis: HYPOCHONDRIASIS; SOMATOFORM DISORDER; NOS AND UNDIFFERENTIATED
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 300.70
CPT: 90220,90800-90899
Line: 632 Category: 13

Diagnosis: SOMATIZATION DISORDER; SOMATOFORM PAIN DISORDER
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 307.80-.81
CPT: 90220,90800-90899
Line: 633 Category: 13

Diagnosis: RAYNAUD SYNDROME
Treatment: MEDICAL THERAPY
ICD-9: 443
CPT: 90000-99999
Line: 634 Category: 13

Diagnosis: REITER'S DISEASE
Treatment: MEDICAL THERAPY
ICD-9: 099.3
CPT: 90000-99999
Line: 635 Category: 13

Diagnosis: URTICARIA, CHRONIC
Treatment: MEDICAL THERAPY
ICD-9: 708,995.1
CPT: 90000-99999,11000-11101
Line: 636 Category: 13

Diagnosis: KERATODERMA, ACQUIRED; ACQUIRED ACANTHOSIS NIGRICANS, STRIAE ATROPHICAE, OTHER AND UNSPECIFIED HYPERTROPHIC AND ATROPHIC CONDITIONS OF SKIN
Treatment: MEDICAL THERAPY
ICD-9: 690,698,700,701.1-.3,701.8,701.9,706.7
CPT: 11000-101,11900,11950-54,90000-99999
Line: 637 Category: 13

Diagnosis: VERTIGINOUS SYNDROMES AND OTHER DISORDERS OF VESTIBULAR SYSTEM
Treatment: MEDICAL THERAPY
ICD-9: 386.0-.2,386.4-.9
CPT: 90000-99999
Line: 638 Category: 13

Diagnosis: DISORDERS OF CERVICAL REGION
Treatment: CERVICAL LAMENINECTOMY, MEDICAL THERAPY
ICD-9: 721.0,722.4,722.81,723
CPT: 63250,63265,63270,63275,63280,63285,63001,63015,63020,63035-40,63045,63048,63075-76,63081-82,63300,63304,63170-72,63180-82,63194,63196,63198,90000-99999
Line: 639 Category: 13

Diagnosis: ERYTHEMATOUS CONDITIONS: TOXIC, NODOSUM, ROSACEA, LUPUS
Treatment: MEDICAL THERAPY
ICD-9: 695.0,695.2-.9
CPT: 90000-99999,11100-11101
Line: 640 Category: 13

Diagnosis: PLANTAR FASCIAL FIBROMATOSIS
Treatment: MEDICAL THERAPY
ICD-9: 728.71
CPT: 90000-99999
Line: 641 Category: 13

Diagnosis: SPONDYLOSIS AND OTHER CHRONIC DISORDERS OF BACK
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 720,721.2-.5,721.7,721.9,722.3-.5,722.7-.9,723.0,724,738.4,756.11,847
CPT: 22100,22105,22110,22140-230,22548-54,22590-650,22820-99,62284,62290-1,63001-48,63075-8,63081-2,63085-8,63090-1,63300-4,90000-99999
Line: 642 Category: 13

Diagnosis: ESOPHAGITIS
Treatment: MEDICAL THERAPY
ICD-9: 530.1
CPT: 90000-99999
Line: 643 Category: 13

Diagnosis: INTERVERTEBRAL DISC DISORDERS
Treatment: THORACIC-LUMBAR LAMINONECTOMY, MEDICAL THERAPY\
ICD-9: 722.0-.1,722.7,952.1-.9
CPT: 63003,63005,63016,63017,63030-31,63035,63042,63046-48,63056-57,63064,63066,63077-78,63085-91,63170,63173,90000-99999
Line: 644 Category: 13

Diagnosis: CONTACT DERMATITIS AND OTHER ECZEMA
Treatment: MEDICAL THERAPY
ICD-9: 692
CPT: 90000-99999,11900-11901
Line: 645 Category: 13

Diagnosis: ACNE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 695.3
CPT: 90000-99999,10040-61,11450-71,11900-11901,17100-05,17340
Line: 646 Category: 13

Diagnosis: PSORIASIS AND SIMILAR DISORDERS
Treatment: MEDICAL THERAPY
ICD-9: 696
CPT: 90000-99999,11900-11901
Line: 647 Category: 13

Diagnosis: CHRONIC PROSTATITIS, OTHER DISORDERS OF PROSTATE
Treatment: MEDICAL THERAPY
ICD-9: 601.1,602
CPT: 90000-99999
Line: 648 Category: 13

Diagnosis: CHRONIC CYSTITIS
Treatment: MEDICAL THERAPY
ICD-9: 595.1-595.3
CPT: 90000-99999
Line: 649 Category: 13

Diagnosis: IMPETIGO HERPETIFORMIS AND SUBCORNEAL PUSTULAR DERMATOSIS
Treatment: MEDICAL THERAPY
ICD-9: 694.0-.3
CPT: 90000-99999
Line: 650 Category: 13

Diagnosis: TRIGEMINAL NERVE DISORDERS
Treatment: MEDICAL & SURGICAL TREATMENT
ICD-9: 350
CPT: 64400,64600-64610,61450,61458,90000-99999
Line: 651 Category: 13

Diagnosis: DISORDERS OF PANCREATIC ENDOCRINE SECRETION
Treatment: MEDICAL THERAPY
ICD-9: 251.4-.9
CPT: 90000-99999,48155
Line: 652 Category: 13

Diagnosis: MYASTHENIA GRAVIS
Treatment: MEDICAL THERAPY, THYMECTOMY
ICD-9: 358
CPT: 90000-99999,60520
Line: 653 Category: 13

Diagnosis: SPRAINS, STRAINS AND NON-ALLOPATHIC SPINAL LESIONS: THORACIC, LUMBAR AND SACRUM ACUTE
Treatment: MEDICAL THERAPY
ICD-9: 847.0-.3,739.0-.4
CPT: 90000-99999
Line: 654 Category: 14

Diagnosis: HORDEOLUM AND OTHER DEEP INFLAMMATION OF EYELID; CHALAZION
Treatment: INCISION AND DRAINAGE/MEDICAL THERAPY
ICD-9: 373.1-.2
CPT: 90000-99999,67700
Line: 655 Category: 14

Diagnosis: LABYRINTHITIS
Treatment: MEDICAL THERAPY
ICD-9: 386.3
CPT: 90000-99999
Line: 656 Category: 14

Diagnosis: VIRAL HEPATITIS
Treatment: MEDICAL THERAPY
ICD-9: 070
CPT: 90000-99999
Line: 657 Category: 14

Diagnosis: ANOVULATION (INFERTILITY)
Treatment: MEDICAL THERAPY
ICD-9: 621.3,626.0-.1,628.0
CPT: 58100,58920-25,58940,61548,90000-99999
Line: 658 Category: 15

Diagnosis: HYDROCELE
Treatment: MEDICAL THERAPY, EXCISION
ICD-9: 603
CPT: 55040-41,55500,90000-99999
Line: 659 Category: 11

Diagnosis: ABSENCE OF BREAST AFTER MASTECTOMY AS TREATMENT FOR NEOPLASM
Treatment: BREAST RECONSTRUCT
ICD-9: 174,217,233.0,238.3
CPT: 19324-42,19360-96
Line: 660 Category: 11

Diagnosis: SPASTIC DYSPHONIA
Treatment: MEDICAL THERAPY
ICD-9: 478.79
CPT: 90000-99999
Line: 661 Category: 11

Diagnosis: FEMALE INFERTILITY OF CERVICAL ORIGIN, MALE INFERTILITY
Treatment: ARTIFICIAL INSEMINATION, MEDICAL THERAPY
ICD-9: 628.8-.9,606
CPT: 90000-99999,58310-58311
Line: 662 Category: 15

Diagnosis: TUBAL DISEASE
Treatment: MICROSURGERY
ICD-9: 256,628.2-.4
CPT: 58700,58740-70
Line: 663 Category: 15

Diagnosis: KELOID SCAR; OTHER ABNORMAL GRANULATION TISSUE
Treatment: INTRA INJECT/DESTR/EXCIS
ICD-9: 701.4-.5
CPT: 11900-11901,17000-17105,11200-11446
Line: 664 Category: 17

Diagnosis: CONJUNCTIVAL CYST
Treatment: EXCISION OF CONJ. CYST
ICD-9: 372.75
CPT: 68110
Line: 665 Category: 17

Diagnosis: HEPATORENAL SYNDROME
Treatment: MEDICAL THERAPY
ICD-9: 572.4
CPT: 90000-99999
Line: 666 Category: 3

Diagnosis: OTHER DEFICIENCIES OF CIRCULATING ENZYMES (ALPHA 1-ANTITRYPSIN DEFICIENCY)
Treatment: LUNG TRANSPLANT
ICD-9: 277.6
CPT: 33935
Line: 667 Category: 5

Diagnosis: LETHAL MIDLINE GRANULOMA
Treatment: MEDICAL THERAPY
ICD-9: 446.3
CPT: MEDICAL THERAPY
Line: 668 Category: 5

Diagnosis: AMYOTROPHIC LATERAL SCLEROSIS (ALS)
Treatment: MEDICAL THERAPY
ICD-9: 335.20,335.22-.29
CPT: 90000-999999
Line: 669 Category: 5

Diagnosis: CANCER OF LIVER AND INTRAHEPATIC BILE DUCTS
Treatment: LIVER TRANSPLANT
ICD-9: 155
CPT: 47135
Line: 670 Category: 5

Diagnosis: HEMATOMA OF AURICLE OR PINNA AND HEMATOMA OF EXTERNAL EAR
Treatment: DRAINAGE
ICD-9: 216.2,380.0,380.31
CPT: 69000-20
Line: 671 Category: 10

Diagnosis: ENOPHTHALMOS
Treatment: EXCISION
ICD-9: 376.5
CPT: 67400
Line: 672 Category: 10

Diagnosis: ACUTE LYMPHADENITIS
Treatment: INCISION AND DRAINAGE
ICD-9: 683
CPT: 10060
Line: 673 Category: 10

Diagnosis: CONGENTIAL ANOMALIES OF FEMALE GENITAL ORGANS
Treatment: SURGICAL TREATMENT
ICD-9: 752.0-.3,752.41
CPT: 57135,57500,57720,58540,58700,58940,58987,58995
Line: 674 Category: 11

Diagnosis: GENERALIZED CONVULSIVE OR PARTIAL EPILEPSY WITHOUT MENTION OF IMPAIRMENT OF CONSCIOUSNESS
Treatment: FOCAL SURGERY
ICD-9: 345.1,345.5
CPT: 61720,61533-61536
Line: 675 Category: 11

Diagnosis: VARICOSE VEINS OF LOWER EXTREMITIES
Treatment: STRIPPING/SCLEROTHERAPY
ICD-9: 454
CPT: 36468-71,37720-35
Line: 676 Category: 11

Diagnosis: DISEASE OF CAPILLARIES
Treatment: EXCISION
ICD-9: 448.1-.9
CPT: 11400-11426
Line: 677 Category: 11

Diagnosis: ANOMALIES OF RELATIONSHIP OF JAW TO CRANIAL BASE, MAJOR ANOMALIES OF JAW SIZE, OTHER SPECIFIED AND UNSPECIFIED DENTOFACIAL ANOMALIES
Treatment: OSTEOPLASTY MAX/MAND
ICD-9: 524.0-.2,524.5,524.85,524.9
CPT: 21110,21200-21208,21250,21209
Line: 678 Category: 11

Diagnosis: CONGENITAL ANOMALIES OF THE EAR WITHOUT IMPAIRMENT OF HEARING
Treatment: OTOPLASTY, REPAIR & AMPUTATION
ICD-9: 744.1-.3
CPT: 69300,69110
Line: 679 Category: 11

Diagnosis: TMJ DISORDER
Treatment: TMJ SPLINTS
ICD-9: 524.6
CPT: 90000-99999
Line: 680 Category: 13

Diagnosis: TMJ DISORDERS
Treatment: TM JOINT SURGERY
ICD-9: 524.6,524.5,718.08,718.18,718.28,718.38,718.58
CPT: 21499,21010,20910,21050-70,21116,21240-21243,21480,21485,21490,21210,21215,29909,21230,21235,20926
Line: 681 Category: 11

Diagnosis: DISEASE OF NAILS, HAIR AND HAIR FOLLICLES
Treatment: MEDICAL THERAPY
ICD-9: 703.8-.9,704.0,704.2-.9,757.4-.5
CPT: 11900,11700-11765,11000-11001,90000-99999
Line: 682 Category: 13

Diagnosis: CIRCUMSCRIBED SCLERODERMA
Treatment: MEDICAL THERAPY
ICD-9: 701.0
CPT: 90000-99999,11900-11901
Line: 683 Category: 13

Diagnosis: CAVUS DEFORMITY OF FOOT
Treatment: MEDICAL THERAPY, ORTHOTIC
ICD-9: 736.73
CPT: 90000-99999
Line: 684 Category: 13

Diagnosis: CERVICAL RIB
Treatment: SURGICAL TREATMENT
ICD-9: 756.2
CPT: 21615-16,21705
Line: 685 Category: 11

Diagnosis: ERYTHROPLAKIA, LEUKOEDEMA OF MOUTH OR TONGUE
Treatment: MEDICAL THERAPY
ICD-9: 528.7
CPT: 90000-99999
Line: 686 Category: 13

Diagnosis: CHRONIC CONJUNCTIVITIS, BLEPHAROCONJUCTIVITIS
Treatment: MEDICAL THERAPY
ICD-9: 372.1-372.3
CPT: 90000-99999
Line: 687 Category: 13

Diagnosis: DERMATOPHYTOSIS
Treatment: MEDICAL THERAPY
ICD-9: 110-111
CPT: 90000-99999,11100
Line: 688 Category: 13

Diagnosis: KERATITIS: SUPERFICIAL W/O CONJUCTIVITIS, CERTAIN TYPES, OTHER AND UNSPEC. K-CONJUNCTIVITIS, INTERSTITIAL & DEEP, CORNEAL NEOVASCULARIZATION, OTHER AND UNSPECIFIED FORMS
Treatment: MEDICAL THERAPY
ICD-9: 370.2-370.9
CPT: 90000-99999
Line: 689 Category: 13

Diagnosis: DISORDERS OF SYNOVIUM, TENDON AND BURSA; DISORDERS OF SOFT TISSUE AND JOINTS
Treatment: MEDICAL THERAPY
ICD-9: 727.2-.3,729
CPT: 90000-99999
Line: 690 Category: 13

Diagnosis: TENDINITIS AND BURSITIS
Treatment: MEDICAL AND SURGICAL THERAPY
ICD-9: 726.33,726.71-.72
CPT: 29105,29125-29131,24105,27060-27062,29240,29260,29270,29280,29345,29355,29365,29405-50,20550,20600-10,29345,29355,29365,90000-99999
Line: 691 Category: 14

Diagnosis: BLEPHARITIS
Treatment: MEDICAL THERAPY
ICD-9: 373.0
CPT: 90000-99999
Line: 692 Category: 13

Diagnosis: XEROSIS
Treatment: MEDICAL THERAPY
ICD-9: 706.8
CPT: 90000-99999,11000-11101
Line: 693 Category: 13

Diagnosis: OBESITY
Treatment: NUTRITIONAL AND LIFE STYLE COUNSELING
ICD-9: 278
CPT: 90000-99999
Line: 694 Category: 13

Diagnosis: DISORDERS OF FUNCTION OF STOMACH AND OTHER FUNCTIONAL DIGESTIVE DISORDERS
Treatment: MEDICAL THERAPY
ICD-9: 536,564
CPT: 90000-99999
Line: 695 Category: 13

Diagnosis: LICHEN PLANUS
Treatment: MEDICAL THERAPY
ICD-9: 697
CPT: 90000-99999,11900-11901
Line: 696 Category: 13

Diagnosis: POSTHERPETIC NEURITIS, MONONEUROPATHY, POLYNEUROPATHY
Treatment: MEDICAL THERAPY
ICD-9: 354.0,354.2-.9
CPT: 90000-99999
Line: 697 Category: 13

Diagnosis: POSTCONCUSSION SYNDROME
Treatment: MEDICAL THERAPY
ICD-9: 310.2
CPT: 90000-99999
Line: 698 Category: 13

Diagnosis: HERPES SIMPLEX WITHOUT COMPLICATIONS
Treatment: MEDICAL THERAPY
ICD-9: 054.0,054.2,054.6,054.8-.9
CPT: 90000-99999
Line: 699 Category: 13

Diagnosis: TESTICULAR AND POLYGLANDULAR DYSFUNCTION
Treatment: MEDICAL THERAPY
ICD-9: 257-258
CPT: 90000-99999
Line: 700 Category: 13

Diagnosis: OTOSCLEROSIS
Treatment: MEDICAL THERAPY
ICD-9: 387
CPT: 90000-99999
Line: 701 Category: 13

Diagnosis: PERIPHERAL ENTHESOPATHIES
Treatment: MEDICAL THERAPY
ICD-9: 726.30-.32,726.4-.6,726.70,726.8,726.90
CPT: 90000-99999
Line: 702 Category: 13

Diagnosis: CHRONIC BRONCHITIS
Treatment: MEDICAL THERAPY
ICD-9: 490-491,493.9
CPT: 90000-99999
Line: 703 Category: 13

Diagnosis: SARCOIDOSIS
Treatment: MEDICAL THERAPY
ICD-9: 135
CPT: 90000-99999
Line: 704 Category: 13

Diagnosis: BENIGN INTRACRANIAL HYPERTENSION
Treatment: MEDICAL THERAPY
ICD-9: 348.2
CPT: 90000-99999
Line: 705 Category: 13

Diagnosis: LYMPHEDEMA
Treatment: MEDICAL THERAPY, OTHER OPERATION ON LYMPH CHANNEL
ICD-9: 457,140-144
CPT: 90000-99999,38300-38308,38382-38555,38700-38761
Line: 706 Category: 13

Diagnosis: PHLEBITIS AND THROMBOPHLEBITIS, SUPERFICIAL
Treatment: MEDICAL THERAPY
ICD-9: 451
CPT: 90000-99999
Line: 707 Category: 13

Diagnosis: CHOLESTEATOMA
Treatment: MEDICAL THERAPY
ICD-9: 385.30
CPT: 90000-99999
Line: 708 Category: 13

Diagnosis: SYNOVITIS AND TENOSYNOVITIS
Treatment: MEDICAL THERAPY
ICD-9: 727.0
CPT: 90000-99999,20550
Line: 709 Category: 14

Diagnosis: DIAPER OR NAPKIN RASH
Treatment: MEDICAL THERAPY
ICD-9: 691.0
CPT: 90000-99999,11100
Line: 710 Category: 14

Diagnosis: ORAL APHTHAE
Treatment: MEDICAL THERAPY
ICD-9: 528.2
CPT: 90000-99999
Line: 711 Category: 14

Diagnosis: DERMATITIS DUE TO SUBSTANCES TAKEN INTERNALLY
Treatment: MEDICAL THERAPY
ICD-9: 693
CPT: 90000-99999,11100
Line: 712 Category: 14

Diagnosis: FOOD ALLERGY
Treatment: MEDICAL THERAPY
ICD-9: 692.5
CPT: 90000-99999
Line: 713 Category: 13

[Diagnosis: IMPULSE DISORDERS
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 312.31-.34
CPT: 90220,90800-90899
Line: 714 Category: 13]

Diagnosis: SPRAINS OF JOINTS AND ADJACENT MUSCLES
Treatment: MEDICAL THERAPY
ICD-9: 717.5,717.8,840.1-844.2,844.8-.9,845.00-.03,845.1,848.5
CPT: 29049-29085,29105-29131,29200-29280,29305-29580,29700-29799,90000-99999
Line: 715 Category: 14

Diagnosis: ACUTE CONJUNCTIVITIS
Treatment: MEDICAL THERAPY
ICD-9: 372.0,077
CPT: 90000-99999
Line: 716 Category: 14

Diagnosis: SUBLINGUAL, SCROTAL, AND PELVIC VARICES
Treatment: VENOUS INJECTION, VASCULAR SURGERY
ICD-9: 456.3-.5
CPT: 36470,37798-9
Line: 717 Category: 11

Diagnosis: SPRAIN/STRAIN OF ACHILLES TENDON
Treatment: MEDICAL THERAPY
ICD-9: 845.09
CPT: 90000-99999
Line: 718 Category: 14

Diagnosis: FRACTURE OF VERTEBRAL COLUMN WITHOUT SPINAL CORD INJURY, SACRUM AND COCCYX
Treatment: LAMINECTOMY
ICD-9: 805.6-805.9
CPT: 61720-61793
Line: 719 Category: 14

Diagnosis: ACUTE URTICARIA
Treatment: MEDICAL THERAPY
ICD-9: 708,995.1
CPT: 90000-99999
Line: 720 Category: 14

Diagnosis: CANDIDIASIS
Treatment: MEDICAL THERAPY
ICD-9: 112.0,112.3
CPT: 90000-99999
Line: 721 Category: 14

Diagnosis: SCLERITIS & EPISCLERITIS
Treatment: MEDICAL THERAPY
ICD-9: 379.0
CPT: 90000-99999
Line: 722 Category: 14

Diagnosis: INTERNAL INFECTIONS AND OTHER BACTERIAL FOOD POISONING
Treatment: MEDICAL THERAPY
ICD-9: 003.0,003.8-.9,005.0,005.2-.9,008-009,027.1-.9
CPT: 90000-99999
Line: 723 Category: 14

Diagnosis: OPEN WOUND OF INTERNAL STRUCTURES OF MOUTH W/O COMPLICATION
Treatment: REPAIR SOFT TISSUSE.
ICD-9: 873.6
CPT: 13300,41251,41282,12011,12017,12018,12051,12052,12056,12057,13131,13132,13152,40831
Line: 724 Category: 14

Diagnosis: VIRAL, SELF-LIMITING ENCEPHALITIS, MYELITIS AND ENCEPHALOMYELITIS
Treatment: MEDICAL THERAPY
ICD-9: 056.0,323
CPT: 90000-99999
Line: 725 Category: 14

Diagnosis: ACUTE TONSILLITIS
Treatment: MEDICAL THERAPY
ICD-9: 463
CPT: 90000-99999
Line: 726 Category: 14

Diagnosis: ERYTHEMA MULTIFORME
Treatment: MEDICAL THERAPY
ICD-9: 695.1
CPT: 90000-99999,11100-11101
Line: 727 Category: 14

Diagnosis: CENTRAL SEROUS RETINOPATHY
Treatment: LASER SURGERY
ICD-9: 362.41
CPT: 67210
Line: 728 Category: 14

Diagnosis: VULVAL VARICES
Treatment: VASCULAR SURGERY
ICD-9: 456.6
CPT: 37799
Line: 729 Category: 14

Diagnosis: ASEPTIC MENINGITIS
Treatment: MEDICAL THERAPY
ICD-9: 047-049
CPT: 90000-99999
Line: 730 Category: 14

Diagnosis: INFECTIOUS MONONUCLEOSIS
Treatment: MEDICAL THERAPY
ICD-9: 075
CPT: 90000-99999
Line: 731 Category: 14

Diagnosis: OTHER NONFATAL VIRAL INFECTIONS
Treatment: MEDICAL THERAPY
ICD-9: 051-053,055,056.9,057,072,074,078.0,078.2-.8,,079,480,487.2-.9
CPT: 90000-99999
Line: 732 Category: 14

Diagnosis: ACUTE PHARYNGITIS AND LARYNGITIS AND OTHER DISEASES OF VOCAL CORDS
Treatment: MEDICAL THERAPY
ICD-9: 462,478.5
CPT: 90000-99999
Line: 733 Category: 14

Diagnosis: PREVENTIVE SERVICES FOR ADULTS WITH QUESTIONABLE OR NO PROVEN EFFECTIVENESS
Treatment: MEDICAL THERAPY
ICD-9: 0
CPT: 90000-99999
Line: 734 Category: 16

Diagnosis: OLD LACERATION OF CERVIX AND VAGINA
Treatment: MEDICAL THERAPY
ICD-9: 622.3,624.4
CPT: 90000-99999
Line: 735 Category: 17

Diagnosis: BENIGN NEOPLASMS OF SKIN
Treatment: MEDICAL THERAPY
ICD-9: 210,214,216,221,222.1,222.4
CPT: 10000-61,10141,11000,11100-446,17000-105,20000-05,21030,21044,21501,23030,23040,23930-31,25028-31,26010-30,26990-91,27301,27603-04,28001,40800-05,41800,90000-99999
Line: 736 Category: 17

Diagnosis: REDUNDANT PREPUCE AND PHIMOSIS
Treatment: MEDICAL THERAPY, DILATION
ICD-9: 605
CPT: 54152,90000-99999
Line: 737 Category: 17

Diagnosis: VITILIGO, CONGENITAL PIGMENTARY ANOMALIES OF SKIN
Treatment: MEDICAL THERAPY
ICD-9: 709.0,757.3,757.9
CPT: 90000-99999
Line: 738 Category: 17

Diagnosis: DENTAL SERVICES (MARGINAL IMPROVEMENT)
Treatment: RESTORATIVE DENTAL SERVICE
ICD-9: 0
CPT: 01204-5,09910,09940,09952,07291,07272,06940,04261-72,03910-20
Line: 739 Category: 17

Diagnosis: SEBORRHEIC KERATOSIS, DYSCHROMIA, AND VASCULAR DISORDERS, SCAR CONDITIONS, AND FIBROSIS OF SKIN
Treatment: MEDICAL THERAPY
ICD-9: 702,709.1-.3,709.8-.9
CPT: 11000,11050,17000,90000-99999
Line: 740 Category: 17

Diagnosis: VIRAL WARTS
Treatment: MEDICAL THERAPY, CRYOSURGERY
ICD-9: 078.1
CPT: 90000-99999,17100,17110,17340,17000,11900,28043,46900-46924,54050-54065,56486,11050,11100-11101,11901
Line: 741 Category: 17

Diagnosis: UPPER EXTREMITY: FINGERTIP EVULSION W/O PEDICLE GRAFT
Treatment: REPAIR
ICD-9: 883.1,883.2
CPT: 12401
Line: 742 Category: 17

Diagnosis: AGENESIS OF LUNG
Treatment: MEDICAL THERAPY
ICD-9: 748.5
CPT: 90000-99999
Line: 743 Category: 17

Diagnosis: GALLSTONES WITHOUT CHOLECYSTITIS
Treatment: MEDICAL THERAPY, CHOLECYSTECTOMY
ICD-9: 574.2,575.6
CPT: 90000-99999,47600-20
Line: 744 Category: 17

Diagnosis: SIMPLE AND UNSPECIFIED GOITER, NONTOXIC NODULAR GOITER
Treatment: MEDICAL THERAPY
ICD-9: 240-241
CPT: 90000-99999
Line: 745 Category: 17

Diagnosis: SICCA SYNDROME
Treatment: MEDICAL THERAPY
ICD-9: 710.2
CPT: 90000-99999
Line: 746 Category: 17

Diagnosis: TRAUMATIC BRAIN INJURY, STATIC DEMENTIA, BRAIN ANOXIA DUE TO INFECTION OR TRAUMA
Treatment: MEDICAL THERAPY
ICD-9: 295.9,299.0,319,348.1,348.3-.4,851.0,850.2-.5,854.0,905.0
CPT: 90000-99999
Line: 747 Category: 17

Diagnosis: ICHTHYOSIS
Treatment: MEDICAL THERAPY
ICD-9: 757.1
CPT: 90000-99999
Line: 748 Category: 17

Diagnosis: PROGRESSIVE DEMENTIA, ORGANIC BRAIN SYNDROME
Treatment: MEDICAL THERAPY
ICD-9: 046.1,090.40,094.1,290,294.1,310,331
CPT: 90000-99999
Line: 749 Category: 17

Diagnosis: INTRAVENTRICULAR AND SUBARACHNOID HEMORRHAGE OF FETUS OR NEONATE
Treatment: MEDICAL THERAPY
ICD-9: 772.1-.2
CPT: 90000-99999
Line: 750 Category: 2

Diagnosis: CANCER OF VARIOUS SITES WITH DISTANT METASTASES WHERE TREATMENT WILL NOT RESULT IN A 10% 5 YEAR SURVIVAL
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 140-198
CPT: 11600-46,38720-24,41110-14,41130,42120,42842-45,42880,47610,44131,47420-40,58951,61500,61510,61518-21,61546-48,90000-99999
Line: 751 Category: 17

Diagnosis: SENSORINEURAL HEARING LOSS
Treatment: COCHLEAR IMPLANT
ICD-9: 389.1
CPT: 69930
Line: 752 Category: 11

* THIS LIST IS SUBJECT TO REVISION UNTIL SUBMITTED TO THE LEGISLATURE

Diagnosis: ALCOHOLIC CIRRHOSIS OF LIVER
Treatment: LIVER TRANSPLANT
ICD-9: 571.2
CPT: 47135
Line: 753 Category: 5

Diagnosis: NON-HODGKIN'S LYMPHOMAS
Treatment: BONE MARROW TRANSPLANT (5-6 LOCI MATCH)
ICD-9: 200,202.0-.2,202.8-.9
CPT: 38230-41
Line: 754 Category: 5

Diagnosis: OBESITY AND OTHER HYPERALIMENTATION
Treatment: GASTROPLASTY
ICD-9: 278
CPT: 43845
Line: 755 Category: 11

Diagnosis: CONGENITAL CYSTIC LUNG - SEVERE
Treatment: LUNG RESECTION
ICD-9: 748.4
CPT: 32500
Line: 756 Category: 7

Diagnosis: BENIGN POLYPS OF VOCAL CORDS
Treatment: MEDICAL THERAPY
ICD-9: 478.4
CPT: 90000-99999
Line: 757 Category: 10

Diagnosis: ACUTE UPPER RESPIRATORY INFECTIONS AND COMMON COLD
Treatment: MEDICAL THERAPY
ICD-9: 460,465
CPT: 90000-99999
Line: 758 Category: 14

Diagnosis: TUBAL DYSFUNCTION AND OTHER CASES OF INFERTILITY
Treatment: IN-VITRO FERTILIZATION, GIFT
ICD-9: 256
CPT: 58970-76
Line: 759 Category: 15

[Diagnosis: ANTI-SOCIAL PERSONALITY DISORDER
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 301.70
CPT: 90220,90800-90899
Line: 760 Category: 5]

[Diagnosis: TRANSSEXUALISM
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 302.50
CPT: 90220,90800-90899
Line: 761 Category: 11]

[Diagnosis: IDENTITY DISORDER
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 313.82
CPT: 90220,90800-90899
Line: 762 Category: 14]

[Diagnosis: PICA
Treatment: MEDICAL/PSYCHOTHERAPY
DSM-III: 307.52
CPT: 90220,90800-90899
Line: 763 Category: 14]

Diagnosis: DENTAL SERVICES (EG. OBSOLETE TREATMENTS FOR VARIOUS CONDITIONS)
Treatment: RESTORATIVE DENTAL SERVICE
ICD-9: 0
CPT: 01310,01380-7,02410-30,02510-630,02710-810,02950,02952-4,02961-2,03460,03960,05215-81,05862,05976,06210,06240,06250-2,06545,06720-51,06790-1,06950,08110-999,09950
Line: 764 Category: 17

* THIS LIST IS SUBJECT TO REVISION UNTIL SUBMITTED TO THE LEGISLATURE

Diagnosis: UNCOMPLICATED HEMORRHOIDS
Treatment: HEMORRHOIDECTOMY
ICD-9: 455.0,455.3,455.6,455.9
CPT: 46221-62,46500
Line: 765 Category: 17

Diagnosis: HEAD INJURY: HEMATOMA/EDEMA W/ NO/BRIEF LOSS OF CONSCIOUSNESS
Treatment: MEDICAL THERAPY
ICD-9: 851.02,851.12,851.82,851.92,851.42,851.52,850.9
CPT: 90000-99999
Line: 766 Category: 17

Diagnosis: GYNECOMASTIA
Treatment: MASTOPEXY
ICD-9: 611.1
CPT: 19316
Line: 767 Category: 17

Diagnosis: CYST OF KIDNEY, ACQUIRED
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 593.2
CPT: 50010,50390,90000-99999
Line: 768 Category: 17

Diagnosis: TERMINAL HIV DISEASE WITH LESS THAN 10% SURVIVAL RATE AT 5 YEARS
Treatment: MEDICAL THERAPY
ICD-9: 042-044
CPT: 90000-99999
Line: 769 Category: 17

Diagnosis: CHRONIC PANCREATITIS
Treatment: SURGICAL TREATMENT
ICD-9: 577.1
CPT: 48000,48999,49000
Line: 770 Category: 17

Diagnosis: SUPERFICIAL WOUNDS WITHOUT INFECTION AND CONTUSIONS
Treatment: MEDICAL THERAPY
ICD-9: 910.0,.2,.4,.6,.8,911.0,.2,.4,.6,.8,912.0,.2,.4,.6,.8,913.0,.2,.4,.6,.8,914.0,.2,.4,.6,.8,915.0,.2,.4,.6,.8,
916.0,.2,.4,.6,.8,917.0,.2,.4,.6,.8,919.0,.2,.4,.6,.8,920-924
CPT: 90000-99999
Line: 771 Category: 17

Diagnosis: CONSTITUTIONAL APLASTIC ANEMIA
Treatment: MEDICAL THERAPY
ICD-9: 284.0,284.9
CPT: 90000-99999
Line: 772 Category: 17

Diagnosis: PROLAPSED URETHRAL MUCOSA
Treatment: SURGICAL TREATMENT
ICD-9: 599.5
CPT: 51840-41
Line: 773 Category: 11

Diagnosis: CENTRAL RETINAL ARTERY OCCLUSION
Treatment: PARACENTESIS OF AQUEOUS
ICD-9: 362.31
CPT: 67015,67505
Line: 774 Category: 17

Diagnosis: EXTREMELY LOW BIRTH WEIGHT (UNDER 500 GM) AND UNDER 23 WEEK GESTATION
Treatment: LIFE SUPPORT
ICD-9: 765.0,765.11
CPT: 0
Line: 775 Category: 17

Diagnosis: ANENCEPHALOUS AND SIMILAR ANOMALIES AND REDUCTION DEFORMITIES OF THE BRAIN
Treatment: LIFE SUPPORT
ICD-9: 740,742.2
CPT: 0
Line: 776 Category: 17

APPENDIX I

ACTUARIAL ANALYSIS

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1) **Report by Coopers & Lybrand**

OREGON MEDICAID
Basic Health Services Program

Calculation of Per Capita Costs
Report
May 1, 1991

Coopers & Lybrand | Solutions for Business™

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May 1, 1991

Ms. Lynn Read
Manager, Basic Health Services Program
Oregon Medical Assistance Programs
203 Public Service Building
Salem, Oregon 97310

Dear Lynn:

Re: Report on Per Capita Costs

At your request we have prepared this report on the Calculation of Per Capita Costs for the Basic Health Services Program.

This report describes our analysis and approach in detail. Please call Sandi Hunt at 415/957-3330 if you have any questions regarding the contents of this report.

Very Truly Yours,

COOPERS & LYBRAND

John M Bertko

By: John M. Bertko
Fellow of the Society
of Actuaries
Member, American Academy
of Actuaries

Sandra S. Hunt

By: Sandra S. Hunt, M.P.A.
Senior Consultant

Oregon Medicaid

Basic Health Services Program

Report on Per Capita Costs

Executive Summary

Coopers & Lybrand

May 1, 1991

We have calculated the per capita costs for health care services under the Oregon Basic Health Services Program. The methods used to calculate the per capita cost were designed to comply with the requirements of Oregon Senate Bill 27, which provides for the extension of Medicaid coverage to nearly all Oregonians below the federal poverty level and mandates specific changes in the methods used to determine provider reimbursement.

Under this legislation, a Health Services Commission ("HSC") has been created that is charged with developing a Prioritized List of health care services.

Changes in reimbursement methods that affect the capitation rates include a requirement that health care providers be reimbursed at "rates that are necessary to cover the costs of services." In addition, the services to be covered by the program are to be determined based on a "Prioritized List" of services and the total amount of funding that is allocated by the Legislature.

We have calculated a total per capita cost value for the program assuming that all health care services are covered and that reimbursement rates are sufficient to cover the costs of providing services. The methods used to calculate the total per capita cost have been designed to provide for the flexibility necessary to calculate capitation rates with varying levels of covered services based on the components of the Prioritized List developed by the HSC.

In developing the per capita costs shown in this report, a variety of assumptions have been used including assumptions related to:

- o the relationship between average charge amounts and the "cost" of providing services;
- o changes in average utilization rates resulting from the changes in eligibility rules;
- o the distribution of the population among the different groups of people who will be participating in the program;
- o enrollment in prepaid plans;
- o payment policy under the demonstration project; and
- o expected savings resulting from case management.

Based on the assumptions used here, we have calculated a per capita cost for the total population expected to be covered by the program in the program start-up period (i.e., July 1, 1992 through June 30, 1993) for four different delivery systems: Health Maintenance Organization providers, Physician Care Organization providers, Primary Care Case Managers, and standard fee-for-service.

In developing our estimates, we assumed that services that are provided through prepaid plans will be paid on a capitation basis, with the capitation rates based on the "costs" of providing services. We assumed that services that are provided on a fee-for-service basis will be reimbursed based on current Medicaid payment levels adjusted for cost and utilization trend.

We have calculated an average per capita cost of $145.15. This average per capita cost reflects the expected mix of enrollees for the first year of the program. The average cost for the portion of the program that is expected to be covered by cost-based reimbursement is $157.05 and the average per capita cost based on current Medicaid payment levels with adjustments for price increases and program changes is $132.10. Table 1 shows the average monthly per capita cost by eligibility category for the program if all services are paid on a cost basis and if all services are paid based on current Medicaid payment levels adjusted for cost and utilization trend. A weighted average for the program is also provided.

Table 1

Per Capita Cost at Program Start-up[1]

Eligibility Category	Cost-Based Reimbursement[2]	Medicaid Payment Based Reimbursement[3]	Weighted Average[4]
Aid to Families with Dependent Children	$131.47	$106.64	$121.44
General Assistance	$679.48	$659.78	$647.76
Poverty Level Medical Adults	$534.89	$408.89	$457.23
Poverty Level Medical Children	$291.73	$251.03	$267.72
New Eligibles (Average)	$90.11	$80.99	$86.51
New Categorical Eligibles[5]	$101.26	$83.99	$94.39
New Noncategorical Eligibles[6]	$87.05	$80.16	$84.35
Average	$157.08	$132.10	$145.15

1/ Program start-up is the first year of operation (i.e., July 1, 1992 through June 30, 1993).

2/ Includes medical and dental costs as well as allowances for Plan administrative expense. Also includes adjustments for case management savings.

3/ Includes medical and dental costs. No allowances are made for provider administrative expense or for case management savings.

4/ Weighted average based on expected distribution of enrollees by delivery system. Some enrollees are expected to have a portion of their expenditures paid on a cost basis and other expenditures based on Medicaid fee-for-service payment levels.

5/ New Categorical Eligibles are those individuals who will become eligible for the demonstration project as a result of the change in income limits compared to the current Medicaid program. These individuals are expected to have demographic characteristics similar to current Medicaid AFDC and PLM recipients.

6/ New Noncategorical Eligibles are those individuals who will become eligible for the demonstration project as a result of the change in income limits and eligibility rules compared to the current Medicaid program. This group includes individuals who do not currently qualify for Medicaid due to their demographic characteristics.

We have also calculated the per capita cost associated with coverage at several different threshold levels on the Prioritized List of services. These per capita cost estimates are calculated based on the assumption that all services up to and including the threshold ranking are covered by the demonstration project and that all services below the threshold are not covered. The per capita cost associated with ten different threshold levels are shown in Table 2.

Table 2

Per Capita Cost at Various Thresholds at Program Start-up[1]

Threshold[2]	Percent of Total Cost	Average Per Capita Cost
200	60.02%	$87.12
255	63.45%	$92.10
310	67.87%	$98.51
365	70.45%	$102.26
420	76.19%	$110.59
475	80.75%	$117.21
530	83.20%	$120.76
585	87.50%	$127.01
640	92.74%	$134.61
695	98.13%	$142.44
709	100.00%	$145.15

1/ Program start-up is the first year of operation (i.e., July 1, 1992 through June 30, 1993).

2/ Threshold ranking on Prioritized List below which services would not be covered.

Following the Legislature's review of this report, we will refine the calculation of the total per capita cost based on the Legislature's need to identify costs associated with different threshold levels on the Prioritized List. The capitation rates to be paid to contracting plans will be calculated following the Legislature's determination of a budget amount per person per month and the level of covered services.

* * *

We appreciate the invaluable assistance provided by Oregon Medical Assistance Program staff and members of the Actuary's Advisory Committee in developing and reviewing the methods used in calculating the per capita costs for this program. Please contact Sandi Hunt at 415/957-3330 if you have any questions regarding this report.

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SECTION I

Overview

Background on SB 27

Oregon Senate Bill 27 provides for the extension of Medicaid coverage to most Oregonians (with certain specific exceptions) with a family income below 100% of the federal poverty level. Under this legislation, a Health Services Commission ("HSC") has been created that is charged with developing a Prioritized List of health care services.

The bill has several major objectives. First, it requires that health care providers be reimbursed at "rates that are necessary to cover the costs of services." In addition, the services to be covered by the program are to be determined based on a "Prioritized List" of services and the total amount of funding that is allocated by the Legislature. The HSC used a cost/utility analysis as part of its approach to determine the "value" of various health care services. For example, the HSC compared the costs of specific treatments for diseases and the benefit derived from the treatments. Following review of the Prioritized List developed by the HSC and the costs associated with the various levels of coverage, the Legislature will determine the amount of funding that will be made available and the resultant specific services that will be covered.

In order to implement SB 27 as a new Medicaid program, a series of waivers must be secured from the Health Care Financing Administration ("HCFA"). It is expected that the Basic Health Services Program will be implemented as a demonstration project under HCFA Medicaid rules. As a demonstration project, the waivers will allow Oregon to receive federal matching funds on a Medicaid program that is substantially different from current federal law.[1]

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1. The current Oregon Medicaid Prepaid Plan program requires a separate set of waivers of Medicaid rules. That program has been in place since 1985.

This program is a continuation of the process set in place in Oregon in 1985 with the development of the existing Prepaid Plan Program. Under that program, Oregon developed innovative managed care contracting arrangements through its Physician Care Organizations ("PCOs"). PCOs contract with the State to provide all physician services and some outpatient hospital and prescription drug services on a capitated basis. The PCOs also operate under an incentive arrangement to manage inpatient services and the remaining hospital outpatient and prescription drug services. Our past analysis of this program has shown substantial savings of over $5 million from 1985 through 1988.[2] An HMO also participates in the current Prepaid Plan Program.

The State intends to contract for services under SB 27 through a variety of managed care arrangements. These arrangements will range from fully capitated programs, where contracting health plans are at risk for the full range of acute health care services covered by the Medicaid demonstration program to partial capitation for a restricted range of services to managed fee-for-service. The specific contracting arrangements will be based in part on the number of Medicaid eligibles in each geographic area and the amount of risk the plans are willing and able to accept.[3] The rates paid to contracting providers are to be based on services that are included in the contract and estimates of the amounts "necessary to cover the costs" of providing those services. The specific contracting arrangements have not yet been finalized.

This report describes the methods used to calculate the per capita cost for the Basic Health Services Program prior to any determinations of specific covered services. The total per capita cost serves as the starting point for calculating capitation rates based on the Prioritized List of services developed by the HSC. The report also describes the methods used to identify the costs associated with coverage of various levels of the Prioritized List of health services. The final per capita cost of the program will be based on the various contracting arrangements developed between the State and prepaid plans, the demographic characteristics of the enrolled population, and the services that the Legislature determines it is able to fund.

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2. Cost Effectiveness Analysis for the PCO/HMO Program for the Period March 1985 Through September 1988, by Coopers & Lybrand, May 19, 1989.

3. OMAP staff are working to develop contracting arrangements with potential participating providers.

Generally Accepted Methods for Calculating Capitation Rates

Capitation rates are generally calculated by multiplying the rate of utilization of covered services by the average payment per unit of service. The utilization rate is usually expressed in terms of the number of services provided per 1000 eligibles (or enrollees) in a program per year. The number of eligibles per year is typically expressed in terms of the number of member-months of eligibility. (A member is an enrollee or a dependent of an enrollee.) Thus, a person eligible for the entire year would have twelve member-months of eligibility, while a person eligible for only half of the year would be counted as having six member-months of eligibility.

For example, the amount to be paid for covered inpatient services would generally be expressed in terms of the number of inpatient days or the number of admissions per 1000 members per year. The average payment (or reimbursement) per unit of service is then multiplied by this utilization rate to determine the capitation payment per person per month for that service. Similar calculations are made for the other categories of service. The sum of the required capitation for all contracted services is the total per capita cost for health care services. Further adjustments to the data include reductions to reflect the effect of managed health care, such as reduced use of inpatient services, on program costs. Under SB 27, Plans will also be paid an allowance for administrative expenses in recognition of the program's demonstration project status and resultant requirements to provide fairly extensive data and reports on utilization of services and a variety of other items.

Issues Associated with Calculating the Total Per Capita Cost

SB 27 requires that the capitation rate for the program be based on "rates necessary to cover the costs of services." As described in our Final Report on Capitation Methods and Methods for Defining Necessary Costs dated March 23, 1990, there are no generally accepted definitions of the costs necessary to provide health care services or payment rates necessary to cover the costs of services. Therefore, a first step in developing a capitation rate according to the requirements of SB 27 is determining an acceptable method for measuring or establishing the cost of providing services.

A second critical issue that must be addressed in developing the overall per capita cost is the expected utilization of all services by the population that will be covered by the new program. Adjustments must be made to available data to reflect the

covered population. In addition to differences in utilization rates among the population that is currently covered by Medicaid and the population that will be covered by the demonstration project, changes in administrative rules are expected to have important effects on utilization rates for specific types of services. The changes in rules and their expected effect on the utilization rates and the specific adjustments made to the data to reflect the rule changes are described in detail in Section III of this report.

A third issue in assuring the accuracy of the total per capita cost is the compatibility of the various data sources used for the calculation. When data from a number of sources are used to calculate total per capita costs, it is important that any differences in reporting practices be understood. Potential variations in reporting practices and the steps taken to minimize the effect of these differences are also discussed in Section III.

Contents of the Report

The following section of the report provides a description of the data used for the analysis. Issues associated with measuring expected utilization and average charges are described in Section III. Section IV reports on the methods used for constructing total per capita costs and adjustments that have been made to the data. This section also provides a discussion of the methods used to convert charge information to values related to the cost of providing services. Results of the analysis of total per capita costs are provided in Section V. The methods used to assign expenditures to the condition/treatment pairs of the Prioritized List and the calculation of per capita costs associated with covering various levels of services on the Prioritized List are presented in Section VI.

SECTION II

Description of Data Sources

Three primary data sources are used for the analysis: Oregon Medicaid Management Information System data, Blue Shield of California data, and Blue Cross/Blue Shield of Oregon data. Each of the data sources is described below.

- **Oregon Medicaid Management Information System ("MMIS")** data are used to estimate utilization rates for services and population groups that are currently covered by Medicaid. These data are also used to measure differences in utilization patterns for Medicaid recipients in different eligibility categories and as the basis for estimating utilization rates under the demonstration project for individuals who qualify for the program under the "categorical" eligibility rules.[1]

  Detailed claims and eligibility data for all current Medicaid eligibility categories that will be included in the demonstration project were provided by MMIS, including the Aid to Families with Dependent Children ("AFDC"), Poverty Level Medical ("PLM"), General Assistance ("GA"), and Medically Needy ("MN") populations. The data included all claims incurred for the three year period of January 1987 through December 1989. Only claims for the most recent two years are used in the analysis to make use of data for the most recent period possible. The third year of data was requested to allow for flexibility if data from the 1988 and 1989 periods showed unexpected

1. The demonstration project will include individuals who meet the demographic requirements to qualify for Medicaid under existing rules (such as single parents with children) as well as individuals who have an income below the poverty level but who do not meet the standard demographic requirements for Medicaid coverage (such as single adults or childless couples). Those who meet both the demographic and income requirements are referred to as "categorical eligibles", while those who qualify only as a result of their income level are referred to as "noncategorical eligibles".

variation. The Medically Needy data is incomplete because it represents only the portion of health care services that are covered by Medicaid; therefore, data for that population group are not used in the analysis.[2]

Separate tapes were provided with institutional, non-institutional, and prescription drug data. All of the tapes included data on actual billed and paid amounts for all services. Diagnosis and procedure codes were also recorded on the institutional and non-institutional tapes, as well as patient information such as date of birth, sex, and program of eligibility. For the prescription drug data, the amount paid for dispensing fees was recorded separately from the cost of goods reimbursement.

For the AFDC population, it is necessary to include claims for inpatient hospital services for both the fee-for-service population and the current prepaid plan population to obtain utilization rates that represent the total AFDC population because of eligibility rules that allow some recipients in areas of the state that require mandatory enrollment in prepaid plans to receive services on a fee-for-service basis. Utilization rates for all other services and population groups are based on utilization by fee-for-service eligibles only.

- **Blue Shield of California ("BSC")** data are used to calculate average charges per unit of service and to measure utilization of services that are not currently covered by Medicaid (such as adult preventive services.) The Blue Shield data are the primary data source for measuring utilization of the very specific condition/treatment pairs identified by the HSC in the Prioritized List of health services and the average cost per unit for those condition/treatment pairs. These data are also used to estimate utilization rates for the "noncategorical" eligibles.

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2. Medically Needy eligibles qualify for Medicaid by incurring health care expenses sufficient to reduce their net income below 133% of the Medicaid income standard. The portion of health care expenses paid by the individual is not included in our data base.

These data are used as the primary data source for calculating the global capitation rate for several reasons.

1) First, the data set represents a substantially larger population group than would be possible through use of only Oregon data.

2) Coopers & Lybrand has significant experience with the BSC data and therefore has a higher degree of confidence with the resulting capitation rates that are calculated from that data; at the start of this project we were less familiar with data from Blue Cross/Blue Shield of Oregon.

3) A data source that represents a population group other than the Medicaid population is required to assure that the average charge levels used in the analysis represent true charges rather than charges that may be adjusted for known differences in Medicaid payment amounts.

4) Utilization rates for a commercial population are needed to estimate the utilization for those population groups that have not historically been covered by Medicaid.

5) Finally, data from Blue Cross/Blue Shield of Oregon was available only in summary format, rather than the detailed format needed to calculate the capitation rates required by this program. Since detailed data are required to calculate the capitation rates for components of the Prioritized List of services, we believe it is important that the same primary data source be used for calculating the global capitation rate.

A five percent sample of all claims incurred by BSC's commercial population for the two year period of January 1988 through December 1989 was provided. The sampling process included selecting all line items of every twentieth claim. Thus, if multiple services were billed on the same claim, all services were included in the sample. For certain high cost/low frequency diagnoses all claims were selected rather than a 5% sample to assure that at least some claims were selected. This is primarily of importance when rates are calculated based on the Prioritized List of services provided by the HSC. A list of the specific diagnoses for which 100% of claims are included is shown in Exhibit 1.

Data elements included on the data set include claim billed, allowed, and paid amounts, service descriptors including diagnosis and procedure codes as well as place and type of service codes, and patient demographic data.

- **Blue Cross / Blue Shield of Oregon ("BCBSO")** data are used as one measure of differences in average charges per unit of service for non-hospital services between California and Oregon. This analysis is based on average charges for specific CPT-4 codes only, rather than average charges for larger groups of services because the service groupings are not consistent between the BCBSO data and the MMIS and BSC data. Variation in utilization patterns in different areas of the State will also be measured using this data to determine the capitation amounts to be paid to different contracting plans.

  The BCBSO data were provided in two formats. Detailed reports on average charges by CPT4 code were provided for calendar year 1989. In addition, complete claims data for a two year time period of July 1987 through June 1989 were provided in summary format. Claims are summarized based on date of incurral, general category of service (inpatient hospital, outpatient hospital, standard physician visit, consultative physician visit, and so on), line of business including Administrative Services Only, Direct Pay, Retrospective Pay, and Prospective Pay, county of residence, and age and sex of the recipient.[3]

In addition to these primary data sources, data from several additional sources are used in the analysis. Information on average compensation levels and the percent of total payments used to cover overhead costs were examined. These data were collected from the American Medical Association, Socioeconomic Characteristics of Medical Practice, Warren Surveys on HMO Executive Compensation, and the Medical Group Management Association.[4]

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3. Lines of business reported in the BCBSO are based on the reporting standards of that organization.

4. "Socioeconomic Characteristics of Medical Practice, 1989," American Medical Association; "Warren Surveys, the HMO Executive Salary Survey," Spring 1990, Henry W. Warren & Associates, Inc; and "Physician Compensation Survey Report, 1989 Report Based on 1988 Data," Medical Group Management Association.

Information on current contracting arrangements in Oregon was also collected from a number of managed care plans in addition to Blue Cross/Blue Shield of Oregon. Information on contracting arrangements for dental plans was obtained from Oregon Dental Service and from a major insurer.[5]

Additional information on reimbursement levels and overhead costs was gathered for specific categories of service. For example, we were provided with copies of recent surveys on dispensing fees and costs associated with dispensing prescription drugs.[6] We also obtained information from the Oregon Dental Association on overhead costs for dentists.[7]

Data on cost-to-charge ratios for hospital services in California and Oregon were initially obtained from a data tape provided by the Health Care Financing Administration containing the most current (1988 data) audited Medicare Cost Reports. However, the calculated cost-to-charge ratios from that tape appeared to be unreliable, as the resulting ratios were calculated at a value below 50%. As a substitute, we used information filed with the California Office of Statewide Health Planning and Development and information from Oregon Office of Health Policy to calculate the relationship between hospital costs and charges. Because this alternative data was available only in a more summarized format, it is not possible to calculate separate cost-to-charge ratios for hospital inpatient and outpatient services. Instead, an average cost-to-charge ratio was calculated.

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5. Information on contracting arrangements for major insurers is included in the analysis. However, the details of the contracting arrangements are considered proprietary and are not reported in detail in this report.

6. Unpublished Data, Oregon State University, March 1990.

7. 1987 Oregon Dental Economic Report.

SECTION III

Issues Associated with Measuring Costs and Utilization

Calculating the "Cost" of Providing Services

The capitation calculations are based on the average allowed charges recorded in the BSC data (with certain specific exceptions that are described in Section IV). To meet the requirements of the legislation, it is necessary to translate this charge data to a measure of average "costs." We have adjusted the BSC data to reflect Oregon average charge levels. We have also calculated cost-to-charge ratios for each of the categories of service based on information that is reported in hospital cost reports and information on managed care contracting arrangements. The specific methods used to adjust the California data to reflect Oregon average charges and to calculate the cost-to-charge ratios are described in detail in Section IV.

Changes in Length of Eligibility

The Basic Health Services Program will expand eligibility to categories of people that are not currently covered by Medicaid. In addition, the eligibility rules are expected to result in a longer average length of enrollment for Medicaid recipients, as well as a change in the demographic characteristics of Medicaid recipients. In calculating expected utilization rates for the Basic Health Services Program, it is important to consider possible changes in utilization that may result from the structure of the program and the eligibility and enrollment rules.

Description of Eligibility Categories

Current Medicaid eligibility rules limit enrollment in Medicaid based on income and asset restrictions and demographic characteristics. Income limits are set at varying levels depending on the category of eligibility and are often associated with eligibility to receive a cash grant.

- The AFDC program covers single parent families with children and two-parent families when the primary wage-earner is unemployed. For the AFDC program, income limits are set at approximately 51% of the Federal Poverty Level ("FPL").

- The Medically Needy program covers individuals with the same demographic characteristics as the AFDC population who have medical expenses that reduce their remaining income to 133% of the AFDC limit, or approximately 67% of FPL.

- During the data reporting period the PLM program covered pregnant women and children under age 3 with an income below 85% of the FPL. As a result of changes in federal law, pregnant women and children under age 6 in families with incomes to 133% of FPL and all children born after September 30, 1983 in families with incomes up to 100% of FPL are now covered. This program change is independent of the implementation of the Basic Health Services Program.

- The GA program covers adults who do not qualify for any of the other programs and who are unable to work due to a medical disability for at least 60 days. The income limit for the GA program is set at 49% of the FPL.

Under the Demonstration Project, the AFDC and GA programs will be retained with their current eligibility rules. The PLM program for individuals with an income between 100% and 133% of FPL will also be governed by the existing eligibility rules with certain exceptions.[1] Under current eligibility rules for those people who qualify for a cash grant, eligibility is generally reassessed monthly for those cases where the wage earner is or has been employed in the last 12 months.

Eligibility will be expanded to include two types of new eligibles: (1) those with demographic characteristics similar to those required to qualify for Medicaid under the AFDC or PLM programs but with an income above the current income limit and below 100% of the FPL, and (2) those with an income below 100% of the FPL but with demographic characteristics that would not allow them to qualify for the AFDC

1. The eligibility rules for the PLM population with incomes from 100% to 133% of FPL will be somewhat different than the rules for other categories of eligibility.

or PLM programs.[2] Individuals falling into this second category include single adults, childless couples, and two-parent households with an employed parent. For contracting purposes, all individuals who do not qualify for a cash grant under one of the welfare programs will be considered "demonstration only" eligibles, including those who qualify for PLM with an income under 100% of the FPL. For these individuals, eligibility will be redetermined once every six months and income from the most current month only will be used to determine eligibility. Household assets will not be considered in establishing eligibility.

In addition to the changes in eligibility that are expected as a result of the demonstration project, federal Welfare Reform rules passed in 1989 are also expected to result in increased lengths of eligibility for the AFDC program. Under this rule change, AFDC recipients who become ineligible to receive a cash grant under that program due to an increase in income are now eligible for 12 months of extended medical coverage under the AFDC program. Prior to implementation of the welfare reform rules, the extended medical coverage period was four months.

Exhibit 2 provides a matrix of the current eligibility categories and the eligibility categories under the demonstration project.

Adjustments to Utilization Rates

Utilization of health care services is generally measured in terms of the number of units of service per 1,000 members per year, with the count of the number per year calculated by summing the number of person-months of eligibility and dividing by 12. If there were no changes in eligibility rules that affect the length of eligibility or the types of people who will be covered by the program, the current utilization rates could be used to forecast future use rates. The change in length of eligibility, however, is expected to affect utilization rates for different services in varying ways. Calculated annual utilization rates for some services are expected to decrease as the length of time over which the same services are spread is increased. Utilization rates for other services are expected to change only nominally as a result of the new eligibility rules.

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2. Individuals who are eligible under the Aid to the Blind, Aid to the Disabled, and Old Age Assistance programs, as well as those who are recipients under the Foster Care program will continue to qualify for Medicaid under current eligibility rules and will not be included in the Demonstration Project at this time.

For example, under the PLM program that was in effect during the data reporting period, pregnant women with an income up to 85% of poverty became eligible for Medicaid when they became pregnant and remained eligible until two months after the birth of their child. The average length of eligibility per year for pregnant women in the PLM program was four months. Under the new eligibility rules, the minimum length of eligibility for pregnant women with an income under 100% of the poverty level will be six months, with eligibility to end no sooner than two months after the birth. Eligibility for children covered by the program will also be expanded to a minimum of six months. Total costs for hospital services associated with each maternity are not expected to change substantially, but the length of time over which those costs are spread is expected to increase. Therefore, the per capita monthly cost of providing services should decrease as the number of births per 1000 member-months decreases, although the number of births per 1000 individuals is expected to remain constant.[3]

We expect that other services that are associated with specific episodes of illness, such as surgeries, will have similar changes in their utilization patterns. In other words, the total number of surgeries per unique enrollee may not change significantly with the increased length of eligibility, and the total utilization rate for those services must be spread over the new average length of eligibility. Services that are provided on a periodic basis, such as physician visits, are expected to be less sensitive to length of eligibility. Therefore, we would expect an increase in total utilization of periodic services roughly equivalent to the increase in average length of eligibility as a result of the increased eligibility period. Exhibit 3 shows the types of services that we expect to be affected by the change in average length of eligibility.

When the Medicaid program is expanded to include nearly all Oregonians up to 100% of the poverty level, it is expected that many of the people who currently qualify for Medicaid only when they have immediate need for health care services will qualify for coverage sooner and their health care costs will be spread over the expanded time period. The actual length of time individuals are enrolled in the program is partially dependent on the methods used for communicating the

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3. As the number of people receiving Medicaid benefits increases the total number of maternities is expected to increase. However, the number of maternities per 1000 member-months of eligibility is expected to decrease.

availability of the program to potential eligibles and the level of outreach efforts. For example, some individuals may learn about the program when they obtain health care services. These individuals will tend to have a high average cost. Others may learn about the program through outreach programs and sign up prior to a direct need for health care services. These individuals may have a somewhat lower average cost.

We have assumed that a mix of people will enroll in the program, including some who have "pent-up" demand for health care services and some who do not have a specific immediate need for services. The result of this assumption is that utilization rates are set at average levels that would be expected for a mature program.

Expected Changes in Length of Eligibility

Estimates of the effects of changes in the eligibility rules on the average length of eligibility were calculated by Oregon Medical Assistance Program staff and by Lewin/ICF in a separate analysis. Calculations were made of the current average length of eligibility for each eligibility category. The effects of the rule changes were then modelled. Exhibit 4 shows the average length of eligibility per year during the data reporting period. This exhibit also shows the expected average length of eligibility as a result of implementation of the Welfare Reform rules and expected changes due to the rules of the demonstration project including changes in eligibility rules for the PLM population.

To estimate the effect of changes in eligibility rules due to Welfare Reform and the changes in the PLM rules, OMAP staff modelled the changes in lengths of eligibility in terms of average number of months of eligibility per person per year that could be expected as a result of the rule changes. Current length of eligibility was calculated by identifying all individuals who were eligible at any time in fiscal year 1989. The sum of the months of eligibility was calculated and divided by the unduplicated count of individuals who were eligible during the time period. The estimated effects of the Welfare Reform rules were then calculated by identifying all individuals who exhausted their eligibility for extended medical coverage during the fiscal year or the prior fiscal year. An additional span of eligibility was added to the original eligibility period for each of these individuals based on estimates of the average increase in length of eligibility. A new count of total eligible months and unduplicated eligibles

in fiscal year 1989 was then made to calculate the revised estimate of average length of eligibility.[4]

The estimated length of eligibility for Demonstration Only eligibles is taken from the Lewin/ICF analysis.

Expected Distribution by Eligibility Category

The average per capita cost of the demonstration program is based in part on assumptions regarding the distribution of eligibles by eligibility category. For this portion of the calculation, we have relied upon estimates made by Lewin/ICF in their analysis of expected enrollment in the demonstration project and on information provided by OMAP budget staff.

Exhibit 5 shows the expected distribution of eligibles among the eligibility categories in 1993 at program start-up and when the program has reached a steady-state. It is assumed that by the end of the first year approximately 60% of expected participants will become enrolled. The program is expected to reach a steady-state of enrollment three years after implementation. The percentages shown here were provided by OMAP staff.

Comparison of Utilization Rates for the Different Data Sources

Data from a variety of sources are used to calculate the total per capita cost. In measuring utilization, it is important that any differences in reporting practices among the different data sources be considered. For example, if physicians in California typically bill separately for each individual procedure, while those participating in the Oregon Medicaid program typically bill a global rate for packages of services, a comparison of the number of units of service provided may be inaccurate and may ultimately result in incorrect capitation rates.

We have reviewed the billing practices for selected services such as surgeries and physician office visits reflected in the BSC, BCBSO, and MMIS data to determine whether significant differences exist in the components of a typical claim. For example, if a secondary surgical procedure is typically billed in conjunction (as a

4. Data for fiscal year 1988 are included in the first portion of the analysis of the effects of the Welfare Reform rules to account for those individuals who would have been eligible in fiscal year 1989 had the rules been in effect at the time.

single claim) with a primary procedure in one data set but is billed as two separate claims in another data set, comparisons of both the average utilization rate and the average charge comparison would be incorrect. Our review has shown that the billing practices reflected in the BSC and MMIS data are similar except in the case of hospital billings for newborns. For the BSC data, the charges associated with healthy newborns are included in the mother's bill, while separate claims are submitted for the mother and baby in the MMIS system. We have made an adjustment to the data to accommodate this difference.

However, the BCBSO data appear to reflect substantially different methods of counting claims. Since these data were provided in summary format we are unable to recategorize the claims to make them comparable to the other data sources. As a result, the summarized BCBSO data will be used primarily as a means of measuring variation in utilization by geographic region within Oregon. The detailed reports of average charges by CPT4 code are used in combination with data from managed care health plans to calculate the differences in average charge amounts for California and Oregon.

SECTION IV

Methods Used for Calculating the Total Per Capita Cost

Measuring Utilization and Average Charges by Category of Service

The total per capita cost was calculated through a series of steps. The first step involved calculating average utilization rates and the average charge amount per unit of service for approximately 70 general categories of service. The categories of service used for the analysis are shown in Exhibit 6. This step was done for each of the three primary data sources.[1] For the MMIS data, a separate analysis was performed for each of the current eligibility categories that will be included in the demonstration project.

The Medicaid data serves as the primary data source for measuring expected utilization rates under the new program for all individuals who have the same demographic characteristics as current eligibles (data for the AFDC Medically Needy population is excluded from the analysis since only a portion of their claims are included in the data base.) Included in this group are those who qualify for the program under existing eligibility rules and those who will qualify due to the increase in the income limit but who have family characteristics similar to those required to qualify under current rules.

Utilization rates from the BSC data are used to estimate utilization for the new population groups that will be eligible for the demonstration project but who do not meet the standard Medicaid "categorical" requirements for eligibility. Because of expected differences between the demonstration project population and the standard BSC population, a demographic adjustment factor is applied to the BSC data. This adjustment is explained in detail in the section titled "Demographic Adjustments to

1. The BCBSO data was provided in a summarized format that reported on 22 categories of service. When BSC data were compared to the BCBSO data, the categories of service were combined in a similar way to allow for a direct comparison.

Reflect Demonstration Project Eligibles." Adjustments are also made to the utilization rates for specific categories of service including maternity services, chiropractic, podiatry, and inpatient psychiatric.

Utilization rates were measured by counting all claims for each of the categories of service. The sum of the number of claims was then divided by the number of member months of enrollment for the appropriate population group. Hospital claims are recorded on a per admission basis, while all other claims are recorded for each separate service that is provided. For example, a series of office visits for a single condition are counted separately for each visit rather than as one episode of illness. Each separate prescription is also counted. Utilization rates for maternity and surgery services were translated into rates per episode.

The BSC data are used as the primary data source for calculating average allowed charges per unit of service for all services except those services that are covered by Medicaid but not covered by BSC such as Maternity Management and certain transportation services. In addition, MMIS data are used to calculate average charges for prescription drugs because the BSC data are incomplete for that category of service. Allowable charges submitted by providers are used in the analysis rather than paid amounts to reduce the effect of any cost sharing arrangements on the calculation of allowable charges. These allowable charge amounts are recorded without consideration for any preferred contracting arrangements that may ultimately reduce the actual contracted allowable charges.

For both the BSC and the MMIS data the claim dollars and units of service were "completed" using completion factors that provide an estimate of the percentage of claims that were incurred but not reported as of the date that the claims tapes were produced. This step is necessary because of the lag that occurs between the time when services are rendered and claims are submitted and paid. By analyzing the claim payment pattern it is possible to estimate the percentage of total claims that remain outstanding at any given time.

The total health care budget includes some services that are not covered by Medicaid, such as adult preventive medicine and adult non-emergency dental care. Some services that are covered by Medicaid are not typically covered by commercial plans or special arrangements are made to subcontract to another payer. These services are not well represented in the BSC data.

As a result, for certain specific services, expected utilization rates for the Medicaid population are derived from the BSC data. In other cases Medicaid data are used to estimate the average charge and cost per unit of service and the utilization rate for the new non-categorical type eligibles. Exhibit 7 shows the categories of service for which adjustments were made to the utilization rates due to differences in covered services between commercial plans and the Oregon Medicaid program.

Specific adjustments have also been made to several categories of service due to differences in utilization rates between the BSC population and our estimates of utilization for a newly insured population. These adjustments are as follows:

- For the BSC data base, there are certain services that are generally covered only through "riders" that are outside the standard benefit package. These services include chiropractic, podiatry, and psychiatric inpatient services. Since a specific decision must be made to select coverage for these services, we believe utilization is higher than average. For chiropractic and podiatry services we have assumed that the utilization rates shown in the data base are ten times higher than average. For psychiatric inpatient services we have assumed that the utilization rates in our data base are three times higher than average. These adjustments are based on our experience with utilization rates for these services and our best judgement of expected utilization.

- In using the BSC data to reflect expected utilization rates for the new noncategorical eligible population, the utilization rates for certain services are lower than might be expected for a newly insured population. In particular, utilization rates shown in the BSC data base for hospital outpatient services are substantially lower than the rates for the AFDC population. While utilization rates for this population group may be somewhat lower than the utilization rates for the AFDC population, we expect that they will be higher than the rates reflected in the data base which represent utilization for a population group that has had health insurance coverage for some time. We have adjusted the utilization rates for all of the hospital outpatient services except outpatient maternity by calculating an average utilization rate using an equal weighting of the BSC and AFDC data.

- The BSC data includes both mother and healthy newborn charges in the same bill. In order to avoid double counting the costs associated with healthy newborns, we have calculated the portion of the maternity charges that are associated with healthy newborns based on the distribution of those charges for the AFDC population. We have also calculated a utilization rate for healthy newborns for the BSC data by calculating the percentage of maternity admissions that result in births for the AFDC population and subtracting the neonatal cases.

Exhibit 8 shows a comparison of the average utilization rates by general category of service for each of the Medicaid eligibility categories and for the BSC data prior to any adjustments to the utilization rates associated with the increased length of eligibility. Exhibit 9 shows the average utilization rates after adjustments for changes in average length of eligibility or changes in expected utilization. The utilization rates shown in Exhibit 9 also reflect adjustments for specific categories of service where alternative data sources are used to estimate utilization under the demonstration project.

Translating Average Charges to Measures of "Cost"

Average charges per unit of service were adjusted to estimate a measure of "cost" for each general category of service. This adjustment was done through a series of steps:

1) High-end outliers were identified and removed from the average allowed charges;

2) The California average allowed charges were adjusted to reflect Oregon average charge levels;

3) A cost-to-charge ratio was calculated and applied.

Each of these steps is described below.

Identify and Remove High-end Outliers

Average charges per unit were adjusted to remove high-end outliers from the calculation since high-end outliers can significantly skew the calculation of average charges upward. This was done by identifying the highest volume services as defined by CPT-4 procedure code, American Dental Association code, and National Drug Code. Average allowed charges were calculated for up to 20 different procedure

codes for several of the primary categories of service. All claims for $5 or less were excluded from the analysis (except for prescription drugs where claims for $1 or less were excluded) to remove the effect of providers who are charging inordinately low amounts for services or possible data errors.

The mean and the standard deviation were calculated for each of the procedure codes. Claims that were more than 1.5 standard deviations higher than the mean charge were then deleted from the data base and the mean was recalculated based on the remaining data. A cut-off point of 1.5 standard deviations from the mean was used because this value allows approximately 93% of all claims to be included in the analysis if the charge amount is distributed according to a "normal" distribution.

This process of adjusting average allowed charges was used to assure that the calculated average allowed charge represented the true average, rather than a few cases with significantly higher than average charges. The percentage reduction in average allowed charges for all procedure codes for each category of service was then calculated and applied to all claims for the category of service. An example of the calculation is provided in Exhibit 10. Removing outliers from the average charge calculation resulted in a reduction in the average charge of approximately 5%. This process was not used for hospital services because the hospital cost-to-charge ratio is used and that value reflects the effect of removing cost outliers. In addition, the wide variation in hospital services based on diagnosis type makes a comparison of this type less reliable.

Adjust California Average Charges to Oregon Average Charges

California average allowed charges per unit of service (using the BSC data) were compared to average allowed charges in Oregon for a large number of the general categories of service by comparing average allowed charges for the BSC, BCBSO and MMIS data for specific CPT4 codes and ADA codes. For the BSC and MMIS data, the average charges per unit of service by CPT4 code were calculated from data in our data base. For the BCBSO data we received separate reports on average allowed charges by CPT4 code. The comparison of the BCBSO and the MMIS data showed that average charges from both sources were similar in most cases. The differences in average charges in California and Oregon by general category of service are shown in Exhibit 11.

Identify and Apply a Cost-to-Charge Ratio

Adjustments unique to each of the categories of service were made to translate the average charge amounts to values that would reflect "rates necessary to cover costs." For example, data on hospital costs and charges reported to state agencies and derived from Medicare Cost Reports on the cost-to-charge ratio were used to adjust the average charge amounts for inpatient and outpatient hospital services to costs.

For other categories of service, there are no generally accepted means of determining the "cost" of providing services. As a substitute, we examined published information on the percentage of total gross revenue (or charges) used to cover overhead expenses where that information was readily available as a first step in estimating the relationship between average charge amounts and the costs associated with providing services. We also obtained information on contracting arrangements and the amount of discounts required by managed care contracts in Oregon as a measure of reimbursement rates that are currently used by commercial managed care plans and reimbursement rates that can be presumed to cover the costs of providing services.

The percent of total charges used to cover overhead costs was determined for a number of the categories of service. Data were obtained for physician and dental services, as well as the dispensing fee portion of prescription drugs. Exhibit 12 shows the average overhead percent by provider type. For other categories of service, information on overhead costs was not available. For this analysis, we have calculated an average overhead percent for all services where information is available, and have assumed that other services have a similar overhead percent. The purpose of collecting the information on overhead expenses was to assure that any proposed reimbursement rates did not fall below the levels that are reported to be necessary to cover overhead costs.

While these overhead percentages serve as a reasonableness check, the information on contracting arrangements has been used to establish the minimum reimbursement that can be considered adequate to cover the costs of providing services.[2] Based on discussions with a number of managed care organizations, we determined that those

2. The minimum has been used rather than the average for this portion of the calculation since the rates are for a public program, and it is assumed that the legislation intends that the reimbursement rates be adequate to attract a sufficient number of providers to participate in the program, but that additional reimbursement would be inappropriate.

organizations are generally able to contract with primary medical care providers at discounts of at least 20% off of standard allowable charges. We have used this 20% discount as a "benchmark" for determining costs for physicians. We then calculated an adjustment factor for specialist physicians using data from the work done for the Physician Payment Review Commission that is in the process of developing the Resource Based Relative Value Scale ("RBRVS").

The RBRVS provides a relative ranking of the resources required to provide different types of medical services. The definition of resources used for the RBRVS includes both physician overhead costs and the amount of time required for performing a particular service. Most of the codes currently included in the CPT4 code book will ultimately receive a ranking. However, all of the work on developing the RBRVS has not yet been completed. As a result, the values that have been calculated could change as the RBRVS is completed and refined. The initial RBRVS values and relative value units ("RVUs") by CPT4 code were published in the Federal Register on September 4, 1990 and these are the values that were used in this analysis.

The relative "cost" for providing specialty services was calculated in comparison to the cost of providing standard office visits by calculating the average charges per "RVU" by CPT4 code from the BSC data. The weighted average dollars per RVU by category of service was then calculated. For example, the average charges per unit of service for physician office visits was $42.72 and average RVUs was 32.623. The average dollars per RVU for physician office visits was then calculated as $42.72/32.623=1.31. A similar calculation for surgeries resulted in an average charge per RVU for surgeries of 1.83. The ratio of surgery dollars per RVU to physician office visit per RVU was calculated as 1.83/1.31=1.40. If we assume that the cost-to-charge ratio for physician office visits is .80, the cost to charge ratio for surgeries is calculated as .80/1.40=0.57. The following table provides an example of the calculation.

Example of RBRVS Calculation

	Standard Office Visit	Surgery
Average Charge per Unit	$42.72	$220.45
Average Relative Value Units	32.62	120.67
Dollars per RVU	1.31	1.83
Ratio of Surgery dollars per RVU to Standard Office Visits dollars per RVU		1.40
Cost to charge ratio	0.80*	0.57**

* Based on managed care contracting arrangements.

** Calculated as .80/1.40

For dental services, we used a discount factor of 30% based on information from managed dental care plans. These plans are generally able to secure discounts of approximately 30% off of standard allowable charges.

For services such as transportation and home health care that represent a relatively small percentage of the total health care budget, and for which separate reports are generally not available on overhead requirements or contracting arrangements, we have assumed a 10% average discount.

The average cost-to-charge ratios for inpatient and outpatient services in Oregon are shown in Exhibit 13. This exhibit also shows the discount factors generally negotiated by managed care plans for general categories of service and the calculated discount factor for specialty medical care. These discount factors are used to adjust charges to measures of "costs" in the final capitation rates.

The methods that are used to calculate the cost-to-charge ratios make no adjustments for current Medicaid payments that are below costs or for uncompensated care that will be reduced when more people are covered by Medicaid. We assume that average charges reflected in the BSC data are increased by the amounts required to fully cover costs based on the amount of revenue that is expected to be collected. As a result, we expect that total reimbursement to providers will increase under the demonstration project if all health care services are covered by the program.

In calculating the per capita cost for prescription drug services, we have assumed that the cost of goods for drugs for all contractors is based on rates necessary to cover the costs for private community pharmacies. Some large entities may be able to negotiate lower payment rates. Therefore, the State may choose to adjust the capitation amount for prescription drugs in its contracts with those entities.

Adjustments for Case Mix Differences

There are substantial differences in the average charge per unit by eligibility category for certain services including inpatient Med/Surg cases, prescription drugs, outpatient services, testing and durable medical equipment. Because the per capita cost per unit of service is calculated by multiplying the average cost per unit of service by the average utilization rate, it is important that the per capita cost calculation recognize these differences. For example, the average charge per inpatient admission for Med/Surg cases for AFDC recipients is $4,221.50 while the average charge per Med/Surg admission for GA recipients is $8,949.16. The calculated average charge per admission from the BSC data is $6,379.68 after adjusting to Oregon average charge levels. These differences are primarily a reflection of differences in the severity of illness of the different types of recipients. With no adjustment for these differences in severity, the average per capita cost for AFDC recipients would be overstated, while the average per capita cost for GA recipients would be understated.

We have calculated and applied a "severity" adjustment to account for these differences. The severity adjustment was calculated by comparing the average adjusted charge per unit of service for each of the eligibility categories and creating a relative charge factor. For example, we compared the BSC average charges adjusted to Oregon average charge levels to the average charge per unit of service for each of the Medicaid eligibility categories by service type. For those categories where there was a difference in the average charge per unit of service among the eligibility categories of more than 10% an adjustment factor was calculated. This factor is applied to the data in the calculation of the per capita cost by service category and reflects the lower than average cost per admission for AFDC eligibles and higher than average cost per admission for GA eligibles. The services for which we have calculated adjustment factors to reflect differences in case mix among the different eligibility category are identified in Exhibit 7.

Method for Trending Data Forward to the 1992/93 Contract Period

The average cost per unit of service for all categories of service was trended forward to reflect the expected contract period of July 1, 1992 through June 30, 1993. To reflect a cost-based trend factor, we used information on changes in medical costs over the period January 1988 to December 1990. We then projected changes in costs for the period January 1991 to January 1993, the midpoint of the expected contract period. Trend rates are calculated using two different approaches due to expected differences in contracting arrangements and payment rates. For the portion of the population that is covered by prepaid health plan contracts, we have calculated trend factors based on changes in input costs. This information was obtained from the Health Care Financing Administration and reflects changes in the "market basket" of goods used to determine changes in the costs of providing medical services for inpatient and outpatient hospital services.[3] We have used information from the Medicare Economic Index for professional and drug services. Utilization rates are projected from national data on utilization trends by category of service.[4] Because the trend rates are based on changes in provider input costs, they are substantially lower than changes in premium rates experienced by commercial insurance plans.[5]

For fee-for-service contracts, we rely on information on changes in fee levels allowed by the legislature in past years and expected changes in fee levels for fiscal years 1992 and 1993. Changes in utilization rates are calculated from changes in the cost per person per month over the data reporting period for the MMIS data.[6] Exhibit 14 shows the trend rates used to update the calculations to the contract period.

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3. Federal Register Vol 53, No. 190, September 30, 1988; Federal Register Vol 53, No. 65, April 5, 1988; and Federal Register Vol 64 No. 170, September 5, 1989. Private communication with Aaron Brown, Health Care Financing Administration, March 19, 1991.

4. Retiree Health Benefits, Field Test of the FASB Proposal, Coopers & Lybrand, 1989

5. Medical Costs Soar, Defying Firms' Cures, The Wall Street Journal, January 29, 1991. Premium rates charged to employer-sponsored medical plans are expected to increase by an average of approximately 20% in 1991. These premium increases are the result of a variety of factors including marketing practices and do not reflect a direct measure of the change in provider input costs such as salaries and other overhead. The cost increase factors we have calculated here are intended to serve as a measure of the change in input costs only, as determined by the Health Care Financing Administration.

6. State of Oregon Medicaid Prepaid Plan Program, Calculation of Capitation Rates for the 1991 Fiscal Year Report, December 11, 1991. By Coopers & Lybrand

Administrative Cost Allowance

The total program cost for the Prepaid Plan portion of the calculation includes a 6% allowance to cover administrative expenses. This amount is intended to cover the costs of administering a mature managed care program that already has information systems in place. Additional costs associated with plan start-up or with marketing individual plans are not intended to be covered by the 6% administrative cost allowance. For the fee-for-service portion of the program, we have assumed a $3.00 per person per month case management fee will be paid to the Primary Care Case Managers.

The administrative cost allowance is typically reported as a percentage of total premium and the amount allocated for administrative costs shown here for the HMO portion of the program is expressed in those terms. For the PCO portion of the program the administrative cost allowance was calculated by taking into account the specific types of services that the PCOs are responsible for. The PCO capitated services generally have a low dollar value per claim compared to the services that are excluded from the PCO contract. (PCOs are capitated for physician and a portion of outpatient hospital services but are not capitated for high dollar items such as inpatient care.) The PCO administrative cost allowance was set at $4.00 per person per month.

Adjustments for Managed Care Savings

A reduction in the total per capita cost is made to reflect the effect of managed care on program costs. The claims included in the data base used to calculate total per capita costs did not reflect any adjustments for careful case management. Under most managed care programs, a reduction in total utilization can be expected. These reductions are typically in hospital services and may also be evident in reduced use of prescription drugs and some diagnostic testing. Use of some services, such as physician visits, may increase under a managed care arrangement.

Savings to the State resulting from the current "Incentive" program for Medicaid PCOs are used as a measure of expected savings under case management. Under that program, PCOs receive an incentive payment for reduced utilization of case managed services equal to 50% of the State's net savings (after subtracting the administrative costs of running the program). Savings are calculated for inpatient, non-capitated outpatient, and non-capitated prescription drug services. Maternity

services are excluded from the savings calculation since the Plans do not have direct control over the number of admissions per capita associated with maternity care in the same way that they can influence utilization of hospital services for other purposes.

For the 1991 contract year, PCO savings are calculated as the equivalent of 11.7% of the total per capita cost of the HMO participating in the Prepaid Plan Program. This 11.7% of costs represents approximately 25% of the costs of the case managed services, with the vast majority of the savings the result of reductions in the use of inpatient and outpatient hospital services. The 11.7% of costs does not include the cost of dental services, as HMOs are not currently capitated for dental services. In addition, only limited adult dental services are currently covered by the Medicaid program. (Expected savings for dental services are unknown, as a large amount of pent-up demand for those services is expected.)

We have applied a 25% managed care savings factor to the inpatient and outpatient hospital services costs for the AFDC, PLM and new eligibles populations for the HMO portion of the calculation (inpatient and outpatient maternity services do not receive a managed care adjustment.) We have also applied a 12.5% managed care savings to the hospital portion of costs for the GA population, since an existing medical management program for the GA population requires all GA enrollees to obtain physician and pharmacy services through a single provider. We do not anticipate that significant additional savings can be realized for those services that are currently covered by the medical management program.[7]

The expected savings for the Primary Care Case Manager portion of the program is set at 4% overall and 9% of inpatient and outpatient hospital claims due to differences in the risk sharing arrangement compared to prepaid plan providers.

For the PCO portion of the program, managed care savings are expected to be 50% of the savings realized under the HMO program, since PCOs will continue to participate in the savings incentive program and will receive payment for 50% of the

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7. We expect that additional managed care savings can be achieved beyond those experienced by the existing GA managed care program when recipients become enrolled in prepaid health care plans that have full responsibility for the utilization and costs associated with GA clients. However, we do not believe that those savings will be at the same level as those experienced by the AFDC program, where expected savings are calculated in relation to a pure fee-for-service program with no managed care.

net savings to the State. In other words, managed care savings for the PCO portion of the program are set at 6% overall and 13% for case managed services.

Demographic Adjustments to Reflect the Demonstration Project Eligibles

Age/sex adjustments to the commercial population were made to reflect the population to be covered under SB 27. The BSC data that are used to estimate utilization for the new noncategorical eligibles reflects a standard distribution of commercially-insured members including men, women and children. However, the newly eligible population for whom we use the commercial data to measure utilization rates has different demographic characteristics. Since most women with children will be eligible for the program as a result of eligibility for AFDC or PLM, the remaining population will have a higher than average percentage of men and non-pregnant women. The percentage of children is expected to be lower than average.

To adjust for the expected differences in costs for the new eligible population, we eliminated nearly all of the maternity and newborn claims that were included in that data base. After removing possible differences in utilization related to maternity and newborn services, we calculated an age/sex adjustment factor for the population based on data from internal C&L data bases. We calculated an adjustment factor of 0.89 for the newly eligible population compared to the average commercial population. This factor indicates that we expect health care costs for this population group to be 89% of costs of an average commercial group and reflects the expectation of a younger average age for the demonstration project population compared to a standard commercial population.

A separate adjustment factor was calculated for the new categorical eligible population. That population is assumed to have utilization similar to the mix of services used by AFDC and PLM eligibles except for the use of maternity services. Most of the maternity cases are expected to occur among the current eligibility categories. We calculated a factor of 1.10 representing the expected age/sex mix of the new eligible population relative to the mix of the current age/sex mix of the AFDC and PLM populations excluding the cost of maternity services. This factor indicates that the mix of new eligibles is somewhat older than the average age of current AFDC and PLM eligibles. This age difference is primarily a result of

children under age 6 being covered by the PLM program. The age/sex distribution of the new eligible population was calculated by Lewin/ICF in a separate analysis.

An adjustment was also made to the expected cost per person calculation for the PLM-child population. During the data reporting period the PLM program covered children through age 3. Welfare reform rules require that older children also be covered. By the time the demonstration project is implemented in 1992/93, children through age 8 must be covered by PLM. Newborns and children through age 3 use a substantially higher amount of health care services per capita than do older children. Using data from the AFDC population on differences in the cost per person per month by age group, we calculated an adjustment factor of 0.71 to reflect the reduction in average medical costs for the additional children who will be covered by the PLM program. We also estimated a factor of 2.5 for dental services to reflect the additional dental services that will be required for this older population of children. This dental factor was calculated based on data on dental utilization patterns by age for the current AFDC population.

Per Capita Cost for Non-capitated Services

In addition to HMOs, the State intends to provide services through PCOs and primary care case managers. A portion of the services provided to PCO enrollees and all services provided to individuals who are enrolled with primary care case managers will be paid on a fee-for-service basis. It is the State's intention to pay for these services based on existing Medicaid fee levels with adjustments for budgeted increases, but with no adjustment to reflect the "cost" of providing services. As a result, the average payment rate for services provided on a fee-for-service basis is expected to be lower.

To calculate the per capita monthly cost of providing services on a fee-for-service basis, we used data for current Medicaid average payments per unit of service trended forward to 1993. For the PCO portion of the calculation, we used the cost-based calculations of average cost per unit for those services that will be covered by the capitation contract and the MMIS average payment amounts for those services that will be paid on a fee-for-service basis. There are some services that the PCOs currently have the option of offering on a capitated basis such as maternity case management. For purposes of this calculation, those services were considered to be covered on a fee-for-service basis.

Some individuals will receive all services on a fee-for-service basis without enrollment with a primary care case manager in the first nine months of the program. It is expected that after nine months all demonstration project enrollees will be associated with a prepaid plan or a primary care case manager.

SECTION V

Results of Total Per Capita Cost Calculation

The total per capita cost was calculated separately for six groups of covered individuals and a blended average was then calculated. For those individuals who meet current categorical requirements for the AFDC, GA, and PLM-adult and PLM-child populations, per capita costs were calculated using average adjusted charge data from the BSC data base and average utilization rates from the MMIS data base (with the exceptions for specific categories of service noted in Section IV). Utilization rates for the newly covered noncategorical population were calculated using the commercial data, since we believe that this population is more similar to commercial groups than to the current AFDC group. For the new eligibles with demographic characteristics that are similar to the AFDC and PLM populations, a blended average utilization rate was calculated based on current utilization rates for those eligibility categories.

Per Capita Cost for HMO Capitated Services

The average cost per unit was determined based on charge information recorded in the BSC data with the adjustments described in Section IV above. Exhibit 15 shows the detailed calculation of total per capita costs for each of the population groups with the expenditures trended to 1993. Exhibits 16-A and 16-B show the average blended per capita cost based on the expected distribution of the population in the first year of the program and when enrollment reaches a steady state. The average per capita cost reflects adjustments for administrative costs and expected savings due to reductions in utilization through case management. The rates shown in these exhibits reflect expected costs for a program that includes HMOs only.

Per Capita Cost for Non-capitated Services

Exhibit 17 shows the detailed calculation of total per capita costs for each of the population groups based on current Medicaid fee levels with the expenditures trended to 1993. Exhibits 18-A and 18-B show the average blended per capita rate based on the expected distribution of the population in the first year of the program and when enrollment reaches a steady state. The average per capita cost reflects adjustments for a case management fee and expected savings due to reductions in utilization through case management. This exhibit shows expected program costs assuming all enrollees receive services through primary care case managers.

Exhibit 19 shows the detailed calculation of total per capita costs for each of the population groups assuming that all enrollees receive services through PCOs. PCOs will be capitated for a portion of the services, and other services will be provided on a fee-for-service basis. The cost for those services that will be provided on a capitated basis is taken from the data used to calculate the per capita cost when everyone is enrolled in an HMO. The per capita cost for services that will be provided on a fee-for-service basis is taken from the data used to calculate the per capita cost when everyone is enrolled with a primary care case manager. Exhibit 20 provides a summary of the per capita cost for PCO enrollees.

In the first three calendar quarters of program start-up, it is expected that some demonstration project enrollees will receive services on a pure fee-for-service basis while the Primary Care Case Management system is implemented. These fee-for-service providers will not be paid a case management fee, and no case management savings are expected. Exhibit 21 shows the detailed calculation of expected per capita costs for the fee-for-service recipients. Exhibits 22-A and 22-B show the average blended per capita cost based on the expected distribution of the population in the first year of the program and when enrollment reaches a steady state.

Claims Incurred Prior to Enrollment in a Prepaid Plan

Some prepaid plan enrollees are expected to receive a portion of their services on a fee-for-service basis. For example, under the current prepaid plan program that requires enrollment in a prepaid plan for AFDC recipients in certain counties of the State, as many as 20% of the AFDC recipients receive services on a fee-for-service basis at any given time. AFDC recipients in mandatory enrollment counties can receive services on a fee-for service basis for a variety of reasons:

- Individuals who have other sources of insurance are not included in the prepaid plan program;

- Pregnant women who become eligible for Medicaid in their third trimester of pregnancy may choose to receive services on a fee-for-service basis until after the birth of their child;

- Individuals who reach their plan's stop loss limit in a given year are removed from the prepaid plan program and receive any remaining services on a fee-for-service basis for the rest of the year; and

- New AFDC recipients may require up to two months to become enrolled in a prepaid plan after determination of eligibility.

We have analyzed the data for fee-for-service recipients in mandatory counties for purposes of calculating capitation rates for the current prepaid plan program. In that analysis we have found that the policy exceptions noted above result in differences in per capita costs for inpatient services between FFS recipients in mandatory enrollment counties and FFS recipients in other areas of the state. We also found that the per capita costs for other services provided to FFS recipients in mandatory counties are similar to the costs for fee-for-service recipients in other areas of the state. Based on this analysis, we have included the inpatient costs of both fee-for-service recipients and PCO recipients (who receive inpatient services on a fee-for-service basis) in the calculation of utilization rates for the AFDC population.

GA Enrollees

For other eligibility categories, we have calculated the expected portion of total per capita costs that will be obtained on a fee-for-service basis. For the GA program, we obtained data on the average per capita costs for the first three weeks of eligibility and compared this data to the average annual expected per capita cost. For example, approximately 75% of the average charges for GA recipients are incurred in the first three weeks of eligibility due to the eligibility rules for that program. (Individuals must be medically unable to work for at least 60 days to qualify for GA and many eligibles become enrolled in GA during a hospital stay.)

It is expected that GA recipients will not be enrolled in prepaid plans during this three week period. Therefore, the per capita cost for GA recipients for the time they

are enrolled in a prepaid plan must be adjusted to reflect these expenditures that are expected to be paid on a fee-for-service basis to avoid double payment for the services. Since fee-for-service expenditures will be paid according to current Medicaid payment standards with adjustments for trend and program changes, the average per capita cost for these services is expected to be lower. Exhibits 23-A and 23-B show the calculation of the average monthly per capita cost for GA enrollees adjusted for expenditures incurred prior to enrollment in an HMO and a PCO, respectively.

PLM Enrollees

For the PLM population, we obtained data on the average length of eligibility and the number of women who become enrolled in the program in their third trimester of pregnancy. This information was used to calculate the adjustment to the capitation rate for PLM children. Children whose mothers receive services on a fee-for-service basis will receive medical services for their first two months of life on a fee-for-service basis. After two months, they will be expected to enroll in an HMO or a PCO in areas of the State that have mandatory enrollment requirements.

We identified the portion of total charges for PLM children that are incurred in their first two months. These charges were then separated between those that are covered by the PCO capitation contract and those that would be paid on a fee-for-service basis for PCO enrollees (primarily hospital services.) For the PCO calculation, we also calculated separate age/sex adjustment factors for the capitated and non-capitated services. Since fee-for-service expenditures will be paid according to current Medicaid payment standards with adjustments for trend and program changes, the average per capita cost for these services is expected to be lower. Exhibits 23-C and 23-D show the calculation of the average monthly per capita cost for PLM children adjusted for expenditures incurred prior to enrollment in an HMO and a PCO, respectively.

PLM women who become enrolled in the program in their third trimester will have the option of receiving services on a fee-for-service basis. Those PLM women who choose to receive services on a FFS basis will never become enrolled in a prepaid plan as PLM enrollees. If the women remain eligible for the demonstration project after their maternity, they will be considered new categorical eligibles. Therefore, no adjustment to the per capita cost is required for PLM women.

Summary

The average per capita cost for the demonstration project is based on the distribution of enrollees by eligibility category and health service delivery system. The expected distribution of enrollees for the first year of the demonstration project is shown in Exhibit 24-A. Exhibit 24-B shows the expected distribution of enrollees when the program reaches a steady-state.

Exhibit 25-A shows the calculation of the weighted average per capita cost for the program if all health services are covered at program start-up. Exhibit 25-B shows the weighted average per capita cost based on the expected distribution of enrollees when enrollment reaches a steady-state. All dollar amounts are expressed in terms of 1993 dollars.

SECTION VI

Detailed Per Capita Cost Calculation

Introduction

The final average per capita cost for the program will be based on the specific services that the Legislature determines will be covered. The rate calculated thus far is based on the assumption that all health care services are included in the program. However, the Legislature may decide that funds are not available to fully cover all health care services and that only a portion of the services can be covered.

Process for Identifying Expenditures by Condition/Treatment Pair

To determine the per capita costs associated with covering a portion of health care services, we used the condition/treatment pairs developed by the HSC. All of the expenditures in our BSC data base were allocated to the line items in the Prioritized List of services, with minor exceptions.[1] We used data from the MMIS data base for the prescription drug portion of the calculation. The specific process used for allocating expenditures to line items is described below.[2]

Types of Condition/Treatment Pairs

The HSC developed condition/treatment pairs based on combinations of ICD9 diagnosis codes and CPT4 procedure codes. Different types of condition/treatment pairs were created by the HSC, and the same diagnosis code was often associated with different types of treatments. In some cases, age and disease staging are used to

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1. A very small percentage of the expenditures in the BSC data base (less than 2% of the total) did not match any of the criteria for assigning expenditures to one of the line items. These expenditures were effectively allocated to each of the line items based on the percentage of total expenditures represented by each line item.

2. The term "line item" is used to describe the condition/treatment pairs developed by the HSC for the Prioritized List.

further differentiate between condition/treatment pairs that are otherwise identical. The primary distinction among treatments was between those that include a surgery and those that are primarily medical in nature. Surgery claims are generally defined by CPT4 codes in the range of 10000-69999. Medical Therapies are generally defined by CPT4 codes in the range of 90000-99999. The remaining CPT4 codes describe Anesthesia (codes 00100-01999), Radiology (codes 70000-79999) and Pathology and Laboratory (codes 80000-89399) services.

In addition to the services that can be identified based on specific combinations of condition/treatment pairs, there are a large proportion of services that are coded based on something other than CPT4 codes. These include ancillary services as well as hospital inpatient and outpatient services and prescription drugs. In addition, the HSC did not specifically identify the laboratory tests, x-rays, anesthesia, or other ancillary services that would be associated with each of the condition/treatment pairs because of the large amount of overlap that would occur (i.e., the same codes would be used for nearly all of the line items).

Initial Diagnosis

All expenditures associated with initial diagnosis were effectively included at the beginning of the list. These expenditures were identified as those with ICD9 codes in the range of 780 through 799. In addition, the HSC identified a number of CPT4 codes that are associated with initial diagnosis. These treatments include biopsies and other diagnostic procedures.

Medical and Surgical Therapies

Medical Therapies are those services that do not include a surgery. These services are coded as CPT4 codes 90000-99999. An issue in developing the condition/treatment pairs is that many of the diagnoses have a primary treatment that is medical only and a companion treatment that is primarily surgical. For example, for most cancer diagnoses, patients can receive either medical therapy or surgical therapy. In addition, in some cases the range of diagnoses on the Prioritized List provided for one condition/treatment pair includes some of the same diagnoses that occur for another line item with the same treatment. In other cases, the patient's age or stage of disease is used to differentiate between condition/treatment pairs. Because the same services could theoretically be allocated to more than one

condition/treatment pair, it was necessary to develop decision rules for allocating the expenditures to each pair.

The nature of medical practice is such that some claims have the potential of falling into more than one of the line items on the Prioritized List. For example, individuals who receive a surgical therapy also generally have some expenditures that may be associated with medical therapy. This issue is most clearly defined for those surgical condition/treatment pairs that do not have a corresponding medical therapy. For example, individuals with Acute Appendicitis are treated by surgical removal of the appendix. There is no appropriate medical therapy that serves as a substitute for the surgical therapy. However, 15% of the expenditures in our data base for individuals who received surgical therapy for appendicitis were for medical services. Similarly, the usual treatment for Acute Cholecystitis is surgical removal of the gall bladder. Approximately 6% of the expenditures associated with this diagnosis were for expenditures that would be considered medical therapy. (Services with CPT4 codes in the range of 90000-99999.) The average dollar amount of expenditures associated with the medical therapies for these two diagnoses was 10%. A general review of the data showed that approximately 10% of the expenditures for medical services were associated with surgical cases.

To allocate the expenditures to each of the line items we used the following logic:

1) Using the BSC data, we first applied factors to the data to convert the claim charge amounts to costs by service type based on the factors used in Exhibit 15 to convert California charges to Oregon costs. This step was necessary to assure that the relative cost for each line item was consistent with the methods used to calculate the overall per capita cost for the program.

2) We then identified all the claims as fitting into one of two general categories: claims with CPT4 codes in a range that we expected to match exactly with at least one of the condition/treatment pairs, and claims that did not fit that criteria.

3) Claims with CPT4 codes that we expected to exactly match a line item on the Prioritized List were further divided into two groups: those that represented surgeries and those that represented medical therapy.

Surgery claims were identified as those with CPT4 codes in the range of 10000-69999. Claims for dental services were also included in this category. Medical Therapies were identified as claims with CPT4 codes in the range of 90000-99999 and ancillary services provided during physician visits.

4) Surgery claims were matched against the Prioritized List and allocated to a specific line item.

5) Medical claims were processed through a complex logic test to determine the amount of the total expenditures for each ICD9 code that should be allocated to the different condition/treatment pairs.

   - Claims for all medical therapies were summarized by ICD9 code. (All CPT4 codes related to medical therapy are included in the same treatment definition on the Prioritized List. Therefore, it was not necessary to know the specific CPT4 code for the expenditure after it was identified as a medical therapy expenditure for a given diagnosis.)

   - Each ICD9 code was then matched against the Prioritized List to identify all of the possible line items that the expenditure might be associated with.

   - We then identified whether any of the line items represented only "Medical Therapy". (Some line items have a description of "Medical Therapy", while others have a description of a specific surgical therapy or a combination of medical and surgical therapies. Those that have a description of Medical Therapy only have their treatment identified by CPT4 codes 90000-99999 with no other CPT4 codes.)

   - In cases where the ICD9 code matched exactly two line items, one of which represented "Medical Therapy" and the other of which represented a form of surgery, 90% of the medical therapy expenditures were allocated to the "Medical Therapy" line item and 10% of the medical therapy expenditures were allocated to the surgical therapy line item based on our analysis of the

"Medical Therapy" expenditures submitted for individuals with Acute Appendicitis and Acute Cholecystitis and a general review of the data.

- In cases where the ICD9 code matched several line items, all of which represented "Medical Therapy", the expenditures were distributed proportionately based on the number of line items except in cases where condition/treatment pairs were differentiated by age or stage of disease. In these cases, more specific criteria developed by the HSC were used.

- In cases where the ICD9 code matched several line items, all of which represented various surgical therapies, the expenditures were distributed proportionately based on the number of line items.

- In cases where there were multiple surgical therapies and a single medical therapy line item, 90% of the medical therapy expenditures were allocated to the medical therapy line and the remaining 10% of the expenditures were allocated to the surgical therapies based on the number of treatments.

- In cases where there were multiple medical therapies and multiple surgical therapies, 90% of the medical expenditures were allocated to the medical therapy line items, with the expenditures allocated to each line based on the number of medical therapy lines. The remaining 10% of the medical therapy expenditures were allocated to the surgical therapies, with the expenditures allocated to each line based on the number of surgical therapy lines.

6) The medical and surgical expenditures were then combined and a total amount for each line item was calculated.

7) The ancillary services, including lab and x-ray services as well as inpatient and outpatient hospital services were next allocated to the condition/treatment pairs based on the number of different line items

that the expenditures might fall into and the amount of dollars for medical and surgical therapy assigned to the line item.

- All expenditures for ancillary services were summarized by ICD9 code.

- Each ICD9 code was then matched against the Prioritized List to identify all of the possible line items that the expenditure might be associated with.

- The total dollars associated with each of the line items that an ICD9 code matched with were identified from the analysis of claims by ICD9 diagnosis code and CPT4 procedure code (the result of step 6 above). A percentage of the total was then calculated for each condition/treatment pair. The ancillary services for each line item for that ICD9 code were then calculated by multiplying the total dollars for ancillary services by the percentage for each condition/treatment pair.

- The expenditures were then summarized by line item.

8) The medical, surgical, and ancillary services were then summarized to obtain one total amount for each line item. Totals were also calculated for each of 28 types of service including inpatient hospital, outpatient hospital, physician, lab and x-ray, and so on. These totals by service type were calculated to allow for future calculation of the capitation rates to be paid to the contracting plans.

9) The total dollars for prescription drug expenditures by line item were calculated separately based on the results of the global per capita cost calculation. From that analysis we found that approximately 7% of the total per capita cost is associated with prescription drugs. The prescription drug dollar amount was calculated as 7% of the total dollars for each line item. (Prescription drug claims do not include a diagnosis code. Therefore, it was not possible to directly match the expenditures to specific condition/treatment pairs.)

10) The expenditures were then summed across all line items to obtain a total dollar amount.

11) Through a separate analysis, we determined that 0.5% of total expenditures would be expected to be consumed by "comfort care" for patients with limited expectation of recovery. Comfort care includes Hospice care and coverage of Physician services and prescription drugs and is expected to serve as a substitute to more costly hospitalization for cases that are believed to be terminal.

12) The percentage of total dollars represented by each line item was calculated by dividing the dollars for the line item by the total dollars for the entire data base.[3]

13) The expenditures were then adjusted to reflect differences in utilization of specific services by the population to be covered by the program compared to the population that makes up the data base. In particular, utilization of maternity services is substantially lower for the BSC population than what is expected for the Demonstration Project population. Based on the results of the global per capita cost calculation, we calculated the percentage of total expenditures that we expect to be consumed by maternity services as 13.2%. An additional 8.75% of total costs are expected to be incurred for newborns that require intensive care. We allocated 13.2% of total dollars to the line item associated with standard maternity services and 8.75% of total costs to the line items associated with high risk infants. The percentage distribution of expenditures for all other condition/treatment pairs was then calculated based on the remaining total expenditures.

14) We then calculated the cost per person per month by multiplying the percentage of the total represented by each line item by the total cost per person per month shown in Exhibit 25-A.

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3. Separate percentages were also calculated for each service type to allow for future calculation of the capitation rates to be paid to contracting plans.

Exhibit 26 provides a summary of the criteria used for assigning claim dollars to each of the condition/treatment pairs. Exhibit 27 provides a diagram of the processing logic used for the expenditures assignment.[4]

Calculating the Cost Per Person Per Month Based on Covered Services

The cost per person per month for several "threshold" levels of services was calculated by determining the services that would be above and below the line at each threshold. Working with OMAP and HSC staff, we identified ten example threshold levels. These thresholds were identified by their rank on the Prioritized List. To provide the Legislature with a range of options, we calculated total per capita costs assuming the line was drawn at line item number:

- 200
- 255
- 310
- 365
- 420
- 475
- 530
- 585
- 640
- 695

The cost per person per month at each threshold was calculated by summing the cost per person per month for each line item through the threshold. In other words, for the threshold at line 200, all lines from 1 through 200 were summed. In addition, the HSC provided us with information on services below the threshold that had a "substitute" among the line items that were above the threshold. For example, the HSC identified that 20% of the services provided by the condition/treatment pair in line 615 could be substituted by the treatment in line 159. (Surgical and medical therapy for Epilepsy, respectively.).

Based on the information provided by the HSC, we allocated the substitute services to the appropriate line items. In addition, we assumed that 15% of the costs associated with services that fell below each threshold would be incurred for services above the threshold which could not be specifically identified.

The costs associated with each threshold were then calculated by summing the per capita cost for the items above each threshold with the adjustments noted above. Exhibit 28-A shows the per capita cost at each of the ten threshold levels based on the expected eligibility distribution at program start-up. Exhibit 28-B shows the per

4. The symbols used in the diagram are provided as an aid in identifying the portions of the process that are related. They are not intended to reflect standard flow chart symbols.

capita cost at each threshold level based on the eligibility distribution when the program reaches a steady-state. The condition/treatment pairs that are above and below each of the thresholds can be identified in the HSC's list of ranked services shown in Appendix J of the HSC report.

Next Steps

Following the Legislature's review of this report, we will refine the calculation of the total per capita cost based on the Legislature's need to identify costs associated with different threshold levels on the Prioritized List. The capitation rates to be paid to contracting plans will be calculated following the Legislature's determination of a budget amount per person per month and the level of covered services.

OREGON BASIC HEALTH SERVICES PROGRAM

Exhibit 1

Procedures That Were Analyzed Based on 100% of Occurrences

05/01/91

Diagnosis	Procedure Description
940–949	Adjacent tissue transfer greater than 30 cm Free transplantation of skinflap greater than 100 sq. cm.
885–887; 895–897	Replantation of any extremity
754.0	Reconstruction of maxilla/facial bones
425, 429.0–429.3	Heart, Heart–lung transplantation
155, 570 571.2, 571.5, 571.6 751.61	Liver Transplant
236.0–236.3	Radical Vaginal Hysterectomy
237	Stereotaxis

OREGON BASIC HEALTH SERVICES PROGRAM
Description of Eligibility Categories

Exhibit 2
05/01/91

	Data Reporting Period Eligibility Categories	Welfare Reform Eligibility Categories	Demonstration Project Eligibility Categories
AFDC	Categorical eligibles under 51% of FPL	AFDC categorical eligibles under 51% of FPL on extended medical coverage	AFDC categorical eligibles under 51% of FPL including those on Welfare Reform under current eligibility rules
PLM under 100% of Federal Poverty Level	Categorical eligibles under 85% of FPL	N/A	Eligible as "Demonstration Only"
PLM 100% - 133% of Federal Poverty Level	N/A	N/A	PLM categorical eligibles with income from 100% to 133% of FPL covered as PLM eligibles.
General Assistance	Categorical eligibles under 49% of FPL	N/A	Categorical eligibles under 49% of FPL under current eligibility rules
AFDC Medically Needy	Categorical eligibles under 67% of FPL	N/A	Eligible as "Demonstration Only"
Demonstration Only	N/A	N/A	AFDC categorical eligibles with income from 52% to 100% of FPL including those who have exhausted extended medical benefits. PLM categorical eligibles with income below 100% of the FPL. All current AFDC Medically Needy recipients with income below 100% of FPL. All other Oregonians except Foster Care, Blind, Disabled and Medicare eligibles with income under 100% of FPL. All eligibles have 6 month periods of guaranteed eligibility.

OREGON BASIC HEALTH SERVICES PROGRAM Exhibit 3

Calculation of Total Per Capita Cost * 05/01/91

Categories of Service Expected to be Affected by the Change in Average Length of Eligibility

CATEGORY OF SERVICE	TYPE OF EXPECTED CHANGE
Anesthesia	B
Dental–Diagnostic	A
Dental–Endodontics	A
Dental–General	A
Dental–Maxillofacial Pros	A
Dental–Oral Surgery	A
Dental–Orthodontics	A
Dental–Periodontics	A
Dental–Pros, Fixed	A
Dental–Restorative	A
Durable Med Equipment	A
Hearing Aid	A
IP–Hospice	B
IP–Maternity	A
IP–Med/Surg	B
IP–Psych & Drug/Alcohol Detox	B
OP–Diagnostic X–Ray	B
OP–Emergency Room	B
OP–Facility	B
OP–Lab	B
OP–Magnetic Resonance Imaging	B
OP–Surgery/Facility	B
OP–Therapeutic X–Ray	B
Other–Diagnostic X–Ray	B
Other–Lab	B
Other–Therapeutic X–Ray	B
Physician Maternity	A
Surgery	B

A: Current utilization is expected to be spread over the length of additional eligibility. No additional utilization on a per capita basis is expected.

B: Current utilization is expected to be spread over the length of additional eligibility, but additional utilization is also expected. For example, some surgeries must be performed on an emergency basis, but others can be scheduled and may be delayed if an individual does not have health insurance.

All other services are assumed to be unaffected by the change in length of eligibility. In other words, we assume that recipients will receive additional services proportional to the increased length of eligibility.

* Per Capita Cost is a combination of fee–for–service expenditures and capitation payments.

OREGON BASIC HEALTH SERVICES PROGRAM
Average Length of Eligibility
Per Year in Months by Medicaid Eligibility Category

Exhibit 4
05/01/91

	Data Reporting Period	Adjusted for Welfare Reform	Adjusted for Welfare Reform and Demon. Project
AFDC / AFDC-UN	6.3	6.5 *	6.5 *
PLM Children	3.4	N/A	4.8 **
PLM Adults	3.9	N/A	5.3 **
General Assistance	4.3	N/A	4.3
Demonstration Only Categorical Eligibles	N/A	N/A	10.5 ***
Demonstration Only Noncategorical Eligibles	N/A	N/A	9.9 ***

* Changes in length of eligibility are based on modelling by OMAP of the changes in eligibility rules. The adjustments for Welfare Reform were calculated by identifying all AFDC enrollees who would have been eligible for the additional extended medical coverage in fiscal year 1989 and adjusting actual eligible months by the expected increase in eligibility and recalculating the average.

** Changes in length of eligibility are based on modelling by OMAP of the changes in eligibility rules. The adjustments for the PLM population were calculated by calculating the additional eligibility period that would have applied for PLM enrollees who were eligible for less than a six month period.

*** The average length of eligibility for demonstration only eligibles was calculated by Lewin/ICF in a separate analysis.

OREGON BASIC HEALTH SERVICES PROGRAM

Distribution of Population to be Covered by the Demonstration Project

Exhibit 5
05/01/91

	Expected Distribution at Program Start-up /1	Expected Distribution at Program Steady-State /2
Aid to Families with Dependent Children	62.4%	47.6%
General Assistance	2.1%	1.6%
Poverty Level Medical - Adults	2.8%	2.1%
Poverty Level Medical - Children	8.1%	6.2%
New Demonstration Only Categorical Eligibles	5.3%	8.9%
New Demonstration Only Noncategorical Eligibles	19.3%	33.6%
TOTAL	100.0%	100.0%

Distributions were calculated by OMAP staff.

/1 Represents the average expected mix of enrollees for the first year of the Demonstration Project (i.e., July 1, 1992 through June 30, 1993).

/2 It is expected that by the end of the first year of the Demonstration Project approximately 60% of potential enrollees will become enrolled. The program is expected to reach a steady-state by the end of the third year of the Demonstration Project.

Anesthesia	OP–Maternity
Chiropractor	OP–Other Outpatient
Dental–Diagnostic	OP–Physician Services
Dental–Endodontics	OP–Somatic Psych
Dental–General	OP–Surgery/Facility
Dental–Maxillofacial Pros	OP–Therapeutic X–Ray
Dental–Oral Surgery	Other–Diagnostic X–Ray
Dental–Orthodontics	Other–Lab
Dental–Periodontics	Other–Therapeutic X–Ray
Dental–Preventive	Physical/Occupational Therapy
Dental–Pros, Fixed	Physician Ancillary
Dental–Pros, Removable	Physician Home Visits
Dental–Restorative	Physician Inpatient Visits
Durable Med Equipment	Physician Maternity
Family Planning – Inpatient	Physician Office Visits
Family Planning – Other	Physician Other
Family Planning – Outpatient	Physician Outpatient Visits
Family Planning – Physician	Physician PT/OT
Hearing Aid	Physician Somatic Psych Visits
Hemodialysis	Physician Well Child Exams
Home Health Nursing	Podiatrist
Home Health Service	Prescription Drugs – Basic
IP–Hospice	Prescription Drugs – Family Planning
IP–Maternity	Prescription Drugs – Psych
IP–Med/Surg	Preventive Medicine
IP–Neonatal ICU	Private Duty Nursing
IP–Newborn	Sterilizations–Professional
IP–Psych & Drug/Alcohol Detox	Supplies
Maternity Management	Surgery
OP–Diagnostic X–Ray	Testing
OP–Emergency Room	Transportation – Ambulance
OP–Facility	Transportation – Other
OP–Lab	Vision Care
OP–Magnetic Resonance Imaging	Vision Supplies

Services not covered by Medicaid for which BSC utilization rates are used to project future Medicaid utilization:

- Adult Dental (in addition to currently covered emergency dental)
- Private Duty Nursing
- Hospice

Services for which Medicaid average charges and utilization are used in calculating the capitation rate because BSC data does not include the information or the data is incomplete:

- Family Planning (all categories)
- Hearing Aid
- Hemodialysis
- Home Health Nursing
- Maternity Management
- Prescription Drugs
- Transportation other than Ambulance

Services for which a combination of Medicaid and BSC data are used to estimate utilization rates for the new noncategorical eligibles:

- OP–Emergency Room
- OP–Facility
- OP–Other Outpatient
- OP–Physician Services
- OP–Somatic Psych
- OP–Surgery/Facility
- OP–Therapeutic X–Ray
- Sterilizations–Professional
- Vision Supplies
- Physical/Occupational Therapy
- Physician Ancillary

OREGON BASIC HEALTH SERVICES PROGRAM

Exhibit 7

05/01/91

Calculation of Average Per Capita Cost *

Services That Are Adjusted for Calculating Cost or Utilization

Services which have a severity adjustment because of expected differences in health status by eligibility category:

- Anesthesia
- Family Planning – Physician
- Home Health Service
- Inpatient Hospital (all categories)
- OP–Diagnostic X–ray
- OP–Emergency Room
- OP – Facility
- OP–Other Outpatient
- OP – Physician Services
- Other Diagnostic X–ray
- Physician Outpatient Visits
- Prescription Drugs (All categories)
- Preventive Medicine
- Sterilizations–Professional
- Supplies
- Surgery
- Transportion – Ambulance
- Transportation – Other
- Vision Care
- Vision Supplies

Services which have an adjustment factor because of expected differences in billing practices between BSC and MMIS

- Durable Medical Equipment
- Physician Ancillary
- Testing

* Per Capita Cost is a combination of fee–for–service expenditures and capitation payments.

OREGON BASIC HEALTH SERVICES PROGRAM

Exhibit 8

05/01/91

MMIS and BSC Data, 1988 and 1989 Combined

Comparison of Utilization Rates by Eligibility Category Before Adjustments for Changes in Average Length of Eligibility and Noncovered Services

CATEGORY OF SERVICE	TYPE OF UNITS	AFDC UNITS/1000	GA UNITS/1000	PLM-ADULT UNITS/1000	PLM-CHILD UNITS/1000	NEW CAT. ELIGIBLES UNITS/1000	NEW NONCAT. ELIGIBLES UNITS/1000
ANESTHESIA	Service	85.87	395.12	455.89	108.29	106.83	102.43
CHIROPRACTOR	Service	157.76	88.09	123.03	3.00	150.65	2331.27
DENTAL-DIAGNOSTIC	Service	1547.79	564.94	613.07	64.44	1446.72	826.45
DENTAL-ENDODONTICS	Service	290.52	89.29	115.07	27.38	272.06	44.00
DENTAL-GENERAL	Service	183.37	54.17	15.86	14.80	168.54	397.88
DENTAL-MAXILLOFACIAL PROS	Service	0.00	0.00	0.00	0.00	0.00	0.00
DENTAL-ORAL SURGERY	Service	299.90	205.62	157.00	9.14	282.29	96.33
DENTAL-ORTHODONTICS	Service	4.08	0.00	0.00	0.00	3.72	2.74
DENTAL-PERIODONTICS	Service	24.45	20.47	23.68	0.00	23.58	137.90
DENTAL-PREVENTIVE	Service	376.18	1.08	20.32	21.10	344.77	501.64
DENTAL-PROS,FIXED	Service	5.39	2.89	0.00	0.00	4.92	133.36
DENTAL-PROS,REMOVABLE	Service	8.44	19.16	1.33	0.00	7.76	26.57
DENTAL-RESTORATIVE	Service	895.68	238.06	341.02	73.36	837.66	506.87
DURABLE MED EQUIPMENT	Service	70.05	504.36	30.26	328.95	76.61	309.75
FAMILY PLANNING - INPATIENT	Service	0.19	0.00	0.44	0.00	0.20	0.00
FAMILY PLANNING - OTHER	Service	12.17	9.22	49.43	9.42	14.12	0.00
FAMILY PLANNING - OUTPATIENT	Service	0.31	0.33	7.69	0.00	0.70	0.00
FAMILY PLANNING - PHYSICIAN	Service	128.70	36.72	423.55	6.57	140.68	5.60
HEARING AID	Service	3.46	9.79	1.10	4.30	3.36	0.31
HEMODIALYSIS	Service	0.51	23.98	0.00	0.00	0.46	0.00
HOME HEALTH NURSING	Service	0.61	45.42	0.00	1.07	0.59	0.30
HOME HEALTH SERVICE	Service	26.02	727.38	50.14	82.47	29.24	138.87
IP-HOSPICE	Admission	0.81	3.79	0.00	1.26	0.45	1.48
IP-MATERNITY	Admission	71.96	8.05	1464.76	0.00	114.75	16.18
IP-MED/SURG	Admission	59.84	644.69	54.97	163.28	61.72	54.69
IP-NEONATAL ICU	Admission	20.85	0.21	0.00	528.56	30.14	2.06
IP-NEWBORN	Admission	39.65	0.00	0.00	1201.57	61.17	12.51
IP-PSYCH & DRUG/ALCOHOL DETOX	Admission	5.74	125.31	9.05	0.94	5.75	27.79
MATERNITY MANAGEMENT	Cases	31.42	1.12	957.86	0.00	80.95	0.00
OP-DIAGNOSTIC X-RAY	Service	356.09	1072.98	1529.63	336.50	419.51	338.90
OP-EMERGENCY ROOM	Service	824.11	970.45	1026.44	1223.64	848.63	132.39
OP-FACILITY	Service	240.76	1315.24	1561.45	537.85	322.90	85.85
OP-LAB	Service	1261.72	5081.90	7396.39	1496.31	1604.63	1433.44
OP-MAGNETIC RESONANCE IMAGING	Service	10.99	122.26	4.54	4.20	10.41	17.20
OP-MATERNITY	Service	28.40	4.06	923.57	7.69	76.59	0.33
OP-OTHER OUTPATIENT	Service	331.01	753.77	967.44	344.45	366.22	203.71
OP-PHYSICIAN SERVICES	Service	667.86	719.85	721.82	956.84	680.55	64.59
OP-SOMATIC PSYCH	Service	0.07	6.59	0.00	0.00	0.06	52.17
OP-SURGERY/FACILITY	Service	24.59	119.68	36.67	38.25	25.71	24.11
OP-THERAPEUTIC X-RAY	Service	10.92	274.52	14.48	2.24	10.82	22.62
OTHER-DIAGNOSTIC X-RAY	Service	631.85	2816.70	2349.79	1054.99	739.93	463.19
OTHER-LAB	Service	1898.77	5206.02	12044.02	1736.85	2447.31	2353.54
OTHER-THERAPEUTIC X-RAY	Service	7.12	336.60	0.00	0.00	6.49	20.29
PHYSICAL/OCCUPATIONAL THERAPY	Service	100.24	766.55	60.86	134.53	99.24	453.31

OREGON BASIC HEALTH SERVICES PROGRAM

Exhibit 8

05/01/91

MMIS and BSC Data, 1988 and 1989 Combined

Comparison of Utilization Rates by Eligibility Category Before Adjustments for Changes in Average Length of Eligibility and Noncovered Services

CATEGORY OF SERVICE	TYPE OF UNITS	AFDC UNITS/1000	GA UNITS/1000	PLM-ADULT UNITS/1000	PLM-CHILD UNITS/1000	NEW CAT. ELIGIBLES UNITS/1000	NEW NONCAT. ELIGIBLES UNITS/1000
PHYSICIAN ANCILLARY	Service	187.08	1077.07	221.04	222.03	190.12	1218.11
PHYSICIAN HOME VISITS	Service	1.69	1.30	1.28	1.07	1.64	2.66
PHYSICIAN INPATIENT VISITS	Service	485.03	3457.14	830.61	4525.38	640.16	398.02
PHYSICIAN MATERNITY	Cases	100.51	0.58	2059.48	0.00	204.10	28.78
PHYSICIAN OFFICE VISITS	Service	3433.10	7021.33	3102.56	7875.88	3564.88	2904.17
PHYSICIAN OTHER	Service	268.78	779.44	1083.51	2244.04	379.89	457.09
PHYSICIAN OUTPATIENT VISITS	Service	141.73	223.03	258.61	321.23	154.16	72.46
PHYSICIAN PT/OT	Service	85.92	452.55	56.61	28.25	82.38	32.66
PHYSICIAN SOMATIC PSYCH VISITS	Service	31.32	714.92	14.05	9.44	29.64	224.18
PHYSICIAN WELL CHILD EXAMS	Service	712.77	0.00	0.00	5579.32	837.97	21.17
PODIATRIST	Service	15.09	64.00	10.87	1.93	14.41	112.40
PRESCRIPTION DRUGS-BASIC	Service	4956.46	22290.29	3004.13	2063.59	4832.01	0.00
PRESCRIPTION DRUGS-FAMILY PLANNING	Service	154.70	60.10	540.27	2.85	164.41	0.00
PRESCRIPTION DRUGS-PSYCH	Service	119.96	4806.73	64.57	9.97	115.86	0.00
PREVENTIVE MEDICINE	Service	278.64	1332.80	1531.66	0.00	337.67	0.00
PRIVATE DUTY NURSING	Service	0.00	0.00	0.00	0.00	0.00	0.00
STERILIZATIONS-PROFESSIONAL	Service	53.25	6.96	226.21	0.00	60.90	4.68
SUPPLIES	Service	127.71	574.67	213.86	169.79	133.84	214.69
SURGERY	Cases	340.20	1500.05	1452.24	432.71	404.05	507.95
TESTING	Service	135.71	358.08	39.85	334.18	137.17	621.56
TRANSPORTATION - AMBULANCE	Service	57.24	1002.93	172.92	165.90	67.22	20.70
TRANSPORTATION - OTHER	Service	135.49	1155.87	161.78	143.18	137.18	1.15
VISION CARE	Service	161.27	248.86	136.09	39.98	155.80	425.79
VISION SUPPLIES	Service	297.87	562.57	305.23	18.93	288.87	1.88

Units/1000: Units per thousand people per year

Service: Charge per visit or procedure
Admission: Charge per hospital admission
Cases: Charge per episode for maternity and surgery cases-includes primary and assistant physician charges only. Does not include ancillary charges such as lab and x-ray associated with the case.

OREGON BASIC HEALTH SERVICES PROGRAM

Exhibit 9

05/01/91

MMIS and BSC Data, 1988 and 1989 Combined

Comparison of Utilization Rates by Eligibility Category After Adjustments for Changes in Average Length of Eligibility and Noncovered Services

CATEGORY OF SERVICE	TYPE OF UNITS	ADJUSTED AFDC UNITS/1000	ADJUSTED GA UNITS/1000	ADJUSTED PLM-ADULT UNITS/1000	ADJUSTED PLM-CHILD UNITS/1000	ADJUSTED NEW CAT. ELIGIBLES UNITS/1000	ADJUSTED NEW NONCAT. ELIGIBLES UNITS/1000
ANESTHESIA	Service	84.53	395.12	386.52	89.81	77.70	102.43
CHIROPRACTOR	Service	157.76	88.09	123.03	3.00	150.65	233.13
DENTAL-DIAGNOSTIC	Service	1703.45	971.50	857.69	45.64	1204.80	826.45
DENTAL-ENDODONTICS	Service	293.50	113.14	108.52	19.40	177.65	44.00
DENTAL-GENERAL	Service	288.85	276.39	233.90	10.48	302.98	397.88
DENTAL-MAXILLOFACIAL PROS	Service	0.00	0.00	0.00	0.00	0.00	0.00
DENTAL-ORAL SURGERY	Service	310.62	245.50	155.42	6.48	198.40	96.33
DENTAL-ORTHODONTICS	Service	4.69	1.47	1.47	0.00	3.50	2.74
DENTAL-PERIODONTICS	Service	68.62	110.33	107.28	0.00	97.04	137.90
DENTAL-PREVENTIVE	Service	495.09	238.91	258.15	21.10	565.95	501.64
DENTAL-PROS,FIXED	Service	39.21	70.86	67.97	0.00	66.02	133.36
DENTAL-PROS,REMOVABLE	Service	17.12	37.05	18.87	0.00	21.08	26.57
DENTAL-RESTORATIVE	Service	1002.26	506.34	519.21	51.96	728.16	506.87
DURABLE MED EQUIPMENT	Service	67.90	504.36	22.26	233.01	43.78	309.75
FAMILY PLANNING - INPATIENT	Service	0.19	0.00	0.44	0.00	0.20	0.20
FAMILY PLANNING - OTHER	Service	12.17	9.22	49.43	9.42	14.12	14.12
FAMILY PLANNING - OUTPATIENT	Service	0.31	0.33	7.69	0.00	0.70	0.70
FAMILY PLANNING - PHYSICIAN	Service	128.70	36.72	423.55	6.57	102.96	102.96
HEARING AID	Service	3.46	9.79	1.10	4.30	3.36	0.31
HEMODIALYSIS	Service	0.51	23.98	0.00	0.00	0.46	0.46
HOME HEALTH NURSING	Service	0.61	45.42	0.00	1.07	0.59	0.59
HOME HEALTH SERVICE	Service	26.02	727.38	50.14	82.47	29.24	34.72
IP-HOSPICE	Admission	0.80	3.79	0.00	1.05	0.33	1.48
IP-MATERNITY	Admission	69.75	8.05	1077.84	0.00	6.56	8.09
IP-MED/SURG	Admission	58.91	644.69	46.61	135.41	44.88	54.69
IP-NEONATAL ICU	Admission	20.21	0.21	0.00	374.40	1.72	1.03
IP-NEWBORN	Admission	38.43	0.00	0.00	851.11	3.50	6.25
IP-PSYCH & DRUG/ALCOHOL DETOX	Admission	5.65	125.31	7.67	0.78	4.18	9.26
MATERNITY MANAGEMENT	Cases	31.42	1.12	957.86	0.00	8.09	0.00
OP-DIAGNOSTIC X-RAY	Service	356.09	1072.98	1529.63	336.50	419.51	338.90
OP-EMERGENCY ROOM	Service	824.11	970.45	1026.44	1223.64	848.63	478.25
OP-FACILITY	Service	240.76	1315.24	1561.45	537.85	322.90	163.31
OP-LAB	Service	1261.72	5081.90	7396.39	1496.31	1604.63	1433.44
OP-MAGNETIC RESONANCE IMAGING	Service	10.82	122.26	3.85	3.48	7.57	17.20
OP-MATERNITY	Service	28.40	4.06	923.57	7.69	7.66	0.33
OP-OTHER OUTPATIENT	Service	331.01	753.77	967.44	344.45	366.22	267.36
OP-PHYSICIAN SERVICES	Service	667.86	719.85	721.82	956.84	680.55	366.22
OP-SOMATIC PSYCH	Service	0.07	6.59	0.00	0.00	0.06	26.12
OP-SURGERY/FACILITY	Service	24.21	119.68	31.09	31.72	18.70	24.16
OP-THERAPEUTIC X-RAY	Service	10.92	274.52	14.48	2.24	10.82	16.77
OTHER-DIAGNOSTIC X-RAY	Service	631.85	2816.70	2349.79	1054.99	739.93	463.19
OTHER-LAB	Service	1898.77	5206.02	12044.02	1736.85	2447.31	2353.54
OTHER-THERAPEUTIC X-RAY	Service	7.12	336.60	0.00	0.00	6.49	20.29
PHYSICAL/OCCUPATIONAL THERAPY	Service	100.24	766.55	60.86	134.53	99.24	226.66

OREGON BASIC HEALTH SERVICES PROGRAM

Exhibit 9

05/01/91

MMIS and BSC Data, 1988 and 1989 Combined

Comparison of Utilization Rates by Eligibility Category After Adjustments for Changes in Average Length of Eligibility and Noncovered Services

CATEGORY OF SERVICE	TYPE OF UNITS	ADJUSTED AFDC UNITS/1000	ADJUSTED GA UNITS/1000	ADJUSTED PLM-ADULT UNITS/1000	ADJUSTED PLM-CHILD UNITS/1000	ADJUSTED NEW CAT. ELIGIBLES UNITS/1000	ADJUSTED NEW NONCAT ELIGIBLES UNITS/1000
PHYSICIAN ANCILLARY	Service	187.08	1077.07	221.04	222.03	190.12	406.04
PHYSICIAN HOME VISITS	Service	1.69	1.30	1.28	1.07	1.64	2.66
PHYSICIAN INPATIENT VISITS	Service	477.45	3457.14	704.21	3752.76	465.57	398.02
PHYSICIAN MATERNITY	Cases	97.42	0.58	1515.47	0.00	11.66	14.39
PHYSICIAN OFFICE VISITS	Service	3433.10	7021.33	3102.56	7875.88	3564.88	2904.17
PHYSICIAN OTHER	Service	268.78	779.44	1083.51	2244.04	379.89	457.09
PHYSICIAN OUTPATIENT VISITS	Service	141.73	223.03	258.61	321.23	154.16	72.46
PHYSICIAN PT/OT	Service	85.92	452.55	56.61	28.25	82.38	32.66
PHYSICIAN SOMATIC PSYCH VISITS	Service	31.32	714.92	14.05	9.44	29.64	224.18
PHYSICIAN WELL CHILD EXAMS	Service	712.77	0.00	0.00	5579.32	83.80	21.17
PODIATRIST	Service	15.09	64.00	10.87	1.93	14.41	11.24
PRESCRIPTION DRUGS-BASIC	Service	4956.46	22290.29	3004.13	2063.59	4832.01	4832.01
PRESCRIPTION DRUGS-FAMILY PLANNING	Service	154.70	60.10	540.27	2.85	164.41	164.41
PRESCRIPTION DRUGS-PSYCH	Service	119.96	4806.73	64.57	9.97	115.86	115.86
PREVENTIVE MEDICINE	Service	278.64	1332.80	1531.66	0.00	337.67	337.67
PRIVATE DUTY NURSING	Service	11.00	11.00	11.00	11.00	11.00	11.00
STERILIZATIONS-PROFESSIONAL	Service	53.25	6.96	226.21	0.00	15.23	15.23
SUPPLIES	Service	127.71	574.67	213.86	169.79	133.84	214.69
SURGERY	Cases	334.88	1500.05	1231.25	358.83	293.85	507.95
TESTING	Service	135.71	358.08	39.85	334.18	137.17	621.56
TRANSPORTATION - AMBULANCE	Service	57.24	1002.93	172.92	165.90	67.22	20.70
TRANSPORTATION - OTHER	Service	135.49	1155.87	161.78	143.18	137.18	137.18
VISION CARE	Service	161.27	248.86	136.09	39.98	155.80	425.79
VISION SUPPLIES	Service	297.87	562.57	305.23	18.93	288.87	288.87

Units/1000: Units per thousand people per year

Service: Charge per visit or procedure

Admission: Charge per hospital admission

Cases: Charge per episode for maternity and surgery cases-includes primary and assistant physician charges only. Does not include ancillary charges such as lab and x-ray associated with the case.

OREGON BASIC HEALTH SERVICES PROGRAM Exhibit 10
Sample Calculation of Average Allowed 05/01/91
Amount Before and After Removing Outlier Claims

Procedure=90020
Office Medical–New Patient, Comprehensive Service *
*** NOTE: These numbers are for illustrative purposes only.**

Number of Observations	3,704
Mean (Average)	$105.18
Standard Deviation	$25.02
1.5 Standard Deviations	$37.53
Threshold (105.18 + 37.53)	$142.71
Number of Observations Deleted	30
New Number of Observations	3,674
Mean after Deleting Outliers	$102.75

DESCRIPTION OF PROCESS:

1. All claims for a a specific CPT–4 code are identified and a mean (average) value and standard deviation are calculated.
2. Claims in excess of the mean plus 1.5 standard deviations are identified and deleted from the data base.
3. The mean allowed amount is then recalculated excluding the outlier claims.
4. The calculation is done for several of the highest volume CPT–4 codes and an average percentage adjustment is calculated.

OREGON BASIC HEALTH SERVICES PROGRAM
Percentage Difference in Average Charges
from California to Oregon by Category of Service

Exhibit 11
05/01/91

CATEGORY OF SERVICE	MMIS	BCBSO	ODS ***	OOHP ****
Family Practitioner	-24%	-27%	-	-
OB/GYN	0%	-8%	-	-
Radiology	-27%	-22%	-	-
Surgery	-12%	-18%	-	-
Inpatient Hospital *	N/A	-12%	-	-23%
Outpatient Hospital **	-	-20%	-	-
Dental	-7%	-7%	-7%	-

* Inpatient hospital charges are billed differently for MMIS and BSC. Therefore, no comparison was made of the difference in average charges.

** Outpatient hospital factor is based on an average of the Surgery and Radiology factors.

*** Oregon Dental Service

**** Oregon Office of Health Policy

OREGON BASIC HEALTH SERVICES PROGRAM

Exhibit 12

Average Percentage of Gross Revenue Used for Overhead Expenses

05/01/91

Type of Physician	Percent Overhead *
Family Practitioner /1	54.71%
Internal Medicine /1	53.71%
OB/GYN /1	51.12%
Pediatrics /1	51.17%
General Surgery /1	51.12%
Orthopedic Surgery /1	51.12%
Urology /1	51.12%
Dentistry /2	62.40%

Sources:

/1 "Socioeconomic Characteristics of Medical Practice, 1989," from AMA Center for Health Policy Research

/2 Unpublished data, Oregon State University, March 1990 and 1987 Oregon Dental Economic Report

* The overhead percentages shown above are for comparison purposes only and are not used directly in the calculation of total per capita costs.

OREGON BASIC HEALTH SERVICES PROGRAM

Exhibit 13

Cost-to-Charge Ratios by Category of Service

05/01/91

Anesthesia /1	58%
Chiropractor /1	75%
Dental /2	70%
Inpatient and Outpatient Hospital /3	76%
Lab & X-Ray /4	58%
Other-Diagnostic X-Ray /1	58%
Other-Lab /1	58%
Other-Therapeutic X-Ray /1	58%
Physician Inpatient Visits /1	74%
Physician Somatic Psych Visits /1	70%
Podiatrist /1	77%
Prescription Drug - Cost of Goods /5	89%
Prescription Drug - Dispensing Fee /6	$3.50
Preventive Medicine /1	75%
Primary Care Physicians /7	80%
Specialty Care Physicians /1	69%
Sterilizations-Professional /1	71%
Supplies & Equipment /8	90%
Surgery /1	58%
Testing /1	60%
Transportation /8	90%
Vision Care /1	61%

/1 Uses unit values from /7 below and applies the RBRVS scale.

/2 Representative of the greatest discounts offered to commercial managed care contractors in Oregon.

/3 Based on hospital cost reports for 1988 and 1989 for Oregon hospitals filed with the Oregon Office of Health Policy.

/4 Uses unit values from /7 below and applies the RBRVS scale. Includes Other Diagnostic X-Ray, Other-Lab, and Other-Therapeutic X-Ray.

/5 Representative of contracts negotiated by OMAP.

/6 Dispensing fee is based on average dispensing fee paid by managed care health plans in Oregon in 1988/1989. Fee is trended to 1993 based on factors shown in Exhibit 14.

/7 Representative of the greatest discounts offered to commercial managed care contractors in Oregon and includes Physician visits, Ancillary services, Physician Maternity, and Physician Well Child services.

/8 Represents lowest expected negotiated rates

OREGON BASIC HEALTH SERVICES PROGRAM

Annual Trend Factors Used to Update Data to 1991 and 1993

Exhibit 14
05/01/91

CATEGORY OF SERVICE	COST-BASED REIMBURSEMENT 1988/89 to 1991			COST-BASED REIMBURSEMENT 1991 to 1993 *		
	Cost/1	Utilization/2	Total	Cost/1	Utilization/2	Total
Inpatient Hospital	4.90%	1.8%	6.70%	4.30%	1.8%	6.10%
Outpatient Hospital	4.90%	4.5%	9.40%	4.30%	4.5%	8.80%
Physician	4.00%	1.8%	5.80%	3.00%	1.8%	4.80%
Prescription Drug	8.30%	1.7%	10.00%	8.30%	1.7%	10.00%
Dental	4.00%	1.8%	5.80%	3.00%	1.8%	4.80%
Miscellaneous Medical	4.00%	1.8%	5.80%	3.00%	1.8%	4.80%

CATEGORY OF SERVICE	MEDICAID PAYMENT BASED 1988/89 to 1991			MEDICAID PAYMENT BASED 1991 to 1993 *		
	Cost/1	Utilization/2	Total	Cost/1	Utilization/2	Total
Inpatient Hospital	3.25%	0.00%	3.25%	15.00%	0.0%	15.0%
Outpatient Hospital	4.00%	0.00%	4.00%	11.00%	0.0%	11.0%
Physician	2.15%	4.60%	6.75%	0.00%	4.6%	4.6%
Prescription Drug	4.24%	2.60%	6.84%	7.00%	2.6%	9.6%
Dental	2.20%	4.60%	6.75%	0.00%	4.6%	4.6%
Miscellaneous Medical	3.25%	8.15%	11.35%	0.00%	4.6%	4.6%

Trend factors include changes in cost and utilization/intensity. The factors used for the managed care plans reflect changes in input costs for the market basket of goods used by the Health Care Financing Administration for inpatient and outpatient hospital services. The Medicare Economic index is used for professional services. Physician, Dental, and Other Professional are combined because separate values are not provided by HCFA. Utilization trend values are based on national data published in Retiree Health Benefits, Field Test of the FASB Proposal by Coopers & Lybrand, 1989.

Trend factors for the fee-for-service portion of the program are calculated from data on changes in the cost per person per month for the existing Medicaid program and include legislated increases in fee levels. Increases in fee levels for fee-for-service providers are based on projections of budget increases as of January 22, 1991. Utilization trend factors for the period 1991 to 1993 are based on historical trends.

All of the trend factors are calculated from the midpoint of the data reporting period, January 1, 1989 to the midpoint of the projection period. For the trend to 1991, the midpoint is January 1, 1991. For the trend to 1993, the midpoint is January 1, 1993.

* Projected

1/ Cost - Change in input costs for cost based reimbursement and legislated cost increases under Medicaid payment based reimbursement.

2/ Utilization - Reflects changes in number of units per 1000 members per year as well as changes in the intensity of services.

OREGON BASIC HEALTH SERVICES PROGRAM – Calculation of Total Monthly Per Capita Costs *

Exhibit 15

05/01/91

Based on Charge Data for Blue Shield of California, 1988 & 1989 Adjusted to Oregon Average Costs Adjusted for MMIS Utilization Rates and Managed Care Savings Trended to 1993

(Assumes all Eligibles are Enrolled in HMOs)

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
CATEGORY OF SERVICE	AVERAGE OREGON CHG PER UNIT	COST-TO-CHARGE RATIO	AVERAGE COST PER UNIT	AFDC COST PMPM	GA COST PMPM	PLM. ADULT COST PMPM	PLM. CHILD COST PMPM	NEW CATEG. ELIGIBLES PMPM	NEW NONCAT. ELIGIBLES PMPM	AVERAGE PMPM
ANESTHESIA	$427.57	58%	$246.09	$1.73	$11.36	$8.23	$2.21	$1.61	$2.10	$2.22
CHIROPRACTOR	$28.71	75%	$21.67	$0.28	$0.16	$0.22	$0.01	$0.27	$0.42	$0.28
DURABLE MED EQUIPMENT	$22.72	90%	$20.45	$0.56	$6.02	$0.12	$3.40	$0.40	$0.53	$0.88
FAMILY PLANNING – INPATIENT /1	$1,342.34	76%	$1,020.18	$0.02	$0.00	$0.04	$0.00	$0.02	$0.02	$0.02
FAMILY PLANNING – OTHER /1	$43.92	80%	$35.14	$0.04	$0.03	$0.14	$0.03	$0.04	$0.04	$0.04
FAMILY PLANNING – OUTPATIENT /1	$28.83	76%	$21.91	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$0.00
FAMILY PLANNING – PHYSICIAN /1	$101.49	80%	$81.19	$0.87	$0.05	$0.53	$0.01	$0.60	$0.70	$0.73
HEARING AID	$129.59	90%	$116.63	$0.03	$0.10	$0.01	$0.04	$0.03	$0.00	$0.03
HEMODIALYSIS /1	$187.33	76%	$142.37	$0.01	$0.28	$0.00	$0.00	$0.01	$0.01	$0.01
HOME HEALTH NURSING /1	$38.00	90%	$34.20	$0.00	$0.13	$0.00	$0.00	$0.00	$0.00	$0.00
HOME HEALTH SERVICE	$102.56	90%	$92.31	$0.21	$6.19	$0.39	$0.67	$0.23	$0.27	$0.39
IP–HOSPICE /1	$123.73	76%	$94.04	$0.00	$0.06	$0.00	$0.01	$0.00	$0.01	$0.01
IP–MATERNITY	$3,090.40	76%	$2,348.71	$13.15	$2.50	$210.29	$0.00	$1.25	$1.58	$14.52
IP–MED/SURG	$8,176.33	76%	$6,214.01	$15.14	$409.76	$14.19	$46.15	$14.58	$21.24	$27.06
IP–NEONATAL ICU	$8,098.10	76%	$6,154.56	$9.84	$0.56	$0.00	$203.04	$0.87	$0.53	$22.75
IP–NEWBORN	$744.05	76%	$565.48	$1.79	$0.00	$0.00	$39.44	$0.16	$0.29	$4.38
IP–PSYCH & DRUG/ALCOHOL DETOX	$6,119.32	76%	$4,650.68	$1.03	$31.12	$1.20	$0.32	$0.76	$2.69	$1.91
IP–PASSTHROUGH PAYMENTS /2				$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
MATERNITY MANAGEMENT /1	$54.04	100%	$54.04	$0.14	$0.01	$4.31	$0.00	$0.04	$0.00	$0.21
OP–DIAGNOSTIC X–RAY	$132.61	76%	$100.79	$2.14	$13.43	$10.34	$2.06	$2.59	$2.13	$2.62
OP–EMERGENCY ROOM	$85.94	76%	$65.31	$2.52	$5.79	$4.62	$3.73	$2.67	$1.95	$2.64
OP–FACILITY	$123.58	76%	$93.92	$1.42	$11.31	$7.00	$2.33	$1.76	$0.96	$1.79
OP–LAB	$21.25	76%	$16.15	$1.27	$5.98	$7.46	$1.51	$1.62	$1.45	$1.62
OP–MAGNETIC RESONANCE IMAGING	$725.54	76%	$551.41	$0.37	$4.92	$0.13	$0.12	$0.26	$0.59	$0.48
OP–MATERNITY	$113.72	76%	$86.43	$0.20	$0.03	$6.65	$0.06	$0.06	$0.00	$0.32
OP–OTHER OUTPATIENT	$268.23	76%	$203.85	$4.22	$19.78	$12.33	$4.39	$4.67	$3.41	$4.65
OP–PHYSICIAN SERVICES	$68.69	76%	$52.21	$2.18	$3.52	$2.36	$3.12	$2.22	$1.19	$2.10
OP–SOMATIC PSYCH /1	$236.57	100%	$236.57	$0.00	$0.11	$0.00	$0.00	$0.00	$0.39	$0.08
OP–SURGERY/FACILITY	$372.13	76%	$282.82	$0.43	$2.47	$0.55	$0.56	$0.33	$0.43	$0.48
OP–THERAPEUTIC X–RAY	$251.42	76%	$191.08	$0.13	$3.82	$0.17	$0.03	$0.13	$0.20	$0.21
OTHER–DIAGNOSTIC X–RAY	$74.47	58%	$43.48	$2.29	$11.24	$13.75	$2.77	$2.68	$1.68	$2.74
OTHER–LAB	$20.71	58%	$11.92	$1.89	$5.17	$11.96	$1.72	$2.43	$2.34	$2.34
OTHER–THERAPEUTIC X–RAY	$130.38	58%	$76.14	$0.05	$2.14	$0.00	$0.00	$0.04	$0.13	$0.10

OREGON BASIC HEALTH SERVICES PROGRAM – Calculation of Total Monthly Per Capita Costs *

Exhibit 15

05/01/91

Based on Charge Data for Blue Shield of California, 1988 & 1989 Adjusted to Oregon Average Costs Adjusted for MMIS Utilization Rates and Managed Care Savings Trended to 1993

(Assumes all Eligibles are Enrolled in HMOs)

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
CATEGORY OF SERVICE	AVERAGE OREGON CHG. PER UNIT	COST-TO-CHARGE RATIO	AVERAGE COST PER UNIT	AFDC COST PMPM	GA COST PMPM	PLM.-ADULT COST PMPM	PLM.-CHILD COST PMPM	NEW CATEG. ELIGIBLES PMPM	NEW NONCAT. ELIGIBLES PMPM	AVERAGE PMPM
PHYSICAL/OCCUPATIONAL THERAPY	$41.93	80%	$33.55	$0.28	$2.14	$0.17	$0.38	$0.28	$0.63	$0.39
PHYSICIAN ANCILLARY	$23.66	80%	$18.93	$0.22	$4.11	$0.34	$0.19	$0.22	$0.64	$0.38
PHYSICIAN HOME VISITS	$46.92	80%	$37.54	$0.01	$0.00	$0.00	$0.00	$0.01	$0.01	$0.01
PHYSICIAN INPATIENT VISITS	$81.07	74%	$60.05	$2.39	$17.30	$3.52	$18.78	$2.33	$1.99	$3.98
PHYSICIAN MATERNITY	$1,317.73	80%	$1,054.18	$8.56	$0.05	$133.13	$0.00	$1.02	$1.26	$9.37
PHYSICIAN OFFICE VISITS	$34.76	80%	$27.81	$7.96	$16.27	$7.19	$18.25	$8.26	$6.73	$8.72
PHYSICIAN OTHER	$30.77	80%	$24.61	$0.55	$1.60	$2.22	$4.60	$0.78	$0.94	$1.03
PHYSICIAN OUTPATIENT VISITS	$53.76	80%	$43.01	$0.58	$1.61	$1.29	$1.32	$0.65	$0.26	$0.62
PHYSICIAN PT/OT	$28.09	80%	$22.47	$0.16	$0.85	$0.11	$0.05	$0.15	$0.06	$0.15
PHYSICIAN SOMATIC PSYCH VISITS	$40.42	70%	$28.12	$0.07	$1.68	$0.03	$0.02	$0.07	$0.53	$0.19
PHYSICIAN WELL CHILD EXAMS	$31.47	80%	$25.18	$1.50	$0.00	$0.00	$11.71	$0.18	$0.04	$1.90
PODIATRIST	$39.95	77%	$30.73	$0.04	$0.16	$0.03	$0.00	$0.04	$0.03	$0.04
PRESCRIPTION DRUGS-BASIC /1	$18.70	100%	$18.70	$7.73	$58.32	$3.92	$2.67	$7.49	$7.53	$8.22
PRESCRIPTION DRUGS-FAM.PLANNING /	$31.90	100%	$31.90	$0.41	$0.15	$1.58	$0.01	$0.44	$0.44	$0.41
PRESCRIPTION DRUGS-PSYCH /1	$23.83	100%	$23.83	$0.24	$9.25	$0.11	$0.02	$0.23	$0.23	$0.40
PREVENTIVE MEDICINE /3	$44.57	75%	$33.64	$0.78	$4.80	$4.13	$0.00	$0.94	$0.95	$0.94
PRIVATE DUTY NURSING	$83.65	80%	$66.92	$0.06	$0.06	$0.06	$0.06	$0.06	$0.06	$0.06
STERILIZATIONS-PROFESSIONAL	$192.17	71%	$136.05	$0.60	$0.06	$2.55	$0.00	$0.17	$0.17	$0.49
SUPPLIES	$24.81	90%	$22.33	$0.24	$1.65	$0.31	$0.32	$0.24	$0.40	$0.31
SURGERY	$265.78	58%	$152.97	$5.40	$47.59	$8.96	$6.89	$4.26	$6.48	$6.66
TESTING	$18.47	60%	$11.03	$0.45	$2.37	$0.15	$1.24	$0.46	$0.57	$0.57
TRANSPORTATION – AMBULANCE	$186.80	90%	$168.12	$0.81	$7.92	$2.79	$2.57	$0.97	$0.29	$1.06
TRANSPORTATION – OTHER /1	$51.02	90%	$45.92	$0.52	$4.07	$2.24	$2.02	$0.66	$0.52	$0.77
VISION CARE	$61.23	61%	$37.39	$0.50	$0.75	$0.38	$0.13	$0.48	$1.33	$0.63
VISION SUPPLIES	$26.73	100%	$26.73	$0.66	$0.82	$0.40	$0.03	$0.63	$0.64	$0.60
TOTAL				$104.67	$741.63	$492.63	$388.99	$73.38	$80.01	$145.52

OREGON BASIC HEALTH SERVICES PROGRAM – Calculation of Total Monthly Per Capita Costs *

Exhibit 15

05/01/91

Based on Charge Data for Blue Shield of California, 1988 & 1989 Adjusted to Oregon Average Costs

Adjusted for MMIS Utilization Rates and Managed Care Savings Trended to 1993

(Assumes all Eligibles are Enrolled in HMOs)

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
CATEGORY OF SERVICE	AVERAGE OREGON CHG. PER UNIT	COST-TO-CHARGE RATIO	AVERAGE COST PER UNIT	AFDC COST PMPM	GA COST PMPM	PLM-ADULT COST PMPM	PLM-CHILD COST PMPM	NEW CATEG. ELIGIBLES PMPM	NEW NONCAT. ELIGIBLES PMPM	AVERAGE PMPM
DENTAL–DIAGNOSTIC /3	$19.86	70%	$13.90	$1.97	$1.13	$0.99	$0.05	$1.40	$0.96	$1.54
DENTAL–ENDODONTICS /3	$263.08	70%	$184.15	$4.50	$1.74	$1.67	$0.30	$2.73	$0.68	$3.19
DENTAL–GENERAL /3	$53.70	70%	$37.59	$0.90	$0.87	$0.73	$0.03	$0.95	$1.25	$0.89
DENTAL–MAXILLOFACIAL PROS /3	$0.00	70%	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
DENTAL–ORAL SURGERY /3	$79.60	70%	$55.72	$1.44	$1.14	$0.72	$0.03	$0.92	$0.45	$1.08
DENTAL–ORTHODONTICS /3	$794.07	70%	$555.85	$0.22	$0.07	$0.07	$0.00	$0.16	$0.13	$0.17
DENTAL–PERIODONTICS /3	$97.97	70%	$68.58	$0.39	$0.63	$0.61	$0.00	$0.55	$0.79	$0.46
DENTAL–PREVENTIVE /3	$40.95	70%	$28.66	$1.18	$0.57	$0.62	$0.05	$1.35	$1.20	$1.07
DENTAL–PROS,FIXED /3	$102.54	70%	$71.78	$0.23	$0.42	$0.41	$0.00	$0.39	$0.80	$0.34
DENTAL–PROS,REMOVABLE /3	$275.77	70%	$193.04	$0.28	$0.60	$0.30	$0.00	$0.34	$0.43	$0.30
DENTAL–RESTORATIVE /3	$133.63	70%	$93.54	$7.81	$3.95	$4.05	$0.41	$5.68	$3.95	$6.17
TOTAL				$18.92	$11.10	$10.17	$0.87	$14.47	$10.62	$15.21

NOTES:

/1 Medicaid data is used to calculate the average charge per unit of service for these items because the BSC data did not reflect all utilization.

/2 IP–Passthrough Payments represent additional payments for hospital services and will apply only to the non–HMO portion of the program. Also includes impact of a recent hospital cost settlement.

/3 BSC utilization data is used in addition to Medicaid utilization data to project Medicaid use for these services for adults because the services are not currently fully covered by Medicaid.

DESCRIPTION OF COLUMN CONTENTS:

(1) Average charge per unit of service is calculated from the Blue Shield of California data for 1988/89 except for those items noted in Exhibit 7, which are calculated from the MMIS data. Charges are then adjusted to reflect Oregon average charges based on data in Exhibit 11. Charges are also increased for trend as shown in Exhibit 14.

(2) Adjustment percent to convert average charges per unit to an average "cost" value. Calculated by first determining the effect of outliers on average charges and by reviewing contracting arrangements for managed care plans operating in Oregon as well as cost–to–charge ratios for hospital services shown in Exhibit 13.

(3) Average cost per unit is calculated by multiplying column (1) by column (2).

(4) AFDC cost PMPM is calculated by multiplying the AFDC utilization rate from Exhibit 9 by the average cost per unit (3) and dividing by 12000 to represent a single person per month. (The utilization rate is expressed in terms of units per 1000 members per year). Case mix adjustments are applied to reflect differences in average charge per unit of service by eligibility category. The cost PMPM for inpatient and outpatient hospital services is also reduced by 25% to reflect managed care savings for medical services.

(5) Similar to (4) but covers the General Assistance population. Managed Care savings is set at 12.5% for inpatient and outpatient hospital services.

(6) Similar to (4) but covers the Poverty Level Medical–Adult population.

(7) Similar to (4) but covers the Poverty Level Medical–Child population.

(8) Similar to (4) but combines both the Poverty Level Medical and the AFDC population. Reflects the new categorical–type eligibles.

(9) Similar to (4) but covers the newly eligible, non–categorical population.

(10) Weighted average based on eligibility distribution at program start–up.

* Per Capita Cost is a combination of fee–for–service expenditures and capitation payments.

OREGON BASIC HEALTH SERVICES PROGRAM

Calculation of Blended Monthly Per Capita Cost* Trended to 1993 Based on the Assumption That All Eligibles are Enrolled in HMOs With Eligibility Distribution at Program Start-up

Exhibit 16-A
05/01/91

MEDICAL	CAP RATE	AGE/SEX ADJUSTMENT	ADJUSTED CAP RATE	PERCENT OF POPULATION	WEIGHTED CAPITATION RATE
Aid to Families with Dependent Children	$104.67	1	$104.67	62.4%	$65.31
General Assistance	$741.63	1	$741.63	2.1%	$15.57
Poverty Level Medical Adults	$492.63	1	$492.63	2.8%	$13.79
Poverty Level Medical Children	$388.99	0.71	$276.18	8.1%	$22.37
Demonstration Only Categorical Eligibles	$73.38	1.10	$80.71	5.3%	$4.28
Demonstration Only Noncategorical Eligibles	$80.01	0.89	$71.21	19.3%	$13.74
Total				100.0%	$135.07

DENTAL	CAP RATE	AGE/SEX ADJUSTMENT	ADJUSTED CAP RATE	PERCENT OF POPULATION	WEIGHTED CAPITATION RATE
Aid to Families with Dependent Children	$18.92	1	$18.92	62.4%	$11.81
General Assistance	$11.10	1	$11.10	2.1%	$0.23
Poverty Level Medical Adults	$10.17	1	$10.17	2.8%	$0.28
Poverty Level Medical Children	$0.87	2.5	$2.17	8.1%	$0.18
Demonstration Only Categorical Eligibles	$14.47	1	$14.47	5.3%	$0.77
Demonstration Only Noncategorical Eligibles	$10.62	1	$10.62	19.3%	$2.05
Total				100.0%	$15.32

MEDICAL PLUS DENTAL	CAP RATE	AGE/SEX ADJUSTMENT	ADJUSTED CAP RATE	PERCENT OF POPULATION	WEIGHTED CAPITATION RATE
Aid to Families with Dependent Children	N/A	N/A	$123.59	62.4%	$77.12
General Assistance	N/A	N/A	$752.73	2.1%	$15.81
Poverty Level Medical Adults	N/A	N/A	$502.80	2.8%	$14.08
Poverty Level Medical Children	N/A	N/A	$278.35	8.1%	$22.55
Demonstration Only Categorical Eligibles	N/A	N/A	$95.18	5.3%	$5.04
Demonstration Only Noncategorical Eligibles	N/A	N/A	$81.83	19.3%	$15.79
Total				100.0%	$150.39

HEALTH CARE EXPENSE + ADMINISTRATION	CAP RATE	AGE/SEX ADJUSTMENT	ADJUSTED CAP RATE	PERCENT OF POPULATION	WEIGHTED CAPITATION RATE
Aid to Families with Dependent Children	N/A	N/A	$131.47	62.4%	$82.04
General Assistance	N/A	N/A	$800.78	2.1%	$16.82
Poverty Level Medical Adults	N/A	N/A	$534.89	2.8%	$14.98
Poverty Level Medical Children	N/A	N/A	$296.12	8.1%	$23.99
Demonstration Only Categorical Eligibles	N/A	N/A	$101.26	5.3%	$5.37
Demonstration Only Noncategorical Eligibles	N/A	N/A	$87.05	19.3%	$16.80
Total				100.0%	$159.99

* Per Capita Cost is a combination of fee-for-service expenditures and capitation payments.

OREGON BASIC HEALTH SERVICES PROGRAM

Exhibit 16-B
05/01/91

Calculation of Blended Monthly Per Capita Cost* Trended to 1993 Based on the Assumption That All Eligibles are Enrolled in HMOs With Eligibility Distribution When Program Reaches a Steady-state

MEDICAL	CAP RATE	AGE/SEX ADJUSTMENT	ADJUSTED CAP RATE	PERCENT OF POPULATION	WEIGHTED CAPITATION RATE
Aid to Families with Dependent Children	$104.67	1	$104.67	47.6%	$49.82
General Assistance	$741.63	1	$741.63	1.6%	$11.87
Poverty Level Medical Adults	$492.63	1	$492.63	2.1%	$10.35
Poverty Level Medical Children	$388.99	0.71	$276.18	6.2%	$17.12
Demonstration Only Categorical Eligibles	$73.38	1.10	$80.71	8.9%	$7.18
Demonstration Only Noncategorical Eligibles	$80.01	0.89	$71.21	33.6%	$23.93
Total				100.0%	$120.27

DENTAL	CAP RATE	AGE/SEX ADJUSTMENT	ADJUSTED CAP RATE	PERCENT OF POPULATION	WEIGHTED CAPITATION RATE
Aid to Families with Dependent Children	$18.92	1	$18.92	47.6%	$9.01
General Assistance	$11.10	1	$11.10	1.6%	$0.18
Poverty Level Medical Adults	$10.17	1	$10.17	2.1%	$0.21
Poverty Level Medical Children	$0.87	2.5	$2.17	6.2%	$0.13
Demonstration Only Categorical Eligibles	$14.47	1	$14.47	8.9%	$1.29
Demonstration Only Noncategorical Eligibles	$10.62	1	$10.62	33.6%	$3.57
Total				100.0%	$14.39

MEDICAL PLUS DENTAL	CAP RATE	AGE/SEX ADJUSTMENT	ADJUSTED CAP RATE	PERCENT OF POPULATION	WEIGHTED CAPITATION RATE
Aid to Families with Dependent Children	N/A	N/A	$123.59	47.6%	$58.83
General Assistance	N/A	N/A	$752.73	1.6%	$12.04
Poverty Level Medical Adults	N/A	N/A	$502.80	2.1%	$10.56
Poverty Level Medical Children	N/A	N/A	$278.35	6.2%	$17.26
Demonstration Only Categorical Eligibles	N/A	N/A	$95.18	8.9%	$8.47
Demonstration Only Noncategorical Eligibles	N/A	N/A	$81.83	33.6%	$27.49
Total				100.0%	$134.65

HEALTH CARE EXPENSE + ADMINISTRATION	CAP RATE	AGE/SEX ADJUSTMENT	ADJUSTED CAP RATE	PERCENT OF POPULATION	WEIGHTED CAPITATION RATE
Aid to Families with Dependent Children	N/A	N/A	$131.47	47.6%	$62.58
General Assistance	N/A	N/A	$800.78	1.6%	$12.81
Poverty Level Medical Adults	N/A	N/A	$534.89	2.1%	$11.23
Poverty Level Medical Children	N/A	N/A	$296.12	6.2%	$18.36
Demonstration Only Categorical Eligibles	N/A	N/A	$101.26	8.9%	$9.01
Demonstration Only Noncategorical Eligibles	N/A	N/A	$87.05	33.6%	$29.25
Total				100.0%	$143.25

* Per Capita Cost is a combination of fee-for-service expenditures and capitation payments.

OREGON BASIC HEALTH SERVICES PROGRAM – Calculation of Total Monthly Per Capita Cost *

Exhibit 17

05/01/91

Based on Paid Data for the Oregon Medicaid Program, 1988 & 1989

Adjusted for MMIS Utilization Rates and Managed Care Savings Trended to FY 1993

(Assumes all Eligibles are enrolled with Primary Care Case Managers)

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
CATEGORY OF SERVICE	AVERAGE OREGON PAID PER UNIT	AFDC COST PMPM	GA COST PMPM	PLM-ADULT COST PMPM	PLM-CHILD COST PMPM	NEW CATEGORICAL ELIGIBLES PMPM	NEW NONCAT. ELIGIBLES PMPM	AVERAGE PMPM
ANESTHESIA	$232.10	$1.63	$10.75	$7.79	$2.09	$1.53	$1.99	$2.10
CHIROPRACTOR	$19.40	$0.26	$0.14	$0.20	$0.00	$0.24	$0.38	$0.25
DURABLE MED EQUIPMENT	$110.73	$0.63	$6.69	$0.13	$3.78	$0.45	$0.59	$0.98
FAMILY PLANNING – INPATIENT	$673.78	$0.01	$0.00	$0.02	$0.00	$0.01	$0.01	$0.01
FAMILY PLANNING – OTHER	$26.45	$0.03	$0.02	$0.11	$0.02	$0.03	$0.03	$0.03
FAMILY PLANNING – OUTPATIENT	$21.96	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$0.00
FAMILY PLANNING – PHYSICIAN	$114.51	$1.23	$0.07	$0.75	$0.01	$0.85	$0.98	$1.02
HEARING AID	$131.55	$0.04	$0.11	$0.01	$0.05	$0.04	$0.00	$0.03
HEMODIALYSIS	$206.89	$0.01	$0.41	$0.00	$0.00	$0.01	$0.01	$0.02
HOME HEALTH NURSING	$13.91	$0.00	$0.05	$0.00	$0.00	$0.00	$0.00	$0.00
HOME HEALTH SERVICE	$68.12	$0.15	$4.13	$0.28	$0.47	$0.17	$0.20	$0.27
IP–HOSPICE	$103.35	$0.01	$0.07	$0.00	$0.01	$0.00	$0.01	$0.01
IP–MATERNITY	$1,417.75	$8.24	$1.56	$131.76	$0.00	$0.79	$0.99	$9.10
IP–MED/SURG	$3,139.48	$14.02	$341.46	$13.14	$42.75	$10.92	$19.68	$24.13
IP–NEONATAL ICU	$4,521.78	$7.62	$0.44	$0.00	$157.10	$0.67	$0.41	$17.60
IP–NEWBORN	$593.57	$1.90	$0.00	$0.00	$41.90	$0.17	$0.31	$4.65
IP–PSYCH & DRUG/ALCOHOL DETOX	$2,141.06	$0.92	$25.01	$1.07	$0.29	$0.68	$2.41	$1.65
IP–PASSTHROUGH PAYMENTS /1		$7.00	$21.12	$32.14	$18.09	$5.41	$5.53	$8.53
MATERNITY MANAGEMENT	$54.41	$0.14	$0.01	$4.34	$0.00	$0.04	$0.00	$0.21
OP–DIAGNOSTIC X–RAY	$59.17	$1.60	$9.02	$7.72	$1.54	$1.93	$1.59	$1.94
OP–EMERGENCY ROOM	$36.30	$2.27	$4.70	$4.16	$3.36	$2.41	$1.76	$2.37
OP–FACILITY	$72.90	$1.33	$9.50	$6.54	$2.17	$1.64	$0.90	$1.65
OP–LAB	$14.03	$1.34	$5.68	$7.87	$1.59	$1.71	$1.53	$1.69
OP–MAGNETIC RESONANCE IMAGING	$255.83	$0.21	$2.49	$0.07	$0.07	$0.15	$0.33	$0.26
OP–MATERNITY	$98.12	$0.23	$0.03	$7.55	$0.06	$0.06	$0.00	$0.37
OP–OTHER OUTPATIENT	$80.44	$2.02	$8.52	$5.90	$2.10	$2.23	$1.63	$2.21
OP–PHYSICIAN SERVICES	$36.21	$1.83	$2.67	$1.98	$2.63	$1.87	$1.01	$1.76
OP–SOMATIC PSYCH	$222.53	$0.00	$0.12	$0.00	$0.00	$0.00	$0.44	$0.09
OP–SURGERY/FACILITY	$195.32	$0.36	$1.86	$0.46	$0.47	$0.28	$0.36	$0.40
OP–THERAPEUTIC X–RAY	$110.23	$0.09	$2.41	$0.12	$0.02	$0.09	$0.14	$0.14
OTHER–DIAGNOSTIC X–RAY	$30.75	$1.62	$7.95	$9.73	$1.96	$1.90	$1.19	$1.94
OTHER–LAB	$11.51	$1.82	$4.99	$11.56	$1.67	$2.35	$2.26	$2.26
OTHER–THERAPEUTIC X–RAY	$63.18	$0.04	$1.77	$0.00	$0.00	$0.03	$0.11	$0.08

OREGON BASIC HEALTH SERVICES PROGRAM – Calculation of Total Monthly Per Capita Cost *

Exhibit 17

Based on Paid Data for the Oregon Medicaid Program, 1988 & 1989

05/01/91

Adjusted for MMIS Utilization Rates and Managed Care Savings Trended to FY 1993

(Assumes all Eligibles are enrolled with Primary Care Case Managers)

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
CATEGORY OF SERVICE	AVERAGE OREGON PAID PER UNIT	AFDC COST PMPM	GA COST PMPM	PLM ADULT COST PMPM	PLM CHILD COST PMPM	NEW CATEGORICAL ELIGIBLES PMPM	NEW NONCAT. ELIGIBLES PMPM	AVERAGE PMPM
PHYSICAL/OCCUPATIONAL THERAPY	$42.57	$0.36	$2.72	$0.22	$0.48	$0.35	$0.80	$0.50
PHYSICIAN ANCILLARY	$11.81	$0.18	$3.46	$0.28	$0.16	$0.19	$0.54	$0.32
PHYSICIAN HOME VISITS	$29.04	$0.00	$0.00	$0.00	$0.00	$0.00	$0.01	$0.00
PHYSICIAN INPATIENT VISITS	$43.09	$1.71	$12.41	$2.53	$13.48	$1.67	$1.43	$2.86
PHYSICIAN MATERNITY	$822.52	$6.68	$0.04	$103.88	$0.00	$0.80	$0.99	$7.31
PHYSICIAN OFFICE VISITS	$28.05	$8.03	$16.41	$7.25	$18.41	$8.33	$6.79	$8.80
PHYSICIAN OTHER	$27.77	$0.62	$1.80	$2.51	$5.19	$0.88	$1.06	$1.17
PHYSICIAN OUTPATIENT VISITS	$28.24	$0.33	$0.92	$0.74	$0.76	$0.37	$0.15	$0.36
PHYSICIAN PT/OT	$19.09	$0.14	$0.72	$0.09	$0.04	$0.13	$0.05	$0.12
PHYSICIAN SOMATIC PSYCH VISITS	$53.21	$0.14	$3.17	$0.06	$0.04	$0.13	$0.99	$0.36
PHYSICIAN WELL CHILD EXAMS	$20.28	$1.20	$0.00	$0.00	$9.43	$0.14	$0.04	$1.53
PODIATRIST	$29.91	$0.04	$0.16	$0.03	$0.00	$0.04	$0.03	$0.04
PRESCRIPTION DRUGS–BASIC	$17.63	$7.28	$54.98	$3.70	$2.52	$7.06	$7.10	$7.75
PRESCRIPTION DRUGS–FAM.PLANNING	$29.54	$0.38	$0.14	$1.46	$0.01	$0.41	$0.40	$0.38
PRESCRIPTION DRUGS–PSYCH	$22.38	$0.22	$8.69	$0.11	$0.02	$0.22	$0.22	$0.38
PREVENTIVE MEDICINE	$29.87	$0.69	$4.27	$3.67	$0.00	$0.83	$0.84	$0.83
PRIVATE DUTY NURSING /2	$67.93	$0.06	$0.06	$0.06	$0.06	$0.06	$0.06	$0.06
STERILIZATIONS–PROFESSIONAL	$109.35	$0.49	$0.04	$2.05	$0.00	$0.14	$0.14	$0.40
SUPPLIES	$23.74	$0.25	$1.76	$0.33	$0.34	$0.26	$0.42	$0.33
SURGERY	$150.69	$4.21	$37.03	$6.97	$5.36	$3.32	$6.38	$5.44
TESTING	$41.99	$0.47	$2.50	$0.15	$1.30	$0.49	$0.67	$0.61
TRANSPORTATION – AMBULANCE	$58.47	$0.28	$2.74	$0.96	$0.89	$0.34	$0.14	$0.38
TRANSPORTATION – OTHER	$43.56	$0.49	$3.87	$2.13	$1.92	$0.63	$0.50	$0.73
VISION CARE	$59.13	$0.79	$1.19	$0.59	$0.20	$0.76	$2.50	$1.08
VISION SUPPLIES	$21.23	$0.53	$0.66	$0.32	$0.02	$0.50	$0.51	$0.48
TOTAL		$94.18	$633.49	$395.53	$344.84	$66.70	$79.53	$129.96

OREGON BASIC HEALTH SERVICES PROGRAM – Calculation of Total Monthly Per Capita Cost *

Exhibit 17

05/01/91

Based on Paid Data for the Oregon Medicaid Program, 1988 & 1989

Adjusted for MMIS Utilization Rates and Managed Care Savings Trended to FY 1993

(Assumes all Eligibles are enrolled with Primary Care Case Managers)

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
CATEGORY OF SERVICE	AVERAGE OREGON PAID PER UNIT	AFDC COST PMPM	GA COST PMPM	PLM-ADULT COST PMPM	PLM-CHILD COST PMPM	NEW CATEGORICAL ELIGIBLES PMPM	NEW NONCAT. ELIGIBLES PMPM	AVERAGE PMPM
DENTAL-DIAGNOSTIC /2	$10.71	$1.52	$0.87	$0.77	$0.04	$1.07	$0.74	$1.19
DENTAL-ENDODONTICS /2	$58.44	$1.43	$0.55	$0.53	$0.09	$0.87	$0.21	$1.01
DENTAL-GENERAL /2	$21.26	$0.51	$0.49	$0.41	$0.02	$0.54	$0.71	$0.51
DENTAL-MAXILLOFACIAL PROS /2	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
DENTAL-ORAL SURGERY /2	$34.82	$0.90	$0.71	$0.45	$0.02	$0.58	$0.28	$0.68
DENTAL-ORTHODONTICS /2	$720.07	$0.28	$0.09	$0.09	$0.00	$0.21	$0.16	$0.22
DENTAL-PERIODONTICS /2	$70.73	$0.40	$0.65	$0.63	$0.00	$0.57	$0.81	$0.47
DENTAL-PREVENTIVE /2	$19.84	$0.82	$0.39	$0.43	$0.03	$0.94	$0.83	$0.74
DENTAL-PROS,FIXED /2	$64.11	$0.21	$0.38	$0.36	$0.00	$0.35	$0.71	$0.31
DENTAL-PROS,REMOVABLE /2	$40.78	$0.06	$0.13	$0.06	$0.00	$0.07	$0.09	$0.06
DENTAL-RESTORATIVE /2	$36.80	$3.07	$1.55	$1.59	$0.16	$2.23	$1.55	$2.42
TOTAL		**$9.20**	**$5.81**	**$5.33**	**$0.37**	**$7.43**	**$6.10**	**$7.61**

NOTES:

/1 IP-Passthrough Payments represent additional payments for hospital services and will apply only to the non-HMO portion of the program. Also includes impact of a recent hospital cost settlement.
/2 BSC utilization data is used in addition to Medicaid utilization data to project Medicaid use for these services for adults because the services are not currently fully covered by Medicaid.

DESCRIPTION OF COLUMN CONTENTS:

(1) Average paid per unit of service is calculated from the MMIS average paid amounts. Charges are also increased for trend as shown in Exhibit 14.

(2) AFDC cost PMPM is calculated by multiplying the AFDC utilization rate from Exhibit 9 by the average cost per unit (1) and dividing by 12000 to represent a single person per month. (The utilization rate is expressed in terms of units per 1000 members per year). Case mix adjustments are applied to reflect differences in average charge per unit of service by eligibility category. The cost PMPM for inpatient and outpatient hospital services is also reduced by 9% to reflect managed care savings for medical services.

(3) Similar to (2) but covers the General Assistance population. Managed care savings is set at 4.5% for inpatient and outpatient hospital services.

(4) Similar to (2) but covers the Poverty Level Medical-Adult population.

(5) Similar to (2) but covers the Poverty Level Medical-Child population.

(6) Similar to (2) but combines both the Poverty Level Medical and the AFDC population. Reflects the new categorical-type eligibles.

(7) Similar to (2) but covers the newly eligible, non-categorical population.

(8) Weighted average based on eligibility distribution at program start-up.

* Per Capita Cost is a combination of fee-for-service expenditures and capitation payments.

OREGON BASIC HEALTH SERVICES PROGRAM

Exhibit 18-A
05/01/91

Calculation of Blended Monthly Per Capita Cost* Trended to 1993 Based on the Assumption That All Eligibles Receive Services on a Fee-For-Service Basis and are Enrolled with Primary Care Case Managers With Eligibility Distribution at Program Start-up

MEDICAL	CAP RATE	AGE/SEX ADJUSTMENT	ADJUSTED CAP RATE	PERCENT OF POPULATION	WEIGHTED CAPITATION RATE
Aid to Families with Dependent Children	$94.18	1	$94.18	62.4%	$58.77
General Assistance	$633.49	1	$633.49	2.1%	$13.30
Poverty Level Medical Adults	$395.53	1	$395.53	2.8%	$11.07
Poverty Level Medical Children	$344.84	0.71	$244.84	8.1%	$19.83
Demonstration Only Categorical Eligibles	$66.70	1.10	$73.37	5.3%	$3.89
Demonstration Only Noncategorical Eligibles	$79.53	0.89	$70.78	19.3%	$13.66
Total				100.0%	$120.53

DENTAL	CAP RATE	AGE/SEX ADJUSTMENT	ADJUSTED CAP RATE	PERCENT OF POPULATION	WEIGHTED CAPITATION RATE
Aid to Families with Dependent Children	$9.20	1	$9.20	62.4%	$5.74
General Assistance	$5.81	1	$5.81	2.1%	$0.12
Poverty Level Medical Adults	$5.33	1	$5.33	2.8%	$0.15
Poverty Level Medical Children	$0.37	2.5	$0.92	8.1%	$0.07
Demonstration Only Categorical Eligibles	$7.43	1	$7.43	5.3%	$0.39
Demonstration Only Noncategorical Eligibles	$6.10	1	$6.10	19.3%	$1.18
Total				100.0%	$7.66

MEDICAL PLUS DENTAL	CAP RATE	AGE/SEX ADJUSTMENT	ADJUSTED CAP RATE	PERCENT OF POPULATION	WEIGHTED CAPITATION RATE
Aid to Families with Dependent Children	N/A	N/A	$103.38	62.4%	$64.51
General Assistance	N/A	N/A	$639.30	2.1%	$13.43
Poverty Level Medical Adults	N/A	N/A	$400.86	2.8%	$11.22
Poverty Level Medical Children	N/A	N/A	$245.75	8.1%	$19.91
Demonstration Only Categorical Eligibles	N/A	N/A	$80.80	5.3%	$4.28
Demonstration Only Noncategorical Eligibles	N/A	N/A	$76.88	19.3%	$14.84
Total				100.0%	$128.18

HEALTH CARE EXPENSE + ADMINISTRATION	CAP RATE	AGE/SEX ADJUSTMENT	ADJUSTED CAP RATE	PERCENT OF POPULATION	WEIGHTED CAPITATION RATE
Aid to Families with Dependent Children	N/A	N/A	$106.38	62.4%	$66.38
General Assistance	N/A	N/A	$642.30	2.1%	$13.49
Poverty Level Medical Adults	N/A	N/A	$403.86	2.8%	$11.31
Poverty Level Medical Children	N/A	N/A	$248.75	8.1%	$20.15
Demonstration Only Categorical Eligibles	N/A	N/A	$83.80	5.3%	$4.44
Demonstration Only Noncategorical Eligibles	N/A	N/A	$79.88	19.3%	$15.42
Total				100.0%	$131.18

* Per Capita Cost is a combination of fee-for-service expenditures and capitation payments.

OREGON BASIC HEALTH SERVICES PROGRAM

Exhibit 18-B
05/01/91

Calculation of Blended Monthly Per Capita Cost* Trended to 1993 Based on the Assumption That All Eligibles Receive Services on a Fee-For-Service Basis and are Enrolled with Primary Care Case Managers With Eligibility Distribution When Program Reaches a Steady-state

MEDICAL	CAP RATE	AGE/SEX ADJUSTMENT	ADJUSTED CAP RATE	PERCENT OF POPULATION	WEIGHTED CAPITATION RATE
Aid to Families with Dependent Children	$94.18	1	$94.18	47.6%	$44.83
General Assistance	$633.49	1	$633.49	1.6%	$10.14
Poverty Level Medical Adults	$395.53	1	$395.53	2.1%	$8.31
Poverty Level Medical Children	$344.84	0.71	$244.84	6.2%	$15.18
Demonstration Only Categorical Eligibles	$66.70	1.10	$73.37	8.9%	$6.53
Demonstration Only Noncategorical Eligibles	$79.53	0.89	$70.78	33.6%	$23.78
Total				100.0%	$108.76

DENTAL	CAP RATE	AGE/SEX ADJUSTMENT	ADJUSTED CAP RATE	PERCENT OF POPULATION	WEIGHTED CAPITATION RATE
Aid to Families with Dependent Children	$9.20	1	$9.20	47.6%	$4.38
General Assistance	$5.81	1	$5.81	1.6%	$0.09
Poverty Level Medical Adults	$5.33	1	$5.33	2.1%	$0.11
Poverty Level Medical Children	$0.37	2.5	$0.92	6.2%	$0.06
Demonstration Only Categorical Eligibles	$7.43	1	$7.43	8.9%	$0.66
Demonstration Only Noncategorical Eligibles	$6.10	1	$6.10	33.6%	$2.05
Total				100.0%	$7.35

MEDICAL PLUS DENTAL	CAP RATE	AGE/SEX ADJUSTMENT	ADJUSTED CAP RATE	PERCENT OF POPULATION	WEIGHTED CAPITATION RATE
Aid to Families with Dependent Children	N/A	N/A	$103.38	47.6%	$49.21
General Assistance	N/A	N/A	$639.30	1.6%	$10.23
Poverty Level Medical Adults	N/A	N/A	$400.86	2.1%	$8.42
Poverty Level Medical Children	N/A	N/A	$245.75	6.2%	$15.24
Demonstration Only Categorical Eligibles	N/A	N/A	$80.80	8.9%	$7.19
Demonstration Only Noncategorical Eligibles	N/A	N/A	$76.88	33.6%	$25.83
Total				100.0%	$116.11

HEALTH CARE EXPENSE + ADMINISTRATION	CAP RATE	AGE/SEX ADJUSTMENT	ADJUSTED CAP RATE	PERCENT OF POPULATION	WEIGHTED CAPITATION RATE
Aid to Families with Dependent Children	N/A	N/A	$106.38	47.6%	$50.64
General Assistance	N/A	N/A	$642.30	1.6%	$10.28
Poverty Level Medical Adults	N/A	N/A	$403.86	2.1%	$8.48
Poverty Level Medical Children	N/A	N/A	$248.75	6.2%	$15.42
Demonstration Only Categorical Eligibles	N/A	N/A	$83.80	8.9%	$7.46
Demonstration Only Noncategorical Eligibles	N/A	N/A	$79.88	33.6%	$26.84
Total				100.0%	$119.11

* Per Capita Cost is a combination of fee-for-service expenditures and capitation payments.

OREGON BASIC HEALTH SERVICES PROGRAM – Calculation of Total Monthly Per Capita Costs * Exhibit 19

Based on Charge Data for Blue Shield of California, 1988 & 1989 Adjusted to Oregon Average Costs 05/01/91

Adjusted for MMIS Utilization Rates and Managed Care Savings Trended to 1993

(Assumes all Eligibles are Enrolled in PCOs)

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
CATEGORY OF SERVICE	AFDC COST PMPM	GA COST PMPM	PLM-ADULT COST PMPM	PLM-CHILD COST PMPM	NEW CATEGORICAL ELIGIBLES PMPM	NEW NONCAT. ELIGIBLES PMPM	AVERAGE PMPM
ANESTHESIA /2	$1.73	$11.36	$8.23	$2.21	$1.61	$2.10	$2.22
CHIROPRACTOR /2	$0.28	$0.16	$0.22	$0.01	$0.27	$0.42	$0.28
DURABLE MED EQUIPMENT /1	$0.63	$6.69	$0.13	$3.78	$0.45	$0.59	$0.98
FAMILY PLANNING – INPATIENT /1	$0.01	$0.00	$0.02	$0.00	$0.01	$0.01	$0.01
FAMILY PLANNING – OTHER /1	$0.03	$0.02	$0.11	$0.02	$0.03	$0.03	$0.03
FAMILY PLANNING – OUTPATIENT /1	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$0.00
FAMILY PLANNING – PHYSICIAN /1	$1.23	$0.07	$0.75	$0.01	$0.85	$0.98	$1.02
HEARING AID /1	$0.04	$0.11	$0.01	$0.05	$0.04	$0.00	$0.03
HEMODIALYSIS /1	$0.01	$0.41	$0.00	$0.00	$0.01	$0.01	$0.02
HOME HEALTH NURSING /1	$0.00	$0.05	$0.00	$0.00	$0.00	$0.00	$0.00
HOME HEALTH SERVICE /1	$0.15	$4.13	$0.28	$0.47	$0.17	$0.20	$0.27
IP–HOSPICE /1	$0.01	$0.07	$0.00	$0.01	$0.00	$0.01	$0.01
IP–MATERNITY /1	$8.24	$1.56	$131.76	$0.00	$0.79	$0.99	$9.10
IP–MED/SURG /1	$13.45	$336.10	$12.60	$40.99	$10.47	$18.87	$23.32
IP–NEONATAL ICU /1	$7.62	$0.44	$0.00	$157.10	$0.67	$0.41	$17.60
IP–NEWBORN /1	$1.90	$0.00	$0.00	$41.90	$0.17	$0.31	$4.65
IP–PSYCH & DRUG/ALCOHOL DETOX /1	$0.88	$24.62	$1.03	$0.28	$0.65	$2.31	$1.60
IP–PASSTHROUGH PAYMENTS /1	$6.71	$20.79	$30.82	$17.35	$5.18	$5.30	$8.19
MATERNITY MANAGEMENT /1	$0.14	$0.01	$4.34	$0.00	$0.04	$0.00	$0.21
OP–DIAGNOSTIC X–RAY /2	$2.49	$14.42	$12.03	$2.40	$3.01	$2.48	$3.03
OP–EMERGENCY ROOM /1	$2.18	$4.62	$3.99	$3.22	$2.31	$1.69	$2.27
OP–FACILITY /1	$1.28	$9.36	$6.27	$2.09	$1.58	$0.86	$1.59
OP–LAB /2	$1.48	$6.43	$8.68	$1.76	$1.88	$1.68	$1.87
OP–MAGNETIC RESONANCE IMAGING /2	$0.43	$5.28	$0.15	$0.14	$0.30	$0.69	$0.55
OP–MATERNITY /1	$0.26	$0.03	$8.30	$0.07	$0.07	$0.00	$0.40
OP–OTHER OUTPATIENT /1	$1.94	$8.38	$5.66	$2.01	$2.14	$1.56	$2.12
OP–PHYSICIAN SERVICES /2	$2.54	$3.78	$2.74	$3.63	$2.58	$1.39	$2.44
OP–SOMATIC PSYCH /1	$0.00	$0.11	$0.00	$0.00	$0.00	$0.42	$0.08
OP–SURGERY/FACILITY /1	$0.34	$1.83	$0.44	$0.45	$0.27	$0.34	$0.38
OP–THERAPEUTIC X–RAY /2	$0.15	$4.45	$0.20	$0.03	$0.15	$0.23	$0.25
OTHER–DIAGNOSTIC X–RAY /2	$2.29	$11.24	$13.75	$2.77	$2.68	$1.68	$2.74
OTHER–LAB /2	$1.89	$5.17	$11.96	$1.72	$2.43	$2.34	$2.34
OTHER–THERAPEUTIC X–RAY /2	$0.05	$2.14	$0.00	$0.00	$0.04	$0.13	$0.10

OREGON BASIC HEALTH SERVICES PROGRAM – Calculation of Total Monthly Per Capita Costs * Exhibit 19

Based on Charge Data for Blue Shield of California, 1988 & 1989 Adjusted to Oregon Average Costs 05/01/91

Adjusted for MMIS Utilization Rates and Managed Care Savings Trended to 1993

(Assumes all Eligibles are Enrolled in PCOs)

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
CATEGORY OF SERVICE	AFDC COST PMPM	GA COST PMPM	PLM-ADULT COST PMPM	PLM-CHILD COST PMPM	NEW CATEGORICAL ELIGIBLES PMPM	NEW NONCAT. ELIGIBLES PMPM	AVERAGE PMPM
PHYSICAL/OCCUPATIONAL THERAPY /1	$0.36	$2.72	$0.22	$0.48	$0.35	$0.80	$0.50
PHYSICIAN ANCILLARY /2	$0.22	$4.11	$0.34	$0.19	$0.22	$0.64	$0.38
PHYSICIAN HOME VISITS /2	$0.01	$0.00	$0.00	$0.00	$0.01	$0.01	$0.01
PHYSICIAN INPATIENT VISITS /2	$2.39	$17.30	$3.52	$18.78	$2.33	$1.99	$3.98
PHYSICIAN MATERNITY /2	$8.56	$0.05	$133.13	$0.00	$1.02	$1.26	$9.37
PHYSICIAN OFFICE VISITS /2	$7.96	$16.27	$7.19	$18.25	$8.26	$6.73	$8.72
PHYSICIAN OTHER /2	$0.55	$1.60	$2.22	$4.60	$0.78	$0.94	$1.03
PHYSICIAN OUTPATIENT VISITS /2	$0.58	$1.61	$1.29	$1.32	$0.65	$0.26	$0.62
PHYSICIAN PT/OT /2	$0.16	$0.85	$0.11	$0.05	$0.15	$0.06	$0.15
PHYSICIAN SOMATIC PSYCH VISITS /1	$0.14	$3.17	$0.06	$0.04	$0.13	$0.99	$0.36
PHYSICIAN WELL CHILD EXAMS /2	$1.50	$0.00	$0.00	$11.71	$0.18	$0.04	$1.90
PODIATRIST /2	$0.04	$0.16	$0.03	$0.00	$0.04	$0.03	$0.04
PRESCRIPTION DRUGS-BASIC /1	$7.28	$54.98	$3.70	$2.52	$7.06	$7.10	$7.75
PRESCRIPTION DRUGS-FAM.PLANNING /1	$0.38	$0.14	$1.46	$0.01	$0.41	$0.40	$0.38
PRESCRIPTION DRUGS-PSYCH /1	$0.22	$8.69	$0.11	$0.02	$0.22	$0.22	$0.38
PREVENTIVE MEDICINE /2	$0.78	$4.80	$4.13	$0.00	$0.94	$0.95	$0.94
PRIVATE DUTY NURSING /1	$0.06	$0.06	$0.06	$0.06	$0.06	$0.06	$0.06
STERILIZATIONS-PROFESSIONAL /1	$0.49	$0.04	$2.05	$0.00	$0.14	$0.14	$0.40
SUPPLIES /1	$0.25	$1.76	$0.33	$0.34	$0.26	$0.42	$0.33
SURGERY /2	$5.40	$47.59	$8.96	$6.89	$4.26	$6.48	$6.66
TESTING /2	$0.45	$2.37	$0.15	$1.24	$0.46	$0.57	$0.57
TRANSPORTATION – AMBULANCE /1	$0.28	$2.74	$0.96	$0.89	$0.34	$0.14	$0.38
TRANSPORTATION – OTHER /1	$0.49	$3.87	$2.13	$1.92	$0.63	$0.50	$0.73
VISION CARE /1	$0.79	$1.19	$0.59	$0.20	$0.76	$2.50	$1.08
VISION SUPPLIES /1	$0.53	$0.66	$0.32	$0.02	$0.50	$0.51	$0.48
TOTAL	$100.21	$660.57	$437.57	$353.99	$71.02	$81.81	$136.88
TOTAL CAPITATED SERVICES **	$41.92	$161.15	$219.05	$77.70	$34.27	$33.10	$50.17

OREGON BASIC HEALTH SERVICES PROGRAM – Calculation of Total Monthly Per Capita Costs *

Exhibit 19

05/01/91

Based on Charge Data for Blue Shield of California, 1988 & 1989 Adjusted to Oregon Average Costs Adjusted for MMIS Utilization Rates and Managed Care Savings Trended to 1993

(Assumes all Eligibles are Enrolled in PCOs)

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
CATEGORY OF SERVICE	AFDC COST PMPM	GA COST PMPM	PLM-ADULT COST PMPM	PLM-CHILD COST PMPM	NEW CATEGORICAL ELIGIBLES PMPM	NEW NONCAT. ELIGIBLES PMPM	AVERAGE PMPM
DENTAL–DIAGNOSTIC /1	$1.52	$0.87	$0.77	$0.04	$1.07	$0.74	$1.19
DENTAL–ENDODONTICS /1	$1.43	$0.55	$0.53	$0.09	$0.87	$0.21	$1.01
DENTAL–GENERAL /1	$0.51	$0.49	$0.41	$0.02	$0.54	$0.71	$0.51
DENTAL–MAXILLOFACIAL PROS /1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
DENTAL–ORAL SURGERY /1	$0.90	$0.71	$0.45	$0.02	$0.58	$0.28	$0.68
DENTAL–ORTHODONTICS /1	$0.28	$0.09	$0.09	$0.00	$0.21	$0.16	$0.22
DENTAL–PERIODONTICS /1	$0.40	$0.65	$0.63	$0.00	$0.57	$0.81	$0.47
DENTAL–PREVENTIVE /1	$0.82	$0.39	$0.43	$0.03	$0.94	$0.83	$0.74
DENTAL–PROS,FIXED /1	$0.21	$0.38	$0.36	$0.00	$0.35	$0.71	$0.31
DENTAL–PROS,REMOVABLE /1	$0.06	$0.13	$0.06	$0.00	$0.07	$0.09	$0.06
DENTAL–RESTORATIVE /1	$3.07	$1.55	$1.59	$0.16	$2.23	$1.55	$2.42
TOTAL	$9.20	$5.81	$5.33	$0.37	$7.43	$6.10	$7.61

NOTES:

/1 This amount reflects PCCM participation from Exhibit 17 & includes all services that may be paid on a FFS basis.

/2 This amount reflects HMO participation from Exhibit 15 & includes all services for which PCOs will be paid a capitation rate.

DESCRIPTION OF COLUMN CONTENTS:

(1) AFDC cost PMPM is calculated by multiplying the AFDC utilization rate from Exhibit 9 by the applicable average cost per unit from Exhibit 15 or 17 cost per unit (3) and dividing by 12000 to represent a single person per month. (The utilization rate is expressed in terms of units per 1000 members per year). Case mix adjustments are applied to reflect differences in average charge per unit of service by eligibility category. The cost PMPM for inpatient and outpatient hospital services is also reduced by 13% to reflect managed care savings for medical services.

(2) Similar to (1) but covers the General Assistance population. Managed Care savings is set at 6% for inpatient and outpatient hospital services.

(3) Similar to (1) but covers the Poverty Level Medical–Adult population.

(4) Similar to (1) but covers the Poverty Level Medical–Child population.

(5) Similar to (1) but combines both the Poverty Level Medical and the AFDC population. Reflects the new categorical–type eligibles.

(6) Similar to (1) but covers the newly eligible, non–categorical population.

(7) Weighted average based on eligibility distribution at program start–up.

* Per Capita Cost is a combination of fee–for–service expenditures and capitation payments.

** These services are capitated, but some may be paid on a fee–for–service basis prior to enrollment, thus the capitation payment may be less.

OREGON BASIC HEALTH SERVICES PROGRAM

Exhibit 20-A
05/01/91

Calculation of Blended Monthly Per Capita Cost* Trended to 1993 Based on the Assumption That All Eligibles are Enrolled in PCOs With Eligibility Distribution at Program Start-up

MEDICAL	CAP RATE	AGE/SEX ADJUSTMENT	ADJUSTED CAP RATE	PERCENT OF POPULATION	WEIGHTED CAPITATION RATE
Aid to Families with Dependent Children	$100.21	1	$100.21	62.4%	$62.53
General Assistance	$660.57	1	$660.57	2.1%	$13.87
Poverty Level Medical Adults	$437.57	1	$437.57	2.8%	$12.25
Poverty Level Medical Children	$353.99	0.71	$251.33	8.1%	$20.36
Demonstration Only Categorical Eligibles	$71.02	1.10	$78.12	5.3%	$4.14
Demonstration Only Noncategorical Eligibles	$81.81	0.89	$72.81	19.3%	$14.05
Total				100.0%	$127.20

DENTAL	CAP RATE	AGE/SEX ADJUSTMENT	ADJUSTED CAP RATE	PERCENT OF POPULATION	WEIGHTED CAPITATION RATE
Aid to Families with Dependent Children	$9.20	1	$9.20	62.4%	$5.74
General Assistance	$5.81	1	$5.81	2.1%	$0.12
Poverty Level Medical Adults	$5.33	1	$5.33	2.8%	$0.15
Poverty Level Medical Children	$0.37	2.5	$0.92	8.1%	$0.07
Demonstration Only Categorical Eligibles	$7.43	1	$7.43	5.3%	$0.39
Demonstration Only Noncategorical Eligibles	$6.10	1	$6.10	19.3%	$1.18
Total				100.0%	$7.66

MEDICAL PLUS DENTAL	CAP RATE	AGE/SEX ADJUSTMENT	ADJUSTED CAP RATE	PERCENT OF POPULATION	WEIGHTED CAPITATION RATE
Aid to Families with Dependent Children	N/A	N/A	$109.41	62.4%	$68.27
General Assistance	N/A	N/A	$666.38	2.1%	$13.99
Poverty Level Medical Adults	N/A	N/A	$442.90	2.8%	$12.40
Poverty Level Medical Children	N/A	N/A	$252.25	8.1%	$20.43
Demonstration Only Categorical Eligibles	N/A	N/A	$85.55	5.3%	$4.53
Demonstration Only Noncategorical Eligibles	N/A	N/A	$78.91	19.3%	$15.23
Total				100.0%	$134.86

HEALTH CARE EXPENSE + ADMINISTRATION	CAP RATE	AGE/SEX ADJUSTMENT	ADJUSTED CAP RATE	PERCENT OF POPULATION	WEIGHTED CAPITATION RATE
Aid to Families with Dependent Children	N/A	N/A	$113.41	62.4%	$70.77
General Assistance	N/A	N/A	$670.38	2.1%	$14.08
Poverty Level Medical Adults	N/A	N/A	$446.90	2.8%	$12.51
Poverty Level Medical Children	N/A	N/A	$256.25	8.1%	$20.76
Demonstration Only Categorical Eligibles	N/A	N/A	$89.55	5.3%	$4.75
Demonstration Only Noncategorical Eligibles	N/A	N/A	$82.91	19.3%	$16.00
Total				100.0%	$138.86

* Per Capita Cost is a combination of fee-for-service expenditures and capitation payments.

OREGON BASIC HEALTH SERVICES PROGRAM

Exhibit 20-B
05/01/91

Calculation of Blended Monthly Per Capita Cost* Trended to 1993 Based on the Assumption That All Eligibles are Enrolled in PCOs With Eligibility Distribution When Program Reaches a Steady-state

MEDICAL	CAP RATE	AGE/SEX ADJUSTMENT	ADJUSTED CAP RATE	PERCENT OF POPULATION	WEIGHTED CAPITATION RATE
Aid to Families with Dependent Children	$100.21	1	$100.21	47.6%	$47.70
General Assistance	$660.57	1	$660.57	1.6%	$10.57
Poverty Level Medical Adults	$437.57	1	$437.57	2.1%	$9.19
Poverty Level Medical Children	$353.99	0.71	$251.33	6.2%	$15.58
Demonstration Only Categorical Eligibles	$71.02	1.10	$78.12	8.9%	$6.95
Demonstration Only Noncategorical Eligibles	$81.81	0.89	$72.81	33.6%	$24.46
Total				100.0%	$114.46

DENTAL	CAP RATE	AGE/SEX ADJUSTMENT	ADJUSTED CAP RATE	PERCENT OF POPULATION	WEIGHTED CAPITATION RATE
Aid to Families with Dependent Children	$9.20	1	$9.20	47.6%	$4.38
General Assistance	$5.81	1	$5.81	1.6%	$0.09
Poverty Level Medical Adults	$5.33	1	$5.33	2.1%	$0.11
Poverty Level Medical Children	$0.37	2.5	$0.92	6.2%	$0.06
Demonstration Only Categorical Eligibles	$7.43	1	$7.43	8.9%	$0.66
Demonstration Only Noncategorical Eligibles	$6.10	1	$6.10	33.6%	$2.05
Total				100.0%	$7.35

MEDICAL PLUS DENTAL	CAP RATE	AGE/SEX ADJUSTMENT	ADJUSTED CAP RATE	PERCENT OF POPULATION	WEIGHTED CAPITATION RATE
Aid to Families with Dependent Children	N/A	N/A	$109.41	47.6%	$52.08
General Assistance	N/A	N/A	$666.38	1.6%	$10.66
Poverty Level Medical Adults	N/A	N/A	$442.90	2.1%	$9.30
Poverty Level Medical Children	N/A	N/A	$252.25	6.2%	$15.64
Demonstration Only Categorical Eligibles	N/A	N/A	$85.55	8.9%	$7.61
Demonstration Only Noncategorical Eligibles	N/A	N/A	$78.91	33.6%	$26.51
Total				100.0%	$121.81

HEALTH CARE EXPENSE + ADMINISTRATION	CAP RATE	AGE/SEX ADJUSTMENT	ADJUSTED CAP RATE	PERCENT OF POPULATION	WEIGHTED CAPITATION RATE
Aid to Families with Dependent Children	N/A	N/A	$113.41	47.6%	$53.98
General Assistance	N/A	N/A	$670.38	1.6%	$10.73
Poverty Level Medical Adults	N/A	N/A	$446.90	2.1%	$9.38
Poverty Level Medical Children	N/A	N/A	$256.25	6.2%	$15.89
Demonstration Only Categorical Eligibles	N/A	N/A	$89.55	8.9%	$7.97
Demonstration Only Noncategorical Eligibles	N/A	N/A	$82.91	33.6%	$27.86
Total				100.0%	$125.81

* Per Capita Cost is a combination of fee-for-service expenditures and capitation payments.

OREGON BASIC HEALTH SERVICES PROGRAM – Calculation of Total Monthly Per Capita Cost *

Exhibit 21

05/01/91

Based on Paid Data for the Oregon Medicaid Program, 1988 & 1989

Adjusted for MMIS Utilization Rates and Managed Care Savings Trended to FY 1993

(Assumes all Eligibles Receive Services on a Fee–For–Service Basis)

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
CATEGORY OF SERVICE	AVERAGE OREGON PAID PER UNIT	AFDC COST PMPM	GA COST PMPM	PLM-ADULT COST PMPM	PLM-CHILD COST PMPM	NEW CATEGORICAL ELIGIBLES PMPM	NEW NONCAT. ELIGIBLES PMPM	AVERAGE PMPM
ANESTHESIA	$232.10	$1.63	$10.75	$7.79	$2.09	$1.53	$1.99	$2.10
CHIROPRACTOR	$19.40	$0.26	$0.14	$0.20	$0.00	$0.24	$0.38	$0.25
DURABLE MED EQUIPMENT	$110.73	$0.63	$6.69	$0.13	$3.78	$0.45	$0.59	$0.98
FAMILY PLANNING – INPATIENT	$673.78	$0.01	$0.00	$0.02	$0.00	$0.01	$0.01	$0.01
FAMILY PLANNING – OTHER	$26.45	$0.03	$0.02	$0.11	$0.02	$0.03	$0.03	$0.03
FAMILY PLANNING – OUTPATIENT	$21.96	$0.00	$0.00	$0.01	$0.00	$0.00	$0.00	$0.00
FAMILY PLANNING – PHYSICIAN	$114.51	$1.23	$0.07	$0.75	$0.01	$0.85	$0.98	$1.02
HEARING AID	$131.55	$0.04	$0.11	$0.01	$0.05	$0.04	$0.00	$0.03
HEMODIALYSIS	$206.89	$0.01	$0.41	$0.00	$0.00	$0.01	$0.01	$0.02
HOME HEALTH NURSING	$13.91	$0.00	$0.05	$0.00	$0.00	$0.00	$0.00	$0.00
HOME HEALTH SERVICE	$68.12	$0.15	$4.13	$0.28	$0.47	$0.17	$0.20	$0.27
IP–HOSPICE	$103.35	$0.01	$0.07	$0.00	$0.01	$0.00	$0.01	$0.01
IP–MATERNITY	$1,417.75	$8.24	$1.56	$131.76	$0.00	$0.79	$0.99	$9.10
IP–MED/SURG	$3,139.48	$15.41	$357.55	$14.44	$46.98	$12.00	$21.62	$26.14
IP–NEONATAL ICU	$4,521.78	$7.62	$0.44	$0.00	$157.10	$0.67	$0.41	$17.60
IP–NEWBORN	$593.57	$1.90	$0.00	$0.00	$41.90	$0.17	$0.31	$4.65
IP–PSYCH & DRUG/ALCOHOL DETOX	$2,141.06	$1.01	$26.19	$1.18	$0.32	$0.74	$2.64	$1.79
IP–PASSTHROUGH PAYMENTS /1		$7.69	$22.12	$35.32	$19.88	$5.94	$6.08	$9.35
MATERNITY MANAGEMENT	$54.41	$0.14	$0.01	$4.34	$0.00	$0.04	$0.00	$0.21
OP–DIAGNOSTIC X–RAY	$59.17	$1.76	$9.44	$8.49	$1.69	$2.12	$1.75	$2.12
OP–EMERGENCY ROOM	$36.30	$2.49	$4.92	$4.57	$3.69	$2.65	$1.93	$2.60
OP–FACILITY	$72.90	$1.46	$9.95	$7.18	$2.39	$1.81	$0.98	$1.80
OP–LAB	$14.03	$1.48	$5.94	$8.65	$1.75	$1.88	$1.68	$1.85
OP–MAGNETIC RESONANCE IMAGING	$255.83	$0.23	$2.61	$0.08	$0.07	$0.16	$0.37	$0.29
OP–MATERNITY	$98.12	$0.23	$0.03	$7.55	$0.06	$0.06	$0.00	$0.37
OP–OTHER OUTPATIENT	$80.44	$2.22	$8.92	$6.49	$2.31	$2.45	$1.79	$2.42
OP–PHYSICIAN SERVICES	$36.21	$2.02	$2.79	$2.18	$2.89	$2.05	$1.10	$1.93
OP–SOMATIC PSYCH	$222.53	$0.00	$0.12	$0.00	$0.00	$0.00	$0.48	$0.10
OP–SURGERY/FACILITY	$195.32	$0.39	$1.95	$0.51	$0.52	$0.30	$0.39	$0.43
OP–THERAPEUTIC X–RAY	$110.23	$0.10	$2.52	$0.13	$0.02	$0.10	$0.15	$0.16
OTHER–DIAGNOSTIC X–RAY	$30.75	$1.62	$7.95	$9.73	$1.96	$1.90	$1.19	$1.94
OTHER–LAB	$11.51	$1.82	$4.99	$11.56	$1.67	$2.35	$2.26	$2.26
OTHER–THERAPEUTIC X–RAY	$63.18	$0.04	$1.77	$0.00	$0.00	$0.03	$0.11	$0.08

OREGON BASIC HEALTH SERVICES PROGRAM – Calculation of Total Monthly Per Capita Cost *

Exhibit 21

05/01/91

Based on Paid Data for the Oregon Medicaid Program, 1988 & 1989

Adjusted for MMIS Utilization Rates and Managed Care Savings Trended to FY 1993

(Assumes all Eligibles Receive Services on a Fee–For–Service Basis)

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
CATEGORY OF SERVICE	AVERAGE OREGON PAID PER UNIT	AFDC COST PMPM	GA COST PMPM	PLM-ADULT COST PMPM	PLM-CHILD COST PMPM	NEW CATEGORICAL ELIGIBLES PMPM	NEW NONCAT. ELIGIBLES PMPM	AVERAGE PMPM
PHYSICAL/OCCUPATIONAL THERAPY	$42.57	$0.36	$2.72	$0.22	$0.48	$0.35	$0.80	$0.50
PHYSICIAN ANCILLARY	$11.81	$0.18	$3.46	$0.28	$0.16	$0.19	$0.54	$0.32
PHYSICIAN HOME VISITS	$29.04	$0.00	$0.00	$0.00	$0.00	$0.00	$0.01	$0.00
PHYSICIAN INPATIENT VISITS	$43.09	$1.71	$12.41	$2.53	$13.48	$1.67	$1.43	$2.86
PHYSICIAN MATERNITY	$822.52	$6.68	$0.04	$103.88	$0.00	$0.80	$0.99	$7.31
PHYSICIAN OFFICE VISITS	$28.05	$8.03	$16.41	$7.25	$18.41	$8.33	$6.79	$8.80
PHYSICIAN OTHER	$27.77	$0.62	$1.80	$2.51	$5.19	$0.88	$1.06	$1.17
PHYSICIAN OUTPATIENT VISITS	$28.24	$0.33	$0.92	$0.74	$0.76	$0.37	$0.15	$0.36
PHYSICIAN PT/OT	$19.09	$0.14	$0.72	$0.09	$0.04	$0.13	$0.05	$0.12
PHYSICIAN SOMATIC PSYCH VISITS	$53.21	$0.14	$3.17	$0.06	$0.04	$0.13	$0.99	$0.36
PHYSICIAN WELL CHILD EXAMS	$20.28	$1.20	$0.00	$0.00	$9.43	$0.14	$0.04	$1.53
PODIATRIST	$29.91	$0.04	$0.16	$0.03	$0.00	$0.04	$0.03	$0.04
PRESCRIPTION DRUGS–BASIC	$17.63	$7.28	$54.98	$3.70	$2.52	$7.06	$7.10	$7.75
PRESCRIPTION DRUGS–FAM.PLANNING	$29.54	$0.38	$0.14	$1.46	$0.01	$0.41	$0.40	$0.38
PRESCRIPTION DRUGS–PSYCH	$22.38	$0.22	$8.69	$0.11	$0.02	$0.22	$0.22	$0.38
PREVENTIVE MEDICINE	$29.87	$0.69	$4.27	$3.67	$0.00	$0.83	$0.84	$0.83
PRIVATE DUTY NURSING /2	$67.93	$0.06	$0.06	$0.06	$0.06	$0.06	$0.06	$0.06
STERILIZATIONS–PROFESSIONAL	$109.35	$0.49	$0.04	$2.05	$0.00	$0.14	$0.14	$0.40
SUPPLIES	$23.74	$0.25	$1.76	$0.33	$0.34	$0.26	$0.42	$0.33
SURGERY	$150.69	$4.21	$37.03	$6.97	$5.36	$3.32	$6.38	$5.44
TESTING	$41.99	$0.47	$2.50	$0.15	$1.30	$0.49	$0.67	$0.61
TRANSPORTATION – AMBULANCE	$58.47	$0.28	$2.74	$0.96	$0.89	$0.34	$0.14	$0.38
TRANSPORTATION – OTHER	$43.56	$0.49	$3.87	$2.13	$1.92	$0.63	$0.50	$0.73
VISION CARE	$59.13	$0.79	$1.19	$0.59	$0.20	$0.76	$2.50	$1.08
VISION SUPPLIES	$21.23	$0.53	$0.66	$0.32	$0.02	$0.50	$0.51	$0.48
TOTAL		$97.44	$653.97	$403.56	$352.27	$69.60	$83.22	$134.12

OREGON BASIC HEALTH SERVICES PROGRAM – Calculation of Total Monthly Per Capita Cost *

Exhibit 21

05/01/91

Based on Paid Data for the Oregon Medicaid Program, 1988 & 1989

Adjusted for MMIS Utilization Rates and Managed Care Savings Trended to FY 1993

(Assumes all Eligibles Receive Services on a Fee–For–Service Basis)

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
CATEGORY OF SERVICE	AVERAGE OREGON PAID PER UNIT	AFDC COST PMPM	GA COST PMPM	PLM-ADULT COST PMPM	PLM-CHILD COST PMPM	NEW CATEGORICAL ELIGIBLES PMPM	NEW NONCAT. ELIGIBLES PMPM	AVERAGE PMPM
DENTAL–DIAGNOSTIC /2	$10.71	$1.52	$0.87	$0.77	$0.04	$1.07	$0.74	$1.19
DENTAL–ENDODONTICS /2	$58.44	$1.43	$0.55	$0.53	$0.09	$0.87	$0.21	$1.01
DENTAL–GENERAL /2	$21.26	$0.51	$0.49	$0.41	$0.02	$0.54	$0.71	$0.51
DENTAL–MAXILLOFACIAL PROS /2	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
DENTAL–ORAL SURGERY /2	$34.82	$0.90	$0.71	$0.45	$0.02	$0.58	$0.28	$0.68
DENTAL–ORTHODONTICS /2	$720.07	$0.28	$0.09	$0.09	$0.00	$0.21	$0.16	$0.22
DENTAL–PERIODONTICS /2	$70.73	$0.40	$0.65	$0.63	$0.00	$0.57	$0.81	$0.47
DENTAL–PREVENTIVE /2	$19.84	$0.82	$0.39	$0.43	$0.03	$0.94	$0.83	$0.74
DENTAL–PROS,FIXED /2	$64.11	$0.21	$0.38	$0.36	$0.00	$0.35	$0.71	$0.31
DENTAL–PROS,REMOVABLE /2	$40.78	$0.06	$0.13	$0.06	$0.00	$0.07	$0.09	$0.06
DENTAL–RESTORATIVE /2	$36.80	$3.07	$1.55	$1.59	$0.16	$2.23	$1.55	$2.42
TOTAL		$9.20	$5.81	$5.33	$0.37	$7.43	$6.10	$7.61

NOTES:

/1 IP–Passthrough Payments represent additional payments for hospital services and will apply only to the non–HMO portion of the program. Also includes impact of a recent hospital cost settlement.
/2 BSC utilization data is used in addition to Medicaid utilization data to project Medicaid use for these services for adults because the services are not currently fully covered by Medicaid.

DESCRIPTION OF COLUMN CONTENTS:

(1) Average paid per unit of service is calculated from the MMIS average paid amounts. Charges are also increased for trend as shown in Exhibit 14.

(2) AFDC cost PMPM is calculated by multiplying the AFDC utilization rate from Exhibit 9 by the average cost per unit (1) and dividing by 12000 to represent a single person per month. (The utilization rate is expressed in terms of units per 1000 members per year). Case mix adjustments are applied to reflect differences in average charge per unit of service by eligibility category.

(3) Similar to (2) but covers the General Assistance population.

(4) Similar to (2) but covers the Poverty Level Medical–Adult population.

(5) Similar to (2) but covers the Poverty Level Medical–Child population.

(6) Similar to (2) but combines both the Poverty Level Medical and the AFDC population. Reflects the new categorical–type eligibles.

(7) Similar to (2) but covers the newly eligible, non–categorical population.

(8) Weighted average based on eligibility distribution at program start–up.

* Per Capita Cost is a combination of fee–for–service expenditures and capitation payments.

Exhibit 22-A
05/01/91

OREGON BASIC HEALTH SERVICES PROGRAM

Calculation of Blended Monthly Per Capita Cost* Trended to 1993
Based on the Assumption That All Eligibles Receive Services on a Fee-For-Service Basis
With Eligibility Distribution at Program Start-up

MEDICAL	CAP RATE	AGE/SEX ADJUSTMENT	ADJUSTED CAP RATE	PERCENT OF POPULATION	WEIGHTED CAPITATION RATE
Aid to Families with Dependent Children	$97.44	1	$97.44	62.4%	$60.80
General Assistance	$653.97	1	$653.97	2.1%	$13.73
Poverty Level Medical Adults	$403.56	1	$403.56	2.8%	$11.30
Poverty Level Medical Children	$352.27	0.71	$250.11	8.1%	$20.26
Demonstration Only Categorical Eligibles	$69.60	1.10	$76.56	5.3%	$4.06
Demonstration Only Noncategorical Eligibles	$83.22	0.89	$74.06	19.3%	$14.29
Total				100.0%	$124.45

DENTAL	CAP RATE	AGE/SEX ADJUSTMENT	ADJUSTED CAP RATE	PERCENT OF POPULATION	WEIGHTED CAPITATION RATE
Aid to Families with Dependent Children	$9.20	1	$9.20	62.4%	$5.74
General Assistance	$5.81	1	$5.81	2.1%	$0.12
Poverty Level Medical Adults	$5.33	1	$5.33	2.8%	$0.15
Poverty Level Medical Children	$0.37	2.5	$0.92	8.1%	$0.07
Demonstration Only Categorical Eligibles	$7.43	1	$7.43	5.3%	$0.39
Demonstration Only Noncategorical Eligibles	$6.10	1	$6.10	19.3%	$1.18
Total				100.0%	$7.66

MEDICAL PLUS DENTAL	CAP RATE	AGE/SEX ADJUSTMENT	ADJUSTED CAP RATE	PERCENT OF POPULATION	WEIGHTED CAPITATION RATE
Aid to Families with Dependent Children	N/A	N/A	$106.64	62.4%	$66.54
General Assistance	N/A	N/A	$659.78	2.1%	$13.86
Poverty Level Medical Adults	N/A	N/A	$408.89	2.8%	$11.45
Poverty Level Medical Children	N/A	N/A	$251.03	8.1%	$20.33
Demonstration Only Categorical Eligibles	N/A	N/A	$83.99	5.3%	$4.45
Demonstration Only Noncategorical Eligibles	N/A	N/A	$80.16	19.3%	$15.47
Total				100.0%	$132.10

* Per Capita Cost is a combination of fee-for-service expenditures and capitation payments.

Exhibit 22-B
05/01/91

OREGON BASIC HEALTH SERVICES PROGRAM

Calculation of Blended Monthly Per Capita Cost* Trended to 1993
Based on the Assumption That All Eligibles Receive Services on a Fee-For-Service Basis
With Eligibility Distribution When Program Reaches a Steady-state

MEDICAL	CAP RATE	AGE/SEX ADJUSTMENT	ADJUSTED CAP RATE	PERCENT OF POPULATION	WEIGHTED CAPITATION RATE
Aid to Families with Dependent Children	$97.44	1	$97.44	47.6%	$46.38
General Assistance	$653.97	1	$653.97	1.6%	$10.46
Poverty Level Medical Adults	$403.56	1	$403.56	2.1%	$8.47
Poverty Level Medical Children	$352.27	0.71	$250.11	6.2%	$15.51
Demonstration Only Categorical Eligibles	$69.60	1.10	$76.56	8.9%	$6.81
Demonstration Only Noncategorical Eligibles	$83.22	0.89	$74.06	33.6%	$24.89
Total				100.0%	$112.53

DENTAL	CAP RATE	AGE/SEX ADJUSTMENT	ADJUSTED CAP RATE	PERCENT OF POPULATION	WEIGHTED CAPITATION RATE
Aid to Families with Dependent Children	$9.20	1	$9.20	47.6%	$4.38
General Assistance	$5.81	1	$5.81	1.6%	$0.09
Poverty Level Medical Adults	$5.33	1	$5.33	2.1%	$0.11
Poverty Level Medical Children	$0.37	2.5	$0.92	6.2%	$0.06
Demonstration Only Categorical Eligibles	$7.43	1	$7.43	8.9%	$0.66
Demonstration Only Noncategorical Eligibles	$6.10	1	$6.10	33.6%	$2.05
Total				100.0%	$7.35

MEDICAL PLUS DENTAL	CAP RATE	AGE/SEX ADJUSTMENT	ADJUSTED CAP RATE	PERCENT OF POPULATION	WEIGHTED CAPITATION RATE
Aid to Families with Dependent Children	N/A	N/A	$106.64	47.6%	$50.76
General Assistance	N/A	N/A	$659.78	1.6%	$10.56
Poverty Level Medical Adults	N/A	N/A	$408.89	2.1%	$8.59
Poverty Level Medical Children	N/A	N/A	$251.03	6.2%	$15.56
Demonstration Only Categorical Eligibles	N/A	N/A	$83.99	8.9%	$7.47
Demonstration Only Noncategorical Eligibles	N/A	N/A	$80.16	33.6%	$26.94
Total				100.0%	$119.88

* Per Capita Cost is a combination of fee-for-service expenditures and capitation payments.

OREGON BASIC HEALTH SERVICES PROGRAM

Exhibit 23-A

Calculation of Average Monthly Per Capita Cost* for GA Recipients who Enroll in an HMO Adjusted For Claims Incurred Prior to HMO Enrollment

05/01/91

1.	Average monthly per capita cost for medical services for GA recipients for the HMO delivery model in 1993 dollars with all adjustments (Exhibit 16-A)	$741.63
2.	Average 1993 monthly per capita charge with no adjustments	$1,077.58
3.	Average months of eligibility in a one year period (Exhibit 4)	4.3
4.	Average annual charges per individual in 1993 dollars (2) X (3)	$4,633.59
5.	Average charges for claims incurred prior to expected enrollment in a prepaid plan in 1989 dollars.	$2,374.02
6.	Average charges for claims incurred prior to expected enrollment in a prepaid plan in 1993 dollars	$2,974.65
7.	Remaining claims (4) - (6)	$1,658.95
8.	Ratio of adjusted monthly per capita cost to unadjusted per capita charges (1) / (2)	0.69
9.	Average annual medical claims to be covered by capitation contract (7) X (8)	$1,141.75
10.	Average expected months of enrollment in a prepaid plan (3) - 3 weeks	3.5
11.	Average monthly capitation payment for medical services for GA recipients enrolled in HMOs (9) / (10)	$326.21

OREGON BASIC HEALTH SERVICES PROGRAM

Exhibit 23-A

Calculation of Average Monthly Per Capita Cost* for GA Recipients who Enroll in an HMO Adjusted For Claims Incurred Prior to HMO Enrollment

05/01/91

12.	Average capitation payment for dental services for GA recipients enrolled in HMOs (Exhibit 16-A)	$11.10
13.	Average capitation payment for all services including administrative cost allowance [(11) + (12)] / .94	$358.85
14.	Average Medicaid paid amount for claims incurred prior to enrollment in an HMO. (6) x 56%	$1,665.80
15.	Average annual per capita cost for GA recipients who enroll in HMOs. [(13) x (10)] + (14)	$2,921.77
16.	Average monthly per capita cost for GA recipients who enroll in HMOs. (15) / (3)	$679.48

* Per Capita Cost is a combination of fee-for-service expenditures and capitation payments.

OREGON BASIC HEALTH SERVICES PROGRAM

Exhibit 23-B

05/01/91

Calculation of the Effect on the Capitation Rate of Claims for General Assistance Recipients Expected Prior to Enrollment in a PCO

	Total	Capitated Services	Noncapitated Services
1. Average monthly per capita cost for PCO enrollees in 1993 dollars with all adjustments (Exhibit 19)	$660.57	$161.15	$499.42
2. Average monthly charges for PCO enrollees in 1993 dollars with no adjustments	$1,077.58	$250.72	$826.86
3. Average months of eligibility in a one year period (Exhibit 4)	4.3	4.3	4.3
4. Average annual charges per individual (2) X (3)	$4,633.59	$1,078.10	$3,555.50
5. Average charges for claims incurred prior to enrollment in a PCO in 1993 dollars	$2,974.65	$725.69	$2,248.96
6. Remaining claims (4) - (5)	$1,658.95	$352.41	$1,306.54
7. Average annual cost for claims incurred after enrollment in a PCO Capitated Services - (6) x 0.68 Noncapitated Services - (6) x 0.56		$239.64	$731.66
8. Average months of enrollment in a PCO		3.5	
9. Average monthly cost for claims incurred after enrollment in a PCO (7) / (8)		$68.47	
10. Average per capita cost for dental services for GA recipients enrolled in a PCO (Exhibit 19)			$5.81
11. Average capitation payment for all services including administrative cost allowance (9) + $4.00		$72.47	
12. Average Medicaid paid amount for services incurred prior to enrollment in a PCO (5) X 56%		$406.38	$1,259.42
13. Average annual cost for GA recipients who enroll in PCOs Capitated services - [(11) x (8)] + (12) Noncapitated services - (7) + (10) + (12)		$660.02	$1,996.89
14. Average monthly cost for GA recipients who enroll in PCOs (13) / (3)	$617.89	$153.49	$464.39

OREGON BASIC HEALTH SERVICES PROGRAM

Exhibit 23-C

05/01/91

Calculation of Average Monthly Per Capita Cost* for PLM Children who Enroll in an HMO Adjusted For Claims Incurred Prior to HMO Enrollment

1.	Average monthly per capita cost for medical services for PLM Children for the HMO delivery model in 1993 dollars with all adjustments (Exhibit 16-A)	$388.99
2.	Average monthly per capita cost adjusted for age/sex differences of new population due to PLM program expansion (1) x 0.71	$276.18
3.	Monthly per capita cost for PLM children in their first two months	$2,269.52
4.	Proportion of member months associated with children in their first two months of life	6.60%
5.	Portion of total per capita costs associated with children in their first two months (3) x (4)	$149.79
6.	Remaining per capita costs associated with all other children (2) - (5)	$126.39
7.	Percentage of pregnant women who are expected to become enrolled in the PLM program in their third trimester	19.10%
8.	Percentage of third trimester enrollees who are expected to receive services on a fee-for-service basis	80%
9.	Total PLM deliveries expected to be done on a FFS basis (7) x (8)	15.28%
10.	Reduction in per capita cost to HMOs for PLM eligibles as a result of a portion of the costs being covered on a fee-for-service basis (5) x (9)	$22.89

OREGON BASIC HEALTH SERVICES PROGRAM

Exhibit 23-C

Calculation of Average Monthly Per Capita Cost* for PLM Children who Enroll in an HMO Adjusted For Claims Incurred Prior to HMO Enrollment

05/01/91

11.	Per capita cost for HMO capitated medical services adjusted for claims incurred on a fee-for-service basis (5) + (6) - (10)	$253.30
12.	Per capita cost for dental services for PLM children (Exhibit 16-A)	$2.23
13.	Total per capita cost for medical and dental services and administrative expense for services provided by HMOs [(11) + (12)] / .94	$271.84
14.	Ratio of costs to Medicaid payment amounts (Based on comparison of Exhibit 15 results to Exhibit 17 results)	0.8695
15.	Per capita cost for medical claims incurred prior to enrollment in a plan (10) x (14)	$19.90
16.	Total per capita cost for HMO enrollees (13) + (15)	$291.73

* Per Capita Cost is a combination of fee-for-service expenditures and capitation payments.

OREGON BASIC HEALTH SERVICES PROGRAM

Exhibit 23-D

Calculation of Average Monthly Per Capita Cost* for PLM Children who Enroll in a PCO Adjusted For Claims Incurred Prior to PCO Enrollment

05/01/91

	Total	Capitated Services	Noncapitated Services
1. Average monthly per capita cost for medical services for PLM Children for the PCO delivery model in 1993 dollars with all adjustments (Exhibit 19)	$353.99	$77.70	$276.29
2. Adjustment factor to account for change in expected differences in per capita costs due to change in the age/sex mix of the population	0.71	0.85	0.67
3. Average monthly per capita cost adjusted for age/sex differences of new population due to PLM program expansion (1) x (2)	$251.33	$66.22	$185.11
4. Monthly per capita cost for PLM children in their first two months	$1,911.08	$159.15	$1,751.93
5. Proportion of member months associated with children in their first two months of life during the first year of the demonstration project	6.6%	6.6%	6.6%
6. Portion of total per capita costs associated with children in their first two months (4) x (5)	$126.13	$10.50	$115.63
7. Remaining per capita costs associated with all other children (3) - (6)	$125.20	$55.72	$69.49
8. Percentage of pregnant women who are expected to become enrolled in the PLM program in their third trimester	19.10%	19.10%	19.10%
9. Percentage of third trimester enrollees who are expected to receive services on a fee-for-service basis	80%	80%	80%
10. Total PLM deliveries expected to be done on a FFS basis (8) x (9)	15.28%	15.28%	15.28%

OREGON BASIC HEALTH SERVICES PROGRAM

Exhibit 23-D

Calculation of Average Monthly Per Capita Cost* for PLM Children who Enroll in a PCO Adjusted For Claims Incurred Prior to PCO Enrollment

05/01/91

	Total	Capitated Services	Noncapitated Services
11. Reduction in per capita cost to PCOs for PLM eligibles as a result of a portion of the costs being covered on a fee-for-service basis (6) x (10)		$1.60	
12. Per capita cost for PCO capitated medical services adjusted for claims incurred on a fee-for-service basis (6) + (7) - (11)		$64.62	
13. Per capita cost for PCO enrollees for noncapitated services (3)			$185.11
14. Per capita cost for dental services for PLM children (Exhibit 20-A)			$2.23
15. Total per capita cost for medical and dental services and administrative expense for services provided by PCOs Capitated services - [(12) + (14)] + $4.00 Noncapitated services - [(13) + (14)]		$68.62	$187.34
16. Ratio of costs to Medicaid payment amounts (Based on comparison of Exhibit 15 results to Exhibit 17 results)		0.8695	
17. Per capita cost for medical claims incurred prior to enrollment in a plan (11) x (16)		$1.40	
18. Total per capita cost for PCO enrollees	$257.36	$70.01	$187.34

* Per Capita Cost is a combination of fee-for-service expenditures and capitation payments.

OREGON BASIC HEALTH SERVICES PROGRAM

Exhibit 24-A

Expected Distribution of Enrollees by Eligibility Category and Delivery System

05//01/91

At Program Start-up

Average Fiscal Year 1993

Eligibility Category	Percentage	DELIVERY SYSTEM *						
		HMO	PCO	PCCM-Man	FFS-Man	PCCM	FFS	Total
AFDC	62.4%	55.25%	16.62%	9.28%	4.15%	9.93%	4.77%	100.00%
General Assistance	2.1%	42.51%	9.21%	31.87%	4.01%	8.61%	3.79%	100.00%
PLM-Adults	2.8%	34.41%	18.10%	25.04%	3.85%	12.74%	5.86%	100.00%
PLM-Children	8.1%	34.41%	18.10%	25.04%	3.85%	12.74%	5.86%	100.00%
New Categorical Eligibles	5.3%	54.91%	17.51%	12.78%	0.00%	14.80%	0.00%	100.00%
New Noncategorical Eligibles	19.3%	54.91%	17.51%	12.78%	0.00%	14.80%	0.00%	100.00%
	100.0%							

AVERAGE BY ELIGIBILITY CATEGORY AND DELIVERY SYSTEM

Average Fiscal Year 1993

Eligibility Category	DELIVERY SYSTEM						
	HMO	PCO	PCCM-Man	FFS-Man	PCCM	FFS	Total
AFDC	34.48%	10.37%	5.79%	2.59%	6.20%	2.97%	62.40%
General Assistance	0.89%	0.19%	0.67%	0.08%	0.18%	0.08%	2.10%
PLM-Adults	0.96%	0.51%	0.70%	0.11%	0.36%	0.16%	2.80%
PLM-Children	2.79%	1.47%	2.03%	0.31%	1.03%	0.47%	8.10%
New Categorical Eligibles	2.91%	0.93%	0.68%	0.00%	0.78%	0.00%	5.30%
New Noncategorical Eligibles	10.60%	3.38%	2.47%	0.00%	2.86%	0.00%	19.30%
Total	52.63%	16.85%	12.33%	3.09%	11.41%	3.69%	100.00%

PCCM-Man: Individuals enrolled with Primary Care Case Managers in areas of the state that required mandatory enrollment in prepaid plans.

FFS-Man: Individuals receiving services on a fee-for-service basis in areas of the state that required mandatory enrollment in prepaid plans.

* Eligibility distribution by delivery system was calculated by C&L based on information provided by OMAP.

OREGON BASIC HEALTH SERVICES PROGRAM

Exhibit 24-B

05/01/91

Expected Distribution of Enrollees by Eligibility Category and Delivery System
With Eligibilty Distribution When Program Reaches a Steady-State

Average Fiscal Year 1993

		DELIVERY SYSTEM *						
Eligibility Category	Percentage	HMO	PCO	PCCM-Man	FFS-Man	PCCM	FFS	Total
AFDC	47.6%	55.25%	17.25%	12.80%	0.00%	14.70%	0.00%	100.00%
General Assistance	1.6%	61.20%	13.26%	13.14%	0.00%	12.40%	0.00%	100.00%
PLM-Adults	2.1%	50.23%	18.96%	12.21%	0.00%	18.60%	0.00%	100.00%
PLM-Children	6.2%	50.23%	18.96%	12.21%	0.00%	18.60%	0.00%	100.00%
New Categorical Eligibles	8.9%	54.91%	17.51%	12.78%	0.00%	14.80%	0.00%	100.00%
New Noncategorical Eligibles	33.6%	54.91%	17.51%	12.78%	0.00%	14.80%	0.00%	100.00%
	100.0%							

AVERAGE BY ELIGIBILITY CATEGORY AND DELIVERY SYSTEM

Average Fiscal Year 1993

	DELIVERY SYSTEM						
Eligibility Category	HMO	PCO	PCCM-Man	FFS-Man	PCCM	FFS	Total
AFDC	26.30%	8.21%	6.09%	0.00%	7.00%	0.00%	47.60%
General Assistance	0.98%	0.21%	0.21%	0.00%	0.20%	0.00%	1.60%
PLM-Adults	1.05%	0.40%	0.26%	0.00%	0.39%	0.00%	2.10%
PLM-Children	3.11%	1.18%	0.76%	0.00%	1.15%	0.00%	6.20%
New Categorical Eligibles	4.89%	1.56%	1.14%	0.00%	1.32%	0.00%	8.90%
New Noncategorical Eligibles	18.45%	5.88%	4.29%	0.00%	4.97%	0.00%	33.60%
Total	54.78%	17.44%	12.75%	0.00%	15.03%	0.00%	100.00%

PCCM-Man: Individuals enrolled with Primary Care Case Managers in areas of the state that required mandatory enrollment in prepaid plans.

FFS-Man: Individuals receiving services on a fee-for-service basis in areas of the state that required mandatory enrollment in prepaid plans.

* Eligibility distribution by delivery system was calculated by C&L based on information provided by OMAP.

OREGON BASIC HEALTH SERVICES PROGRAM

Average Per Capita Cost* at Program Start-up

Exhibit 25-A

05/01/91

AVERAGE MONTHLY PER CAPITA COST BY ELIGIBILITY CATEGORY AND DELIVERY SYSTEM

Average Fiscal Year 1993

Eligibility Category	DELIVERY SYSTEM **					
	HMO	PCO	PCCM-Man	FFS-Man	PCCM	FFS
AFDC	$131.47	$113.41	$106.38	$106.64	$106.38	$106.64
General Assistance	$679.48	$617.89	$617.89	$617.89	$642.30	$659.78
PLM-Adults	$534.89	$446.90	$403.86	$408.89	$403.86	$408.89
PLM-Children	$291.73	$257.36	$257.36	$257.36	$248.75	$251.03
New Categorical Eligibles	$101.26	$89.55	$83.80	$83.99	$83.80	$83.99
New Noncategorical Eligibles	$87.05	$82.91	$79.88	$80.16	$79.88	$80.16

WEIGHTED AVERAGE MONTHLY PER CAPITA COST

Average Fiscal Year 1993

Eligibility Category	DELIVERY SYSTEM						
	HMO	PCO	PCCM-Man	FFS-Man	PCCM	FFS	Total
AFDC	$45.33	$11.76	$6.16	$2.76	$6.59	$3.17	$75.78
General Assistance	$6.07	$1.20	$4.14	$0.52	$1.16	$0.52	$13.60
PLM-Adults	$5.15	$2.26	$2.83	$0.44	$1.44	$0.67	$12.80
PLM-Children	$8.13	$3.77	$5.22	$0.80	$2.57	$1.19	$21.69
New Categorical Eligibles	$2.95	$0.83	$0.57	$0.00	$0.66	$0.00	$5.00
New Noncategorical Eligibles	$9.23	$2.80	$1.97	$0.00	$2.28	$0.00	$16.28
Total	$76.85	$22.63	$20.89	$4.52	$14.70	$5.56	$145.15

PCCM-Man: Individuals enrolled with Primary Care Case Managers in areas of the state that required mandatory enrollment in prepaid plans.

FFS-Man: Individuals receiving services on a fee-for-service basis in areas of the state that required mandatory enrollment in prepaid plans.

* Per Capita Cost is a combination of fee-for-service expenditures and capitation payments.

** Eligibility distribution by delivery system was calculated by C&L based on information provided by OMAP.

OREGON BASIC HEALTH SERVICES PROGRAM

Exhibit 25-B

Average Per Capita Cost* When Program Reaches a Steady-State

05/01/91

AVERAGE MONTHLY PER CAPITA COST BY ELIGIBILITY CATEGORY AND DELIVERY SYSTEM

Average Fiscal Year 1993

Eligibility Category	DELIVERY SYSTEM **					
	HMO	PCO	PCCM-Man	FFS-Man	PCCM	FFS
AFDC	$131.47	$113.41	$106.38	$106.64	$106.38	$106.64
General Assistance	$679.48	$617.89	$617.89	$617.89	$642.30	$659.78
PLM-Adults	$534.89	$446.90	$403.86	$408.89	$403.86	$408.89
PLM-Children	$291.73	$257.36	$257.36	$257.36	$248.75	$251.03
New Categorical Eligibles	$101.26	$89.55	$83.80	$83.99	$83.80	$83.99
New Noncategorical Eligibles	$87.05	$82.91	$79.88	$80.16	$79.88	$80.16

WEIGHTED AVERAGE MONTHLY PER CAPITA COST

Average Fiscal Year 1993

Eligibility Category	DELIVERY SYSTEM						
	HMO	PCO	PCCM-Man	FFS-Man	PCCM	FFS	Total
AFDC	$34.58	$9.31	$6.48	$0.00	$7.44	$0.00	$57.81
General Assistance	$6.65	$1.31	$1.30	$0.00	$1.27	$0.00	$10.54
PLM-Adults	$5.64	$1.78	$1.04	$0.00	$1.58	$0.00	$10.03
PLM-Children	$9.09	$3.02	$1.95	$0.00	$2.87	$0.00	$16.93
New Categorical Eligibles	$4.95	$1.40	$0.95	$0.00	$1.10	$0.00	$8.40
New Noncategorical Eligibles	$16.06	$4.88	$3.43	$0.00	$3.97	$0.00	$28.34
Total	$76.97	$21.70	$15.14	$0.00	$18.24	$0.00	$132.06

PCCM-Man: Individuals enrolled with Primary Care Case Managers in areas of the state that required mandatory enrollment in prepaid plans.

FFS-Man: Individuals receiving services on a fee-for-service basis in areas of the state that required mandatory enrollment in prepaid plans.

* Per Capita Cost is a combination of fee-for-service expenditures and capitation payments.

** Eligibility distribution by delivery system was calculated by C&L based on information provided by OMAP.

OREGON BASIC HEALTH SERVICES PROGRAM

Exhibit 26

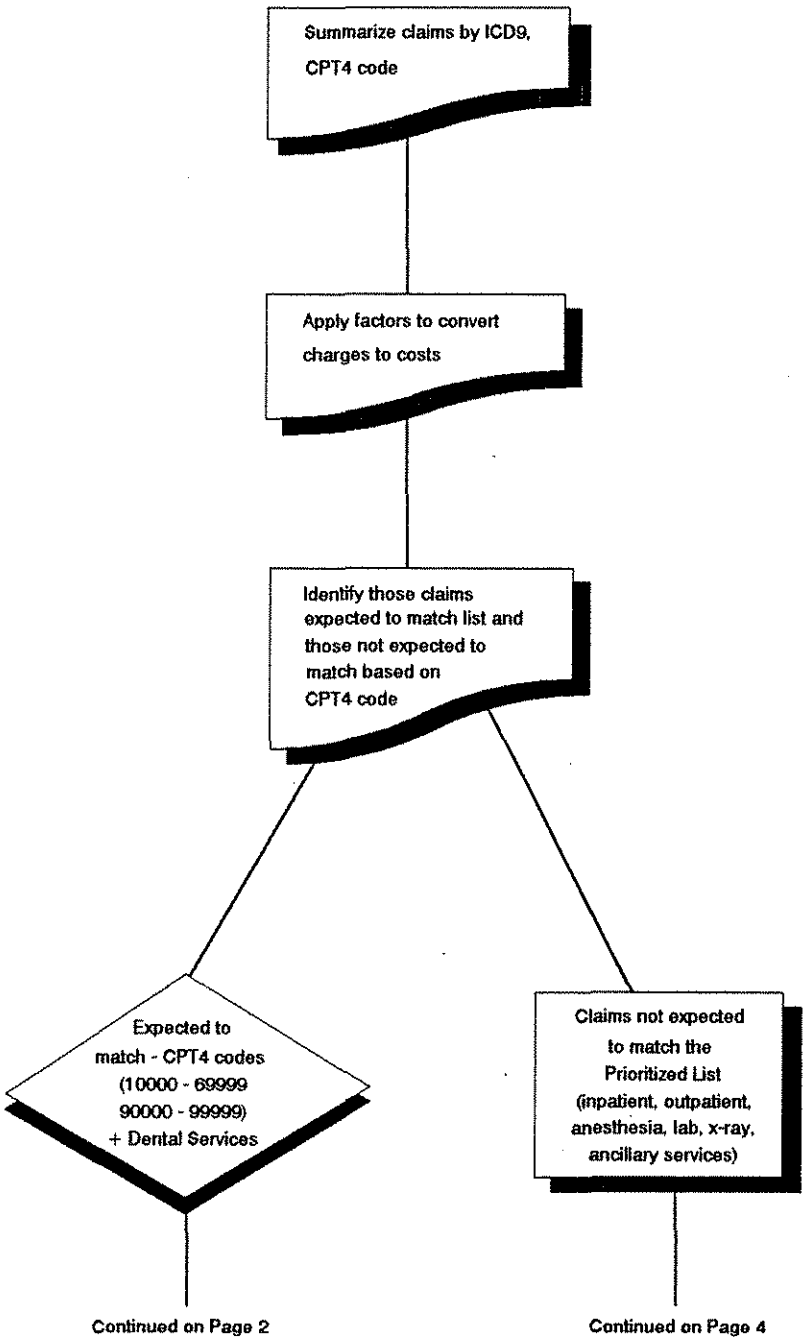
Description of Allocation of Claims to Condition/Treatment Pairs

05/01/91

TREATMENT TYPE	ICD 9 CODES	CPT 4 CODES	EXPENDITURE ALLOCATION
Initial diagnosis	780-799 Any	Any + Ancillary Services Biopsies, Other Diagnostic Tests	Beginning of the List
Medical treatment	001-779 V01-V82	90000-99999 + Ancillary Services	Based on whether there is a matching surgical treatment and the number of line items with the same range of ICD9 codes. Generally, if there is a single matching surgical line item, 90% of the medical claims are allocated to the medical line item and 10% are allocated to the surgical line item. When there are no matching surgical line items, claims are allocated to the medical treatment line items based on the number of lines with matching ICD9 codes. In most cases that have no matching surgical treatment, no additional allocation of claims is required.
Surgical treatment	001-779 V01-V82	10000-69999 + Ancillary Services	Based on the number of line items with matching diagnosis and treatment pairs. Generally, all claims go to a single line.
		90000-99999 + Ancillary Services	Based on whether there is a matching medical treatment and the number of line items with the same range of ICD9 codes. Generally, 10% of medical claims are allocated to the surgical line item.
Ancillary services	Any	Lab tests X-rays Anesthesia Inpatient hospital Outpatient hospital Supplies Miscellaneous Medical	Based on the number of line items with matching ICD9 codes. When more than one line item contains the same ICD9 codes, claims are allocated based on the percentage of total dollars for the ICD9 code represented by each line item. This allocation is done after all other claims have been allocated.
Prescription Drugs	Not Applicable	National Drug Codes	Allocated based on the assumption that prescription drugs make up 7% of the costs associated with each line item. 7% factor is calculated from Exhibit 15 results.

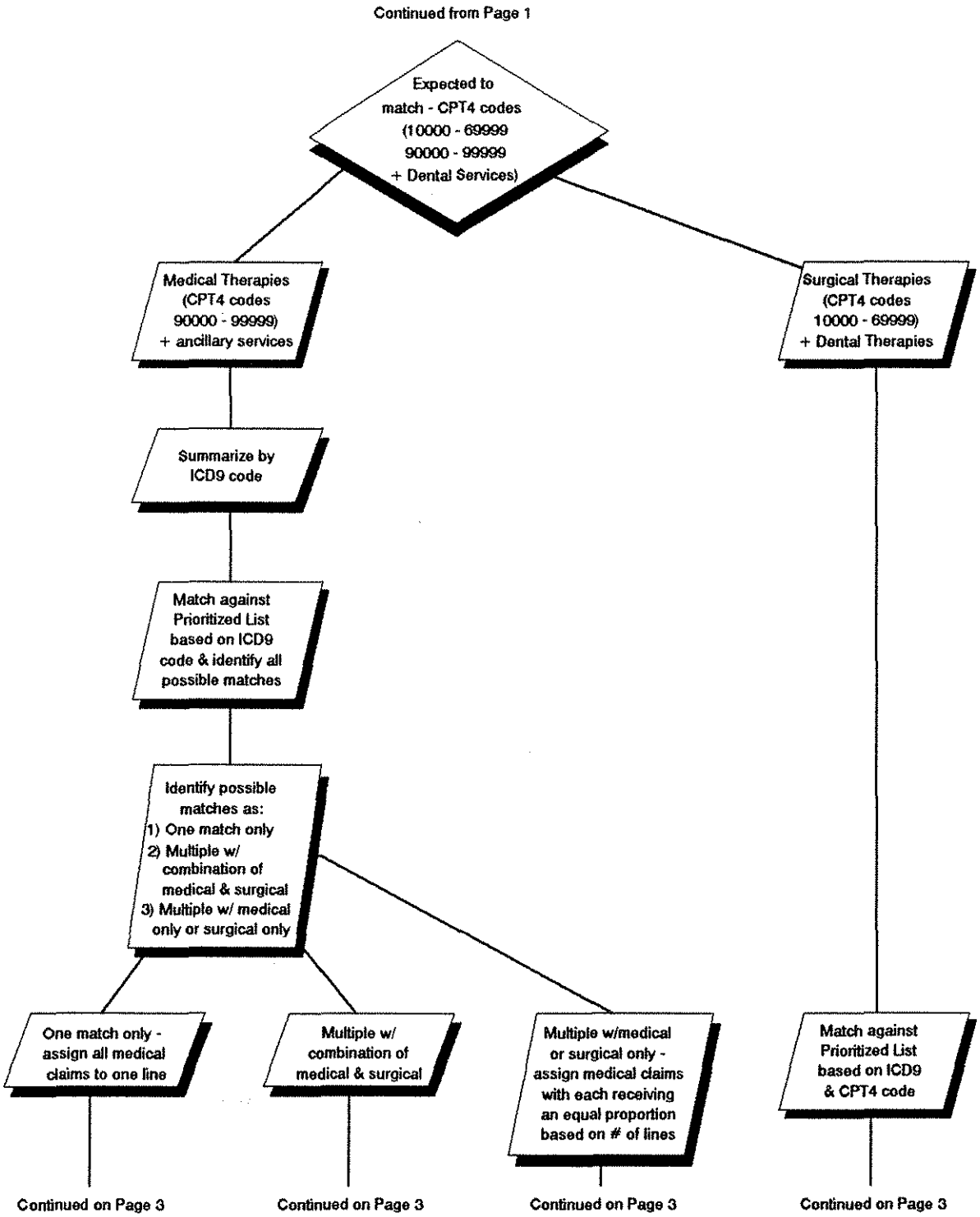
Oregon Basic Health Services Program
Calculation of Per Capita Costs

Decision Tree for Assigning Claims to Condition/Treatment Pairs



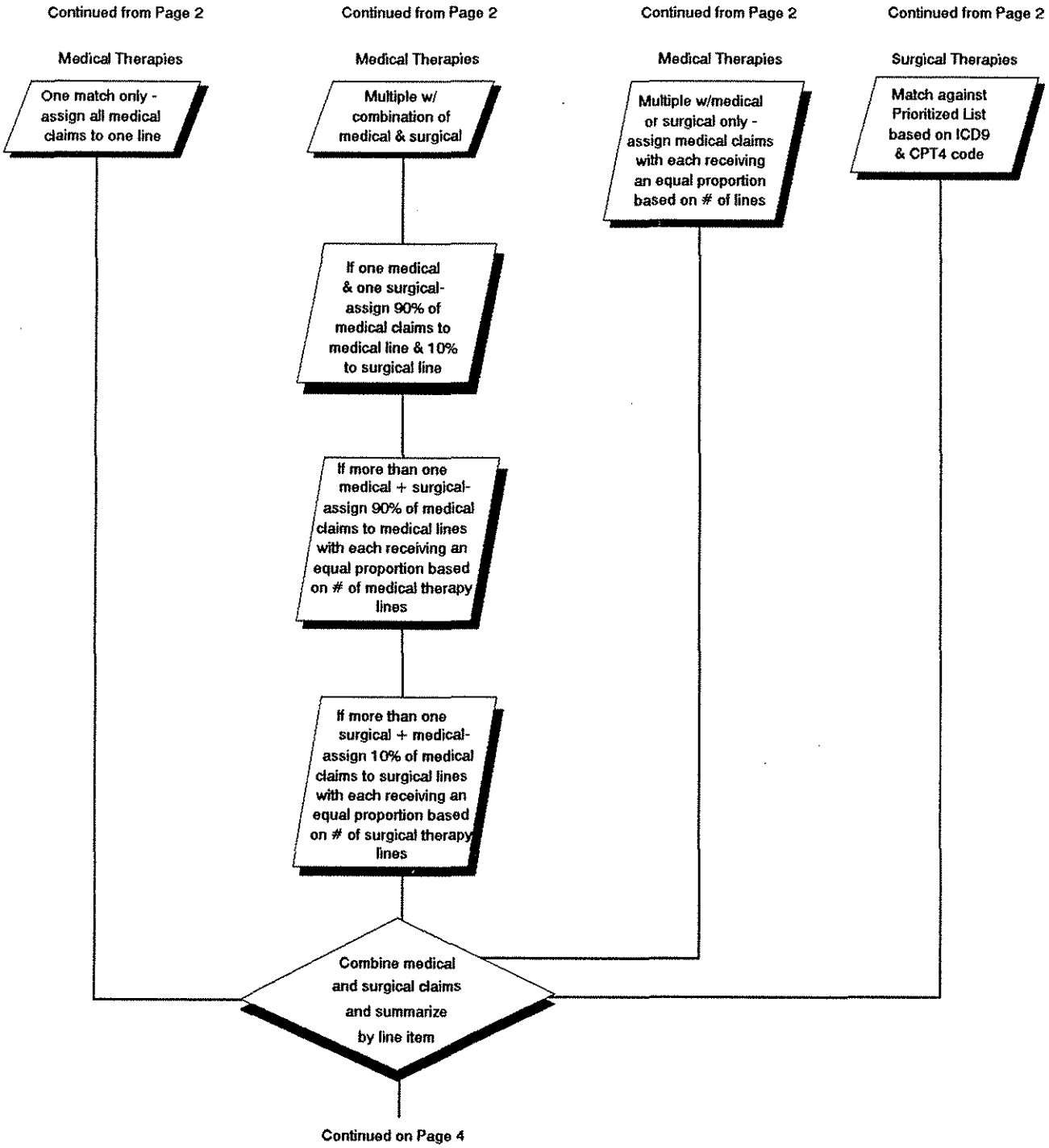
Oregon Basic Health Services Program
Calculation of Per Capita Costs

Decision Tree for Assigning Claims to Condition/Treatment Pairs



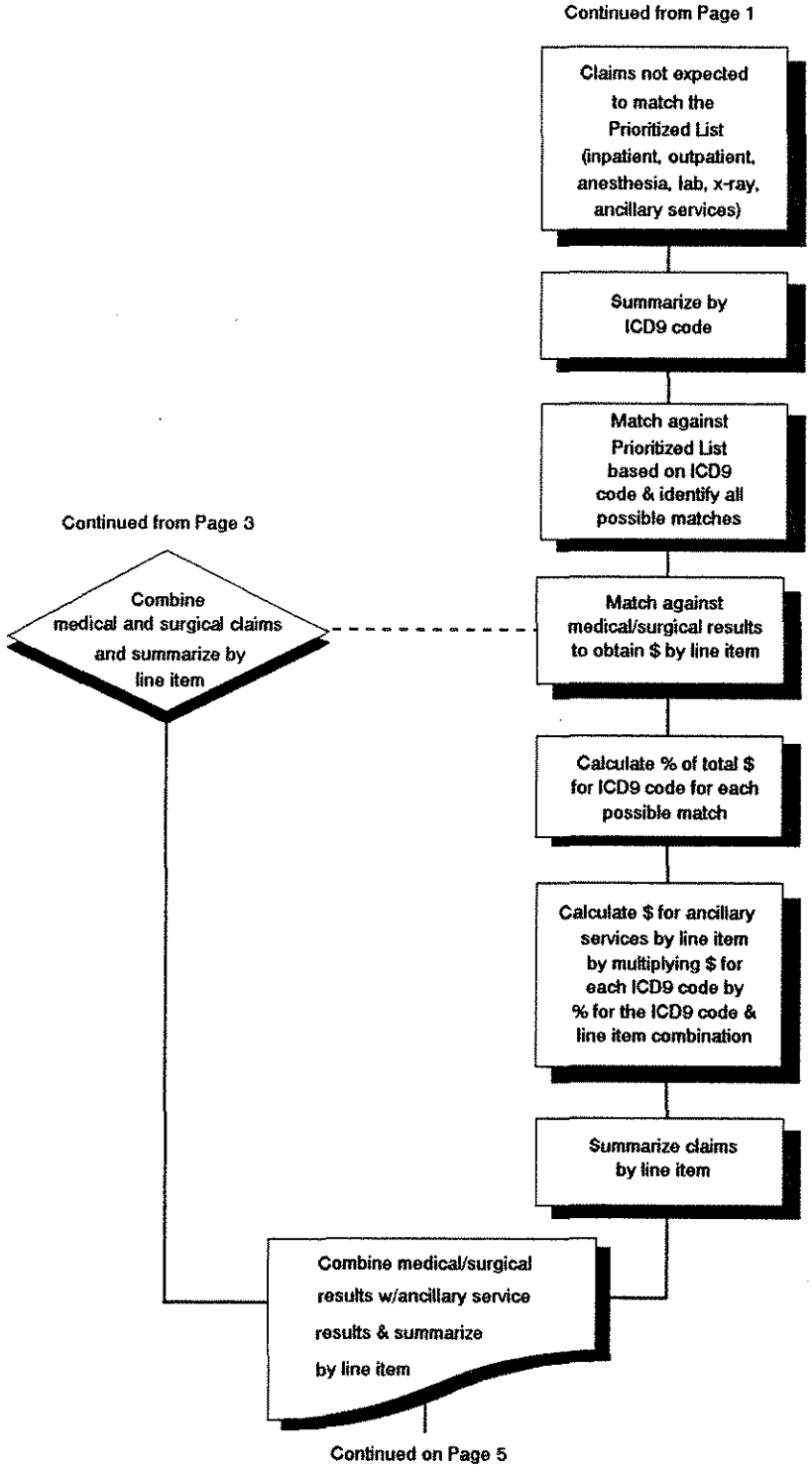
Oregon Basic Health Services Program
Calculation of Per Capita Costs

Decision Tree for Assigning Claims to Condition/Treatment Pairs



Oregon Basic Health Services Program
Calculation of Per Capita Costs

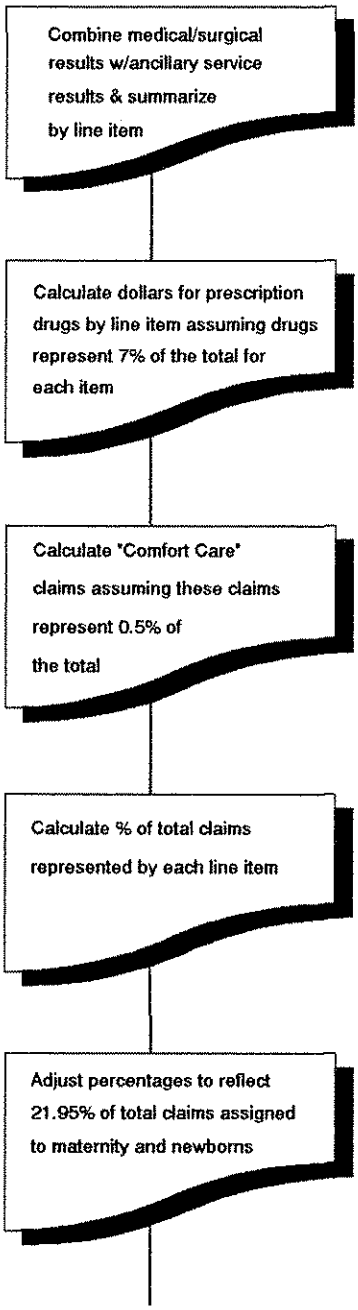
Decision Tree for Assigning Claims to Condition/Treatment Pairs



Oregon Basic Health Services Program
Calculation of Per Capita Costs

Decision Tree for Assigning Claims to Condition/Treatment Pairs

Continued from Page 4

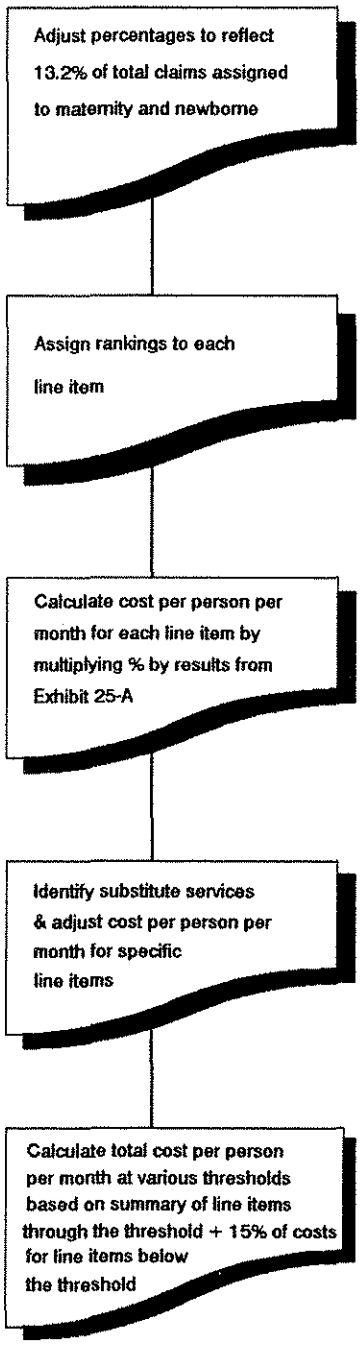


Continued on Page 6

Oregon Basic Health Services Program
Calculation of Per Capita Costs

Decision Tree for Assigning Claims to Condition/Treatment Pairs

Continued from Page 5



OREGON BASIC HEALTH SERVICES PROGRAM

Exhibit 28-A

05/01/91

Calculation of Per Capita Costs*

Per Capita Cost at Various Thresholds at Program Start-up /1

THRESHOLD /2	PERCENT OF TOTAL COST	AVERAGE PER CAPITA COST
200	60.02%	$87.12
255	63.45%	$92.10
310	67.87%	$98.51
365	70.45%	$102.26
420	76.19%	$110.59
475	80.75%	$117.21
530	83.20%	$120.76
585	87.50%	$127.01
640	92.74%	$134.61
695	98.13%	$142.44
709	100.00%	$145.15

* Per Capita Cost is a combination of fee-for-service expenditures and capitation payments.

1\ Program start-up is the first year of operation (i.e., July 1, 1992 through June 30, 1993).

2\ Threshold ranking on Prioritized List below which services would not be covered.

OREGON BASIC HEALTH SERVICES PROGRAM

Exhibit 28-B

05/01/91

Calculation of Per Capita Costs*

Per Capita Cost at Various Thresholds When Program Reaches a Steady-State /1

THRESHOLD /2	PERCENT OF TOTAL COST	AVERAGE PER CAPITA COST
200	60.02%	$79.26
255	63.45%	$83.79
310	67.87%	$89.63
365	70.45%	$93.04
420	76.19%	$100.62
475	80.75%	$106.64
530	83.20%	$109.87
585	87.50%	$115.55
640	92.74%	$122.47
695	98.13%	$129.59
709	100.00%	$132.06

* Per Capita Cost is a combination of fee-for-service expenditures and capitation payments.

1/ Steady-state assumes all projected recipients are participating from Day 1 (i.e., July 1, 1992). In actuality, it is expected that participation will increase steadily during the first three years of the demonstration and then stabilize (i.e., reach a steady state) by July 1, 1995.

2/ Threshold ranking on Prioritized List below which services would not be covered.

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APPENDIX J

LIST OF HEALTH SERVICES

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1) **Orientation to the List**

2) **List of Health Services, priced and ranked**

   -- **Index to List of Health Services**

3) **Expanded Definition of Preventive Services**

4) **Expanded Definition of Ancillary Services**

ORIENTATION TO THE LIST

AN ORIENTATION TO THE LIST OF PRIORITIZED HEALTH SERVICES

The 1991 final List of Prioritized Health Services follows this User's Guide. The objective of the User's Guide is to explain the format, to define some of the terms used, and to define some of the services.

What are all those numbers?

The first thing you might notice is all the numbers. The numbers are standard code numbers used as a form of shorthand to describe the huge numbers of conditions and treatments. You will see three basic types of codes.

ICD-9 *(International Classification of Diseases-9th edition)* codes are used to describe the types of conditions or diseases which are to be treated. These codes are labeled as ICD-9 on the document.

Example: 037.0 - Tetanus

CPT-4 *(Physician's Current Procedural Terminology, Fourth edition)* codes are used to accurately capture the procedure(s) used to treat the condition. These are also expressed in number format and have 5 digits.

Examples: 90050 - office visit, brief
59400 - obstetrical care and delivery

On the other hand, CPT-4 codes can be quite specific, for example 27754, (treatment of open tibial shaft fracture with uncomplicated soft tissue closure).

The line numbers represent the rank order of the condition/treatment pairs, with line item 1 most important and line item 709 least important to the population to be served.

The last set of numbers, you will notice, is the **category number** (e.g.: 1, 2, 3). Categories have been used by the Health Services Commission to organize the 709 condition/treatment pairs into types of health services (e.g., comfort care) or health services for types of conditions (e.g., acute, fatal with full recovery). The Commission ranked them in order of most to least important. You will notice that while many line items from the same category are grouped together others are scattered throughout the list. This is the result of the Commissioners bringing public values and

their professional judgment to bear in their final decision-making process. (See Chapter 2 for further information.)

Why do many services appear more than once?

Each line in the document includes a diagnosis (ICD-9 code) and a procedure/treatment (CPT-4 code). The same procedure/treatment is often provided for several diagnoses. For example, CPT-4 code 90050 stands for office visit, brief service; this is a very general sort of service which applies to many diagnoses.

Why do many diagnoses appear more than once?

A given diagnosis may be treatable with several treatment options. Each of these service options is listed, and the diagnosis appears in each listing.

Are services missing?

All diagnosis and treatment codes which are used for the population to be served are represented somewhere on the list with the exception of mental health and chemical dependency services diagnoses and treatments.

One service which is not missing is termination of pregnancy, or abortions. This service will **not** be funded with federal funds. The service is included explicitly on the list because of the Commission's decision to include all possible conditions. The Oregon legislature has supported this health service with state general funds.

What about mental health and chemical dependency services?

The Mental Health and Chemical Dependency (MHCD) Subcommittee worked in tandem with the Commission. It ranked MHCD treatments and suggested placement within the overall list of health services (i.e., an integrated list). A draft of an integrated list can be found in Appendix H of this report. You will find MHCD conditions highlighted on the list and notice that DSM-III-R codes *(Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised)* are used instead of ICD-9 codes to describe conditions.

The following list does not contain MHCD conditions. They were exempted by law from the initial prioritization report. However, preventive services for MHCD conditions are included in the prevention tables appended to the list.

What about diagnosis?

Diagnostic services are not identified on the prioritized list. However, all diagnostic services necessary to making a complete diagnosis are part of the benefits package. An example is treatment for the common cold which has a low effectiveness. The visit to make the diagnosis will be covered even if the treatment of the common cold is not.

What are preventive services?

Preventive services appear on the list as those for adults and children and preventive dental services (line item 166). Services for adults are separated into those which have substantial proof of effectiveness and those which have demonstrated little effectiveness (line item 671).

You will find the definition of preventive services for children (line item 143) and those which have good evidence of effectiveness for adults (line item 167) appended to the list of prioritized health services. The services are grouped by age into seven tables ranging from infancy to the elderly.

What is comfort care?

Comfort care has been specifically defined in Chapter 4 of the report, and the definition is repeated here.

Comfort care (line item 164) includes the provision of services or items that give comfort and/or pain relief to a terminally ill person whose death is imminent--regardless of diagnosis.

This category of care does not include services that are diagnostic, curative or focused on active treatment of the primary condition and intended to prolong life. Examples of comfort care include:

1. Pain medication and/or pain management devices
2. In-home and day care services and hospice services as defined by OMAP in Ancillary Services
3. Medical equipment and supplies (beds, wheelchairs, bedside commodes, etc.)

What are ancillary services?

Ancillary services are those services which are considered to be integral to successful treatment of a condition and are appended to the list of prioritized health services.

Examples of ancillary services which may be medically necessary are: hospital services, laboratory services, prescription drugs, medical transportation, maternity case management, and hospice services.

PRIORITIZED HEALTH SERVICES LIST

OF

MAY 1, 1991

PRIORITIZED HEALTH SERVICES LIST OF MAY 1, 1991

Diagnosis: PNEUMOCOCCAL PNEUMONIA, OTHER BACTERIAL PNEUMONIA, BRONCHOPNEUMONIA, INFLUENZA WITH PNEUMONIA
Treatment: MEDICAL THERAPY
ICD-9: 020.3-.5,022.1,073,466,481-483,485-486,487.1
CPT: 90000-99999
Line: 1 Category: 1

Diagnosis: TUBERCULOSIS
Treatment: MEDICAL THERAPY
ICD-9: 010-012
CPT: 90000-99999
Line: 2 Category: 5

Diagnosis: PERITONITIS
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 567
CPT: 90000-99999
Line: 3 Category: 1

Diagnosis: FOREIGN BODY IN PHARYNX, LARYNX, TRACHEA, BRONCHUS & ESOPHAGUS
Treatment: REMOVAL OF FOREIGN BODY
ICD-9: 933.0-.1,934.0-.1,935.1
CPT: 31635,40804
Line: 4 Category: 1

Diagnosis: APPENDICITIS
Treatment: APPENDECTOMY
ICD-9: 540-543
CPT: 44950,44900,44960
Line: 5 Category: 1

Diagnosis: RUPTURED INTESTINE
Treatment: REPAIR
ICD-9: 569.3
CPT: 44600-10
Line: 6 Category: 1

Diagnosis: HERNIA WITH OBSTRUCTION AND/OR GANGRENE
Treatment: REPAIR
ICD-9: 550.0-.1,551-552
CPT: 39502-41,43330-31,43885,44050,44346,49500-611,49000,51500,55540
Line: 7 Category: 1

Diagnosis: CROUP SYNDROME, ACUTE LARYNGOTRACHEITIS
Treatment: MEDICAL THERAPY, INTUBATION, TRACHEOTOMY
ICD-9: 464.0-.4
CPT: 90000-99999,31500,31600
Line: 8 Category: 1

Diagnosis: ACUTE ORBITAL CELLULITIS
Treatment: MEDICAL THERAPY
ICD-9: 376.0
CPT: 90000-99999
Line: 9 Category: 1

Diagnosis: ECTOPIC PREGNANCY
Treatment: SURGERY
ICD-9: 633
CPT: 58700,58720,58770,58980,59135
Line: 10 Category: 1

Diagnosis: INJURY TO MAJOR BLOOD VESSELS OF UPPER EXTREMITY
Treatment: LIGATION
ICD-9: 903
CPT: 37618
Line: 11 Category: 1

Diagnosis: RUPTURED SPLEEN
Treatment: REPAIR/SPLENECTOMY/INCISION
ICD-9: 865.04
CPT: 38100,49000,38115
Line: 12 Category: 1

Diagnosis: ACUTE PELVIC INFLAMMATORY DISEASE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 614.0,614.3,614.5,615.0
CPT: 11043,58150,58805,58925,58980,90000-99999
Line: 13 Category: 1

Diagnosis: ACUTE PYELONEPHRITIS, RENAL & PERINEPHRIC ABSCESS
Treatment: MEDICAL AND SURGICAL THERAPY
ICD-9: 590.1-.2
CPT: 50200,50220,90000-99999
Line: 14 Category: 1

Diagnosis: ANAPHYLACTIC SHOCK DUE TO FOOD, DRUG OR OTHER NON-VENOMOUS SOURCE
Treatment: MEDICAL THERAPY
ICD-9: 995.0,995.2
CPT: 90000-99999
Line: 15 Category: 1

Diagnosis: GALLSTONE WITH CHOLECYSTITIS AND OTHER DISORDERS OF BILE DUCT
Treatment: CHOLECYSTECTOMY
ICD-9: 574.0-.1,574.3-.4,575.0-.5,576.1-.3
CPT: 47420-60,47480-90,47500-605,49000
Line: 16 Category: 1

Diagnosis: RESPIRATORY OBSTRUCTION
Treatment: REPAIR OF CHOANAL ATRESIA
ICD-9: 748.0
CPT: 30540
Line: 17 Category: 2

Diagnosis: SYPHILIS
Treatment: MEDICAL THERAPY
ICD-9: 090-097
CPT: 90000-99999
Line: 18 Category: 5

Diagnosis: HEMOLYTIC DISEASE DUE TO ISOIMMUNIZATION, LATE ANEMIA DUE TO ISOIMMUNIZATION, AND FETAL AND NEONATAL JAUNDICE
Treatment: MEDICAL THERAPY
ICD-9: 773.0-.2,773.4-.5,774.0-.4,774.6-.7
CPT: 90000-99999
Line: 19 Category: 2

Diagnosis: POLYCYTHEMIA NEONATORUM, SYMPTOMATIC
Treatment: MEDICAL THERAPY
ICD-9: 776.4
CPT: 36450,90000-99999
Line: 20 Category: 2

Diagnosis: PREGNANCY
Treatment: OBSTETRICAL CARE
ICD-9: 622.5,640-676,760-763,766,768,772.0,772.3-.4,776.5,V22-V28,V30-V39
CPT: 59000-59899,57700,90000-99999
Line: 21 Category: 2

Diagnosis: LOW BIRTH WEIGHT (500 GM AND OVER)
Treatment: MEDICAL THERAPY
ICD-9: 765.12-.19,769,778.1
CPT: 90000-99999
Line: 22 Category: 2

Diagnosis: SYNDROME OF "INFANT OF A DIABETIC MOTHER" AND NEONATAL HYPOGLYCEMIA
Treatment: MEDICAL THERAPY
ICD-9: 775.0,775.6
CPT: 36510,36660,90000-99999
Line: 23 Category: 2

Diagnosis: OMPHALITIS OF THE NEWBORN AND NEONATAL INFECTIVE MASTITIS
Treatment: MEDICAL THERAPY
ICD-9: 771.4-.5
CPT: 90000-99999
Line: 24 Category: 2

PRIORITIZED HEALTH SERVICES LIST OF MAY 1, 1991

Diagnosis: GALACTOSEMIA
Treatment: MEDICAL THERAPY
ICD-9: 271.1,774.5
CPT: 90000-99999
Line: 25 Category: 2

Diagnosis: HYPOGLYCEMIC COMA; HYPOGLYCEMIA
Treatment: MEDICAL THERAPY
ICD-9: 251.0-251.2
CPT: 90000-99999
Line: 26 Category: 3

Diagnosis: WHOOPING COUGH
Treatment: MEDICAL THERAPY
ICD-9: 032-033
CPT: 90000-99999
Line: 27 Category: 1

Diagnosis: PHENYLKETONURIA (PKU)
Treatment: MEDICAL THERAPY
ICD-9: 270.1
CPT: 90000-99999
Line: 28 Category: 4

Diagnosis: CONGENITAL HYPOTHYROIDISM
Treatment: MEDICAL THERAPY
ICD-9: 243
CPT: 90000-99999
Line: 29 Category: 4

Diagnosis: ACUTE OSTEOMYELITIS
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 730.0
CPT: 90000-99999
Line: 30 Category: 1

Diagnosis: DEEP OPEN WOUND OF NECK, INCLUDING LARYNX; FRACTURE OF LARYNX OR TRACHEA, OPEN
Treatment: REPAIR
ICD-9: 874,807.6
CPT: 12001-12007,13101,13131-50
Line: 31 Category: 1

Diagnosis: DISEASES OF PHARYNX INCLUDING RETROPHARYNGEAL ABSCESS
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 478.21-.22,478.24
CPT: 42700-42999,90000-99999
Line: 32 Category: 1

Diagnosis: PNEUMOTHORAX AND HEMOTHORAX
Treatment: TUBE THORACOSTOMY/THORACOTOMY, MEDICAL THERAPY
ICD-9: 512,860.2
CPT: 90000-99999,32020,32100,32500
Line: 33 Category: 1

Diagnosis: HYPOTENSION
Treatment: MEDICAL THERAPY
ICD-9: 458
CPT: 90000-99999
Line: 34 Category: 1

Diagnosis: FRACTURE OF SHAFT OF BONE, OPEN
Treatment: REDUCTION
ICD-9: 812.3,813.3,813.9,818.1,821.1,823.3,823.9
CPT: 24500-15,25500-25575,25610-25620,27500-06,27750-58,27800-06
Line: 35 Category: 1

Diagnosis: PERIPHERAL NERVE INJURY
Treatment: NEUROPLASTY
ICD-9: 953.4-.9,955-956,957.9
CPT: 64413-50,64830,64787,64732-92,64716-21,64830-76,64702-27
Line: 36 Category: 12

Diagnosis: PYOGENIC ARTHRITIS
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 711
CPT: 24000,25040,26070-80,27030,27310,27610,29843,29871-72,29894,90000-99999
Line: 37 Category: 1

Diagnosis: INTESTINAL OBSTRUCTION W/O MENTION OF HERNIA
Treatment: EXCISION
ICD-9: 560.0,560.2,560.8-.9
CPT: 44005,44020,44050,44110-30,44140-44
Line: 38 Category: 1

Diagnosis: PATENT DUCTUS ARTERIOSUS
Treatment: LIGATION
ICD-9: 747.0
CPT: 33820-22
Line: 39 Category: 2

Diagnosis: HEMATOLOGICAL DISORDERS OF FETUS AND NEWBORN
Treatment: MEDICAL THERAPY
ICD-9: 776.0-.1,776.3
CPT: 90000-99999
Line: 40 Category: 2

Diagnosis: CONDITIONS INVOLVING THE TEMPERATURE REGULATION OF NEWBORNS
Treatment: MEDICAL THERAPY
ICD-9: 778.2-.4
CPT: 90000-99999
Line: 41 Category: 2

Diagnosis: BIRTH TRAUMA FOR BABY
Treatment: MEDICAL THERAPY
ICD-9: 767
CPT: 90000-99999
Line: 42 Category: 2

Diagnosis: HYPOCALCEMIA, HYPOMAGNESEMIA AND OTHER ENDOCRINE AND METABOLIC DISTURBANCES SPECIFIC TO THE FETUS AND NEWBORN
Treatment: MEDICAL THERAPY
ICD-9: 775.4-.5,775.7-.9
CPT: 36510,36660,90000-99999
Line: 43 Category: 2

Diagnosis: PERINATAL DISORDERS OF DIGESTIVE SYSTEM
Treatment: MEDICAL THERAPY
ICD-9: 777.1-.4
CPT: 90000-99999
Line: 44 Category: 2

Diagnosis: ANEMIA OF PREMATURITY OR TRANSIENT NEONATAL NEUTROPENIA
Treatment: MEDICAL THERAPY
ICD-9: 776.6-.9
CPT: 90000-99999
Line: 45 Category: 2

Diagnosis: HYDROPS FETALIS
Treatment: MEDICAL THERAPY
ICD-9: 778.0,773.3
CPT: 90000-99999
Line: 46 Category: 2

Diagnosis: ACUTE BACTERIAL MENINGITIS
Treatment: MEDICAL THERAPY
ICD-9: 024,027.0,036,320
CPT: 90000-99999
Line: 47 Category: 3

Diagnosis: HYPOTHERMIA
Treatment: MEDICAL THERAPY
ICD-9: 991.6
CPT: 90000-99999
Line: 48 Category: 3

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Diagnosis: BURN, PARTIAL THICKNESS WITHOUT VITAL SITE, 10-30% OF BODY SURFACE
Treatment: FREE SKIN GRAFT, MEDICAL THERAPY
ICD-9: 941.26-.27,.36-.37,942.20-.24,.29-.34,.39,943.2-.3,944.20-.24,.26-.34,.36-.38,945.20-.21,.23-.31,.33-.39,946.2-.3,948,949.2-.3
CPT: 11000,11040-1,11960-70,14020,14040-1,15000-15121,15200,15220,15240,15260,15350,15400,15500-10,16000-16035,35206,90000-99999
Line: 49 Category: 3

Diagnosis: ACUTE MYOCARDIAL INFARCTION
Treatment: MEDICAL THERAPY
ICD-9: 410
CPT: 90000-99999
Line: 50 Category: 3

Diagnosis: ACUTE PULMONARY HEART DISEASE AND PULMONARY EMBOLI
Treatment: MEDICAL THERAPY
ICD-9: 415
CPT: 90000-99999
Line: 51 Category: 3

Diagnosis: THYROTOXICOSIS WITH OR WITHOUT GOITER, ENDOCRINE EXOPHTHALMOS; CHRONIC THYROIDITIS
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 242,245.1-.9,246.8,376.2
CPT: 60245,67440,67599-67622,90000-99999
Line: 52 Category: 5

Diagnosis: LIFE-THREATENING ARRHYTHMIAS
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 427.1,427.4-.5,746.86,996.01
CPT: 33200-33208,33212,33820,90000-99999
Line: 53 Category: 3

Diagnosis: FRACTURE OF RIBS AND STERNUM, OPEN
Treatment: STABILIZE
ICD-9: 807.1,807.3
CPT: 21805,21810,21825
Line: 54 Category: 1

Diagnosis: FATAL RICKETTSIAL AND OTHER ARTHROPOD-BORNE DISEASES
Treatment: MEDICAL THERAPY
ICD-9: 080-083,085.0,085.5,085.9
CPT: 90000-99999
Line: 55 Category: 1

Diagnosis: POISONING BY INGESTION AND INJECTION
Treatment: MEDICAL THERAPY
ICD-9: 960.2-.5,961.0,.3-.9,962.0,.2-.8,963.0,.2-.9,964.5,.7-.8,965.5-.7,966,968.0,968.5-.7,969.6,970.1,971.0-.2,972.3,972.6,972.8,974.0-.4,974.7,975.0-.1,975.7,977.0,978-985
CPT: 43235-47,90000-99999
Line: 56 Category: 1

Diagnosis: PERITONSILLAR ABSCESS
Treatment: INCISION AND DRAINAGE OF ABSCESS, MEDICAL THERAPY
ICD-9: 475
CPT: 10160,42700,90000-99999
Line: 57 Category: 1

Diagnosis: RUPTURE BLADDER, NONTRAUMATIC
Treatment: CYSTORRHAPHY SUTURE
ICD-9: 596.6
CPT: 51860-51865
Line: 58 Category: 1

Diagnosis: FRACTURE OF FACE BONES
Treatment: SURGERY
ICD-9: 802
CPT: 21310-37,21454-5,21461,21462,21360,21365,21385-6,21406,21421-22,21470,30140,30520,30620,31021
Line: 59 Category: 1

Diagnosis: LIFE-THREATENING EPISTAXIS
Treatment: SEPTOPLASTY/REPAIR/CONTROL HEMORRHAGE
ICD-9: 784.7
CPT: 30520-30999
Line: 60 Category: 1

Diagnosis: ACUTE MASTOIDITIS
Treatment: MASTOIDECTOMY, MEDICAL THERAPY
ICD-9: 383.0
CPT: 69601-46,69670,90000-99999
Line: 61 Category: 1

Diagnosis: ACQUIRED DEFORMITY OF HEAD AND COMPOUND/DEPRESSED FRACTURES OF SKULL
Treatment: CRANIOTOMY/CRANIECTOMY
ICD-9: 738.0-.1,800,803,804
CPT: 21365,21395,61304-576,62000
Line: 62 Category: 1

Diagnosis: DISLOCATION OF ELBOW, HAND, ANKLE, FOOT, CLAVICLE AND SHOULDER, OPEN
Treatment: RELOCATION
ICD-9: 831.04,831.1,832.1,833.1,834.1,837.1,838.1
CPT: 23520-52,23650-80,24600-35,25660-95,26641-715,27840-48
Line: 63 Category: 1

Diagnosis: SEPTICEMIA
Treatment: MEDICAL THERAPY
ICD-9: 002,003.1,004.9,020.0-.2,020.8-.9,021,022.3,024,027,036.2,038,054.5,098.89,771.8,998.5,999.3
CPT: 90000-99999
Line: 64 Category: 1

Diagnosis: ERYSIPELAS
Treatment: MEDICAL THERAPY
ICD-9: 035
CPT: 90000-99999
Line: 65 Category: 1

Diagnosis: STEVENS-JOHNSON SYNDROME
Treatment: MEDICAL THERAPY
ICD-9: 695.1
CPT: 90000-99999,11100-11101
Line: 66 Category: 1

Diagnosis: DISORDERS OF BILE DUCT
Treatment: EXCISION, REPAIR
ICD-9: 576.4-.9
CPT: 47420-60,47500-999
Line: 67 Category: 1

Diagnosis: RUPTURE LIVER
Treatment: SUTURE/REPAIR
ICD-9: 864.04
CPT: 47350,47360
Line: 68 Category: 1

Diagnosis: RESPIRATORY FAILURE
Treatment: MEDICAL THERAPY
ICD-9: 518.81
CPT: 31600,90000-99999
Line: 69 Category: 1

Diagnosis: LUNG CONTUSION OR LACERATION
Treatment: MEDICAL THERAPY
ICD-9: 861.21,861.31
CPT: 90000-99999
Line: 70 Category: 1

Diagnosis: TRANSPLACENTAL HEMORRHAGE
Treatment: MEDICAL THERAPY
ICD-9: 772.0,772.3-.4,776.5
CPT: 90000-99999
Line: 71 Category: 2

Diagnosis: NEONATAL THYROTOXICOSIS
Treatment: MEDICAL THERAPY
ICD-9: 775.3
CPT: 90000-99999
Line: 72 Category: 2

Diagnosis: DRUG REACTIONS & INTOXICATIONS SPECIFIC TO NEWBORN
Treatment: MEDICAL THERAPY
ICD-9: 779.4
CPT: 90000-99999
Line: 73 Category: 2

Diagnosis: NEONATAL MYASTHENIA GRAVIS
Treatment: MEDICAL THERAPY
ICD-9: 775.2
CPT: 90000-99999
Line: 74 Category: 2

Diagnosis: CLEFT PALATE WITH AIRWAY OBSTRUCTION, PIERRE ROBIN DEFORMITY
Treatment: LIP-TONGUE SUTURE, MEDICAL THERAPY
ICD-9: 749.0,519.8
CPT: 30140,30520,30620,41510,90000-99999
Line: 75 Category: 2

Diagnosis: DRUG WITHDRAWAL SYNDROME IN NEWBORN
Treatment: MEDICAL THERAPY
ICD-9: 779.5
CPT: 90000-99999
Line: 76 Category: 2

Diagnosis: TOXIC EFFECT OF GASES, FUMES, AND VAPORS REQUIRING HYPERBARIC OXYGEN
Treatment: HYPERBARIC OXYGEN
ICD-9: 986-987
CPT: 99180-99182
Line: 77 Category: 3

Diagnosis: PHLEBITIS & THROMBOPHLEBITIS, DEEP
Treatment: LIGATION AND DIVISION, MEDICAL THERAPY
ICD-9: 451.0-.2,451.8
CPT: 11042,37720,37721,37735,37785,90000-99999
Line: 78 Category: 3

Diagnosis: DISLOCATION KNEE & HIP, OPEN
Treatment: RELOCATION
ICD-9: 835.1,836.4,836.6
CPT: 27250-55,27550-27557
Line: 79 Category: 3

Diagnosis: EMPYEMA AND ABSCESS OF LUNG
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 510,513.0
CPT: 90000-99999,31622,32000-32100
Line: 80 Category: 3

Diagnosis: CERVICAL VERTEBRAL DISLOCATIONS, OPEN OR CLOSED; OTHER VERTEBRAL DISLOCATIONS, OPEN
Treatment: REPAIR/RECONSTRUCTION
ICD-9: 839.0-.1,839.3,839.5,839.7
CPT: 22315,22325-22327,22505,22590-22650,22840-22855
Line: 81 Category: 3

Diagnosis: OPEN FRACTURE OF EPIPHYSIS OF LOWER EXTREMITIES
Treatment: REDUCTION
ICD-9: 820.11,821.32
CPT: 27516-27519
Line: 82 Category: 3

Diagnosis: SPINAL CORD INJURY WITHOUT EVIDENCE OF VERTEBRAL INJURY
Treatment: MEDICAL THERAPY
ICD-9: 952
CPT: 90000-99999
Line: 83 Category: 3

Diagnosis: ASPIRATION PNEUMONIA
Treatment: MEDICAL THERAPY
ICD-9: 507
CPT: 90000-99999,31645,31500
Line: 84 Category: 3

Diagnosis: ACUTE INFLAMMATION OF THE HEART DUE TO RHEUMATIC FEVER
Treatment: MEDICAL THERAPY
ICD-9: 391,392.0
CPT: 90000-99999
Line: 85 Category: 3

Diagnosis: FRACTURE AND OTHER INJURY OF CERVICAL VERTEBRA
Treatment: CERVICAL LAMINECTOMY, MEDICAL THERAPY
ICD-9: 806.0-806.1,805.0-805.1,952.0
CPT: 22315,22326,22845,63250,63265,63270,63275,63280,63285,63001,63015,63020,63035-40,63045,63048,63075-76, 63081-82,63300,63304,63170-72,63180-82,63194,63196,63198,90000-99999
Line: 86 Category: 3

Diagnosis: FRACTURE OF HIP, CLOSED
Treatment: REDUCTION
ICD-9: 820.00,820.02-.09,820.2,820.8
CPT: 27230-27232,27235-27240,27242-27248
Line: 87 Category: 3

Diagnosis: SUBARACHNOID AND INTERCEREBRAL HEMORRHAGE/HEMATOMA
Treatment: BURR HOLES, CRANIECTOMY/CRANIOTOMY
ICD-9: 430-432,852-853
CPT: 22640,61120-61151,61154,61210,61304,61314-61315,61522-61712,62223
Line: 88 Category: 3

Diagnosis: ACUTE PANCREATITIS
Treatment: MEDICAL THERAPY
ICD-9: 577.0
CPT: 90000-99999
Line: 89 Category: 3

Diagnosis: HYDATIDIFORM MOLE
Treatment: D & C, HYSTERECTOMY
ICD-9: 630
CPT: 58120,58150-200
Line: 90 Category: 1

Diagnosis: THROMBOCYTOPENIA
Treatment: MEDICAL THERAPY
ICD-9: 287
CPT: 90000-99999
Line: 91 Category: 1

Diagnosis: TOXIC EFFECT OF VENOM
Treatment: MEDICAL THERAPY
ICD-9: 989.5
CPT: 90000-99999
Line: 92 Category: 1

Diagnosis: CANCRUM ORIS
Treatment: MEDICAL THERAPY
ICD-9: 528.1
CPT: 90000-99999
Line: 93 Category: 1

Diagnosis: CANDIDIASIS OF LUNG, DISSEMINATED CANDIDIASIS, CANDIDAL ENDOCARDITIS AND MENINGITIS
Treatment: MEDICAL THERAPY
ICD-9: 112.4-.5,112.81,112.83
CPT: 90000-99999
Line: 94 Category: 1

Diagnosis: MYOCARDITIS, PERICARDITIS AND ENDOCARDITIS
Treatment: MEDICAL THERAPY
ICD-9: 420-423
CPT: 90000-99999
Line: 95 Category: 1

Diagnosis: RUPTURE OF ESOPHAGUS
Treatment: SURGERY
ICD-9: 530.4
CPT: 43100-01,43110-43235,43330-31
Line: 96 Category: 1

Diagnosis: TOXIC EPIDERMAL NECROLYSIS AND STAPHYLOCOCCAL SCALDED SKIN SYNDROME
Treatment: MEDICAL THERAPY
ICD-9: 695.1
CPT: 90000-99999,11100-11101
Line: 97 Category: 1

Diagnosis: CHOLERA, RAT-BITE FEVER AND TOXIC EFFECTS OF MUSHROOMS, FISH, BERRIES, ETC.
Treatment: MEDICAL THERAPY
ICD-9: 001,026,988
CPT: 90000-99999
Line: 98 Category: 1

Diagnosis: DELIRIUM: AMPHETAMINE, COCAINE, OR OTHER PSYCHOACTIVE SUBSTANCE
Treatment: MEDICAL THERAPY
ICD-9: 292.81,293.00
CPT: 90220
Line: 99 Category: 1

Diagnosis: INJURY TO BLOOD VESSELS OF THE THORACIC CAVITY
Treatment: REPAIR
ICD-9: 901
CPT: 37616
Line: 100 Category: 1

Diagnosis: NECROTIZING ENTEROCOLITIS IN FETUS OR NEWBORN AND PERINATAL INTESTINAL PERFORATION
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 777.5-.6
CPT: 36510,36660,90000-99999
Line: 101 Category: 2

Diagnosis: DISSEMINATED INTRAVASCULAR COAGULATION
Treatment: MEDICAL THERAPY
ICD-9: 286.6,776.2
CPT: 90000-99999
Line: 102 Category: 2

Diagnosis: CEREBRAL DEPRESSION, COMA, & OTHER ABNORMAL CEREBRAL SIGNS OF NEWBORN
Treatment: MEDICAL THERAPY
ICD-9: 779.2
CPT: 36510,36660,90000-99999
Line: 103 Category: 2

Diagnosis: TORSION OF OVARY
Treatment: OOPHORECTOMY, OVARIAN CYSTECTOMY
ICD-9: 620.5
CPT: 58925,58940-43,59120-26
Line: 104 Category: 1

Diagnosis: SPONTANEOUS ABORTION COMPLICATED BY INFECTION AND/OR HEMORRHAGE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 634.0-.1
CPT: 59820-21,90000-99999
Line: 105 Category: 1

Diagnosis: OTHER RESPIRATORY CONDITIONS OF FETUS AND NEWBORN
Treatment: MEDICAL THERAPY
ICD-9: 770.0-.6,770.8-.9
CPT: 90000-99999
Line: 106 Category: 2

Diagnosis: OTHER NONINFECTIOUS GASTROENTERITIS AND COLITIS
Treatment: MEDICAL THERAPY
ICD-9: 558
CPT: 90000-99999
Line: 107 Category: 3

Diagnosis: UNSPECIFIED DISEASES DUE TO MYCOBACTERIA, ACTINOMYCOTIC INFECTIONS, AND TOXOPLASMOSIS
Treatment: MEDICAL THERAPY
ICD-9: 031.9,039,130
CPT: 90000-99999
Line: 108 Category: 3

Diagnosis: BOTULISM
Treatment: MEDICAL THERAPY
ICD-9: 005.1
CPT: 90000-99999
Line: 109 Category: 3

Diagnosis: FRACTURE OF JOINT, OPEN
Treatment: REDUCTION
ICD-9: 810.1,811.1,812.1,812.5,813.1,813.5,820.10,820.12-.19,820.3,820.9,821.30-.31,821.33-.39,822.1,823.1,824.1,.3,.5,.7,.9,825.1,.3,826.1,828.1,814.1,815.1,816.1,817.1,819.1
CPT: 23500-15,23570-630,24530-88,24650-85,25600-50,26600-15,26720-85,27230-48,27409,27420,27508-14,27520-40,27610,27764-66,27780-92,27806-23,27846-8,28400-530,28730,29874-9
Line: 110 Category: 3

Diagnosis: ABSCESS OF INTESTINE
Treatment: DRAIN ABSCESS, MEDICAL THERAPY
ICD-9: 569.5
CPT: 90000-99999,45355,45386,45310-45315
Line: 111 Category: 3

Diagnosis: ADULT RESPIRATORY DISTRESS SYNDROME
Treatment: MEDICAL THERAPY
ICD-9: 518.4-.5
CPT: 90000-99999
Line: 112 Category: 3

Diagnosis: HERPETIC ENCEPHALITIS
Treatment: MEDICAL THERAPY
ICD-9: 054.3
CPT: 90000-99999
Line: 113 Category: 3

Diagnosis: ARTHROPOD-BORNE VIRAL DISEASES
Treatment: MEDICAL THERAPY
ICD-9: 060-066
CPT: 90000-99999
Line: 114 Category: 3

Diagnosis: BURN, PARTIAL THICKNESS WITH VITAL SITE; FULL THICKNESS WITH VITAL SITE, LESS THAN 10% OF BODY SURFACE
Treatment: FREE SKIN GRAFT, MEDICAL THERAPY
ICD-9: 941.20-25,.28-.35,.38-.39,942.25,.35,944.25,.35,945.22,.32,946.2-.3,948,949.2-.3
CPT: 11000,11040-2,11970,14020,14040-1,15000-15121,15200,15220,15240,15260,15350,15500-10,15400-10,15505,15770,16000-16035,35206,90000-99999
Line: 115 Category: 3

Diagnosis: FRACTURE OF PELVIS, OPEN AND CLOSED
Treatment: REDUCTION
ICD-9: 808
CPT: 27033,27210-27225
Line: 116 Category: 3

Diagnosis: BURN FULL THICKNESS GREATER THAN 10% OF BODY SURFACE
Treatment: FREE SKIN GRAFT, MEDICAL THERAPY
ICD-9: 940,941.30-.35,941.4-.5,942.35,.4-.5,943.4-.5,944.35,.4-.5,945.32,.4-.5,946.3-.5,947,948.11-.19,.21-.29,.31-.39,.41-.49,.51-.59,.61-.69,.71-.79,.81-.89,.91-.99,949.4-.5
CPT: 11000,11040-1,11960-70,14020,14040-1,15000-15121,15200,15220,15240,15260,15350,15400,15500-10,15770,16000-16035,20550,35206,90000-99999
Line: 117 Category: 3

Diagnosis: SUBACUTE MENINGITIS (EG. TUBERCULOSIS, CRYPTOCOCCOSIS)
Treatment: MEDICAL THERAPY
ICD-9: 013,054.72,117.5,117.9,123.1,130.8,321-322
CPT: 90000-99999
Line: 118 Category: 3

Diagnosis: CRUSH INJURIES: TRUNK, UPPER LIMBS, LOWER LIMB INCLUDING BLOOD VESSELS
Treatment: SURGICAL TX
ICD-9: 900,902,926.11-.12,927.03,927.2-.9,927.10,928,925,927.00,927.01
CPT: 15220,24495,25020,25023,27600-27602,29105-29131,29240-29280,29345-29440,29520-29580,37615-18
Line: 119 Category: 3

Diagnosis: ACUTE GLOMERULONEPHRITIS AND OTHER ACUTE RENAL FAILURE
Treatment: MEDICAL THERAPY INCLUDING DIALYSIS
ICD-9: 580.0,580.8-.9,584
CPT: 90000-99999
Line: 120 Category: 3

Diagnosis: ACCIDENTS INVOLVING EXPOSURE TO NATURAL ELEMENTS (EG. LIGHTNING STRIKE, HEATSTROKE)
Treatment: MEDICAL THERAPY
ICD-9: 991.0-.5,992.0,993.2,994.0-.1,994.4-.9
CPT: 90000-99999
Line: 121 Category: 1

Diagnosis: DISSECTING OR RUPTURED ANEURYSM
Treatment: SURGICAL TREATMENT
ICD-9: 441.0-.1,441.3,441.5
CPT: 33860-77,35081-103,35301-11,35331-51,35450-515,35526-31,35536-52,35560-63,35601-16,35626-46,35651,35663
Line: 122 Category: 1

Diagnosis: ARTERIAL EMBOLISM/THROMBOSIS: ABDOMINAL AORTA, THORACIC AORTA
Treatment: SURGICAL TREATMENT
ICD-9: 444.0-.1,.8
CPT: 34101,34201,35081,35363,35381,35536-51
Line: 123 Category: 3

Diagnosis: CONGENITAL ANOMALIES OF DIGESTIVE SYSTEM EXCLUDING NECROSIS
Treatment: MEDICAL AND SURGICAL THERAPY
ICD-9: 751
CPT: 44050,45100,45120-21,46070,46080
Line: 124 Category: 2

Diagnosis: CONVULSIONS AND OTHER CEREBRAL IRRITABILITY IN NEWBORN
Treatment: MEDICAL THERAPY
ICD-9: 779.0-.1
CPT: 90000-99999
Line: 125 Category: 2

Diagnosis: ACUTE NECROSIS OF LIVER
Treatment: MEDICAL THERAPY
ICD-9: 570
CPT: 90000-99999
Line: 126 Category: 3

Diagnosis: COCCIDIOIDOMYCOSIS, HISTOPLASMOSIS, BLASTOMYCOTIC INFECTION, OPPORTUNISTIC AND OTHER MYCOSES
Treatment: MEDICAL THERAPY
ICD-9: 114-118
CPT: 90000-99999
Line: 127 Category: 3

Diagnosis: INTRASPINAL AND INTRACRANIAL ABSCESS
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 324
CPT: 63172-63173,63266-63273,90000-99999
Line: 128 Category: 3

Diagnosis: ANEURYSM OF PULMONARY ARTERY
Treatment: SURGICAL TREATMENT
ICD-9: 417.1
CPT: 33910-33915
Line: 129 Category: 3

Diagnosis: FLAIL CHEST
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 807.4
CPT: 21800-25,90000-99999
Line: 130 Category: 3

Diagnosis: SEVERE HEAD INJURY: HEMATOMA/EDEMA W/ MODERATE/PROLONGED LOSS OF CONSCIOUSNESS
Treatment: SURGICAL TREATMENT
ICD-9: 851.03,851.13,851.83,851.93,851.43,851.53
CPT: 61108,61314-15,62140-41
Line: 131 Category: 3

Diagnosis: RUPTURE OF PAPILLARY MUSCLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 429.5-.6
CPT: 33542,90000-99999
Line: 132 Category: 3

Diagnosis: ANAEROBIC INFECTIONS REQUIRING HYPERBARIC OXYGEN
Treatment: HYPERBARIC OXYGEN
ICD-9: 611.3,639.0,639.6,670.2,670.4,673.0,709.3,729.4,785.4,958.0,996.52,996.6-.7,998.8,999.1
CPT: 99180-99182
Line: 133 Category: 3

Diagnosis: TRAUMATIC AMPUTATION OF ARM(S) & HAND(S) (COMPLETE)(PARTIAL) W & W/O COMPLICATION
Treatment: REPLANTATION/AMPUTATE
ICD-9: 887.0-.3,887.5-.7
CPT: 20802,20804,20805,20806,23900,23920,23921,24900,24920,24925,24930,24931,24935,24940,25900-9
Line: 134 Category: 3

Diagnosis: ACUTE VASCULAR INSUFFICIENCY OF INTESTINE
Treatment: COLECTOMY
ICD-9: 557.0
CPT: 44140,44120-25,44141,44143,34151,34421,34451
Line: 135 Category: 3

Diagnosis: BURN, PARTIAL THICKNESS GREATER THAN 30% OF BODY SURFACE
Treatment: FREE SKIN GRAFT, MEDICAL THERAPY
ICD-9: 941.26-.27,942.20-.24,.29,943.2,944.20-.24,.26-.28,945.20-.21,.23-.29,946.2,948.30,.40,.50,.60,.70,.80,.90,949.2
CPT: 11000,11040-1,11960-70,14020,14040-1,15000-15121,15200,15220,15240,15260,15350,15400,15500-10,15770,90200,16000-16035,35206,90000-99999
Line: 136 Category: 3

Diagnosis: ACUTE GLOMERULONEPHRITIS: WITH LESION OF RAPIDLY PROGRESSIVE GLOMERULONEPHRITIS
Treatment: MEDICAL THERAPY INCLUDING DIALYSIS
ICD-9: 580.4
CPT: 90000-99999
Line: 137 Category: 3

Diagnosis: IRON DEFICIENCY ANEMIA AND OTHER NUTRITIONAL DEFICIENCIES
Treatment: MEDICAL THERAPY
ICD-9: 260-268,269.0-.3,280
CPT: 90000-99999
Line: 138 Category: 5

Diagnosis: TETANUS NEONATORUM
Treatment: MEDICAL THERAPY
ICD-9: 771.3
CPT: 90000-99999
Line: 139 Category: 2

Diagnosis: TRAUMATIC AMPUTATION OF LEG(S) (COMPLETE)(PARTIAL) W/ & W/O COMPLICATION
Treatment: REPLANTATION/AMPUTATE
ICD-9: 897.0-.3,897.6-.7
CPT: 20832,20834,27290-27598,27880-27889,27880-84,27886-89
Line: 140 Category: 3

Diagnosis: TRAUMATIC AMPUTATION OF FOOT/FEET (COMPLETE)(PARTIAL) W/ & W/O COMPLICATION
Treatment: REPLANTATION/AMPUTATE
ICD-9: 896,897.6-.7
CPT: 20838,20840,27888,28800-28805
Line: 141 Category: 3

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Diagnosis: ALCOHOL WITHDRAWAL DELIRIUM; ALCOHOL HALLUCINOSIS; UNCOMPLICATED ALCOHOL WITHDRAWAL; WITHDRAWAL FROM AMPHETAMINES, COCAINE, OPIOID, SEDATIVES, HYPNOTICS, ETC.
Treatment: MEDICAL THERAPY
ICD-9: 291.00,291.30,291.80
CPT: 90220,90844
Line: 142 Category: 1

Diagnosis: PREVENTIVE SERVICES, CHILDREN
Treatment: MEDICAL THERAPY
ICD-9: V01-V06,V20-V21,V40-V41,V60,V62.3-.4,V70.0,V77,V79
CPT: 90000-99999
Line: 143 Category: 4

Diagnosis: STREPTOCOCCAL SORE THROAT AND SCARLET FEVER
Treatment: MEDICAL THERAPY
ICD-9: 034
CPT: 90000-99999
Line: 144 Category: 10

Diagnosis: RHEUMATIC FEVER
Treatment: MEDICAL THERAPY
ICD-9: 390
CPT: 90000-99999
Line: 145 Category: 10

Diagnosis: CONGENITAL ANOMALIES OF UPPER ALIMENTARY TRACT, EXCLUDING TONGUE
Treatment: MEDICAL AND SURGICAL THERAPY
ICD-9: 750.2-.9
CPT: 43300-52,90000-99999
Line: 146 Category: 2

Diagnosis: HYPERTENSION AND HYPERTENSIVE DISEASE
Treatment: MEDICAL THERAPY
ICD-9: 401,402.01
CPT: 90000-99999
Line: 147 Category: 5

Diagnosis: HYPERTENSIVE HEART AND RENAL DISEASE
Treatment: MEDICAL THERAPY
ICD-9: 404
CPT: 90000-99999
Line: 148 Category: 5

Diagnosis: ACUTE AND SUBACUTE ISCHEMIC HEART DISEASE
Treatment: SURGICAL TREATMENT
ICD-9: 411.1,996.03
CPT: 92950-93799,33510-16,33210,33570
Line: 149 Category: 3

Diagnosis: DIABETES MELLITUS, TYPE I
Treatment: MEDICAL THERAPY
ICD-9: 250.01,250.1-250.3,250.6,251.3,775.1
CPT: 10060,10100,11000,11042,11050-1,11400-2,11420,11700-1,11710-1,11730,11740,12001,17002, 17100,17110,17200,17340,20550,20605,23420,25810,35656,39000,43204,43245,45310,45355,47600,59025,69200, 69210,90000-99999
Line: 150 Category: 5

Diagnosis: ASTHMA
Treatment: MEDICAL THERAPY
ICD-9: 493
CPT: 90000-99999
Line: 151 Category: 5

Diagnosis: ULCERS, GASTRITIS AND DUODENITIS
Treatment: MEDICAL THERAPY
ICD-9: 531-535
CPT: 90000-99999
Line: 152 Category: 5

Diagnosis: NON-INSULIN DEPENDENT DIABETES
Treatment: MEDICAL THERAPY
ICD-9: 250.00
CPT: 10060,10100,11000,11042,11050-1,11400-2,11420,11700-1,11710-1,11730,11740,12001,17000-2,17100,17110,17200,17340,20550,20600-5,23420,25810,35656,39000,43204,43245,45310,45355,47600,59025,69200,69210,90000-99999
Line: 153 Category: 5

Diagnosis: ACQUIRED HYPOTHYROIDISM, DYSHORMONOGENIC GOITER
Treatment: MEDICAL THERAPY
ICD-9: 244,246.1
CPT: 90000-99999
Line: 154 Category: 5

Diagnosis: CALCULUS OF BILE DUCT WITH OTHER CHOLECYSTITIS
Treatment: MEDICAL THERAPY
ICD-9: 574.4
CPT: 90000-99999
Line: 155 Category: 5

Diagnosis: PHYSICAL AND SEXUAL ABUSE INCLUDING RAPE
Treatment: MEDICAL THERAPY
ICD-9: 992.91,994.2-.3,995.5,995.81,V61.21
CPT: 90000-99999
Line: 156 Category: 1

Diagnosis: GONOCOCCAL INFECTION OF EYE
Treatment: MEDICAL THERAPY
ICD-9: 098.4
CPT: 90000-99999
Line: 157 Category: 10

Diagnosis: HIV DISEASE INCLUDING ACQUIRED IMMUNODEFICIENCY SYNDROME
Treatment: MEDICAL THERAPY
ICD-9: 042.9,043.9,044.9
CPT: 90000-99999
Line: 158 Category: 5

Diagnosis: EPILEPSY
Treatment: MEDICAL THERAPY
ICD-9: 345.1,345.9
CPT: 90000-99999
Line: 159 Category: 5

Diagnosis: HEREDITARY HEMOLYTIC ANEMIAS (EG. SICKLE CELL)
Treatment: MEDICAL THERAPY
ICD-9: 282
CPT: 90000-99999
Line: 160 Category: 5

Diagnosis: STERILIZATION
Treatment: VASECTOMY
ICD-9: V25.2
CPT: 55250
Line: 161 Category: 6

Diagnosis: STERILIZATION
Treatment: TUBAL LIGATION
ICD-9: V25.2
CPT: 58600-11
Line: 162 Category: 6

Diagnosis: BIRTH CONTROL
Treatment: CONTRACEPTION MANAGEMENT
ICD-9: V25.0-.1,V25.4-.9
CPT: 90000-99999
Line: 163 Category: 6

PRIORITIZED HEALTH SERVICES LIST OF MAY 1, 1991

Diagnosis: IMMINENT DEATH REGARDLESS OF DIAGNOSIS
Treatment: COMFORT CARE
ICD-9: 0
CPT: 90000-99999
Line: 164 Category: 7

Diagnosis: DENTAL SERVICES (EG. INFECTIONS)
Treatment: RESTORATIVE DENTAL SERVICE
ICD-9: 0
CPT: 00415,00501,01550,02910,02920,02940,03110,03120,03220,03310,03320,03330,03340,03350,05410-1,05420,05510,05951,06930,07110,07210,07440-1,07510,07520,07910-12,07990,09110
Line: 165 Category: 10

Diagnosis: PREVENTIVE DENTAL SERVICES
Treatment: CLEANING AND FLUORIDE
ICD-9: V72.2
CPT: 00502,00999,01201,01203,01330,01351,05931-5,05952-3,05956-7,05982,05986,07260,07490,07940-9,07955,09610
Line: 166 Category: 8

Diagnosis: PREVENTIVE SERVICES FOR ADULTS WITH PROVEN EFFECTIVENESS
Treatment: MEDICAL THERAPY
ICD-9: V01-V07,V10-V19,V41,V60-V65,V70.0,V70.9,V71,V72.0-.3,V72.8-.9,V73-V82
CPT: 90000-99999
Line: 167 Category: 9

Diagnosis: SOMATIC MEDICINE
Treatment: MEDICAL THERAPY
ICD-9: V70.4
CPT: 90000-99999
Line: 168 Category: 5

Diagnosis: CANCER OF CERVIX, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 180
CPT: 37799,38770,44320,51040,57452-54,57500,57505,57513,57820,58150,58200,58210,90000-99999
Line: 169 Category: 5

Diagnosis: GONOCOCCAL INFECTIONS AND OTHER VENEREAL DISEASES
Treatment: MEDICAL THERAPY
ICD-9: 098,099.0-099.2,099.4-099.9
CPT: 90000-99999
Line: 170 Category: 10

Diagnosis: DYSPLASIA OF CERVIX AND CERVICAL CARCINOMA IN SITU
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 078.1,233.1,622.0-.2,623.0-.1,623.4,623.7,795.0
CPT: 11623,11960-70,15720,19120,38745,45355,52240,56515,58200-10,58960,56501,57061-105,57150,57180,57400,57454,57510-20,90000-99999
Line: 171 Category: 5

Diagnosis: CANCER OF BREAST, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 174-175,198.2,233.0,238.3,239.2
CPT: 11200,11401-02,11623,11950-70,13132,13300,15720,17100,17200,17999,19120,19160-240,19316-8,19350,19499,20605,32000,37799,38525-30,38745,45355,49000,49080,49999,52240,56515,57510,62192,57260,58200-10,58960,62256,90000-99999
Line: 172 Category: 5

Diagnosis: UNDESCENDED TESTICLE
Treatment: ORCHIECTOMY, REPAIR
ICD-9: 752.5
CPT: 54520-54565,54300-440
Line: 173 Category: 5

Diagnosis: CANCER OF TESTIS, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 186,236.4
CPT: 49200,54521-35,54660,55530,38564,38780,64450,90000-99999
Line: 174 Category: 5

Diagnosis: COARCTATION OF THE AORTA
Treatment: SURGICAL/EXCISION
ICD-9: 747.10
CPT: 33840-33851
Line: 175 Category: 5

Diagnosis: PYODERMA
Treatment: MEDICAL THERAPY
ICD-9: 686.0-.1
CPT: 90000-99999
Line: 176 Category: 3

Diagnosis: ANGINA PECTORIS; OTHER FORMS OF CHRONIC ISCHEMIC HEART DISEASE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 412-414,996.03
CPT: 33210,33405,33510-33516,92950-93799,33525,33570,35001,35226,35286,35518,35661,90000-99999
Line: 177 Category: 5

Diagnosis: CANCER OF ENDOCRINE SYSTEM, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 164.0,193-194,198.7,234.8,237.0-.4,239.7
CPT: 11050-51,11600-46,12042,13132,14060,17000-1,17100,17340,31505,49081,21632,32095-100,32480-90,32480-525,38510,60200,60220-5,60240-5,60540,63277,90000-99999
Line: 178 Category: 5

Diagnosis: CANCER OF OVARY, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 183.0,198.6,236.2
CPT: 32000,32020,38760,44005,44320,44625,49000,49085,49999,51010,58180,58210,58720-40,58940-3,58943,58951,58960-85,90000-99999
Line: 179 Category: 5

Diagnosis: ADDISON'S DISEASE
Treatment: MEDICAL THERAPY
ICD-9: 255.4,255.5
CPT: 90000-99999
Line: 180 Category: 5

Diagnosis: CONSTITUTIONAL APLASTIC ANEMIA
Treatment: MEDICAL THERAPY
ICD-9: 284.0
CPT: 90000-99999
Line: 181 Category: 5

Diagnosis: CORONARY ARTERY ANOMALY
Treatment: ANOMALOUS CORONARY ARTERY LIGATION
ICD-9: 746.85
CPT: 33502
Line: 182 Category: 2

Diagnosis: CONGENITAL ANOMALIES OF URINARY SYSTEM
Treatment: RECONSTRUCTION
ICD-9: 753.0-.1,753.3-.9
CPT: 55899
Line: 183 Category: 5

Diagnosis: TOTAL ANOMALOUS PULMONARY VENOUS CONNECTION
Treatment: COMPLETE REPAIR
ICD-9: 747.41
CPT: 33730
Line: 184 Category: 2

Diagnosis: ULCERS, GI HEMORRHAGE
Treatment: HEMIGASTRECTOMY
ICD-9: 531-534,578
CPT: 43204,43610-41,43825-40
Line: 185 Category: 5

Diagnosis: CANCER OF UTERUS, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 179,182,236.0
CPT: 29811,38780,49201,56515,57065,57452-54,57500,57513,58210,58120,58150-285,58950-51,90000-99999
Line: 186 Category: 5

Diagnosis: COAGULATION DEFECTS
Treatment: MEDICAL THERAPY
ICD-9: 286.0-.5,.7-.9
CPT: 90000-99999
Line: 187 Category: 5

Diagnosis: COMMON TRUNCUS
Treatment: TOTAL REPAIR/REPLANT ARTERY
ICD-9: 745.0
CPT: 33786,33788
Line: 188 Category: 5

Diagnosis: HODGKIN'S DISEASE
Treatment: CHEMOTHERAPY, RADIATION THERAPY
ICD-9: 201
CPT: 38100,49000,49200,49220,90000-99999
Line: 189 Category: 5

Diagnosis: CONGENITAL STENOSIS AND INSUFFICIENCY OF AORTIC VALVE
Treatment: SURGICAL VALVE REPLACEMENT
ICD-9: 746.3-.4
CPT: 33405-33417
Line: 190 Category: 5

Diagnosis: ACQUIRED HEMOLYTIC ANEMIAS
Treatment: MEDICAL THERAPY
ICD-9: 283
CPT: 90000-99999
Line: 191 Category: 5

Diagnosis: BULBUS CORDIS ANOMALIES & ANOMALIES OF CARDIAC SEPTAL CLOSURE: DOUBLE OUTLET RIGHT VENTRICLE
Treatment: SHUNT
ICD-9: 745.11
CPT: 33750-33766
Line: 192 Category: 2

Diagnosis: CONGENITAL PULMONARY VALVE ATRESIA
Treatment: SHUNT
ICD-9: 746.01
CPT: 33750-33766
Line: 193 Category: 5

Diagnosis: NON-DISSECTING ANEURYSM WITHOUT RUPTURE
Treatment: SURGICAL TREATMENT
ICD-9: 441.2,441.4,441.9,442
CPT: 33860-77,35081-103,35188,35301-11,35331-51,35450-515,35526-31,35536-52,35560-63,35601-16,35626-46,35651,35663,37618,61532,61700,61712
Line: 194 Category: 5

Diagnosis: PITUITARY DISORDERS: PANHYPOPITUITARISM, IATROGENIC AND OTHER
Treatment: MEDICAL THERAPY
ICD-9: 253.2,253.4,253.7,253.8
CPT: 90000-99999
Line: 195 Category: 5

Diagnosis: OTHER AND UNSPECIFIED TYPE ENDOCARDIAL CUSHION DEFECTS
Treatment: REPAIR ATRIOVENTRICULAR
ICD-9: 745.60,745.69,745.8,745.9
CPT: 33670
Line: 196 Category: 5

Diagnosis: INTERRUPTED AORTIC ARCH
Treatment: TRANSVERSE ARCH GRAFT
ICD-9: 747.11
CPT: 33870
Line: 197 Category: 2

Diagnosis: HEREDITARY FRUCTOSE INTOLERANCE, INTESTINAL DISACCHARIDASE AND OTHER DEFICIENCIES
Treatment: MEDICAL THERAPY
ICD-9: 271.2-.9
CPT: 90000-99999
Line: 198 Category: 5

Diagnosis: CONGENITAL TRICUSPID ATRESIA AND STENOSIS
Treatment: REPAIR
ICD-9: 746.1
CPT: 33649
Line: 199 Category: 5

Diagnosis: DISEASES AND DISORDERS OF AORTIC VALVE
Treatment: AV REPLACEMENT, VALVULOPLASTY, MEDICAL THERAPY
ICD-9: 395,424.1,996.02
CPT: 33400,33411,90000-99999
Line: 200 Category: 5

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Diagnosis: CONGENITAL MITRAL VALVE STENOSIS
Treatment: MITRAL VALUE REPLACEMENT
ICD-9: 746.5
CPT: 33420-33430
Line: 201 Category: 2

Diagnosis: DISEASES OF MITRAL VALVE
Treatment: VALVULOPLASTY, MV REPLACE, MEDICAL THERAPY
ICD-9: 394,424.0,996.02
CPT: 33430,33425,90000-99999
Line: 202 Category: 5

Diagnosis: ADRENOGENITAL DISORDERS
Treatment: MEDICAL THERAPY
ICD-9: 255.2
CPT: 90000-99999,50700
Line: 203 Category: 5

Diagnosis: CANCER OF VAGINA, VULVA AND OTHER FEMALE GENITAL ORGANS, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 181,183.2-.9,184,236.1,236.3
CPT: 11400-22,17000-2,32000,44005,46917,49000,49085,51010,56515,56620,57065,57150,57513,58180,58150,58200,58210,
58240,58260,58720,58960,90000-99999
Line: 204 Category: 5

Diagnosis: CANCER OF URINARY SYSTEM, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 188-189,198.0-.1,233.7,236.7,236.9,239.4
CPT: 11400,11440,11623,11960-70,15720,17000,19120,38745,45355,56515,57510,58200-10,58960,20550,50220-90,50650-
60,51530,51550-97,51700,51720,52234-40,52281,52500,53670,53220,63277,90000-99999
Line: 205 Category: 5

Diagnosis: CANCER OF EYE & ORBIT, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 190,234.0,238.8
CPT: 11050-51,11600-46,12042,13132,14060,17000-1,17100,17340,31505,49081,11401-02,11440,65101-05,90000-99999
Line: 206 Category: 5

Diagnosis: CANCER OF SOFT TISSUE, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 164.1,171,238.1
CPT: 14040,21555-57,21925-35,23075-77,24075-77,25075-77,26115-17,27047-49,27075-79,27327-29,27615-19,27899,
28043-46,32522,90000-99999
Line: 207 Category: 5

Diagnosis: ARTERIAL ANEURYSM OF NECK
Treatment: REPAIR
ICD-9: 442.81-.82
CPT: 35321,35355-81,35516-21,35533,35556-58,35565-87,35621,35650-61,35665-71
Line: 208 Category: 5

Diagnosis: HODGKIN'S DISEASE
Treatment: BONE MARROW TRANSPLANT (5-6 LOCI MATCH)
ICD-9: 201
CPT: 38230-41
Line: 209 Category: 5

Diagnosis: TETRALOGY OF FALLOT (TOF)
Treatment: TOTAL REPAIR TETRALOGY
ICD-9: 745.2
CPT: 33692-33696
Line: 210 Category: 5

Diagnosis: COMPLETE , CORRECTED AND OTHER TGA
Treatment: TRANSPOSITION OF VESSELS
ICD-9: 745.10,745.12,745.19
CPT: 33782-33784
Line: 211 Category: 2

Diagnosis: CONGENITAL CYSTIC LUNG - MILD AND MODERATE
Treatment: LUNG RESECTION
ICD-9: 748.4
CPT: 32500
Line: 212 Category: 5

Diagnosis: CHRONIC HEPATITIS
Treatment: MEDICAL THERAPY
ICD-9: 571.4,571.8-.9
CPT: 90000-99999
Line: 213 Category: 5

Diagnosis: OTHER SPECIFIED APLASTIC ANEMIAS
Treatment: BONE MARROW TRANSPLANT (5-6 LOCI MATCH)
ICD-9: 284.8
CPT: 38240
Line: 214 Category: 5

Diagnosis: CANCER OF PENIS AND OTHER MALE GENITAL ORGAN, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 187,233.5
CPT: 11623,11960-70,15720,19120,38745,45355,52240,56515,57510,58200-10,58960,54120-35,90000-99999
Line: 215 Category: 5

Diagnosis: BENIGN NEOPLASM OF THE BRAIN
Treatment: CRANIOTOMY/CRANIECTOMY
ICD-9: 225.0
CPT: 61304-61576,61712,62223,63276
Line: 216 Category: 5

Diagnosis: INFECTIOUS SKIN CONDITIONS
Treatment: MEDICAL THERAPY
ICD-9: 526.4,706.2,757.32,757.39,757.9
CPT: 10000-61,10141,11000,11100-446,17000-105,20000-05,21030,21044,21501,23030,23040,23930-31,25028-31,26010-30,26990-91,27301,27603-04,28001,40800-05,41800,90000-99999
Line: 217 Category: 5

Diagnosis: HEARING LOSS - AGE 3 OR UNDER
Treatment: MEDICAL THERAPY
ICD-9: 388-389
CPT: 90000-99999
Line: 218 Category: 4

Diagnosis: URETERAL CALCULUS
Treatment: CYSTOURETHROSCOPY W/FRAGMENTATION OF CALCULUS, MEDICAL THERAPY
ICD-9: 592.1
CPT: 50392,50561,50951-80,52320,52325,52332,52335-36,53020,90000-99999
Line: 219 Category: 5

Diagnosis: BENIGN CEREBRAL CYSTS
Treatment: DRAINAGE
ICD-9: 348.0,349.2
CPT: 61120-61152,61314-61315,61522-61524,61680-61712
Line: 220 Category: 5

Diagnosis: CANCER OF BONES, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 170,198.5,238.0,239.2
CPT: 14001,17002,21620,23140,23900,24900-31,25900-31,26200,26910-52,27290,27365,27590-98,27880-89,28800-25,32500,60252-54,60500-605,63276,90000-99999
Line: 221 Category: 5

Diagnosis: AMEBIASIS
Treatment: MEDICAL THERAPY
ICD-9: 006.0-.1,006.9
CPT: 90000-99999
Line: 222 Category: 10

Diagnosis: LIVER ABSCESS AND SEQUELAE OF CHRONIC LIVER DISEASE
Treatment: MEDICAL THERAPY
ICD-9: 572.0-.2
CPT: 90000-99999
Line: 223 Category: 5

Diagnosis: PEMPHIGUS, PEMPHIGOID; BENIGN MUCOUS MEMBRANE PEMPHIGOID, OTHER AND UNSPECIFIED BULLOUS DERMATOSES
Treatment: MEDICAL THERAPY
ICD-9: 694.4-.9
CPT: 90000-99999
Line: 224 Category: 5

Diagnosis: INTESTINAL MALABSORPTION
Treatment: MEDICAL THERAPY
ICD-9: 579
CPT: 90000-99999
Line: 225 Category: 5

Diagnosis: ACROMEGALY & GIGANTISM, OTHER & UNSPECIFIED ANTERIOR PITUITARY HYPERFUNCTION, BENIGN NEOPLASM OF THYROID GLANDS & OTHER ENDOCRINE GLANDS
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 253.0,253.1,253.6,253.9,226,227.0-.1,227.4-.9
CPT: 11401,14000,17000,17102,17200,52281,53670,60200-45,61548,61712,90000-99999
Line: 226 Category: 5

Diagnosis: MALIGNANT MELANOMA OF SKIN, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 172,238.2,239.2
CPT: 11400-46,11600-46,12032,13120,14040-61,17000-110,17340,17999,19200-29,19272,21555-7,21632,21925-35,23075-7,24075-7,25075-7,26115-7,27047-9,27075-9,27327-9,27615-9,28043-6,28315,32480,38500-780,51575-95,54135,55842-45,90000-99999
Line: 227 Category: 5

Diagnosis: PARALYTIC ILEUS
Treatment: MEDICAL THERAPY
ICD-9: 560.1
CPT: 90000-99999
Line: 228 Category: 5

Diagnosis: URETERAL STRICTURE OR OBSTRUCTION
Treatment: OPEN RESECTION, PERCUTANEOUS NEPHROSTOLITHOTOMY, NEPHROLITHOTOMY, LITHOTRIPSY
ICD-9: 593.3-.4
CPT: 50060-81,50700-16,50590,52276
Line: 229 Category: 5

Diagnosis: TREATABLE DEMENTIA
Treatment: MEDICAL THERAPY
ICD-9: 291.2,290.40,292.82,293.9,294.8
CPT: 90000-99999
Line: 230 Category: 5

Diagnosis: CHRONIC OSTEOMYELITIS
Treatment: INCISION & DRAINAGE
ICD-9: 730.1-.2
CPT: 23035,23170-82,23189,23935,24134-24147,25035,25145-25151,26034,26230-36,26992,27303,27075-79,27070-1,27607,28005,27360,27640-1,28120-4
Line: 231 Category: 5

Diagnosis: CHRONIC PYELONEPHRITIS
Treatment: MEDICAL THERAPY
ICD-9: 590.0
CPT: 90000-99999
Line: 232 Category: 5

Diagnosis: TORSION OF TESTIS
Treatment: ORCHIECTOMY, REPAIR
ICD-9: 608.2
CPT: 54520-54560,54600,54640
Line: 233 Category: 10

Diagnosis: LEUKOPLAKIA OF CERVIX, DYSTROPHY OF VULVA
Treatment: MEDICAL THERAPY
ICD-9: 622.2,624.0
CPT: 90000-99999
Line: 234 Category: 5

Diagnosis: CANCER OF LUNG, BRONCHUS, PLEURA, TRACHEA, MEDIASTINUM & OTHER RESPIRATORY ORGANS, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 162-163,164.2-.9,165,195.1,197.0,197.2-.3,231.1-.2,235.7-.8
CPT: 11601,13151,17001-2,20605-10,22900,31300,31540-1,31640-45,31785-86,31899,32000,32020,32095-100,32480-90,32440-50,32500,32900,37799,38542,39010,39200,39400,42415,45333,46917,49421,63030,6471-21,66984,69433,90000-99999
Line: 235 Category: 5

Diagnosis: ACUTE LYMPHOCYTIC LEUKEMIA (CHILD)
Treatment: CHEMOTHERAPY, RADIATION THERAPY
ICD-9: 204.0
CPT: 90000-99999
Line: 236 Category: 5

Diagnosis: DISORDERS OF AMINO-ACID TRANSPORT AND METABOLISM (NON PKU)
Treatment: MEDICAL THERAPY
ICD-9: 270.0,270.2-270.9
CPT: 90000-99999
Line: 237 Category: 5

Diagnosis: PNEUMOCYSTIS CARINII PNEUMONIA
Treatment: MEDICAL THERAPY
ICD-9: 136.3
CPT: 90000-99999
Line: 238 Category: 5

Diagnosis: NON-HODGKIN'S LYMPHOMAS
Treatment: CHEMOTHERAPY, RADIATION THERAPY
ICD-9: 200,202.0-.2,202.8-.9
CPT: 11402,19340,20550,27125,38510,49080,38100,38510-25,38720,90000-99999
Line: 239 Category: 5

Diagnosis: CANCER OF STOMACH, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 151,230.2,235.2
CPT: 31300,31540-1,32100,38542,39200,42415,45170,45333,45385,46917,43120,43620-38,44100-30,44140-47,44625,45111,45550,46938,49000,60540,90000-99999
Line: 240 Category: 5

Diagnosis: DISORDERS OF THYROCALCITONIN SECRETION
Treatment: THYROIDECTOMY
ICD-9: 246.0
CPT: 60240
Line: 241 Category: 5

Diagnosis: AORTIC PULMONARY FISTULA
Treatment: REPAIR SINUS OF VALSALVA
ICD-9: 417.0
CPT: 33702-33710
Line: 242 Category: 5

Diagnosis: POLYARTERITIS NODOSA AND ALLIED CONDITIONS
Treatment: MEDICAL THERAPY
ICD-9: 446.0,446.4,446.6-.7
CPT: 90000-99999
Line: 243 Category: 5

Diagnosis: MYELOID, MONOCYTIC, ACUTE LYMPHOCYTIC AND OTHER SPECIFIED LEUKEMIAS
Treatment: BONE MARROW TRANSPLANT (5-6 LOCI MATCH)
ICD-9: 204.0,205.1-.9,206.1-.9,207.1-.8
CPT: 38230-41
Line: 244 Category: 5

Diagnosis: CANCER OF COLON, RECTUM, SMALL INTESTINE AND ANUS, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 152-154,197.5,230.3-.4,235.5
CPT: 31300,31540-1,32100,39200,42415,45333,46917,11042,32020,32420,32900,37799,43630,44140-50,44345,44620-25,45110-12,45180,45360,45385,45550,49000,49999,50230,50810,60540,68760,90000-99999
Line: 245 Category: 5

Diagnosis: CARDIOMYOPATHY, HYPERTROPHIC MUSCLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 425
CPT: 21633,32100,33010,33245,33516,33999,43030,43130-36,90000-99999
Line: 246 Category: 5

Diagnosis: PERNICIOUS ANEMIA
Treatment: MEDICAL THERAPY
ICD-9: 281
CPT: 90000-99999
Line: 247 Category: 5

Diagnosis: CYSTIC FIBROSIS
Treatment: MEDICAL THERAPY
ICD-9: 277.0
CPT: 90000-99999
Line: 248 Category: 5

Diagnosis: AGRANULOCYTOSIS
Treatment: BONE MARROW TRANSPLANTATION (5-6 LOCI MATCH)
ICD-9: 288.0
CPT: 38240
Line: 249 Category: 5

Diagnosis: ATRIAL SEPTAL DEFECT, SECUNDUM
Treatment: REPAIR SEPTAL DEFECT
ICD-9: 745.5
CPT: 33640-33643
Line: 250 Category: 5

Diagnosis: ATRIAL SEPTAL DEFECT, PRIMUM
Treatment: REPAIR SEPTAL DEFECT
ICD-9: 745.61
CPT: 33640
Line: 251 Category: 5

Diagnosis: STROKE
Treatment: MEDICAL THERAPY
ICD-9: 434,436
CPT: 90000-99999
Line: 252 Category: 3

Diagnosis: GANGRENE; ATHEROSCLEROSIS OF ARTERIES OF EXTREMITIES, DIABETES MELLITUS W/PERIPHERAL CIRCULATORY DISORDER, CHRONIC ULCER OF SKIN, GAS GANGRENE, OTHER PERIPHERAL VASCULAR DISEASE
Treatment: AMPUTATION
ICD-9: 785.4,440.2,250.7,707.0,040.0,443.0
CPT: 11050-1,28800-25,27880-89,27590-98,27290-95,26910-52,25900-31,24900-40,23900-21,23930,25020-28,26025-30,26990-91,27301,27305,27600-03,28001-03
Line: 253 Category: 5

Diagnosis: BUDD-CHIARI SYNDROME, AND OTHER VENOUS EMBOLISM AND THROMBOSIS
Treatment: THROMBECTOMY/LIGATION
ICD-9: 453
CPT: 34101,37140,37160,37500,34401
Line: 254 Category: 5

Diagnosis: OPPORTUNISTIC INFECTIONS IN IMMUNOCOMPROMISED HOSTS
Treatment: MEDICAL THERAPY
ICD-9: 003.9,007.2,007.7,031.9,039,042.0-.2,042.9,043.0-.2,043.9,047.9,053-054,078.5,110,111.1,112.0,115,117.5,118,130,136.3,173,285.9,287.5,298.9,323.9,336.9,357
CPT: 90000-99999
Line: 255 Category: 5

$92.10 Per Capita Cost Per Month

Diagnosis: VENTRICULAR SEPTAL DEFECT
Treatment: CLOSURE
ICD-9: 745.4,745.7
CPT: 33681-33688
Line: 256 Category: 5

Diagnosis: CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 173,198.2
CPT: 10040-61,11000-51,11400-46,11600-46,12011,12031-2,13100-52,14000-60,14300,15240-60,15700,17000-999,19200-29,19272,21555-7,21632,21925-35,23075-7,24075-7,25075-7,26115-7,27047-9,27075-9,27327-9,27615-9,28043-6,38500-780,51575-95,54135,55842-45,90000-99999
Line: 257 Category: 5

Diagnosis: CANCER OF PROSTATE GLAND, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 185,233.4,236.5
CPT: 11442-4,11623,11960-70,15720,17000-1,19120,38745,45355,52240,56515,57510,58200-10,58960,38564,38780,51700,52234,52281,52340,52601,52640,53600-1,54530,55000,55810-45,55899,90000-99999
Line: 258 Category: 5

Diagnosis: HEART FAILURE
Treatment: MEDICAL THERAPY
ICD-9: 428
CPT: 90000-99999
Line: 259 Category: 5

Diagnosis: APLASTIC ANEMIAS DUE TO DISEASE OR TREATMENT
Treatment: MEDICAL THERAPY
ICD-9: 284.8
CPT: 90000-99999
Line: 260 Category: 5

Diagnosis: ULCERATION OF INTESTINE
Treatment: COLECTOMY, ENTEROSTOMY
ICD-9: 569.82
CPT: 44150-60,44300-16,45385
Line: 261 Category: 5

Diagnosis: CANCER OF RETROPERITONEUM, PERITONEUM, OMENTUM & MESENTERY, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 158,197.6,197.8,235.5
CPT: 31300,31540-1,32100,39200,42415,45333,46917,21044-45,30117-18,30500,32900,39010,40810-16,41116,41135,41150-55,42104-20,42842-45,42880,49081,90000-99999
Line: 262 Category: 5

Diagnosis: EBSTEIN'S ANOMALY
Treatment: REPAIR SEPTAL DEFECT
ICD-9: 746.2
CPT: 33640-33647
Line: 263 Category: 5

Diagnosis: DISEASES OF WHITE BLOOD CELLS
Treatment: MEDICAL THERAPY
ICD-9: 288.1-.9
CPT: 90000-99999
Line: 264 Category: 5

Diagnosis: CANCER OF ORAL CAVITY, PHARYNX, NOSE AND LARYNX, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 140-149,160-161,231.0,235.0-.1,235.6
CPT: 11050,11420,11440-2,11601,13132,13151,17000-2,17100,17201,27090,31300,31540-1,32100,32480,39200,40525-30,40899,41130,41110-16,41155,42415,42826,43200,45333,46917,67961,90000-99999
Line: 265 Category: 5

Diagnosis: BENIGN NEOPLASM OF ISLETS OF LANGERHANS
Treatment: EXCISION OF TUMOR
ICD-9: 211.7
CPT: 60699
Line: 266 Category: 5

Diagnosis: PREMALIGNANT LESIONS AND CARCINOMA IN SITU OF SKIN
Treatment: DESTRUCT/EXCISION/MEDICAL THERAPY
ICD-9: 232,702
CPT: 10000,10040,11000,11400-46,13121,13131-2,14040-060,14300,17000-17200,17304,17340,11600-11646,19350,26116,30117,38745,58120,67405-13,67450,69100,69110-20,69300,90000-99999
Line: 267 Category: 5

Diagnosis: ADRENAL OR CUTANEOUS HEMORRHAGE OF FETUS OR NEONATE
Treatment: MEDICAL THERAPY
ICD-9: 772.5-.9
CPT: 90000-99999
Line: 268 Category: 2

Diagnosis: SIALOADENITIS, ABSCESS, FISTULA OF SALIVARY GLANDS
Treatment: SURGERY
ICD-9: 527.2-.4
CPT: 42305,42325,42330,42340,42408,42410,42440-42507,42509,42600,42665,40810-40816,42650,42655
Line: 269 Category: 5

Diagnosis: LIPIDOSES AND OTHER DISORDERS OF METABOLISM
Treatment: MEDICAL THERAPY
ICD-9: 272,277.1,277.5,277.9,330.1
CPT: 90000-99999
Line: 270 Category: 5

Diagnosis: LEUKOPLAKIA OF ORAL MUCOSA, INCLUDING TONGUE
Treatment: INCISION/EXCISION TONGUE, BIOPSY
ICD-9: 528.6
CPT: 41000-41599
Line: 271 Category: 5

Diagnosis: MALARIA AND RELAPSING FEVER
Treatment: MEDICAL THERAPY
ICD-9: 084,087
CPT: 90000-99999
Line: 272 Category: 1

Diagnosis: REGIONAL ENTERITIS, IDIOPATHIC PROCTOCOLITIS
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 555,556
CPT: 90000-99999,49000,44110,44140-60,44345,45112,44625,44650
Line: 273 Category: 5

Diagnosis: CONGENITAL PULMONARY VALVE STENOSIS
Treatment: PULMONARY VALVE REPAIR
ICD-9: 746.02
CPT: 33470-33471
Line: 274 Category: 2

Diagnosis: URETERAL FISTULA (INTESTINAL)
Treatment: NEPHROSTOMY
ICD-9: 593.82
CPT: 50951-50980,50040-50045, 50395-50398,50686-50688,50930
Line: 275 Category: 5

Diagnosis: DISORDERS OF ARTERIES, VISCERAL
Treatment: BYPASS GRAFT
ICD-9: 447.0,447.2-.9
CPT: 35501-15,35526-31,35536-51,35560-63,35601-16,35626-46,35663
Line: 276 Category: 5

Diagnosis: DISEASES OF ENDOCARDIUM
Treatment: MEDICAL THERAPY
ICD-9: 424
CPT: 90000-99999
Line: 277 Category: 5

Diagnosis: CHRONIC LEUKEMIAS
Treatment: CHEMOTHERAPY, RADIATION THERAPY
ICD-9: 202.4,203.1,204.1-.9,205.1-.9,206.1-.9,207.1-.8,208.1-.9
CPT: 11402,11646,22899,36825,37799,38100,38308,38520-25,38760,38999,43832,45360,58150,58720,58805,59840,60500,90000-99999
Line: 278 Category: 5

Diagnosis: CYSTICERCOSIS, OTHER CESTODE INFECTION, TRICHINOSIS
Treatment: MEDICAL THERAPY
ICD-9: 123.1-.9,124
CPT: 90000-99999
Line: 279 Category: 5

Diagnosis: LEPTOSPIROSIS
Treatment: MEDICAL THERAPY
ICD-9: 100
CPT: 90000-99999
Line: 280 Category: 1

Diagnosis: ENCEPHALOCELE; CONGENITAL HYDROCEPHALUS
Treatment: SHUNT
ICD-9: 742.0,742.3
CPT: 62180-62258
Line: 281 Category: 2

Diagnosis: ANAL AND RECTAL POLYP
Treatment: EXCISION OF POLYP
ICD-9: 569.0
CPT: 45310,45333,45170
Line: 282 Category: 5

Diagnosis: BENIGN NEOPLASMS OF DIGESTIVE SYSTEM
Treatment: SURGICAL TREATMENT
ICD-9: 211.0-.6,211.8-.9
CPT: 11400-3,17000-2,43202,43251,43450,43600,44100-20,44140-45,44152,44369,44392,45310,45333,45355-85,45383-5,46500,46610
Line: 283 Category: 11

Diagnosis: DIABETES INSIPIDUS
Treatment: MEDICAL THERAPY
ICD-9: 253.5
CPT: 90000-99999
Line: 284 Category: 5

Diagnosis: DISORDERS OF PLASMA PROTEIN METABOLISM
Treatment: MEDICAL THERAPY
ICD-9: 273
CPT: 90000-99999
Line: 285 Category: 5

Diagnosis: CUSHING'S SYNDROME; HYPERALDOSTERONISM, OTHER CORTICOADRENAL OVERACTIVITY, MEDULLOADRENAL HYPERFUNCTION
Treatment: MEDICAL THERAPY/ADRENALECTOMY
ICD-9: 255.0,255.1,255.3,255.6
CPT: 90000-99999,60540,61546
Line: 286 Category: 5

Diagnosis: DISORDERS OF PANCREATIC ENDOCRINE SECRETION
Treatment: MEDICAL THERAPY
ICD-9: 251.4-.9
CPT: 90000-99999,48155
Line: 287 Category: 13

Diagnosis: GUILLAIN-BARRE SYNDROME
Treatment: MEDICAL THERAPY
ICD-9: 357.0
CPT: 90000-99999
Line: 288 Category: 3

Diagnosis: LEUKOPLAKIA OF ORAL MUCOSA, INCLUDING TONGUE
Treatment: MEDICAL THERAPY
ICD-9: 528.6
CPT: 90000-99999
Line: 289 Category: 5

Diagnosis: HEREDITARY ANGIONEUROTIC EDEMA
Treatment: MEDICAL THERAPY
ICD-9: 277.6
CPT: 90000-99999
Line: 290 Category: 5

Diagnosis: METASTATIC INFECTIONS WITH LOCALIZED SITES
Treatment: MEDICAL THERAPY
ICD-9: 003.2,006.3-.9,014-018,022.1
CPT: 90000-99999
Line: 291 Category: 5

Diagnosis: CHRONIC RESPIRATORY DISEASE ARISING IN THE NEONATAL PERIOD
Treatment: MEDICAL THERAPY
ICD-9: 770.7
CPT: 90000-99999
Line: 292 Category: 5

Diagnosis: NON LIFE-THREATENING ARRHYTHMIAS
Treatment: MEDICAL THERAPY, PACEMAKER
ICD-9: 426,427.3,427.6,996.01
CPT: 33201,33210,33212,33999,90000-99999
Line: 293 Category: 5

Diagnosis: LYMPHOID LEUKEMIA
Treatment: BONE MARROW TRANSPLANT (5-6 LOCI MATCH)
ICD-9: 204.1-.9
CPT: 38240
Line: 294 Category: 5

Diagnosis: SYSTEMIC LUPUS ERYTHEMATOSUS, OTHER DIFFUSE DISEASES OF CONNECTIVE TISSUE
Treatment: MEDICAL THERAPY
ICD-9: 710.0,710.8,710.9
CPT: 90000-99999
Line: 295 Category: 5

Diagnosis: HYPOPLASIA AND DYSPLASIA OF LUNG
Treatment: MEDICAL THERAPY
ICD-9: 748.5
CPT: 90000-99999
Line: 296 Category: 2

Diagnosis: PORTAL VEIN THROMBOSIS
Treatment: SHUNT
ICD-9: 452
CPT: 37140,49425
Line: 297 Category: 5

Diagnosis: TETANUS
Treatment: MEDICAL THERAPY
ICD-9: 037
CPT: 90000-99999
Line: 298 Category: 1

Diagnosis: VESICOURETERAL REFLUX
Treatment: MEDICAL THERAPY, REPLANTATION
ICD-9: 593.7
CPT: 90000-99999
Line: 299 Category: 5

Diagnosis: CONGENITAL HYDRONEPHROSIS
Treatment: NEPHRECTOMY/REPAIR
ICD-9: 753.2
CPT: 50230,50400-504
Line: 300 Category: 5

Diagnosis: DISORDERS OF PARATHYROID GLAND; BENIGN NEOPLASM OF PARATHYROID GLAND
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 227.1,252
CPT: 60500-05,90000-99999
Line: 301 Category: 5

Diagnosis: PULMONARY FIBROSIS
Treatment: MEDICAL THERAPY
ICD-9: 515-517
CPT: 90000-99999
Line: 302 Category: 5

Diagnosis: INTRACEREBRAL HEMORRHAGE
Treatment: MEDICAL THERAPY
ICD-9: 431
CPT: 90000-99999
Line: 303 Category: 3

Diagnosis: COARCTATION OF THE AORTA
Treatment: BALLOON DILATION - VALVE REPLACEMENT
ICD-9: 747.10
CPT: 33405-33417
Line: 304 Category: 5

Diagnosis: LEPROSY
Treatment: MEDICAL THERAPY
ICD-9: 030
CPT: 90000-99999
Line: 305 Category: 5

Diagnosis: CHRONIC OBSTRUCTIVE PULMONARY DISEASE
Treatment: MEDICAL THERAPY
ICD-9: 492,496
CPT: 90000-99999
Line: 306 Category: 5

Diagnosis: CONSTITUTIONAL APLASTIC ANEMIAS
Treatment: BONE MARROW TRANSPLANT (5-6 LOCI MATCH)
ICD-9: 284.0
CPT: 38240
Line: 307 Category: 5

Diagnosis: ACUTE LYMPHOCYTIC LEUKEMIAS (ADULT) AND MULTIPLE MYELOMA
Treatment: CHEMOTHERAPY, RADIATION THERAPY
ICD-9: 204.0,203.0,203.8
CPT: 45360,90000-99999
Line: 308 Category: 5

Diagnosis: DISORDERS RELATING TO LONG GESTATION AND HIGH BIRTHWEIGHT
Treatment: MEDICAL THERAPY
ICD-9: 766
CPT: 90000-99999
Line: 309 Category: 2

Diagnosis: NEPHROTIC SYNDROME AND OTHER CHRONIC RENAL FAILURE
Treatment: MEDICAL THERAPY INCLUDING DIALYSIS
ICD-9: 581.0-581.2,581.8-.9,582,585,587-589
CPT: 90000-99999
Line: 310 Category: 5

$98.51 Per Capita Cost Per Month

Diagnosis: ACUTE NON-LYMPHOCYTIC LEUKEMIAS
Treatment: BONE MARROW TRANSPLANT (5-6 LOCI MATCH)
ICD-9: 205.0,206.0,207.0,208.0
CPT: 38230-41
Line: 311 Category: 5

Diagnosis: END STAGE RENAL DISEASE
Treatment: RENAL TRANSPLANT
ICD-9: 583.8-.9
CPT: 50360
Line: 312 Category: 5

Diagnosis: OTHER ANEURYSM OF ARTERY, PERIPHERAL
Treatment: SURGICAL TREATMENT
ICD-9: 442.0,442.3,442.9
CPT: 24900-31,25900-31,26910-52,27080,27590-98,27880-89,28800-25,37609,64510-20,64802-18,35001-03,35011,35013-21,35141-62
Line: 313 Category: 5

Diagnosis: DISORDERS MINERAL METABOLISM
Treatment: MEDICAL THERAPY
ICD-9: 275
CPT: 90000-99999
Line: 314 Category: 5

Diagnosis: NEONATAL CONJUNCTIVITIS, DACRYOCYSTITIS AND CANDIDA INFECTION
Treatment: MEDICAL THERAPY
ICD-9: 771.6-.7
CPT: 90000-99999
Line: 315 Category: 2

Diagnosis: ESOPHAGEAL VARICES
Treatment: MEDICAL THERAPY/SHUNT/SCLEROTHERAPY
ICD-9: 456.0-.2
CPT: 90000-99999,37145,37160,37181,38100,43400
Line: 316 Category: 5

Diagnosis: CHRONIC PANCREATITIS
Treatment: MEDICAL THERAPY
ICD-9: 577.1
CPT: 90000-99999
Line: 317 Category: 5

Diagnosis: HYPERPLASIA OF PROSTATE
Treatment: TRANSURETHRAL RESECTION, MEDICAL THERAPY
ICD-9: 600
CPT: 52601,55040,55821,90000-99999
Line: 318 Category: 11

Diagnosis: END STAGE RENAL DISEASE
Treatment: MEDICAL THERAPY INCLUDING DIALYSIS
ICD-9: 250.4,583.8-.9
CPT: 11060,90000-99999
Line: 319 Category: 5

Diagnosis: GIANT CELL ARTERITIS, KAWASAKI DISEASE, HYPERSENSITIVITY ANGIITIS
Treatment: MEDICAL THERAPY
ICD-9: 446.1-.2,446.5
CPT: 90000-99999
Line: 320 Category: 3

Diagnosis: DERMATOMYOSITIS, POLYMYOSITIS
Treatment: MEDICAL THERAPY
ICD-9: 710.3,710.4
CPT: 90000-99999
Line: 321 Category: 5

Diagnosis: SYSTEMIC SCLEROSIS
Treatment: MEDICAL THERAPY
ICD-9: 710.1
CPT: 90000-99999
Line: 322 Category: 5

Diagnosis: UNWANTED PREGNANCY (Note: This line item is not priced as part of the list.)
Treatment: ABORTION
ICD-9: 635-639,779.6
CPT: 59105-06,59840-52
Line: 323 Category: 6

Diagnosis: COMMON VENTRICLE
Treatment: TOTAL REPAIR TETRALOGY
ICD-9: 745.3
CPT: 33692-33696
Line: 324 Category: 5

Diagnosis: HERPES ZOSTER & HERPES SIMPLEX W/OPHTHALMIC COMPLICATIONS
Treatment: MEDICAL THERAPY
ICD-9: 053.2,054.4
CPT: 90000-99999
Line: 325 Category: 10

Diagnosis: HYPHEMA
Treatment: REMOVAL OF BLOOD CLOT
ICD-9: 364.41
CPT: 65815,65930
Line: 326 Category: 10

Diagnosis: PENETRATING WOUND OF ORBIT
Treatment: SURGICAL TREATMENT
ICD-9: 870.3,870.8,870.9
CPT: 12011-3,12051-2,13132,13150-2,67400-50
Line: 327 Category: 12

Diagnosis: PURULENT ENDOPHTHALMITIS
Treatment: VITRECTOMY
ICD-9: 360.0
CPT: 67005-67036
Line: 328 Category: 12

Diagnosis: PRIMARY AND OTHER ANGLE-CLOSURE GLAUCOMA
Treatment: IRIDECTOMY, LASER SURGERY
ICD-9: 365.20,365.22
CPT: 66761,66505,66625-66630
Line: 329 Category: 10

Diagnosis: GLAUCOMA ASSOCIATED WITH DISORDERS OF THE LENS
Treatment: EXTRACTION OF CATARACT
ICD-9: 365.5,360.19
CPT: 66920-66984
Line: 330 Category: 11

Diagnosis: PRIMARY AND OPEN ANGLE GLAUCOMA
Treatment: TRABECULECTOMY
ICD-9: 365.10-365.11
CPT: 66170
Line: 331 Category: 11

Diagnosis: GLAUCOMA: BORDERLINE, OPEN-ANGLE, CORTICOSTEROID-INDUCED, ASSOC. W/CONGENITAL ANOMALIES, DYSTROPHIES & SYSTEMIC SYNDROMES, ASSOC. W/DISORDER OF THE LENS, ASSOC. W/OTHER OCULAR DISORDERS, OTHER & UNSPECIFIED
Treatment: MEDICAL THERAPY
ICD-9: 365.0-365.1,365.3-365.9
CPT: 90000-99999
Line: 332 Category: 13

Diagnosis: DEGENERATION OF MACULA AND POSTERIOR POLE
Treatment: VITRECTOMY, LASER SURGERY
ICD-9: 362.5
CPT: 67038,67210
Line: 333 Category: 11

Diagnosis: VITREOUS HEMORRHAGE
Treatment: VITRECTOMY
ICD-9: 379.23
CPT: 67036
Line: 334 Category: 12

Diagnosis: PRIMARY AND OTHER OPEN-ANGLE GLAUCOMA
Treatment: LASER TRABECULOPLASTY
ICD-9: 365.10-365.11
CPT: 65855
Line: 335 Category: 11

Diagnosis: PRIMARY AND OTHER OPEN-ANGLE GLAUCOMA
Treatment: CYCLOCRYOTHERAPY
ICD-9: 365.10-365.11
CPT: 66720-66721
Line: 336 Category: 11

Diagnosis: CATARACT
Treatment: EXTRACTION OF CATARACT
ICD-9: 366.0-.3
CPT: 66920-84
Line: 337 Category: 11

Diagnosis: RETINAL DETACHMENT WITH RETINAL DEFECT
Treatment: VITRECTOMY
ICD-9: 361.0
CPT: 67036-67112
Line: 338 Category: 12

Diagnosis: OPEN WOUND OF EYEBALL
Treatment: CORNEAL LACERATION REPAIR
ICD-9: 871
CPT: 65280-65285
Line: 339 Category: 12

Diagnosis: CHRONIC INFLAMMATORY DISORDER OF ORBIT
Treatment: MEDICAL THERAPY
ICD-9: 376.1
CPT: 90000-99999
Line: 340 Category: 13

Diagnosis: AFTER CATARACT
Treatment: DISCISSION, LENS CAPSULE
ICD-9: 366.5
CPT: 66800-66821
Line: 341 Category: 11

Diagnosis: ACUTE, SUBACUTE, CHRONIC AND OTHER CERTAIN TYPES OF IRIDOCYCLITIS
Treatment: MEDICAL THERAPY
ICD-9: 364.0-.3
CPT: 90000-99999
Line: 342 Category: 13

Diagnosis: DIABETIC AND OTHER RETINOPATHY
Treatment: LASER SURGERY
ICD-9: 250.5,362.0-362.2
CPT: 67210,67227-8
Line: 343 Category: 11

Diagnosis: RETROLENTAL FIBROPLASIA
Treatment: CRYOSURGERY
ICD-9: 362.21
CPT: 67101-67122
Line: 344 Category: 11

Diagnosis: APHAKIA AND OTHER DISORDERS OF LENS
Treatment: INTRAOCULAR LENS
ICD-9: 379.3
CPT: 66985
Line: 345 Category: 11

Diagnosis: EXOTROPIA
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 378
CPT: 67311-67335,90000-99999
Line: 346 Category: 11

Diagnosis: FOREIGN BODY IN CONJUNCTIVAL SAC
Treatment: REMOVAL CONJUNCTIVAL FOREIGN BODY
ICD-9: 930.1
CPT: 65205-22
Line: 347 Category: 10

Diagnosis: BENIGN NEOPLASM OF PITUITARY GLAND
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 227.3
CPT: 11401,14000,17000,17102,17200,52281,53670,60225,61070,61305,61548,61546-48,61712,90000-99999
Line: 348 Category: 5

Diagnosis: TRAUMATIC AMPUTATION OF THUMB OR OTHER FINGER (COMPLETE)(PARTIAL) W/ & W/O COMPLICATION
Treatment: REPLANTATION/AMPUTATE
ICD-9: 885-886
CPT: 11000-1,11042,20812-28,26350-6,26410-8,26910-52,64450,64830-2
Line: 349 Category: 12

Diagnosis: OPEN WOUNDS
Treatment: REPAIR
ICD-9: 872.0-.1,872.62-.69,872.7-.9,878.4-
.9,880.00,880.10,880.13,880.20,880.23,881.00,881.02,881.10,881.12,881.20,881.22,883,884.2,890-
891,892.2,893,894.2
CPT: 11043,12001-13300,15000-15510,15540-15550,15580-15625,15650-15720,15710-15770,24999,25260-72,56800,64856-
7,69440,69666,69667
Line: 350 Category: 10

Diagnosis: ABSCESSES AND CYSTS OF BARTHOLIN'S GLAND AND VULVA
Treatment: INCISION AND DRAINAGE, MEDICAL THERAPY
ICD-9: 616.2-.9
CPT: 90000-99999,56400,56420,56440,56501,56600
Line: 351 Category: 10

Diagnosis: PILONIDAL CYST WITH ABSCESS
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 685.0
CPT: 10080-81,11770-72,90000-99999
Line: 352 Category: 14

Diagnosis: ACUTE THYROIDITIS
Treatment: MEDICAL THERAPY
ICD-9: 245.0
CPT: 90000-99999
Line: 353 Category: 10

Diagnosis: ACUTE OTITIS MEDIA
Treatment: MEDICAL THERAPY
ICD-9: 381.0-.4,381.8-.9,382.0,382.4,382.9
CPT: 90000-99999
Line: 354 Category: 10

Diagnosis: CHRONIC OTITIS MEDIA
Treatment: PE TUBES/T & A/TYMPANOPLASTY
ICD-9: 381.5-.7,382.1-.3
CPT: 69400-69410,42820,69631-69633
Line: 355 Category: 11

Diagnosis: CHOLESTEATOMA
Treatment: SURGICAL TREATMENT
ICD-9: 385.30
CPT: 69501-5,69511,69601-5,69610,69620,60131-7,69641-6,69670
Line: 356 Category: 13

Diagnosis: ACUTE SINUSITIS
Treatment: MEDICAL THERAPY
ICD-9: 461
CPT: 90000-99999
Line: 357 Category: 1

Diagnosis: ACUTE CONJUNCTIVITIS
Treatment: MEDICAL THERAPY
ICD-9: 372.0,077
CPT: 90000-99999
Line: 358 Category: 14

Diagnosis: SPINA BIFIDA WITHOUT HYDROCEPHALUS
Treatment: MEDICAL THERAPY
ICD-9: 741.9
CPT: 90000-99999
Line: 359 Category: 2

Diagnosis: EDEMA AND OTHER CONDITIONS INVOLVING THE INTEGUMENT OF THE FETUS AND NEWBORN
Treatment: MEDICAL THERAPY
ICD-9: 778.5-.9
CPT: 90000-99999
Line: 360 Category: 2

Diagnosis: CONGENITAL RUBELLA AND OTHER CONGENITAL INFECTIOUS DISEASES
Treatment: MEDICAL THERAPY
ICD-9: 771.0-.2
CPT: 90000-99999
Line: 361 Category: 2

Diagnosis: FEEDING PROBLEMS IN NEWBORN
Treatment: MEDICAL THERAPY
ICD-9: 779.3
CPT: 90000-99999
Line: 362 Category: 2

Diagnosis: DYSTONIA (UNCONTROLLABLE)
Treatment: MEDICAL THERAPY
ICD-9: 333
CPT: 90000-99999
Line: 363 Category: 5

Diagnosis: MULTIPLE VALVULAR DISEASE
Treatment: SURGICAL TREATMENT
ICD-9: 396-397
CPT: 33450-74,33480-92
Line: 364 Category: 5

Diagnosis: BILIARY ATRESIA
Treatment: LIVER TRANSPLANT
ICD-9: 751.61
CPT: 47135
Line: 365 Category: 5
$102.26 Per Capita Cost Per Month

Diagnosis: CIRRHOSIS OF LIVER OR BILIARY TRACT WITHOUT MENTION OF ALCOHOL
Treatment: LIVER TRANSPLANT
ICD-9: 571.5-.6
CPT: 47135
Line: 366 Category: 5

Diagnosis: CHRONIC PULMONARY HEART DISEASE, OTHER DISEASES OF PULMONARY CIRCULATION, ACUTE & SUBACUTE ENDOCARDITIS, ACUTE MYOCARDITIS, CARDIOMYOPATHY, OTHER CONG. ANOMALIES OF HEART AND CIRC. SYSTEM
Treatment: CARDIAC TRANSPLANT
ICD-9: 416-417,421-422,425,746-747
CPT: 33945
Line: 367 Category: 5

Diagnosis: ACUTE AND SUBACUTE NECROSIS OF LIVER
Treatment: LIVER TRANSPLANT
ICD-9: 570
CPT: 47135
Line: 368 Category: 3

Diagnosis: DIVERTICULITIS OF COLON
Treatment: COLON RESECTION
ICD-9: 562.1
CPT: 44005,44140,44141,44143,44144,44145,44147,44320,44620-25,49000
Line: 369 Category: 3

Diagnosis: CYST AND PSEUDOCYST OF PANCREAS
Treatment: DRAINAGE OF PANCREATIC CYST
ICD-9: 577.2
CPT: 47480,47610,48100-45,48151,48180,48500-40
Line: 370 Category: 5

Diagnosis: CANCER OF BRAIN AND NERVOUS SYSTEM, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 191-192,198.3-.4,237.5-.9,239.6
CPT: 10060,61310,61516,61712,62141,62223,61516,61712,61751,61770,62223,63241,63275-90,64774-818,90000-99999
Line: 371 Category: 5

Diagnosis: ATHEROSCLEROSIS, VISCERAL
Treatment: SURGICAL TREATMENT
ICD-9: 440.0-.1
CPT: 35501-15,35526-31,35536-51,35560-63,35601-16,35626-46,35663
Line: 372 Category: 5

Diagnosis: HYPERSOMNIA W/SLEEP APNEA
Treatment: MEDICAL THERAPY, TRACHEOTOMY
ICD-9: 780.53,347
CPT: 90000-99999,31600-10
Line: 373 Category: 5

Diagnosis: DISLOCATION KNEE & HIP, CLOSED
Treatment: RELOCATION
ICD-9: 835.0,836.3,836.5,718.35-.36
CPT: 27250-55,27550-27557
Line: 374 Category: 12

Diagnosis: DISLOCATION OF ELBOW, HAND, ANKLE, FOOT, CLAVICLE AND SHOULDER, CLOSED
Treatment: RELOCATION
ICD-9: 831.0,832.0,833.0,834.0,837.0,838.0,718.30-.34,718.36-.39
CPT: 23520-52,23650-80,24600-24635,25660-95,26641-715,27840-48,
Line: 375 Category: 12

Diagnosis: TRACHOMA
Treatment: MEDICAL THERAPY
ICD-9: 076
CPT: 90000-99999
Line: 376 Category: 10

Diagnosis: CLEFT LIP, CONGENITAL FISTULA OF LIP
Treatment: LIP EXCISION AND REPAIR
ICD-9: 749.1,750.25
CPT: 40650-720
Line: 377 Category: 11

Diagnosis: CLEFT PALATE
Treatment: REPAIR & PALATOPLASTY
ICD-9: 749.0
CPT: 42200-26,42235-81
Line: 378 Category: 11

Diagnosis: CLEFT PALATE WITH CLEFT LIP
Treatment: EXCISION & REPAIR VESTIBULE OF MOUTH
ICD-9: 749.2
CPT: 40800-40899
Line: 379 Category: 11

Diagnosis: CLOSED FRACTURE OF EPIPHYSIS OF LOWER EXTREMITIES
Treatment: REDUCTION
ICD-9: 820.01,821.22
CPT: 27516-27519
Line: 380 Category: 12

Diagnosis: FRACTURE OF SHAFT OF BONE, CLOSED
Treatment: REDUCTION
ICD-9: 812.2,813.2,813.8,818.0,821.0,823.2,823.8
CPT: 24500-15,25500-25575,25610-25620,27409,27500-06,27664,27750-58,27800-06
Line: 381 Category: 10

Diagnosis: PARAPLEGIA, QUADRIPLEGIA
Treatment: MEDICAL THERAPY AND REHABILITATION
ICD-9: 343,344.0-.1
CPT: 90000-99999
Line: 382 Category: 13

Diagnosis: PARKINSON'S DISEASE
Treatment: MEDICAL THERAPY
ICD-9: 332
CPT: 90000-99999
Line: 383 Category: 13

Diagnosis: MULTIPLE SCLEROSIS AND OTHER DEMYELINATING DISEASES OF CENTRAL NERVOUS SYSTEM
Treatment: MEDICAL THERAPY AND REHABILITATION
ICD-9: 340-341,334
CPT: 90000-99999
Line: 384 Category: 5

Diagnosis: CEREBRAL PALSY
Treatment: MEDICAL THERAPY
ICD-9: 343.0-.3,.9,344.1,741.9,335.21,335.11,335.0
CPT: 90000-99999
Line: 385 Category: 13

Diagnosis: SUPERFICIAL INJURIES WITH INFECTION
Treatment: MEDICAL THERAPY
ICD-9: 910.1,.3,.5,.7,.9,911.1,.3,.5,.7,.9,912.1,.3,.5,.7,.9,913.1,.3,.5,.7,.9,914.1,.3,.5,.7,.9,915.1,.3,.5,
.7,.9,916.1,.3,.5,.7,.9,917.1,.3,.5,.7,.9,919.1,.3,.5,.7,.9
CPT: 12001-14,90000-99999
Line: 386 Category: 10

Diagnosis: LYME DISEASE
Treatment: MEDICAL THERAPY
ICD-9: 088
CPT: 90000-99999
Line: 387 Category: 13

Diagnosis: CHRONIC ULCER OF SKIN
Treatment: MEDICAL THERAPY
ICD-9: 707
CPT: 90000-99999,11000-44,15920-99
Line: 388 Category: 13

Diagnosis: CELLULITIS, NON-ORBITAL
Treatment: MEDICAL THERAPY
ICD-9: 527.3,566,597.0,607.2,608.4,611.0,616.0,681-682,686.8
CPT: 90000-99999
Line: 389 Category: 10

Diagnosis: ATOPIC DERMATITIS
Treatment: MEDICAL THERAPY
ICD-9: 691.8
CPT: 90000-99999,11100
Line: 390 Category: 13

Diagnosis: CONTACT DERMATITIS AND OTHER ECZEMA
Treatment: MEDICAL THERAPY
ICD-9: 692
CPT: 90000-99999,11900-11901
Line: 391 Category: 13

Diagnosis: ACNE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 695.3
CPT: 90000-99999,10040-61,11450-71,11900-11901,17100-05,17340
Line: 392 Category: 13

Diagnosis: PSORIASIS AND SIMILAR DISORDERS
Treatment: MEDICAL THERAPY
ICD-9: 696
CPT: 90000-99999,11900-11901
Line: 393 Category: 13

Diagnosis: ABSCESS OF BURSA OR TENDON
Treatment: INCISION AND DRAINAGE
ICD-9: 727.89
CPT: 27301,26990,26034,23930,23030,28001,27603
Line: 394 Category: 10

Diagnosis: ABSCESS OF PROSTATE
Treatment: TURP, DRAIN ABSCESS
ICD-9: 601.2
CPT: 52601
Line: 395 Category: 10

Diagnosis: INFECTIVE OTITIS EXTERNA
Treatment: MEDICAL THERAPY
ICD-9: 380.1-.2,054.73,112.82
CPT: 90000-99999
Line: 396 Category: 14

Diagnosis: CHRONIC OTITIS MEDIA
Treatment: MEDICAL THERAPY
ICD-9: 381.5-.7,382.1-.3
CPT: 90000-99999
Line: 397 Category: 13

Diagnosis: DENTAL SERVICES (EG. DENTAL CARIES, FRACTURED TOOTH)
Treatment: RESTORATIVE DENTAL SERVICE
ICD-9: 0
CPT: 01110-20,02110-61,02210,02330-35,02930-2,02951,02970-80,03410-50,04910,05983-5,07120-30,07220-50,07285-6,07430-1,07450-65,07530-50,07981,09210-40,09310,09410-40
Line: 398 Category: 10

Diagnosis: RHEUMATOID ARTHRITIS, OSTEOARTHRITIS, AND ASEPTIC NECROSIS OF BONE
Treatment: ARTHROPLASTY
ICD-9: 714.0,714.3,715.1-.3,715.9,733.4
CPT: 27437-27454,27457,27580 ,23470-23472,23800-23802,27284-27286,27122-27132,27700-27703,27870-27871,24360-24366,24800-24802,26516-26536
Line: 399 Category: 11

Diagnosis: RHEUMATOID ARTHRITIS AND OTHER INFLAMMATORY POLYARTHROPATHIES
Treatment: MEDICAL THERAPY
ICD-9: 714
CPT: 90000-99999
Line: 400 Category: 13

Diagnosis: GOUT
Treatment: MEDICAL THERAPY
ICD-9: 274
CPT: 90000-99999
Line: 401 Category: 13

Diagnosis: CRYSTAL ARTHROPATHIES
Treatment: MEDICAL THERAPY
ICD-9: 712
CPT: 90000-99999
Line: 402 Category: 13

Diagnosis: SYMPATHETIC UVEITIS AND DEGENERATIVE DISORDERS AND CONDITIONS
Treatment: ENUCLEATION
ICD-9: 360.11,360.2,360.4
CPT: 65105
Line: 403 Category: 12

Diagnosis: DISLOCATIONS OF NON-CERVICAL VERTEBRA, CLOSED
Treatment: REPAIR/RECONSTRUCTION
ICD-9: 839.2,839.4,839.6
CPT: 22315,22325-22327,22505,22590-22650,22840-22855
Line: 404 Category: 12

Diagnosis: LUMBAR SPINAL STENOSIS
Treatment: LAMINECTOMY/LAMINOTOMY
ICD-9: 344.6
CPT: 63005,63017,63031,63042,63047
Line: 405 Category: 11

Diagnosis: FISTULA INVOLVING FEMALE GENITAL TRACT
Treatment: CLOSURE OF FISTULA
ICD-9: 619
CPT: 57300,57310,57320,51900-51920,50930,46715,44660
Line: 406 Category: 11

Diagnosis: HYMEN AND VAGINAL SEPTUM
Treatment: HYMENECTOMY
ICD-9: 623.2-.3,752.40,752.42
CPT: 56700-20
Line: 407 Category: 11

Diagnosis: RECTAL PROLAPSE
Treatment: PARTIAL COLECTOMY
ICD-9: 569.1
CPT: 44140-44
Line: 408 Category: 11

Diagnosis: CONGENITAL ABSENCE OF VAGINA
Treatment: ARTIFICIAL VAGINA
ICD-9: 752.49
CPT: 57291-57292
Line: 409 Category: 11

Diagnosis: PLEURISY
Treatment: MEDICAL THERAPY
ICD-9: 511
CPT: 90000-99999,32000
Line: 410 Category: 10

Diagnosis: HYPOSPADIAS AND EPISPADIAS
Treatment: REPAIR
ICD-9: 752.6
CPT: 54300-440
Line: 411 Category: 11

Diagnosis: FRACTURE OF VERTEBRAL COLUMN WITH SPINAL CORD INJURY, SACRUM AND COCCYX
Treatment: LAMINECTOMY
ICD-9: 806.6-806.9
CPT: 61720-61793
Line: 412 Category: 10

Diagnosis: LOWER EXTREMITY: COMPARTMENT SYNDROME
Treatment: DECOMPRESSION
ICD-9: 958.8
CPT: 27600-02
Line: 413 Category: 3

Diagnosis: OCCLUSION AND STENOSIS OF PRECEREBRAL ARTERIES
Treatment: THROMBOENDARTERECTOMY
ICD-9: 433
CPT: 35301
Line: 414 Category: 11

Diagnosis: ATHEROSCLEROSIS, PERIPHERAL
Treatment: SURGICAL TREATMENT
ICD-9: 440.2-.9,444.2
CPT: 20605,27590,34101,34201,35081,35361,35381,35516-21,35533,35556-58,35565-87,35621,35650-61,35665-71,35721,37609,64510-20,64802-19
Line: 415 Category: 11

Diagnosis: DISPLACEMENT OF CERVICAL INTERVERTEBRAL DISC WITHOUT MYELOPATHY
Treatment: CERVICAL LAMINECTOMY, MEDICAL THERAPY
ICD-9: 722.0,722.2
CPT: 63250,63265,63270,63275,63280,63285,63001,63015,63020,63035-40,63045,63048,63075-76,63081-82,63300,63304,63170-72,63180-82,63194,63196,63198,90000-99999
Line: 416 Category: 11

Diagnosis: FRACTURE OF JOINT, CLOSED (EXCEPT HIP)
Treatment: REDUCTION
ICD-9: 810.0,811.0,812.0,.4,813.0,813.4,814.0,815.0,816.0,817.0,819.0,821.20-.21,821.23-.29,,822.0,823.0,824.0,.2,.4,.6,.8,825.0,.2,826.0,828.0
CPT: 23500-23515,23570-23630,24530-88,24650-52,25350,25440,25600-50,26600-15,26720-85,27330,27409,27424,27508-14,27520-40,27610,27760-62,27780-92,27808-23,27846-8,28400-530,28730,29874-9
Line: 417 Category: 12

Diagnosis: CALCULUS OF BLADDER OR KIDNEY
Treatment: OPEN RESECTION, PERCUTANEOUS NEPHROSTOLITHOTOMY, NEPHROLITHOTOMY, LITHOTRIPSY
ICD-9: 592.0,594.1
CPT: 50060-81,50130,50392-93,50700-16,50590,52317
Line: 418 Category: 11

Diagnosis: ANAL FISTULA
Treatment: FISTULECTOMY
ICD-9: 565.1
CPT: 46211,46270-85,46000-30
Line: 419 Category: 10

Diagnosis: RESIDUAL FOREIGN BODY IN SOFT TISSUE
Treatment: REMOVAL
ICD-9: 729.6
CPT: 28190,28192
Line: 420 Category: 10

Diagnosis: GLYCOGENOSIS
Treatment: MEDICAL THERAPY
ICD-9: 271.0
CPT: 90000-99999
Line: 421 Category: 5

Diagnosis: MALUNION & NONUNION OF FRACTURE
Treatment: SURGICAL TX
ICD-9: 733.8
CPT: 24410,24430-35,23840-85,25400-25440,27165-27170,27470-27472,27720-25,28320-22,24400
Line: 422 Category: 11

Diagnosis: OSTEOPOROSIS
Treatment: MEDICAL THERAPY
ICD-9: 733.0
CPT: 90000-99999
Line: 423 Category: 13

Diagnosis: OPHTHALMIC INJURY: LACRIMAL SYSTEM LACERATION
Treatment: CLOSURE
ICD-9: 870.2
CPT: 68760
Line: 424 Category: 17

Diagnosis: DISORDERS OF REFRACTION AND ACCOMMODATION
Treatment: MEDICAL THERAPY
ICD-9: 367
CPT: 90000-99999
Line: 425 Category: 13

Diagnosis: VINCENT'S DISEASE
Treatment: MEDICAL THERAPY
ICD-9: 101
CPT: 90000-99999
Line: 426 Category: 1

Diagnosis: URETHRITIS
Treatment: MEDICAL THERAPY
ICD-9: 597
CPT: 90000-99999
Line: 427 Category: 10

Diagnosis: TRICHOMONAL URETHRITIS, TRICHOMONAL PROSTATITIS
Treatment: MEDICAL THERAPY
ICD-9: 131.02,131.03,131.8,131.9
CPT: 90000-99999
Line: 428 Category: 10

Diagnosis: UTERINE LEIOMYOMA
Treatment: TOTAL HYSTERECTOMY OR MYOMECTOMY
ICD-9: 218-219
CPT: 11422,49581,51010,51840,57410,57511,57820,58120-80,58200,58260-5,58340,58400,58720,58740,58925,58940,58951,58980-95,59050,59820,64435,
Line: 429 Category: 11

Diagnosis: REDUCTION DEFORMITY OF LOWER LIMB
Treatment: EPIPHYSEAL,OSTEOPLASTY
ICD-9: 755.3
CPT: 27475-27485,27466-27468,27730-27742,27715
Line: 430 Category: 11

Diagnosis: MIGRAINE
Treatment: MEDICAL THERAPY
ICD-9: 346
CPT: 90000-99999
Line: 431 Category: 13

Diagnosis: ANAL FISSURE
Treatment: FISSURECTOMY
ICD-9: 565.0
CPT: 46200,46700,46940
Line: 432 Category: 10

Diagnosis: STRESS INCONTINENCE, FEMALE
Treatment: URETHROPEXY/PESSARY
ICD-9: 625.6
CPT: 51840-41,57160
Line: 433 Category: 11

Diagnosis: BODY INFESTATIONS (EG. LICE, SCABIES)
Treatment: MEDICAL THERAPY
ICD-9: 132-134
CPT: 90000-99999
Line: 434 Category: 14

Diagnosis: SIALOLITHIASIS, MUCOCELE, DISTURBANCE OF SALIVARY SECRETION, OTHER AND UNSPECIFIED DISEASES OF SALIVARY GLANDS
Treatment: SURGERY
ICD-9: 527.5-527.9
CPT: 42305,42325,42330,42340,42408,42410,42440-42507,42509,42600,42665,40810-40816,42650,42655
Line: 435 Category: 11

Diagnosis: ANOMALIES OF EXTERNAL EAR W/ IMPAIRMENT OF HEARING
Treatment: RECONSTRUCT OF EAR CANAL
ICD-9: 744.0
CPT: 69320
Line: 436 Category: 11

Diagnosis: CERVICITIS, ENDOCERVICITIS, HEMATOMA OF VULVA, OVARIAN CYSTS AND NONINFLAMMATORY DISORDERS OF THE VAGINA
Treatment: MEDICAL THERAPY
ICD-9: 616.0,620.0-.2,620.9,622.3-.4,622.6-.7,623.6,623.8-.9,624.5,626.7
CPT: 90000-99999
Line: 437 Category: 10

Diagnosis: BENIGN NEOPLASM OF KIDNEY
Treatment: MEDICAL THERAPY
ICD-9: 223.1
CPT: 90000-99999
Line: 438 Category: 11

Diagnosis: NONINFLAMMATORY DISORDERS OF CERVIX
Treatment: MEDICAL THERAPY
ICD-9: 622.4-.9,624.2,624.5-.9
CPT: 90000-99999
Line: 439 Category: 11

Diagnosis: CEREBRAL PALSY
Treatment: REPAIR/RECONSTRUCTION
ICD-9: 343.0-.3,343.9,344.1,741.9,335.21,335.11,335.0
CPT: 27097-122,27140-85,27315,27320,27390-400,27605-06,27685-92,28010-11,28030,28130,28220-36,28240,28705-60,27306-07,28300-13
Line: 440 Category: 11

Diagnosis: HYPOPLASTIC LEFT HEART SYNDROME
Treatment: NORWOOD PROCEDURE
ICD-9: 746.7
CPT: 33480-33485
Line: 441 Category: 2

Diagnosis: OTHER SPECIFIED ANOMALIES OF HEART
Treatment: APICAL-AORTIC CONDUIT
ICD-9: 746.8
CPT: 33404
Line: 442 Category: 5

Diagnosis: UTERINE PROLAPSE
Treatment: SURGICAL REPAIR
ICD-9: 618
CPT: 57160,58150,58260-85
Line: 443 Category: 11

Diagnosis: SHIGELLOSIS, GIARDIASIS, INTESTINAL HELMINTHIASIS
Treatment: MEDICAL THERAPY
ICD-9: 004,007.1,120-122,123.0,125-129
CPT: 90000-99999
Line: 444 Category: 10

Diagnosis: CORNEAL ULCER
Treatment: MEDICAL THERAPY
ICD-9: 370.0
CPT: 90000-99999,65286
Line: 445 Category: 10

Diagnosis: CARPAL TUNNEL SYNDROME, CONTRACTURE OF PALMAR FACIA
Treatment: SURGICAL TREATMENT
ICD-9: 354.0,354.2,728.6
CPT: 26035-60,26120-80,26440-597,26820-63,27095-7,27100-22,27140-85,27306-7,27448-55,27466-8,27475-85,27715,27730-42,64702-4,64718-27,64774-83,64788-95,64850-7,64872-999
Line: 446 Category: 11

Diagnosis: DEFORMITIES OF UPPER BODY & LIMBS
Treatment: REPAIR/REVISION/RECONSTRUCTION/RELOCATION/FASCIECTOMY
ICD-9: 354.0,354.2,718.25,718.35,732.1-.3,736.06,736.21-.22,736.3-.5,736.8
CPT: 26035-60,26120-80,26440-597,26820-63,27095-7,27100-22,27140-85,27306-7,27448-55,27466-8,27475-85,27715,27730-42,64702-4,64718-27,64774-83,64788-95,64850-7,64872-999
Line: 447 Category: 11

Diagnosis: MENSTRUAL BLEEDING DISORDERS
Treatment: MEDICAL THERAPY
ICD-9: 626.2-.6,626.8,627.0
CPT: 90000-99999
Line: 448 Category: 10

Diagnosis: RUPTURE OF SYNOVIUM
Treatment: REMOVAL OF BAKER'S CYST
ICD-9: 727.51
CPT: 27435
Line: 449 Category: 11

Diagnosis: DEFORMITIES OF FOOT
Treatment: FASCIOTOMY/INCISION/REPAIR/ARTHRODESIS
ICD-9: 727.1,736.73,700,736.74,736.71,754.71,754.69,755.67,735.0-.2,735.4-.9,732.5,355.6,355.5
CPT: 28008,28010,28035,28050-28092,28110-28119,28126-28160,28220-28238,28240-28360,28705-28760,29425
Line: 450 Category: 11

Diagnosis: FOREIGN BODY IN UTERUS, VULVA AND VAGINA
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 939.1-.2
CPT: 57410,58120,90000-99999
Line: 451 Category: 10

Diagnosis: VAGINITIS
Treatment: MEDICAL THERAPY
ICD-9: 112.1,131.00-.01,131.09,623.5,625.1
CPT: 57150,90000-99999
Line: 452 Category: 10

Diagnosis: PRIAPISM, ORCHITIS, EPIDIDYMITIS, SEMINAL VESICULITIS, FOREIGN BODY IN PENIS, URETHRAL STRICTURE
Treatment: MEDICAL THERAPY, REMOVAL OF FOREIGN BODY, DILATION
ICD-9: 595.0,598,604,607.3,608.0,939.9
CPT: 51700,52275-76,53600-01,53620-21,53660-61,53670,54115,54154,54640,54700-861,55401,55450,90000-99999
Line: 453 Category: 10

Diagnosis: BENIGN NEOPLASM OF EXTERNAL FEMALE GENITAL ORGANS
Treatment: BIOPSY/EXCISION
ICD-9: 221.1-221.9
CPT: 56440,56501,56600,57105,57135
Line: 454 Category: 11

Diagnosis: BALANOPOSTHITIS AND OTHER DISORDERS OF PENIS
Treatment: MEDICAL THERAPY
ICD-9: 607.1,607.8
CPT: 90000-99999
Line: 455 Category: 10

Diagnosis: NONINFLAMMATORY DISORDERS AND BENIGN NEOPLASMS OF OVARY AND FALLOPIAN TUBES
Treatment: SALPINGECTOMY, OOPHORECTOMY
ICD-9: 620.4,620.8,220,221.0
CPT: 58140-50,58700-58720,58925,58940
Line: 456 Category: 11

Diagnosis: BONE SPUR
Treatment: OSTECTOMY
ICD-9: 726.91
CPT: 28119,28899
Line: 457 Category: 11

Diagnosis: BELL'S PALSY, EXPOSURE KERATOCONJUNCTIVITIS
Treatment: TARSORRHAPHY
ICD-9: 351.0,370.34
CPT: 67880
Line: 458 Category: 10

Diagnosis: NASAL POLYP, BENIGN NEOPLASM OF NASAL CAVITIES, MIDDLE EAR & ACCESSORY SINUSES
Treatment: RECONSTRUCTION
ICD-9: 471.9,212.0
CPT: 17000,31032,31201,31020,30425,30520,39010,39400
Line: 459 Category: 11

Diagnosis: CYST OF THYROID
Treatment: SURGERY - EXCISION
ICD-9: 246.2
CPT: 60200,60100
Line: 460 Category: 11

Diagnosis: ORBITAL CYST
Treatment: ORBITOTOMY
ICD-9: 376.81
CPT: 67400-67450
Line: 461 Category: 11

Diagnosis: OTOSCLEROSIS
Treatment: STAPEDECTOMY
ICD-9: 387
CPT: 69650-62
Line: 462 Category: 11

Diagnosis: FOREIGN BODY: ACCIDENTALLY LEFT DURING A PROCEDURE, GRANULOMA OF MUSCLE, GRANULOMA OF SKIN & SUBCUTANEOUS TISSUE
Treatment: REMOVAL OF FOREIGN BODY
ICD-9: 998.4,728.82,709.4
CPT: 22330,22331,24200,24201,25248,20520,20525,27086,27087,27372,28190,28192,28193
Line: 463 Category: 11

Diagnosis: HYPERTROPHY OF BREAST
Treatment: SUBCUTANEOUS TOTAL MASTECTOMY, BREAST REDUCTION
ICD-9: 611.1
CPT: 19140,19318
Line: 464 Category: 11

Diagnosis: OBSTRUCTION OF NASOLACRIMAL DUCT, NEONATAL
Treatment: PROBING NASOLACRIMAL DUCT
ICD-9: 375.55
CPT: 68825-68830
Line: 465 Category: 11

Diagnosis: THROMBOSED AND COMPLICATED HEMORRHOIDS
Treatment: HEMORRHOIDECTOMY, INCISION
ICD-9: 455.1-.2,455.4-.5,455.7-.8
CPT: 10140,45336,46083,46220,46250-62,46320,46934-36
Line: 466 Category: 11

Diagnosis: STENOSIS OF NASOLACRIMAL DUCT (ACQUIRED)
Treatment: DACRYOCYSTORHINOSTOMY
ICD-9: 375.4,375.56
CPT: 68720-68750
Line: 467 Category: 11

Diagnosis: URETHRAL FISTULA
Treatment: EXCISION, MEDICAL THERAPY
ICD-9: 599.1
CPT: 50650-50660,90000-99999
Line: 468 Category: 11

Diagnosis: ENDOMETRIOSIS
Treatment: MEDICAL AND SURGICAL TREATMENT WITHOUT HYSTERECTOMY
ICD-9: 617
CPT: 58145-50,58984,90000-99999
Line: 469 Category: 13

Diagnosis: PTOSIS (ACQUIRED) WITH VISION IMPAIRMENT
Treatment: PTOSIS REPAIR
ICD-9: 374.3
CPT: 15823,67904
Line: 470 Category: 11

Diagnosis: ENTROPION AND TRICHIASIS OF EYELID; ECTROPION; BENIGN NEOPLASM OF EYELID
Treatment: ECTROPION/ENTROPION REP.
ICD-9: 216.1,374.0-374.1
CPT: 17340,67700-67850,67880,67914-67924
Line: 471 Category: 11

Diagnosis: BENIGN NEOPLASM BONE & ARTICULAR CARTILAGE, OTHER BENIGN NEOPLASM OF CONNECTIVE AND OTHER SOFT TISSUE
Treatment: BIOPSY-EXCISION
ICD-9: 213,215,225.3-.4
CPT: 10003,11050,11400-46,13131,17100-200,20550,21556,21600,21920-21935,22106,23065-23077,23140-23156,23100-23101,24065-24077,24110,25120-25136,25170,26100-26117,26200-15,26250-62,26449,27040-49,27065-7,27075-9,27323-9,27637,28108,28122-4,28285,64774,69140
Line: 472 Category: 11

Diagnosis: FOREIGN BODY IN EAR & NOSE
Treatment: REMOVAL OF FOREIGN BODY
ICD-9: 931-932
CPT: 69200-69205,30300-20
Line: 473 Category: 10

Diagnosis: PTERYGIUM
Treatment: EXCISION OR TRANSPOSITION OF PTERYGIUM W/O GRAFT
ICD-9: 372.4
CPT: 65420
Line: 474 Category: 11

Diagnosis: OPEN WOUND OF EAR DRUM
Treatment: TYMPANOPLASTY
ICD-9: 872.61
CPT: 69610-43
Line: 475 Category: 10

\$117.21 Per Capita Cost Per Month

Diagnosis: ENOPHTHALMOS
Treatment: ORBITAL IMPLANT
ICD-9: 376.50
CPT: 67550
Line: 476 Category: 11

Diagnosis: HEARING LOSS - OVER AGE OF THREE
Treatment: MEDICAL THERAPY
ICD-9: 388-389
CPT: 90000-99999
Line: 477 Category: 11

Diagnosis: PARALYSIS OF VOCAL CORDS OR LARYNX, OTHER DISEASES OF LARYNX
Treatment: INCISION/EXCISION/ENDOSCOPY
ICD-9: 478.3,478.7
CPT: 31300-31579,31580-31605
Line: 478 Category: 11

Diagnosis: DENTAL CARIES (PERIAPICAL INFECTION)
Treatment: SURGERY
ICD-9: 521.0
CPT: 41899
Line: 479 Category: 11

Diagnosis: IMPACTED TEETH
Treatment: SURGERY
ICD-9: 520.6,524.3-.4
CPT: 21254,30520,41899
Line: 480 Category: 11

Diagnosis: RECURRENT EROSION OF THE CORNEA
Treatment: CORNEAL TATTOO, REMOVAL OF CORNEAL EPITHELIUM; WITH OR WITHOUT CHEMOCAUTERIZATION
ICD-9: 371.42
CPT: 65600,65435
Line: 481 Category: 11

Diagnosis: CHRONIC SINUSITIS, NASAL POLYPS, OTHER DISORDERS OF NASAL CAVITY AND SINUSES
Treatment: SURGICAL
ICD-9: 471,473,478.1
CPT: 11426-41,30000-31299
Line: 482 Category: 11

Diagnosis: OSTEOARTHRITIS AND ALLIED DISORDERS
Treatment: MEDICAL THERAPY
ICD-9: 715
CPT: 90000-99999
Line: 483 Category: 13

Diagnosis: DEVIATED NASAL SEPTUM, ACQUIRED DEFORMITY OF NOSE, OTHER DISEASES OF UPPER RESPIRATORY TRACT
Treatment: EXCISION OF CYST/RHINECTOMY/PROSTHESIS
ICD-9: 470,738.0,478.0,478.2-.9
CPT: 14060,15823,20912,21325-35,30115-17,30124-30320,30400-30,30520,30580,30620,30999,31021-90,31200
Line: 484 Category: 11

Diagnosis: ADHESIVE CAPSULITIS OF SHOULDER, ARTICULAR CARTILAGE DISORDER OF SHOULDER, PERIOSTITIS OF SHOULDER
Treatment: REPAIR/RECONSTRUCTION
ICD-9: 718.01,726.0,726.2,730.31
CPT: 29815-29825,23410-23420,23440-23466,23107-23125,23190,23000,23020
Line: 485 Category: 11

Diagnosis: MENOPAUSAL MANAGEMENT
Treatment: MEDICAL THERAPY OTHER THAN HORMONE REPLACEMENT
ICD-9: 627.2-.9
CPT: 90000-99999
Line: 486 Category: 13

Diagnosis: EQUINUS DEFORMITY OF FOOT, ACQUIRED
Treatment: ARTHROTOMY
ICD-9: 736.72
CPT: 27612
Line: 487 Category: 11

Diagnosis: CYSTS OF ORAL SOFT TISSUES
Treatment: MEDICAL THERAPY
ICD-9: 528.4
CPT: 90000-99999
Line: 488 Category: 11

Diagnosis: STOMATITIS, CELLULITIS AND ABSCESS OF ORAL SOFT TISSUE, AND DISEASES OF LIPS
Treatment: MEDICAL THERAPY
ICD-9: 528.0,528.3,528.5
CPT: 90000-99999
Line: 489 Category: 10

Diagnosis: OTHER SPECIFIED CONDITIONS OF THE TONGUE
Treatment: EXCISION, BIOPSY
ICD-9: 529.8
CPT: 41100,41105,41110,41112-41114,41599
Line: 490 Category: 11

Diagnosis: SPECIFIC DISORDERS OF THE TEETH AND SUPPORTING STRUCTURES
Treatment: EXCISION OF DENTOALVEOLAR STRUCTURE
ICD-9: 525.8
CPT: 41822,41823,41830,41874,41825-41827,41828,42299,41899,40899,17999
Line: 491 Category: 11

Diagnosis: PARAPLEGIA
Treatment: SURGICAL PREVENTION OF CONTRACTURES
ICD-9: 344.1
CPT: 27003
Line: 492 Category: 11

Diagnosis: PERIPHERAL ENTHESOPATHIES
Treatment: SURGICAL TREATMENT
ICD-9: 726.30-.32,726.4-.6,726.70,726.8,726.90
CPT: 29105,29125-29131,24105,27060-27062,29240,29260,29270,29280,29345,29355,29365,29405-50,20550,20600-10,29345,29355,29365
Line: 493 Category: 11

Diagnosis: CHRONIC DISEASE OF TONSILS AND ADENOIDS
Treatment: TONSILLECTOMY AND ADENOIDECTOMY
ICD-9: 474
CPT: 42820-36,42860,42870
Line: 494 Category: 11

Diagnosis: GANGLION OF TENDON OR JOINT
Treatment: EXCISION
ICD-9: 727.4
CPT: 28090
Line: 495 Category: 11

Diagnosis: KERATOCONJUNCTIVITIS SICCA, NOT SPECIFIED AS SJOGREN'S
Treatment: PUNCTAL OCCLUSION,TARSORRHAPHY
ICD-9: 370.33
CPT: 68760,67880
Line: 496 Category: 11

Diagnosis: PARAPLEGIA
Treatment: ARTHRODESIS
ICD-9: 344.1
CPT: 27870
Line: 497 Category: 11

Diagnosis: OVARIAN CYST
Treatment: OOPHORECTOMY
ICD-9: 256.1,256.4
CPT: 58940
Line: 498 Category: 12

Diagnosis: HISTIOCYTOSIS
Treatment: MEDICAL THERAPY
ICD-9: 277.8
CPT: 90000-99999
Line: 499 Category: 5

Diagnosis: CANCER OF ESOPHAGUS, TREATABLE
Treatment: MEDICAL AND SURGICAL THERAPY
ICD-9: 150,195.2,230.1
CPT: 17002,38542,43260,44305,47600-20,47710,43100-43120,43340-41,44140-47,45111,45550,49000,60540,90000-99999
Line: 500 Category: 5

Diagnosis: OCCUPATIONAL LUNG DISEASES
Treatment: MEDICAL THERAPY
ICD-9: 500-505
CPT: 90000-99999
Line: 501 Category: 5

Diagnosis: LESION OF PLANTAR NERVE
Treatment: MEDICAL THERAPY, EXCISION
ICD-9: 355.6
CPT: 28080,90000-99999
Line: 502 Category: 11

Diagnosis: NONTOXIC NODULAR GOITER
Treatment: THYROIDECTOMY
ICD-9: 241
CPT: 60245,60220
Line: 503 Category: 11

Diagnosis: HERNIA WITHOUT OBSTRUCTION OR GANGRENE
Treatment: REPAIR
ICD-9: 550.9,553
CPT: 39502-41,43330-31,43885,44050,44346,49000,49500-611,51500,55540
Line: 504 Category: 11

Diagnosis: BENIGN NEOPLASM OF RESPIRATORY AND INTRATHORACIC ORGANS
Treatment: LOBECTOMY, MEDICAL THERAPY
ICD-9: 212
CPT: 17000,31512,31599,90000-99999,60220-60225
Line: 505 Category: 11

Diagnosis: MUSCULAR DYSTROPHY
Treatment: MEDICAL THERAPY
ICD-9: 359
CPT: 90000-99999
Line: 506 Category: 5

Diagnosis: TRANSIENT CEREBRAL ISCHEMIA
Treatment: MEDICAL THERAPY
ICD-9: 435
CPT: 90000-99999
Line: 507 Category: 10

Diagnosis: PERITONEAL ADHESION
Treatment: SURGICAL TREATMENT
ICD-9: 568
CPT: 44005,44610,45110,49000
Line: 508 Category: 1

Diagnosis: ALCOHOLIC FATTY LIVER OR ALCOHOLIC HEPATITIS
Treatment: MEDICAL THERAPY
ICD-9: 571.0-.1
CPT: 90000-99999
Line: 509 Category: 5

Diagnosis: SPINA BIFIDA WITH HYDROCEPHALUS
Treatment: MEDICAL THERAPY
ICD-9: 741.0
CPT: 90000-999999,63706
Line: 510 Category: 5

Diagnosis: OTHER DEFICIENCIES OF CIRCULATING ENZYMES (ALPHA 1-ANTITRYPSIN DEFICIENCY)
Treatment: MEDICAL THERAPY
ICD-9: 277.6
CPT: 90000-99999
Line: 511 Category: 5

Diagnosis: DIABETES MELLITUS WITH END STAGE RENAL DISEASE
Treatment: PANCREAS/KIDNEY TRANSPLANT
ICD-9: 250.4
CPT: 50389
Line: 512 Category: 5

Diagnosis: CANCER OF GALLBLADDER AND OTHER BILIARY, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 156,197.8,230.8
CPT: 36845,47600-20,47710,49000,60540,90000-99999
Line: 513 Category: 5

Diagnosis: ACUTE POLIOMYELITIS
Treatment: MEDICAL THERAPY
ICD-9: 045
CPT: 90000-99999
Line: 514 Category: 3

Diagnosis: PITUITARY DWARFISM
Treatment: MEDICAL THERAPY
ICD-9: 253.3
CPT: 90000-99999
Line: 515 Category: 13

Diagnosis: UNSPECIFIED POLYNEUROPATHY
Treatment: MEDICAL THERAPY
ICD-9: 357.9
CPT: 90000-99999
Line: 516 Category: 3

Diagnosis: HEREDITARY HEMORRHAGIC TELANGIECTASIA
Treatment: EXCISION
ICD-9: 448.0
CPT: 11400-11426
Line: 517 Category: 5

Diagnosis: DISEASES OF THYMUS GLAND
Treatment: MEDICAL THERAPY
ICD-9: 254
CPT: 90000-99999
Line: 518 Category: 5

Diagnosis: CEREBRAL DEGENERATIONS USUALLY MANIFEST IN CHILDHOOD
Treatment: MEDICAL THERAPY
ICD-9: 330
CPT: 90000-99999
Line: 519 Category: 5

Diagnosis: CHRONIC RHEUMATIC PERICARDITIS, RHEUMATIC MYOCARDITIS
Treatment: MEDICAL THERAPY
ICD-9: 393,398.0
CPT: 90000-99999
Line: 520 Category: 5

Diagnosis: CANCER OF LIVER, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 155,197.7,235.3
CPT: 31300,31540-1,32100,39200,42415,45333,46917,11042,32900,37617,43260,43630-38,43860,44005,44025,44305,47010,48150,44131,47120-30,47600-20,47710,49000,49080,90000-99999
Line: 521 Category: 5

Diagnosis: ACUTE NON-LYMPHOCYTIC LEUKEMIAS
Treatment: CHEMOTHERAPY
ICD-9: 205.0,206.0,207.0,208.0
CPT: 11646,37799,38100,38308,38760,38999,45360,58150,58720,58805,59840,60500,90000-99999
Line: 522 Category: 5

Diagnosis: MULTIPLE MYELOMA AND CHRONIC LEUKEMIAS
Treatment: BONE MARROW TRANSPLANT (5-6 LOCI MATCH)
ICD-9: 202.4,203,205.1-.9,206.1-.9,207.1-.8,208.1-.9
CPT: 38230-41
Line: 523 Category: 5

Diagnosis: MALIGNANT NEOPLASM OF OTHER ENDOCRINE GLANDS AND RELATED STRUCTURES, TREATABLE
Treatment: BONE MARROW RESCUE AND TRANSPLANT
ICD-9: 194
CPT: 38240,38230
Line: 524 Category: 5

Diagnosis: ANOMALIES OF GALLBLADDER, BILE DUCTS, AND LIVER
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 751.6
CPT: 90000-99999,47400-47999
Line: 525 Category: 5

Diagnosis: CANCER OF PANCREAS, TREATABLE
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 157,230.9
CPT: 31370-82,37799,42410-26,47760,47721,49000,60540,90000-99999
Line: 526 Category: 5

Diagnosis: PARASITIC INFESTATION OF EYELID
Treatment: MEDICAL THERAPY
ICD-9: 373.6
CPT: 90000-99999
Line: 527 Category: 10

Diagnosis: ATELECTASIS (COLLAPSE OF LUNG)
Treatment: MEDICAL THERAPY
ICD-9: 518.0-.1
CPT: 90000-99999,31645
Line: 528 Category: 10

Diagnosis: HEMORRHAGE AND INFARCTION OF THYROID
Treatment: MEDICAL THERAPY
ICD-9: 246.3
CPT: 90000-99999
Line: 529 Category: 10

Diagnosis: RETINAL TEAR
Treatment: LASER PROPHYLAXIS
ICD-9: 361.30
CPT: 67141-67145
Line: 530 Category: 10

\$120.76 Per Capita Cost Per Month

Diagnosis: SPONTANEOUS AND MISSED ABORTION
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 631-632,634.2-.9
CPT: 59820-21,90000-99999
Line: 531 Category: 10

Diagnosis: INFLAMMATION OF LACRIMAL PASSAGES
Treatment: MEDICAL THERAPY
ICD-9: 375
CPT: 90000-99999
Line: 532 Category: 10

Diagnosis: MINOR BURNS
Treatment: MEDICAL THERAPY
ICD-9: 941.0-.1,942.0-.1,943.0-.1,944.0-.1,945.0-.1,946.0-.1,948.00,.10,.20,.30,.40,.50,.60,.70,.80,.90,949.0-.1
CPT: 11000-1,11040-4,11960-70,14020,14040-1,14060,15200,15220,15240,15260,15350,15400,15500-10,15770,16000-16035,20550,20610,35206,64450,90000-99999
Line: 533 Category: 10

Diagnosis: ALLERGIC RHINITIS AND CONJUNCTIVITIS
Treatment: MEDICAL THERAPY
ICD-9: 477,471,472,372.00-.14
CPT: 90000-99999
Line: 534 Category: 13

Diagnosis: CORNEAL ULCER
Treatment: CONJUNCTIVAL FLAP
ICD-9: 370.0
CPT: 68360
Line: 535 Category: 10

Diagnosis: HYPERESTROGENISM
Treatment: HYSTERECTOMY, MEDICAL THERAPY
ICD-9: 256.0
CPT: 58120,58150,90000-99999
Line: 536 Category: 10

Diagnosis: PELVIC PAIN SYNDROME
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 614.1-.2,614.4,614.6-.9,615.1-.9,625.0-.2,625.4-.5,625.8-.9
CPT: 11043,58150,58805,58925,58980,90000-99999
Line: 537 Category: 13

Diagnosis: RETAINED DENTAL ROOT
Treatment: EXCISION OF DENTOALVEOLAR STRUCTURE
ICD-9: 525.3
CPT: 41822,41823,41830,41874,41825-41827,41828,42299,41899,40899,17999
Line: 538 Category: 10

Diagnosis: KERATITIS: CORNEAL ULCER, SUPERFICIAL W/O CONJUNCTIVITIS, OTHER AND UNSPECIFIED KERATOCONJUNCTIVITIS, INTERSTITIAL & DEEP, CORNEAL NEOVASCULARIZATION
Treatment: KERATOPLASTY
ICD-9: 370.0,371.0-371.1,371.23,371.4-371.6
CPT: 65730,65920,66985
Line: 539 Category: 10

Diagnosis: TRANSIENT NEPHROTIC SYNDROME WITH LESION OF MINIMAL CHANGE GLOMERULONEPHRITIS
Treatment: MEDICAL THERAPY
ICD-9: 581.3
CPT: 90000-99999
Line: 540 Category: 10

Diagnosis: TONGUE TIE AND OTHER ANOMALIES OF TONGUE
Treatment: FRENOTOMY, TONGUE TIE
ICD-9: 750.0-.1
CPT: 40806,40819,41010,41115
Line: 541 Category: 11

Diagnosis: BRANCHIAL CLEFT CYST
Treatment: EXCISION
ICD-9: 744.42
CPT: 42810,42815
Line: 542 Category: 11

Diagnosis: ATROPHY OF EDENTULOUS ALVEOLAR RIDGE
Treatment: VESTIBULOPLASTY, GRAFTS, IMPLANTS
ICD-9: 525.2
CPT: 40840,40842,40845,15999,20902,15350,15510,21210,21215,21244-50
Line: 543 Category: 11

Diagnosis: SPINE DEFORMITIES
Treatment: ARTHRODESIS/REPAIR/RECONSTRUCTION
ICD-9: 754.2,268.1,756.14,737.0,756.19,737.11-.12,356.1,731.0,252.0,737.30-.31,737.33-.39,724.3
CPT: 22800-22812,22820,22840-22899,22210-22230,22590-22650,22554-22585,29010-29035
Line: 544 Category: 11

Diagnosis: BENIGN NEOPLASM OF MALE GENITAL ORGANS: TESTIS, PROSTATE, EPIDIDYMIS
Treatment: MEDICAL THERAPY
ICD-9: 222.0,222.2,222.3,222.8, 222.9
CPT: 90000-99999
Line: 545 Category: 11

Diagnosis: DISORDERS OF BLADDER
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 596.0-.5,596.7-.9
CPT: 90000-99999,51800-45,51880-980,53660-61,53670
Line: 546 Category: 11

Diagnosis: HYPERTELORISM OF ORBIT
Treatment: ORBITOTOMY
ICD-9: 376.41
CPT: 67400
Line: 547 Category: 11

Diagnosis: DENTAL SERVICES (EG. TOOTH LOSS)
Treatment: RESTORATIVE DENTAL SERVICE
ICD-9: 0
CPT: 01510-25,04240-60,04345,05110-40,05213-4,05860,05911-21,05954-5,05949,07270,07310-20,07560,07610-80,07710-80,07950,09630
Line: 548 Category: 12

Diagnosis: DENTAL SERVICES (EG. MALPOSITIONED TOOTH)
Treatment: RESTORATIVE DENTAL SERVICE
ICD-9: 0
CPT: 02960,05211-2,05520,05610,05630-60,05710-21,05750-61,06212,06242,06792,06972-80,07271,07280-1,07290,07340-50,07470-80,07810-50,07860-80,07920,07960-80,079823,079914
Line: 549 Category: 11

Diagnosis: DENTAL SERVICES (EG. INSUFFICIENT ROOM TO RESTORE TOOTH)
Treatment: RESTORATIVE DENTAL SERVICE
ICD-9: 0
CPT: 03950,04210-1,04320-1,05620,05730-41,05810-05850,06211,06241,06520-40,06752,06780,06970
Line: 550 Category: 11

Diagnosis: UNSPECIFIED DISEASE OF HARD TISSUES OF TEETH (AVULSION)
Treatment: INTERDENTAL WIRING
ICD-9: 525.9
CPT: 21497
Line: 551 Category: 12

Diagnosis: RETAINED INTRAOCULAR FOREIGN BODY, MAGNETIC & NONMAGNETIC
Treatment: FOREIGN BODY REMOVAL
ICD-9: 360.5-360.6
CPT: 65230,65260-65265
Line: 552 Category: 12

Diagnosis: INTERNAL DERANGEMENT OF KNEE
Treatment: ARTHROSCOPIC REPAIR
ICD-9: 717.1-.3,717.40,717.42-.49
CPT: 29870-89,27403-29
Line: 553 Category: 12

Diagnosis: CLOSED FRACTURE OF EPIPHYSIS OF UPPER EXTREMITIES
Treatment: REDUCTION
ICD-9: 812.09,812.44,813.43
CPT: 25350,25600-20
Line: 554 Category: 12

Diagnosis: CONGENITAL DISLOCATION OF HIP; COXA VARA & VALGA, CONGENITAL
Treatment: REPAIR/RECONSTRUCTION
ICD-9: 754.3,755.62,755.61
CPT: 27179,27181,27185
Line: 555 Category: 12

Diagnosis: MECHANICAL AND OTHER COMPLICATION OF INTERNAL ORTHOPEDIC AND PROSTHETIC DEVICE, IMPLANT AND GRAFT; IMPLANT OR GRAFT; INFECTION & INFLAMMATORY REACTION DUE TO INTERNAL PROSTHETIC DEVICE
Treatment: TREATMENT, ARTHROPLASTY
ICD-9: 996.4,996.77,996.66
CPT: 27485-27488,27265,27266,27134,27137,27138
Line: 556 Category: 12

Diagnosis: DISORDERS OF SHOULDER
Treatment: REPAIR/RECONSTRUCTION
ICD-9: 727.61,726.10,840.4
CPT: 29815-29825,23410-23420,23440-23466,23107-23125,23190,23000,23020
Line: 557 Category: 12

Diagnosis: CONGENITAL DISLOCATION OF KNEE, GENU VARUM & VALGUM (ACQ'D), CONGENITAL BOWING OF FEMUR, TIBIA & FIBULA, GENU RECURVATUM (ACQ'D), CONGITAL GENU RECURVATUM LONG BONES OF LEGS, CONGENITAL DEFORMITIES OF KNEE
Treatment: OSTEOTOMY
ICD-9: 736.42,754.40-.43,755.64
CPT: 27455,27448-27450
Line: 558 Category: 12

Diagnosis: CONGENITAL DEFORMITIES OF KNEE
Treatment: ARTHROSCOPIC REPAIR
ICD-9: 755.64
CPT: 29870-89,27403-29
Line: 559 Category: 13

Diagnosis: UNSPECIFIED RETINAL VASCULAR OCCLUSION; CENTRAL RETINAL VEIN OCCLUSION, VENOUS TRIBUTARY (BRANCH) OCCLUSION
Treatment: LASER SURGERY
ICD-9: 362.30,362.35,362.36
CPT: 67228
Line: 560 Category: 12

Diagnosis: EXFOLIATION OF TEETH DUE TO SYSTEMIC CAUSES
Treatment: EXCISION OF DENTOALVEOLAR STRUCTURE
ICD-9: 525.0
CPT: 41822,41823,41830,41874,41825-41827,41828,42299,41899,40899,17999
Line: 561 Category: 12

Diagnosis: RUBEOSIS IRIDIS
Treatment: LASER SURGERY
ICD-9: 364.42
CPT: 67228,66720-66721
Line: 562 Category: 12

Diagnosis: TRAUMATIC AMPUTATION OF TOE (COMPLETE)(PARTIAL) W/ & W/O COMPLICATION
Treatment: REPLANTATION/AMPUTATE
ICD-9: 895
CPT: 20838-40,28810-25
Line: 563 Category: 12

Diagnosis: PERIPHERAL NERVE DISORDERS (NON-INJURY)
Treatment: NEUROPLASTY
ICD-9: 353.0-.4,354.1,354.9,355.0,350.2,355.6,355.8
CPT: 64702-64727,64413-64450,64774-64792
Line: 564 Category: 12

Diagnosis: DISORDERS OF SWEAT GLANDS
Treatment: MEDICAL THERAPY
ICD-9: 705.0,705.81,705.89,705.9,780.8
CPT: 90000-99999
Line: 565 Category: 13

Diagnosis: CHONDROMALACIA
Treatment: MEDICAL THERAPY
ICD-9: 733.92
CPT: 90000-99999
Line: 566 Category: 13

Diagnosis: EPIPHYSEAL ARREST
Treatment: MEDICAL THERAPY
ICD-9: 733.91
CPT: 90000-99999
Line: 567 Category: 13

Diagnosis: DIAPHYSITIS
Treatment: MEDICAL THERAPY
ICD-9: 733.99
CPT: 90000-99999
Line: 568 Category: 13

Diagnosis: FRACTURES OF RIBS AND STERNUM, CLOSED
Treatment: MEDICAL THERAPY
ICD-9: 807.0,807.2
CPT: 90000-99999
Line: 569 Category: 10

Diagnosis: FRACTURE OF ONE OR MORE PHALANGES OF FOOT
Treatment: SET
ICD-9: 826
CPT: 29425,28470,28480,28505,28550
Line: 570 Category: 10

Diagnosis: BRACHIAL PLEXUS LESIONS
Treatment: MEDICAL THERAPY
ICD-9: 353.0
CPT: 90000-99999
Line: 571 Category: 13

Diagnosis: CHRONIC SINUSITIS
Treatment: MEDICAL THERAPY
ICD-9: 473
CPT: 90000-99999
Line: 572 Category: 13

Diagnosis: LUMBAGO; THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS, UNSPECIFIED; POSTLAMINECTOMY SYNDROME
Treatment: MEDICAL THERAPY
ICD-9: 724.2,724.4,722.8
CPT: 90000-99999
Line: 573 Category: 13

Diagnosis: DYSMENORRHEA
Treatment: MEDICAL THERAPY
ICD-9: 625.3
CPT: 90000-99999
Line: 574 Category: 13

Diagnosis: TIBIAL BURSITIS, OSTEOCHONDROPATHIES AND CONGENITAL DEFORMITIES OF KNEE
Treatment: MEDICAL THERAPY
ICD-9: 726.62,726.69,732.4,732.7,755.64
CPT: 90000-99999
Line: 575 Category: 13

Diagnosis: EPICONDYLITIS AND RADIAL STYLOID TENOSYNOVITIS
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 726.31-.32,727.04
CPT: 26035-60,26120-80,26440-597,26820-63,27095-7,27100-22,27140-85,27306-7,27448-55,27466-8,27475-85,27715,27730-42,64702-4,64718-27,64774-95,64850-7,64872-999,90000-99999
Line: 576 Category: 13

Diagnosis: POLYMYALGIA RHEUMATICA
Treatment: MEDICAL THERAPY
ICD-9: 725
CPT: 90000-99999
Line: 577 Category: 13

Diagnosis: RAYNAUD SYNDROME
Treatment: MEDICAL THERAPY
ICD-9: 443
CPT: 90000-99999
Line: 578 Category: 13

Diagnosis: REITER'S DISEASE
Treatment: MEDICAL THERAPY
ICD-9: 099.3
CPT: 90000-99999
Line: 579 Category: 13

Diagnosis: URTICARIA, CHRONIC
Treatment: MEDICAL THERAPY
ICD-9: 708,995.1
CPT: 90000-99999,11000-11101
Line: 580 Category: 13

Diagnosis: KERATODERMA, ACQUIRED; ACQUIRED ACANTHOSIS NIGRICANS, STRIAE ATROPHICAE, OTHER AND UNSPECIFIED HYPERTROPHIC AND ATROPHIC CONDITIONS OF SKIN
Treatment: MEDICAL THERAPY
ICD-9: 690,698,700,701.1-.3,701.8,701.9,706.7
CPT: 11000-101,11900,11950-54,90000-99999
Line: 581 Category: 13

Diagnosis: VERTIGINOUS SYNDROMES AND OTHER DISORDERS OF VESTIBULAR SYSTEM
Treatment: MEDICAL THERAPY
ICD-9: 386.0-.2,386.4-.9
CPT: 90000-99999
Line: 582 Category: 13

Diagnosis: DISORDERS OF CERVICAL REGION
Treatment: CERVICAL LAMINECTOMY, MEDICAL THERAPY
ICD-9: 721.0,722.4,722.81,723
CPT: 63250,63265,63270,63275,63280,63285,63001,63015,63020,63035-40,63045,63048,63075-76,63081-82,63300,63304,63170-72,63180-82,63194,63196,63198,90000-99999
Line: 583 Category: 13

Diagnosis: ERYTHEMATOUS CONDITIONS: TOXIC, NODOSUM, ROSACEA, LUPUS
Treatment: MEDICAL THERAPY
ICD-9: 695.0,695.2-.9
CPT: 90000-99999,11100-11101
Line: 584 Category: 13

Diagnosis: PLANTAR FASCIAL FIBROMATOSIS
Treatment: MEDICAL THERAPY
ICD-9: 728.71
CPT: 90000-99999
Line: 585 Category: 13

\$127.01 Per Capita Cost Per Month

Diagnosis: SPONDYLOSIS AND OTHER CHRONIC DISORDERS OF BACK
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 720,721.2-.5,721.7,721.9,722.3-.5,722.7-.9,723.0,724,738.4,756.11,847
CPT: 22100,22105,22110,22140-230,22548-54,22590-650,22820-99,62284,62290-1,63001-48,63075-8,63081-2,63085-8,63090-1,63300-4,90000-99999
Line: 586 Category: 13

Diagnosis: ESOPHAGITIS
Treatment: MEDICAL THERAPY
ICD-9: 530.1
CPT: 90000-99999
Line: 587 Category: 13

Diagnosis: INTERVERTEBRAL DISC DISORDERS
Treatment: THORACIC-LUMBAR LAMINECTOMY, MEDICAL THERAPY
ICD-9: 722.0-.1,722.7,952.1-.9
CPT: 63003,63005,63016,63017,63030-31,63035,63042,63046-48,63056-57,63064,63066,63077-78,63085-91,63170,63173,90000-99999
Line: 588 Category: 13

Diagnosis: CHRONIC PROSTATITIS, OTHER DISORDERS OF PROSTATE
Treatment: MEDICAL THERAPY
ICD-9: 601.1,602
CPT: 90000-99999
Line: 589 Category: 13

Diagnosis: CHRONIC CYSTITIS
Treatment: MEDICAL THERAPY
ICD-9: 595.1-595.3
CPT: 90000-99999
Line: 590 Category: 13

Diagnosis: IMPETIGO HERPETIFORMIS AND SUBCORNEAL PUSTULAR DERMATOSIS
Treatment: MEDICAL THERAPY
ICD-9: 694.0-.3
CPT: 90000-99999
Line: 591 Category: 13

Diagnosis: TRIGEMINAL NERVE DISORDERS
Treatment: MEDICAL & SURGICAL TREATMENT
ICD-9: 350
CPT: 64400,64600-64610,61450,61458,90000-99999
Line: 592 Category: 13

Diagnosis: MYASTHENIA GRAVIS
Treatment: MEDICAL THERAPY, THYMECTOMY
ICD-9: 358
CPT: 90000-99999,60520
Line: 593 Category: 13

Diagnosis: SPRAINS, STRAINS AND NON-ALLOPATHIC SPINAL LESIONS: THORACIC, LUMBAR AND SACRUM ACUTE
Treatment: MEDICAL THERAPY
ICD-9: 847.0-.3,739.0-.4
CPT: 90000-99999
Line: 594 Category: 14

Diagnosis: HORDEOLUM AND OTHER DEEP INFLAMMATION OF EYELID; CHALAZION
Treatment: INCISION AND DRAINAGE/MEDICAL THERAPY
ICD-9: 373.1-.2
CPT: 90000-99999,67700
Line: 595 Category: 14

Diagnosis: LABYRINTHITIS
Treatment: MEDICAL THERAPY
ICD-9: 386.3
CPT: 90000-99999
Line: 596 Category: 14

Diagnosis: VIRAL HEPATITIS
Treatment: MEDICAL THERAPY
ICD-9: 070
CPT: 90000-99999
Line: 597 Category: 14

Diagnosis: ANOVULATION (INFERTILITY)
Treatment: MEDICAL THERAPY
ICD-9: 621.3,626.0-.1,628.0
CPT: 58100,58920-25,58940,61548,90000-99999
Line: 598 Category: 15

Diagnosis: HYDROCELE
Treatment: MEDICAL THERAPY, EXCISION
ICD-9: 603
CPT: 54840,55000,55040-41,55060,55500,90000-99999
Line: 599 Category: 11

Diagnosis: ABSENCE OF BREAST AFTER MASTECTOMY AS TREATMENT FOR NEOPLASM
Treatment: BREAST RECONSTRUCT
ICD-9: 174,217,233.0,238.3
CPT: 11400-46,17340,19120-60,19324-42,19360-96,19499
Line: 600 Category: 11

Diagnosis: SPASTIC DYSPHONIA
Treatment: MEDICAL THERAPY
ICD-9: 478.79
CPT: 90000-99999
Line: 601 Category: 11

Diagnosis: FEMALE INFERTILITY OF CERVICAL ORIGIN, MALE INFERTILITY
Treatment: ARTIFICIAL INSEMINATION, MEDICAL THERAPY
ICD-9: 628.8-.9,606
CPT: 90000-99999,58310-58311
Line: 602 Category: 15

Diagnosis: TUBAL DISEASE
Treatment: MICROSURGERY
ICD-9: 256,628.2-.4
CPT: 58700,58740-70
Line: 603 Category: 15

Diagnosis: KELOID SCAR; OTHER ABNORMAL GRANULATION TISSUE
Treatment: INTRALESIONAL INJECTIONS/DESTRUCTION/EXCISION
ICD-9: 701.4-.5
CPT: 11900-11901,17000-17105,11200-11446
Line: 604 Category: 17

Diagnosis: CONJUNCTIVAL CYST
Treatment: EXCISION OF CONJUNCTIVAL CYST
ICD-9: 372.75
CPT: 68110
Line: 605 Category: 17

Diagnosis: HEPATORENAL SYNDROME
Treatment: MEDICAL THERAPY
ICD-9: 572.4
CPT: 90000-99999
Line: 606 Category: 3

Diagnosis: OTHER DEFICIENCIES OF CIRCULATING ENZYMES (ALPHA 1-ANTITRYPSIN DEFICIENCY)
Treatment: LUNG TRANSPLANT
ICD-9: 277.6
CPT: 33935
Line: 607 Category: 5

Diagnosis: LETHAL MIDLINE GRANULOMA
Treatment: MEDICAL THERAPY
ICD-9: 446.3
CPT: MEDICAL THERAPY
Line: 608 Category: 5

Diagnosis: AMYOTROPHIC LATERAL SCLEROSIS (ALS)
Treatment: MEDICAL THERAPY
ICD-9: 335.20,335.22-.29
CPT: 90000-999999
Line: 609 Category: 5

Diagnosis: CANCER OF LIVER AND INTRAHEPATIC BILE DUCTS
Treatment: LIVER TRANSPLANT
ICD-9: 155
CPT: 47135
Line: 610 Category: 5

Diagnosis: HEMATOMA OF AURICLE OR PINNA AND HEMATOMA OF EXTERNAL EAR
Treatment: DRAINAGE
ICD-9: 216.2,380.0,380.31
CPT: 69000-20
Line: 611 Category: 10

Diagnosis: ENOPHTHALMOS
Treatment: REVISION
ICD-9: 376.5
CPT: 67400
Line: 612 Category: 10

Diagnosis: ACUTE LYMPHADENITIS
Treatment: INCISION AND DRAINAGE
ICD-9: 683
CPT: 10060
Line: 613 Category: 10

Diagnosis: CONGENITAL ANOMALIES OF FEMALE GENITAL ORGANS
Treatment: SURGICAL TREATMENT
ICD-9: 752.0-.3,752.41
CPT: 57135,57500,57720,58540,58700,58940,58987,58995
Line: 614 Category: 11

Diagnosis: GENERALIZED CONVULSIVE OR PARTIAL EPILEPSY WITHOUT MENTION OF IMPAIRMENT OF CONSCIOUSNESS
Treatment: FOCAL SURGERY
ICD-9: 345.1,345.5
CPT: 61720,61533-61536
Line: 615 Category: 11

Diagnosis: VARICOSE VEINS OF LOWER EXTREMITIES
Treatment: STRIPPING/SCLEROTHERAPY
ICD-9: 454
CPT: 36468-71,37700,37720-35,37760,37785-99
Line: 616 Category: 11

Diagnosis: DISEASE OF CAPILLARIES
Treatment: EXCISION
ICD-9: 448.1-.9
CPT: 11400-11426
Line: 617 Category: 11

Diagnosis: ANOMALIES OF RELATIONSHIP OF JAW TO CRANIAL BASE, MAJOR ANOMALIES OF JAW SIZE, OTHER SPECIFIED AND UNSPECIFIED DENTOFACIAL ANOMALIES
Treatment: OSTEOPLASTY, MAXILLA/MANDIBLE
ICD-9: 524.0-.2,524.5,524.85,524.9
CPT: 21110,21200-21208,21250-54,21209,30520
Line: 618 Category: 11

Diagnosis: CONGENITAL ANOMALIES OF THE EAR WITHOUT IMPAIRMENT OF HEARING
Treatment: OTOPLASTY, REPAIR & AMPUTATION
ICD-9: 744.1-.3
CPT: 69300,69110
Line: 619 Category: 11

Diagnosis: TMJ DISORDER
Treatment: TMJ SPLINTS
ICD-9: 524.6
CPT: 90000-99999
Line: 620 Category: 13

Diagnosis: TMJ DISORDERS
Treatment: TMJ SURGERY
ICD-9: 524.6,524.5,718.08,718.18,718.28,718.38,718.58
CPT: 21499,21010,20910,21050-70,21116,21240-21243,21480,21485,21490,21210,21215,29909,21230,21235,21254,20926,30520
Line: 621 Category: 11

Diagnosis: DISEASE OF NAILS, HAIR AND HAIR FOLLICLES
Treatment: MEDICAL THERAPY
ICD-9: 703.8-.9,704.0,704.2-.9,757.4-.5
CPT: 11900,11700-11765,11000-11001,90000-99999
Line: 622 Category: 13

Diagnosis: CIRCUMSCRIBED SCLERODERMA
Treatment: MEDICAL THERAPY
ICD-9: 701.0
CPT: 90000-99999,11900-11901
Line: 623 Category: 13

Diagnosis: CAVUS DEFORMITY OF FOOT
Treatment: MEDICAL THERAPY, ORTHOTIC
ICD-9: 736.73
CPT: 90000-99999
Line: 624 Category: 13

Diagnosis: CERVICAL RIB
Treatment: SURGICAL TREATMENT
ICD-9: 756.2
CPT: 21615-16,21705
Line: 625 Category: 11

Diagnosis: ERYTHROPLAKIA, LEUKOEDEMA OF MOUTH OR TONGUE
Treatment: MEDICAL THERAPY
ICD-9: 528.7
CPT: 90000-99999
Line: 626 Category: 13

Diagnosis: CHRONIC CONJUNCTIVITIS, BLEPHAROCONJUNCTIVITIS
Treatment: MEDICAL THERAPY
ICD-9: 372.1-372.3
CPT: 90000-99999
Line: 627 Category: 13

Diagnosis: DERMATOPHYTOSIS
Treatment: MEDICAL THERAPY
ICD-9: 110-111
CPT: 90000-99999,11100
Line: 628 Category: 13

Diagnosis: KERATITIS: SUPERFICIAL W/O CONJUNCTIVITIS, CERTAIN TYPES, OTHER AND UNSPECIFIED K-CONJUNCTIVITIS, INTERSTITIAL & DEEP, CORNEAL NEOVASCULARIZATION, OTHER AND UNSPECIFIED FORMS
Treatment: MEDICAL THERAPY
ICD-9: 370.2-370.9
CPT: 90000-99999
Line: 629 Category: 13

Diagnosis: DISORDERS OF SYNOVIUM, TENDON AND BURSA; DISORDERS OF SOFT TISSUE AND JOINTS
Treatment: MEDICAL THERAPY
ICD-9: 727.2-.3,729
CPT: 90000-99999
Line: 630 Category: 13

Diagnosis: TENDINITIS AND BURSITIS
Treatment: MEDICAL AND SURGICAL THERAPY
ICD-9: 726.33,726.71-.72
CPT: 29105,29125-29131,24105,27060-27062,29240,29260,29270,29280,29345,29355,29365,29405-50,20550,20600-10,29345,29355,29365,90000-99999
Line: 631 Category: 14

Diagnosis: BLEPHARITIS
Treatment: MEDICAL THERAPY
ICD-9: 373.0
CPT: 90000-99999
Line: 632 Category: 13

Diagnosis: XEROSIS
Treatment: MEDICAL THERAPY
ICD-9: 706.8
CPT: 90000-99999,11000-11101
Line: 633 Category: 13

Diagnosis: OBESITY
Treatment: NUTRITIONAL AND LIFE STYLE COUNSELING
ICD-9: 278
CPT: 90000-99999
Line: 634 Category: 13

Diagnosis: DISORDERS OF FUNCTION OF STOMACH AND OTHER FUNCTIONAL DIGESTIVE DISORDERS
Treatment: MEDICAL THERAPY
ICD-9: 536,564
CPT: 90000-99999
Line: 635 Category: 13

Diagnosis: LICHEN PLANUS
Treatment: MEDICAL THERAPY
ICD-9: 697
CPT: 90000-99999,11900-11901
Line: 636 Category: 13

Diagnosis: MONONEUROPATHY
Treatment: MEDICAL THERAPY
ICD-9: 354.0,354.2-.9
CPT: 90000-99999
Line: 637 Category: 13

Diagnosis: POSTCONCUSSION SYNDROME
Treatment: MEDICAL THERAPY
ICD-9: 310.2
CPT: 90000-99999
Line: 638 Category: 13

Diagnosis: HERPES SIMPLEX WITHOUT COMPLICATIONS
Treatment: MEDICAL THERAPY
ICD-9: 054.0,054.2,054.6,054.8-.9
CPT: 90000-99999
Line: 639 Category: 13

Diagnosis: TESTICULAR AND POLYGLANDULAR DYSFUNCTION
Treatment: MEDICAL THERAPY
ICD-9: 257-258
CPT: 90000-99999
Line: 640 Category: 13

$134.61 Per Capita Cost Per Month

Diagnosis: OTOSCLEROSIS
Treatment: MEDICAL THERAPY
ICD-9: 387
CPT: 90000-99999
Line: 641 Category: 13

Diagnosis: PERIPHERAL ENTHESOPATHIES
Treatment: MEDICAL THERAPY
ICD-9: 726.30-.32,726.4-.6,726.70,726.8,726.90
CPT: 90000-99999
Line: 642 Category: 13

Diagnosis: CHRONIC BRONCHITIS
Treatment: MEDICAL THERAPY
ICD-9: 490-491,493.9
CPT: 90000-99999
Line: 643 Category: 13

Diagnosis: SARCOIDOSIS
Treatment: MEDICAL THERAPY
ICD-9: 135
CPT: 90000-99999
Line: 644 Category: 13

Diagnosis: BENIGN INTRACRANIAL HYPERTENSION
Treatment: MEDICAL THERAPY
ICD-9: 348.2
CPT: 90000-99999
Line: 645 Category: 13

Diagnosis: LYMPHEDEMA
Treatment: MEDICAL THERAPY, OTHER OPERATION ON LYMPH CHANNEL
ICD-9: 457,140-144
CPT: 90000-99999,38300-38308,38382-38555,38700-38761
Line: 646 Category: 13

Diagnosis: PHLEBITIS AND THROMBOPHLEBITIS, SUPERFICIAL
Treatment: MEDICAL THERAPY
ICD-9: 451
CPT: 90000-99999
Line: 647 Category: 13

Diagnosis: SYNOVITIS AND TENOSYNOVITIS
Treatment: MEDICAL THERAPY
ICD-9: 727.0
CPT: 90000-99999,20550
Line: 648 Category: 14

Diagnosis: DIAPER OR NAPKIN RASH
Treatment: MEDICAL THERAPY
ICD-9: 691.0
CPT: 90000-99999,11100
Line: 649 Category: 14

Diagnosis: ORAL APHTHAE
Treatment: MEDICAL THERAPY
ICD-9: 528.2
CPT: 90000-99999
Line: 650 Category: 14

Diagnosis: DERMATITIS DUE TO SUBSTANCES TAKEN INTERNALLY
Treatment: MEDICAL THERAPY
ICD-9: 693
CPT: 90000-99999,11100
Line: 651 Category: 14

Diagnosis: FOOD ALLERGY
Treatment: MEDICAL THERAPY
ICD-9: 692.5
CPT: 90000-99999
Line: 652 Category: 13

Diagnosis: SPRAINS OF JOINTS AND ADJACENT MUSCLES
Treatment: MEDICAL THERAPY
ICD-9: 717.5,717.8,840.1-844.2,844.8-.9,845.00-.03,845.1,848.5
CPT: 29049-29085,29105-29131,29200-29280,29305-29580,29700-29799,90000-99999
Line: 653 Category: 14

Diagnosis: SUBLINGUAL, SCROTAL, AND PELVIC VARICES
Treatment: VENOUS INJECTION, VASCULAR SURGERY
ICD-9: 456.3-.5
CPT: 36470,37798-9,55530-35
Line: 654 Category: 11

Diagnosis: SPRAIN/STRAIN OF ACHILLES TENDON
Treatment: MEDICAL THERAPY
ICD-9: 845.09
CPT: 90000-99999
Line: 655 Category: 14

Diagnosis: FRACTURE OF VERTEBRAL COLUMN WITHOUT SPINAL CORD INJURY, SACRUM AND COCCYX
Treatment: LAMINECTOMY
ICD-9: 805.6-805.9
CPT: 22845,61720-61793
Line: 656 Category: 14

Diagnosis: ACUTE URTICARIA
Treatment: MEDICAL THERAPY
ICD-9: 708,995.1
CPT: 90000-99999
Line: 657 Category: 14

Diagnosis: CANDIDIASIS
Treatment: MEDICAL THERAPY
ICD-9: 112.0,112.3
CPT: 90000-99999
Line: 658 Category: 14

Diagnosis: SCLERITIS & EPISCLERITIS
Treatment: MEDICAL THERAPY
ICD-9: 379.0
CPT: 90000-99999
Line: 659 Category: 14

Diagnosis: INTERNAL INFECTIONS AND OTHER BACTERIAL FOOD POISONING
Treatment: MEDICAL THERAPY
ICD-9: 003.0,003.8-.9,005.0,005.2-.9,008-009,027.1-.9
CPT: 90000-99999
Line: 660 Category: 14

Diagnosis: OPEN WOUND OF INTERNAL STRUCTURES OF MOUTH W/O COMPLICATION
Treatment: REPAIR SOFT TISSUES
ICD-9: 873.6
CPT: 13300,41251,41282,12001-57,13131,13132,13151-2,40831
Line: 661 Category: 14

Diagnosis: VIRAL, SELF-LIMITING ENCEPHALITIS, MYELITIS AND ENCEPHALOMYELITIS
Treatment: MEDICAL THERAPY
ICD-9: 056.0,323
CPT: 90000-99999
Line: 662 Category: 14

Diagnosis: ACUTE TONSILLITIS
Treatment: MEDICAL THERAPY
ICD-9: 463
CPT: 90000-99999
Line: 663 Category: 14

Diagnosis: ERYTHEMA MULTIFORME
Treatment: MEDICAL THERAPY
ICD-9: 695.1
CPT: 90000-99999,11100-11101
Line: 664 Category: 14

Diagnosis: CENTRAL SEROUS RETINOPATHY
Treatment: LASER SURGERY
ICD-9: 362.41
CPT: 67210
Line: 665 Category: 14

Diagnosis: VULVAL VARICES
Treatment: VASCULAR SURGERY
ICD-9: 456.6
CPT: 37799
Line: 666 Category: 14

Diagnosis: ASEPTIC MENINGITIS
Treatment: MEDICAL THERAPY
ICD-9: 047-049
CPT: 90000-99999
Line: 667 Category: 14

Diagnosis: INFECTIOUS MONONUCLEOSIS
Treatment: MEDICAL THERAPY
ICD-9: 075
CPT: 90000-99999
Line: 668 Category: 14

Diagnosis: OTHER NONFATAL VIRAL INFECTIONS
Treatment: MEDICAL THERAPY
ICD-9: 051-053,055,056.9,057,072,074,078.0,078.2-.8,,079,480,487.2-.9
CPT: 90000-99999
Line: 669 Category: 14

Diagnosis: ACUTE PHARYNGITIS AND LARYNGITIS AND OTHER DISEASES OF VOCAL CORDS
Treatment: MEDICAL THERAPY
ICD-9: 462,478.5
CPT: 90000-99999
Line: 670 Category: 14

Diagnosis: PREVENTIVE SERVICES FOR ADULTS WITH QUESTIONABLE OR NO PROVEN EFFECTIVENESS
Treatment: MEDICAL THERAPY
ICD-9: 0
CPT: 90000-99999
Line: 671 Category: 16

Diagnosis: OLD LACERATION OF CERVIX AND VAGINA
Treatment: MEDICAL THERAPY
ICD-9: 622.3,624.4
CPT: 90000-99999
Line: 672 Category: 17

Diagnosis: BENIGN NEOPLASMS OF SKIN
Treatment: MEDICAL THERAPY
ICD-9: 210,214,216,221,222.1,222.4
CPT: 10000-61,10120-61,11000,11050-446,11600-46,12031-2,13100-51,14001,17000-306,19120,20000-5,20550,21030,21044,21499,21501,23030,23040,23930-1,25028-31,26010-30,26989-91,27301,27603-4,28001,31540,40800-12,41116,41800,41826,41899,42415,42440,42808,90000-99999
Line: 673 Category: 17

Diagnosis: REDUNDANT PREPUCE AND PHIMOSIS
Treatment: MEDICAL THERAPY, DILATION
ICD-9: 605
CPT: 54150-61,90000-99999
Line: 674 Category: 17

Diagnosis: VITILIGO, CONGENITAL PIGMENTARY ANOMALIES OF SKIN
Treatment: MEDICAL THERAPY
ICD-9: 709.0,757.3,757.9
CPT: 90000-99999
Line: 675 Category: 17

Diagnosis: DENTAL SERVICES (MARGINAL IMPROVEMENT)
Treatment: RESTORATIVE DENTAL SERVICE
ICD-9: 0
CPT: 01204-5,09910,09940,09952,07291,07272,06940,04261-72,03910-20
Line: 676 Category: 17

Diagnosis: SEBORRHEIC KERATOSIS, DYSCHROMIA, AND VASCULAR DISORDERS, SCAR CONDITIONS, AND FIBROSIS OF SKIN
Treatment: MEDICAL THERAPY
ICD-9: 702,709.1-.3,709.8-.9
CPT: 11000,11050,17000,90000-99999
Line: 677 Category: 17

Diagnosis: VIRAL WARTS
Treatment: MEDICAL THERAPY, CRYOSURGERY
ICD-9: 078.1
CPT: 90000-99999,17100,17110,17340,17000,11900,28043;46900-46924,54050-54065,56486,11050,11100-11101,11901
Line: 678 Category: 17

Diagnosis: UPPER EXTREMITY: FINGERTIP EVULSION W/O PEDICLE GRAFT
Treatment: REPAIR
ICD-9: 883.1,883.2
CPT: 12401
Line: 679 Category: 17

Diagnosis: AGENESIS OF LUNG
Treatment: MEDICAL THERAPY
ICD-9: 748.5
CPT: 90000-99999
Line: 680 Category: 17

Diagnosis: GALLSTONES WITHOUT CHOLECYSTITIS
Treatment: MEDICAL THERAPY, CHOLECYSTECTOMY
ICD-9: 574.2,575.6
CPT: 90000-99999,47490,47600-20,49000
Line: 681 Category: 17

Diagnosis: SIMPLE AND UNSPECIFIED GOITER, NONTOXIC NODULAR GOITER
Treatment: MEDICAL THERAPY
ICD-9: 240-241
CPT: 90000-99999
Line: 682 Category: 17

Diagnosis: SICCA SYNDROME
Treatment: MEDICAL THERAPY
ICD-9: 710.2
CPT: 90000-99999
Line: 683 Category: 17

Diagnosis: TRAUMATIC BRAIN INJURY, STATIC DEMENTIA, BRAIN ANOXIA DUE TO INFECTION OR TRAUMA
Treatment: MEDICAL THERAPY
ICD-9: 295.9,299.0,319,348.1,348.3-.4,851.0,850.2-.5,854.0,905.0
CPT: 61107,90000-99999
Line: 684 Category: 17

Diagnosis: ICHTHYOSIS
Treatment: MEDICAL THERAPY
ICD-9: 757.1
CPT: 90000-99999
Line: 685 Category: 17

Diagnosis: PROGRESSIVE DEMENTIA, ORGANIC BRAIN SYNDROME
Treatment: MEDICAL THERAPY
ICD-9: 046.1,090.40,094.1,290,294.1,310,331
CPT: 90000-99999
Line: 686 Category: 17

Diagnosis: INTRAVENTRICULAR AND SUBARACHNOID HEMORRHAGE OF FETUS OR NEONATE
Treatment: MEDICAL THERAPY
ICD-9: 772.1-.2
CPT: 90000-99999
Line: 687 Category: 2

Diagnosis: CANCER OF VARIOUS SITES WITH DISTANT METASTASES WHERE TREATMENT WILL NOT RESULT IN A 10% 5 YEAR SURVIVAL
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 140-198
CPT: 11600-46,38720-24,41110-14,41130,42120,42842-45,42880,47610,44131,47420-40,58951,61500,61510,61518-21,
61546-48,90000-99999
Line: 688 Category: 17

Diagnosis: SENSORINEURAL HEARING LOSS
Treatment: COCHLEAR IMPLANT
ICD-9: 389.1
CPT: 69930
Line: 689 Category: 11

Diagnosis: ALCOHOLIC CIRRHOSIS OF LIVER
Treatment: LIVER TRANSPLANT
ICD-9: 571.2
CPT: 47135
Line: 690 Category: 5

Diagnosis: NON-HODGKIN'S LYMPHOMAS
Treatment: BONE MARROW TRANSPLANT (5-6 LOCI MATCH)
ICD-9: 200,202.0-.2,202.8-.9
CPT: 38230-41
Line: 691 Category: 5

Diagnosis: OBESITY
Treatment: GASTROPLASTY
ICD-9: 278
CPT: 43845
Line: 692 Category: 11

Diagnosis: CONGENITAL CYSTIC LUNG - SEVERE
Treatment: LUNG RESECTION
ICD-9: 748.4
CPT: 32500
Line: 693 Category: 17

Diagnosis: BENIGN POLYPS OF VOCAL CORDS
Treatment: MEDICAL THERAPY
ICD-9: 478.4
CPT: 90000-99999
Line: 694 Category: 10

Diagnosis: ACUTE UPPER RESPIRATORY INFECTIONS AND COMMON COLD
Treatment: MEDICAL THERAPY
ICD-9: 460,465
CPT: 90000-99999
Line: 695 Category: 14

$142.44 Per Capita Cost Per Month

Diagnosis: TUBAL DYSFUNCTION AND OTHER CASES OF INFERTILITY
Treatment: IN-VITRO FERTILIZATION, GIFT
ICD-9: 256
CPT: 58970-76
Line: 696 Category: 15

Diagnosis: DENTAL SERVICES (EG. OBSOLETE TREATMENTS FOR VARIOUS CONDITIONS)
Treatment: RESTORATIVE DENTAL SERVICE
ICD-9: 0
CPT: 01310,01380-7,02410-30,02510-630,02710-810,02950,02952-4,02961-2,03460,03960,05215-81,05862,05976,06210,06240,06250-2,06545,06720-51,06790-1,06950,08110-999,09950
Line: 697 Category: 17

Diagnosis: UNCOMPLICATED HEMORRHOIDS
Treatment: HEMORRHOIDECTOMY
ICD-9: 455.0,455.3,455.6,455.9
CPT: 10140,45336,46083,46220-62,46320,46500,46934-36
Line: 698 Category: 17

Diagnosis: MINOR HEAD INJURY: HEMATOMA/EDEMA W/ NO/BRIEF LOSS OF CONSCIOUSNESS
Treatment: MEDICAL THERAPY
ICD-9: 851.02,851.12,851.82,851.92,851.42,851.52,850.9
CPT: 90000-99999
Line: 699 Category: 17

Diagnosis: GYNECOMASTIA
Treatment: MASTOPEXY
ICD-9: 611.1
CPT: 19316
Line: 700 Category: 17

Diagnosis: CYST OF KIDNEY, ACQUIRED
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 593.2
CPT: 50010,50390,90000-99999
Line: 701 Category: 17

Diagnosis: END STAGE HIV DISEASE
Treatment: MEDICAL THERAPY
ICD-9: 042-043
CPT: 90000-99999
Line: 702 Category: 17

Diagnosis: CHRONIC PANCREATITIS
Treatment: SURGICAL TREATMENT
ICD-9: 577.1
CPT: 48000,48999,49000
Line: 703 Category: 17

Diagnosis: SUPERFICIAL WOUNDS WITHOUT INFECTION AND CONTUSIONS
Treatment: MEDICAL THERAPY
ICD-9: 910.0,.2,.4,.6,.8,911.0,.2,.4,.6,.8,912.0,.2,.4,.6,.8,913.0,.2,.4,.6,.8,914.0,.2,.4,.6,.8,915.0,.2,.4,.6,.8,916.0,.2,.4,.6,.8,917.0,.2,.4,.6,.8,919.0,.2,.4,.6,.8,920-924
CPT: 10140,11740,12001-14,90000-99999
Line: 704 Category: 17

Diagnosis: CONSTITUTIONAL APLASTIC ANEMIA
Treatment: MEDICAL THERAPY
ICD-9: 284.0
CPT: 90000-99999
Line: 705 Category: 17

Diagnosis: PROLAPSED URETHRAL MUCOSA
Treatment: SURGICAL TREATMENT
ICD-9: 599.5
CPT: 51840-41
Line: 706 Category: 11

Diagnosis: CENTRAL RETINAL ARTERY OCCLUSION
Treatment: PARACENTESIS OF AQUEOUS
ICD-9: 362.31
CPT: 67015,67505
Line: 707 Category: 17

Diagnosis: EXTREMELY LOW BIRTH WEIGHT (UNDER 500 GM) AND UNDER 23 WEEK GESTATION
Treatment: LIFE SUPPORT
ICD-9: 765.0,765.11
CPT: 0
Line: 708 Category: 17

Diagnosis: ANENCEPHALOUS AND SIMILAR ANOMALIES AND REDUCTION DEFORMITIES OF THE BRAIN
Treatment: LIFE SUPPORT
ICD-9: 740,742.2
CPT: 0
Line: 709 Category: 17

\$145.15 Per Capita Cost Per Month

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ANAL	419
FEMALE GENITAL TRACT	406

CONDITION	LINE
FISTULA (CON'T)	
LIP (CONGENITAL)	377
PULMONARY, AORTIC	242
SALIVARY GLANDS	269
URETERAL (INTESTINAL)	275
URETHRAL	468
FLAIL CHEST	130
FOOD ALLERGY	652
FOREIGN BODY	
ACCIDENTALLY LEFT DURING PROCEDURE	463
BRONCHUS	4
CONJUNCTIVAL SAC	347
EAR	473
ESOPHAGUS	4
INTRAOCULAR, MAGNETIC & NONMAGNETIC, RETAINED	552
LARYNX	4
NOSE	473
PENIS	453
PHARYNX	4
TRACHEA	4
UTERUS	451
VAGINA	451
VULVA	451
FRACTURE	
EPIPHYSIS OF LOWER EXTREMITIES	
CLOSED	380
OPEN	82
EPIPHYSIS OF UPPER EXTREMITIES	
CLOSED	554
FACE BONES	59
HIP, CLOSED	87
JOINT	
EXCEPT HIP, CLOSED	417
OPEN	110
LARYNX, OPEN	31
PELVIS	116
PHALANGE(S) OF FOOT	570
RIBS	
CLOSED	569
OPEN	54
SHAFT OF BONE	
CLOSED	381
OPEN	35
SKULL, COMPOUND/DEPRESSED	62
STERNUM	
CLOSED	569
OPEN	54
TRACHEA, OPEN	31
VERTEBRAL COLUMN	
SACRUM & COCCYX	
WITH SPINAL CORD INJURY	412
WITHOUT SPINAL CORD INJURY	656
CERVICAL	86
GALACTOSEMIA	25
GALLSTONE	
WITH CHOLECYSTITIS	16
WITHOUT CHOLECYSTITIS	681
GANGLION OF TENDON OR JOINT	495
GANGRENE	253
GAS GANGRENE	253
GASTRITIS	152
GASTROENTERITIS, NONINFECTIOUS	107
GENU RECURVATUM	558
GENU VARUM & VALGUM (ACQUIRED)	558
GIARDIASIS	444
GIGANTISM	226
GLAUCOMA	332
ANGLE-CLOSURE	329
ASSOCIATED WITH DISORDERS OF THE LENS	330

CONDITION	LINE
GLAUCOMA (CON'T)	
OPEN ANGLE	
CYCLOCRYOTHERAPY	336
LASER TRABECULOPLASTY	335
TRABECULECTOMY	331
GLOMERULONEPHRITIS, ACUTE	120
WITH LESION OF RAPIDLY PROGRESSIVE GLOMERULONEPHRITIS	137
GLYCOGENOSIS	421
GOITER	
DYSHORMONOGENIC	154
NONTOXIC NODULAR	
MEDICAL THERAPY	682
THYROIDECTOMY	503
SIMPLE	682
GONOCOCCAL INFECTIONS	170
OF EYE	157
GOUT	401
GRANULATION TISSUE, ABNORMAL	604
GRANULOMA	
LETHAL MIDLINE	608
SKIN, MUSCLE & SUBCUTANEOUS TISSUE	463
GUILLAIN-BARRE SYNDROME	288
GYNECOMASTIA	700
HEARING LOSS	
AGE 3 OR UNDER	218
OVER AGE OF THREE	477
SENSORINEURAL	689
HEART FAILURE	259
HELMINTHIASIS, INTESTINAL	444
HEMATOMA	
AURICLE, PINNA OR EXTERNAL EAR	611
SUBARACHNOID AND INTERCEREBRAL	88
VULVA	437
HEMOLYTIC DISEASE DUE TO ISOIMMUNIZATION	19
HEMORRHAGE	
ADRENAL, FETUS OR NEONATE	268
CUTANEOUS, FETUS OR NEONATE	268
GASTROINTESTINAL	185
INTERCEREBRAL	88
INTRACEREBRAL	303
INTRAVENTRICULAR, FETAL OR NEONATE	687
SUBARACHNOID	88
FETUS OR NEONATE	687
THYROID	529
TRANSPLACENTAL	71
VITREOUS	334
HEMORRHOIDS	
COMPLICATED	466
THROMBOSED	466
UNCOMPLICATED	698
HEMOTHORAX	33
HEPATITIS	
ALCOHOLIC	509
CHRONIC	213
VIRAL	597
HERNIA	
WITH OBSTRUCTION AND/OR GANGRENE	7
WITHOUT OBSTRUCTION OR GANGRENE	504
HERPES SIMPLEX	
W/OPHTHALMIC COMPLICATIONS	325
WITHOUT COMPLICATIONS	639
HERPES ZOSTER W/OPHTHALMIC COMPLICATIONS	325
HERPETIC ENCEPHALITIS	113
HISTIOCYTOSIS	499
HISTOPLASMOSIS	127
HIV DISEASE, INCLUDING AIDS	158
END STAGE	
COMFORT CARE	164
MEDICAL THERAPY	702
OPPORTUNISTIC INFECTIONS OF	255

CONDITION	LINE
HODGKIN'S DISEASE	
BONE MARROW TRANSPLANT	209
CHEMOTHERAPY, RADIATION THERAPY	189
HORDEOLUM AND OTHER DEEP INFLAMMATION OF EYELID	595
HYDATIDIFORM MOLE	90
HYDROCELE	599
HYDROCEPHALUS (CONGENITAL)	281
HYDRONEPHROSIS (CONGENITAL)	300
HYDROPS FETALIS	46
HYPERALDOSTERONISM	286
HYPERESTROGENISM	536
HYPERFUNCTION	
MEDULLOADRENAL	286
PITUITARY (ANTERIOR)	226
HYPERPLASIA OF PROSTATE	318
HYPERSENSITIVITY ANGIITIS	320
HYPERSOMNIA W/SLEEP APNEA	373
HYPERTELORISM OF ORBIT	547
HYPERTENSION	147
INTRACRANIAL, BENIGN	645
HYPERTENSIVE HEART AND RENAL DISEASE	148
HYPERTROPHIC	
BREAST	464
MUSCLE	246
SKIN	581
HYPHEMA	326
HYPOCALCEMIA	43
HYPOGLYCEMIA	26
NEONATAL	23
HYPOGLYCEMIC COMA	26
HYPOMAGNESEMIA	43
HYPOPLASIA	296
HYPOPLASTIC LEFT HEART SYNDROME	441
HYPOSPADIAS	411
HYPOTENSION	34
HYPOTHERMIA	48
HYPOTHYROIDISM	
ACQUIRED	154
CONGENITAL	29
ICHTHYOSIS	685
IMPACTED TEETH	480
IMPETIGO HERPETIFORMIS	591
INCONTINENCE, STRESS (FEMALE)	433
INFARCTION	
MYOCARDIAL (ACUTE)	50
THYROID	529
INFECTIONS	
ANAEROBIC, REQUIRING HYPERBARIC OXYGEN	133
METASTATIC WITH LOCALIZED SITES	291
OPPORTUNISTIC IN IMMUNOCOMPROMISED HOSTS	255
RESPIRATORY, UPPER (ACUTE)	695
VIRAL, NONFATAL	669
INFECTIOUS SKIN CONDITIONS	217
INFERTILITY	
FEMALE, CERVICAL ORIGIN	602
MALE	602
INFESTATIONS	
BODY (EG. LICE, SCABIES)	434
EYELID, PARASITIC	527
INFLAMMATION	
LACRIMAL PASSAGES	532
ORBIT, CHRONIC	340
INFLAMMATORY DISEASE, PELVIC (ACUTE)	13
INFLUENZA WITH PNEUMONIA	1
INJURY	
BLOOD VESSELS OF THE THORACIC CAVITY	100
BRAIN, TRAUMATIC	684

CONDITION	LINE
INJURY (CON'T)	
HEAD	
MINOR	699
SEVERE	131
MAJOR BLOOD VESSELS OF UPPER EXTREMITY	11
NERVE, PERIPHERAL	36
SPINAL CORD	
CERVICAL	86
WITHOUT VERTEBRAL INJURY	83
SUPERFICIAL	
WITH INFECTION	386
WITHOUT INFECTION OR CONTUSION	704
INSUFFICIENCY	
AORTIC VALVE (CONGENITAL)	190
VASCULAR, INTESTINE (ACUTE)	135
INTERRUPTED AORTIC ARCH	197
INTOLERANCE, FRUCTOSE (HEREDITARY)	198
INTOXICATION SPECIFIC TO NEWBORN	73
IRIDOCYCLITIS	342
IRON DEFICIENCY ANEMIA	138
ISCHEMIA, CEREBRAL, TRANSIENT	507
ISCHEMIC HEART DISEASE, ACUTE/SUBACUTE	149
JAUNDICE, FETAL AND NEONATAL	19
KAWASAKI DISEASE	320
KELOID SCAR	604
KERATITIS, EXCLUDING CORNEAL ULCER	629
KERATOCONJUNCTIVITIS	
EXPOSURE	458
SICCA, NOT SPECIFIED AS SJOGREN'S	496
KERATODERMA (ACQUIRED)	581
LABYRINTHITIS	596
LACERATION	
CERVIX, OLD	672
LACRIMAL SYSTEM	424
LUNG	70
VAGINA, OLD	672
LARYNGITIS	670
LARYNGOTRACHEITIS (ACUTE)	8
LEIOMYOMA OF UTERUS	429
LEPROSY	305
LEPTOSPIROSIS	280
LESION	
BRACHIAL PLEXUS	571
PLANTAR NERVE	502
PREMALIGNANT	267
SPINAL, NON-ALLOPATHIC (ACUTE)	594
LEUKEMIA	
CHRONIC	
BONE MARROW TRANSPLANT	523
CHEMOTHERAPY, RADIATION THERAPY	278
LYMPHOCYTIC, ACUTE	244
ADULT	308
CHILD	236
LYMPHOID	294
MONOCYTIC	244
MYELOID	244
NON-LYMPHOCYTIC, ACUTE	
BONE MARROW TRANSPLANT	311
CHEMOTHERAPY	522
LEUKOEDEMA, MOUTH AND TONGUE	626
LEUKOPLAKIA	
CERVIX	234
ORAL MUCOSA, INCLUDING TONGUE	
MEDICAL THERAPY	289
SURGICAL TREATMENT	271
LICHEN PLANUS	636
LIPIDOSES	270
LUMBAGO	573
LUPUS ERYTHEMATOSUS	584

CONDITION	LINE
LYME'S DISEASE	387
LYMPHADENITIS (ACUTE)	613
LYMPHEDEMA	646
LYMPHOMA, NON-HODGKIN'S	
BONE MARROW TRANSPLANT	691
CHEMOTHERAPY, RADIATION THERAPY	239
MALABSORPTION, INTESTINAL	225
MALARIA	272
MALUNION OF FRACTURE	422
MASTITIS, INFECTIVE, NEONATAL	24
MASTOIDITIS (ACUTE)	61
MELANOMA OF SKIN, MALIGNANT, TREATABLE	227
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ASEPTIC	667
BACTERIAL (ACUTE)	47
SUBACUTE	118
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MONONEUROPATHY	637
MONONUCLEOSIS, INFECTIOUS	668
MUCOCELE	435
MYASTHENIA GRAVIS	593
NEONATAL	74
MYCOBACTERIAL INFECTIONS	108
MYCOSES	127
MYELITIS, VIRAL, SELF-LIMITING	662
MYELOMA, MULTIPLE	
BONE MARROW TRANSPLANT	523
CHEMOTHERAPY, RADIATION THERAPY	308
MYOCARDITIS	
CARDIAC TRANSPLANT	367
MEDICAL THERAPY	95
NAPKIN RASH	649
NECROLYSIS, TOXIC EPIDERMAL	97
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BONE, ASEPTIC	399
LIVER, ACUTE	
LIVER TRANSPLANT	368
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NEOPLASM, BENIGN	
BONE & ARTICULAR CARTILAGE	472
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CONNECTIVE AND OTHER SOFT TISSUE	472
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EYELID	471
FALLOPIAN TUBES	456
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NASAL CAVITIES AND ACCESSORY SINUSES	459
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PITUITARY GLAND	348
RESPIRATORY AND INTRATHORACIC ORGANS	505
SKIN	673
NEPHROTIC SYNDROME	310
TRANSIENT WITH LESION OF MINIMAL CHANGE GLOMERULONEPHRITIS	540
NEURITIS, THORACIC OR LUMBOSACRAL	573
NONUNION OF FRACTURE	422
NUTRITIONAL DEFICIENCIES	138
OBESITY	
GASTROPLASTY	692
MEDICAL THERAPY	634
OBSTRUCTION	
BILE DUCT	16
INTESTINE W/O MENTION OF HERNIA	38
NASOLACRIMAL DUCT, NEONATAL	465
RESPIRATORY SYSTEM	17
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CONDITION	LINE
OCCLUSION	
CENTRAL RETINAL ARTERY	707
CENTRAL RETINAL VEIN	560
PRECEREBRAL ARTERIES	414
VENOUS TRIBUTARY (BRANCH)	560
OMPHALITIS OF THE NEWBORN	24
ORCHITIS	453
OSTEOARTHRITIS	
ARTHROPLASTY	399
MEDICAL THERAPY	483
OSTEOCHONDROPATHIES	575
OSTEOMYELITIS	
ACUTE	30
CHRONIC	231
OSTEOPOROSIS	423
OTITIS EXTERNA, INFECTIVE	396
OTITIS MEDIA	
ACUTE	354
CHRONIC	
MEDICAL THERAPY	397
SURGICAL TREATMENT	355
OTOSCLEROSIS	
MEDICAL THERAPY	641
STAPEDECTOMY	462
OVERACTIVITY, CORTICOADRENAL	286
PALSY, CEREBRAL	
MEDICAL THERAPY	385
SURGICAL TREATMENT	440
PANCREATITIS, ACUTE	89
PANCREATITIS, CHRONIC	
MEDICAL THERAPY	317
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PANHYPOPITUITARISM	195
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PEMPHIGUS/PEMPHIGOID	224
PERFORATION OF INTESTINE, PERINATAL	101
PERICARDITIS	95
PERIOSTITIS OF SHOULDER	485
PERITONITIS	3
PHARYNGITIS	670
PHENYLKETONURIA (PKU)	28
PHLEBITIS	
DEEP	78
SUPERFICIAL	647
PIERRE ROBIN DEFORMITY	75
PIGMENTARY ANOMALIES OF	
SKIN (CONGENITAL)	675
PLEURISY	410
PNEUMONIA	
ASPIRATION	84
BACTERIAL	1
BRONCHIAL	1
PNEUMOCOCCAL	1
PNEUMOCYSTIS CARINII	238
PNEUMOTHORAX	33
POISONING	
FOOD, BACTERIAL AND OTHER	660
GAS/FUMES/VAPORS, REQUIRING HYPERBARIC OXYGEN	77
INGESTION AND INJECTION	56
MUSHROOMS, FISH, BERRIES, ETC.	98
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POLYARTERITIS NODOSA AND ALLIED CONDITIONS	243
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CONDITION	LINE
POLYCYTHEMIA NEONATORUM, SYMPTOMATIC	20
POLYMYALGIA RHEUMATICA	577
POLYMYOSITIS	321
POLYNEUROPATHY, UNSPECIFIED	516
POLYPS	
ANAL AND RECTAL	282
NASAL	
RECONSTRUCTION	459
SURGICAL TREATMENT	482
VOCAL CORDS, BENIGN	694
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POSTLAMINECTOMY SYNDROME	573
PREGNANCY	21
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ADULTS	
WITH PROVEN EFFECTIVENESS	167
WITH QUESTIONABLE OR NO PROVEN EFFECTIVENESS	671
CHILDREN	143
DENTAL	166
PRIAPISM	453
PROCTOCOLITIS, IDIOPATHIC	273
PROLAPSE	
RECTAL	408
UTERINE	443
PROLAPSED URETHRAL MUCOSA	706
PROSTATITIS	589
TRICHOMONAL	428
PSEUDOCYST OF PANCREAS	370
PSORIASIS AND SIMILAR DISORDERS	393
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ACUTE	14
CHRONIC	232
PYODERMA	176
QUADRIPLEGIA	382
RADICULITIS, THORACIC OR LUMBOSACRAL	573
RAT-BITE FEVER	98
RAYNAUD'S SYNDROME	578
REDUNDANT PREPUCE AND PHIMOSIS	674
REFLUX, VESICOURETERAL	299
REITER'S DISEASE	579
RELAPSING FEVER	272
RENAL DISEASE, END STAGE	
MEDICAL THERAPY INCLUDING DIALYSIS	319
RENAL TRANSPLANT	312
RESPIRATORY CONDITIONS OF FETUS AND NEWBORN	106
RESPIRATORY FAILURE	69
RETAINED	
DENTAL ROOT	538
FOREIGN BODY IN SOFT TISSUE	420
RETINOPATHY	
CENTRAL SEROUS	665
DIABETIC/OTHER	343
RHEUMATIC MYOCARDITIS AND PERICARDITIS (CHRONIC)	520
RHINITIS, ALLERGIC	534
ROSACEA	584
RUBELLA	361
RUBEOSIS IRIDIS	562
RUPTURE	
BLADDER, NONTRAUMATIC	58
ESOPHAGUS	96
INTESTINE	6
LIVER	68
PAPILLARY MUSCLE	132
SPLEEN	12
SYNOVIUM	449

CONDITION	LINE
SARCOIDOSIS	644
SCALDED SKIN SYNDROME	97
SCAR CONDITIONS	677
SCARLET FEVER	144
SCLERITIS	659
SCLERODERMA, CIRCUMSCRIBED	623
SCLEROSIS	
MULTIPLE	384
SYSTEMIC	322
SEBORRHEIC KERATOSIS	677
SEPTICEMIA	64
SEPTUM, HYMEN AND VAGINAL	407
SHIGELLOSIS	444
SIALOADENITIS	269
SIALOLITHIASIS	435
SICCA SYNDROME	683
SINUSITIS	
ACUTE	357
CHRONIC	
MEDICAL THERAPY	572
SURGICAL TREATMENT	482
SOMATIC MEDICINE	168
SORE THROAT, STREPTOCOCCAL	144
SPINA BIFIDA	
WITH HYDROCEPHALUS	510
WITHOUT HYDROCEPHALUS	359
SPONDYLOSIS	586
SPRAIN/STRAIN	
ACHILLES TENDON	655
BACK	594
JOINTS AND ADJACENT MUSCLES	653
STENOSIS	
AORTIC VALVE (CONGENITAL)	190
MITRAL VALVE (CONGENITAL)	201
NASOLACRIMAL DUCT (ACQUIRED)	467
PRECEREBRAL ARTERIES	414
PULMONARY VALVE (CONGENITAL)	274
SPINAL, LUMBAR	405
TRICUSPID VALVE (CONGENITAL)	199
STEVENS-JOHNSON SYNDROME	66
STOMATITIS	489
STRIAE ATROPHICAE	581
STRICTURE	
URETER	229
URETHRAL	453
STROKE	252
SYNDROME	
COMPARTMENT	413
HEPATORENAL	606
"INFANT OF A DIABETIC MOTHER"	23
ORGANIC BRAIN	686
RESPIRATORY DISTRESS (ADULT)	112
VERTIGINOUS	582
SYNOVITIS AND TENOSYNOVITIS	648
SYPHILIS	18
SYSTEMIC LUPUS ERYTHEMATOSUS	295
TEAR, RETINAL	530
TELANGIECTASIA, HEMORRHAGIC, HEREDITARY	517
TEMPERATURE REGULATION OF NEWBORNS, CONDITIONS INVOLVING THE	41
TENDINITIS	631
TENOSYNOVITIS, RADIAL STYLOID	576
TETANUS	298
NEONATORUM	139
TETRALOGY OF FALLOT (TOF)	210
THROMBOCYTOPENIA	91
THROMBOPHLEBITIS	
DEEP	78
SUPERFICIAL	647

CONDITION	LINE
THROMBOSIS	
AORTIC, ABDOMINAL AND THORACIC	123
PORTAL VEIN	297
VENOUS	254
THYROIDITIS	
ACUTE	353
CHRONIC	52
THYROTOXICOSIS	52
NEONATAL	72
TMJ DISORDERS	
SPLINTS	620
SURGICAL TREATMENT	621
TONGUE TIE	541
TONSILLITIS (ACUTE)	663
TORSION	
OVARY	104
TESTIS	233
TOXOPLASMOSIS	108
TRACHOMA	376
TRANSPOSITION OF GREAT VESSELS	211
TRICHIASIS OF EYELID	471
TRICHINOSIS	279
TUBERCULOSIS	2
ULCER	
CORNEA	
CONJUNCTIVAL FLAP	535
MEDICAL THERAPY	445
GASTRIC, DUODENAL, PEPTIC, GASTROJEJUNAL	
HEMIGASTRECTOMY	185
MEDICAL THERAPY	152
INTESTINAL	261
SKIN, CHRONIC	
AMPUTATION	253
MEDICAL THERAPY	388
UNDESCENDED TESTICLE	173
URETHRITIS	427
TRICHOMONAL	428
URTICARIA	
ACUTE	657
CHRONIC	580
UVEITIS, SYMPATHETIC	403
VAGINITIS	452
VARICES	
ESOPHAGEAL	316
LOWER EXTREMITIES	616
SUBLINGUAL, SCROTAL AND PELVIC	654
VULVAL	666
VENEREAL DISEASES	170
VENOM POISONING	92
VESICULITIS, SEMINAL	453
VINCENT'S DISEASE	426
VITILIGO	675
WARTS, VIRAL	678
WHOOPING COUGH	27
WITHDRAWAL	
ALCOHOL	142
DRUG OR NARCOTIC	142
SYNDROME, NEWBORN DUE TO DRUGS	76
WOUND, OPEN	350
EAR DRUM	475
EYEBALL	339
MOUTH W/O COMPLICATION	661
NECK, INCLUDING LARYNX (DEEP)	31
ORBIT, PENETRATING	327
XEROSIS	633

EXPANDED DEFINITION
OF
PREVENTIVE SERVICES

April 4, 1991

The following document describes preventive care as defined by the Oregon Health Services Commission on March 27, 1991.

This document is divided into seven tables which are arranged by age group. Each table consists of three columns; screening, counseling and immunizations, indicating those preventive care services identified for each age group. Tables are also accompanied by several footnotes which more fully describe the patients determined to be at high risk.

Tables also contain a "Remain Alert For" section listing those special circumstances which pertain to specific age groups.

Highlighted items indicate those mental health care and chemical dependency services.

Please contact Commission staff if you have questions regarding this document.

TABLE 1
Birth to 18 Months

Leading Causes of Death:
- Conditions originating in perinatal period
- Congenital anomalies
- Heart disease
- Injuries (nonmotor vehicle)
- Pneumonia/influenza

Screening

- Height and weight
- Hemoglobin and hematocrit(1)
- Parent's substance abuse during lactation and perinatal period(s) (HR5)
- Guidelines for referral(See checklists)
- Infant motor & developmental screens (as indicated)
- HIV antibody test (HR8)

HIGH RISK GROUPS
- HEARING(2) (HR1)
- ERYTHROCYTE PROTOPORPHYRIN(HR2)
- FAS, FAE, DRUG AFFECTED (HR7)

This list of preventive services is not exhaustive. Clinicians may which to add other preventive services on a routine basis after considering the patient's medical history and other individual circumstances. Examples of target conditions include:
- Developmental disorders
- Musculosketal malformations
- Cardiac anomalies
- Genitourinary disorders
- Metabolic disorders
- Speech problems
- Behavioral disorders
- Parent/family dysfunction

Parent Counseling

Diet
- Breastfeeding
- Nutrient intake, especially iron-rich foods

Injury Prevention
- Child safety seats
- Smoke detector
- Hot water heater temperature
- Stairway gates, window guards, pool fence
- Storage of drugs and toxic chemicals
- Syrup of ipecac, poison control telephone number

Dental Health
- Baby bottle tooth decay

Mental Health/ Chemical Dependency
Parent education regarding:
- Child development
- Attachment/ bonding
- Behavior management
- Special needs of a child due to:
  - Familial disruption
  - Health problems
  - Temperament incongruence with parent
- Increased well-child visits (HR6)
- Targeted case management, as indicated (3)
- Referral for MHCD services

Other Primary Preventive Measures
- Effects of passive smoking

Immunizations & Chemoprophylaxis

- Diphtheria-tetanus pertussis (DPT) vaccine
- Oral poliovirus vaccine (OPV)
- Measles-mumps-rubella (MMR) vaccine
- Haemophilus influenzae type b (Hib) conjugate vaccine

HIGH RISK GROUPS
- FLUORIDE SUPPLEMENTS (HR3)

First Week
- Ophthalmic antibiotics
- Hemoglobin electrophoresis (HR4)
- T4/TSH
- Phenylalanine
- Hearing (HR1)

Remain Alert For:
- Ocular misalignment
- Tooth decay
- Signs of child abuse or neglect

1. Once during infancy. 2. At age 18-month visit, if not tested earlier.
3. As defined in Ancillary Services.

TABLE 1 - Birth to 18 Months	High Risk Categories

HR1 Infants with a family history of childhood hearing impairment or a personal history of congenital perinatal infection with herpes, syphilis, rubella, cytomegalovirus, or toxoplasmosis; malformations involving the head or neck (e.g., dysmorphic and syndromal abnormalities, cleft palate, abnormal pinna); birthweight below 1500 g; bacterial meningitis; hyperbilirubinemia requiring exchange transfusion; or severe perinatal asphyxia (Apgar scores of 0-3, absence of spontaneous respirations for 10 minutes, or hypotonia at 2 hours of age).

HR2 Infants who live in or frequently visit housing built before 1950 that is dilapidated or undergoing renovation; who come in contact with other children with known lead toxicity; who live near lead processing plants or whose parents or household members work in a lead-related occupation; or who live near busy highways or hazardous waste sites.

HR3 Infants living in areas with inadequate water fluoridation (less than 0.7 parts per million).

HR4 Newborns of Caribbean, Latin American, Asian, Mediterranean, or African descent.

HR5 Drug affected neonate or family history of previous drug affected babies. Parents with history of alcohol and/or drug use.

HR6 Having a: chronically mentally ill parent; substance abusing parent; mother who began parenting as a teen. Living at or below poverty. Having: parents involved in criminal behavior; experienced an out-of-home placement(s), multiple moves, failed adoption(s). Being homeless. Having suffered physical, emotional or sexual abuse, or severe neglect. Having: a chronic health problem in the family; an absence of a family support system. Being substance affected at birth.

HR7 Parents with alcohol and/or drug use. Children with history of intrauterine addiction. Physical and behavioral indicators: hypertension, gastritis, esophagitis, hematological disorders, poor nutritional status, cardiac, arrhythmias, neurological disorders, intrauterine growth retardation, mood swings, difficulty concentrating, inappropriateness, irritability or agitation, depression, bizarre behavior, abuse and neglect, behavior problems.

HR8 HIV positive mother

TABLE 2
Ages 19 months-6 years*

Leading Causes of Death:
- Injuries (nonmotor vehicle)
- Motor vehicle crashes
- Congenital anomalies
- Homicide
- Heart disease

Screening

- Height and weight
- Blood pressure
- Eye exam for amblyopia and strabismus(1)
- Urinalysis for bacteriuria
- Guidelines for referral (See Checklists)
- HIV antibody test (HR8)

HIGH RISK GROUPS
- ERYTHROCYTE PROTOPORPHYRIN(2) (HR1)
- TUBERCULIN SKIN TEST (PPD) (HR2)
- HEARING(3) (HR3)
- FAS, FAE, DRUG AFFECTED (HR6)

This list of preventive services is not exhaustive. Clinicians may wish to add other preventive services on a routine basis after considering the patient's medical history and other individual circumstances. Examples of target conditions include:
- Developmental disorders
- Speech problems
- Behavioral and learning disorders
- Parent/family dysfunction

Patient and Parent Counseling

Diet and Exercise
- Sweets and between-meal snacks, iron-enriched foods, sodium
- Caloric balance
- Selection of exercise program

Injury Prevention
- Safety belts
- Smoke detector
- Hot water heater temperature
- Window guards and pool fence
- Bicycle safety helmets
- Storage of drugs, toxic chemicals, matches, and firearms
- Syrup of ipecac, poison control telephone number

Dental Health
- Tooth brushing and dental visits

Mental Health/ Chemical Dependency
Parental education regarding:
- Child development
- Attachment/bonding
- Behavior management
- Special needs of a child due to:
  - Familial disruption
  - Health problems
  - Temperament incongruence with parent
- Increased well-child visits (HR7)
- Targeted case management resulting from screening (5)
- Referral for MHCD services

Other Primary Preventive Measures
- Effects of passive smoking

HIGH RISK GROUPS
- SKIN PROTECTION FROM ULTRAVIOLET LIGHT (HR4)

Immunizations and Chemoprophylaxis

- Diphtheria-tetanus-pertussis (DTP) vaccine(4)
- Oral poliovirus vaccine (OPV)(4)

HIGH RISK GROUPS
- FLUORIDE SUPPLEMENTS (HR5)

Remain Alert for:
- Vision disorders
- Dental decay, malalignment, premature loss of teeth, mouth breathing
- Abnormal bereavement
- Signs of child abuse or neglect

*One visit is required for immunizations. Because of lack of data and differing patient risk profiles, the scheduling of additional visits and frequency of the individual preventive services listed in this table are left to clinical discretion.

1. Ages 3-4. 2. Annually. 3. Before age 3, if not tested earlier.
4. Once between ages 4 and 6. 5. As defined in Ancillary Services.

HR1 Children who live in or frequently visit housing built before 1950 that is dilapidated or undergoing renovation; who come in contact with other children with know lead toxicity; who live near lead processing plants or whose parents or household members work in a lead-related occupation; or who live near busy highways or hazardous waste sites.

HR2 Household members of persons of tuberculosis or others at risk for close contact with the disease; recent immigrants or refugees from countries in which tuberculosis is common (e.g., Asia, Africa, Central and South America, Pacific Islands); family members of migrant workers; residents of homeless shelters; or persons with underlying medical disorders.

HR3 Children with a family history of childhood hearing impairment or a personal history of congenital perinatal infection with herpes, syphilis, rubella, cytomegalovirus, or toxoplasmosis; malformations involving the head or neck (e.g., dysmorphic and syndromal abnormalities, cleft palate, abnormal pinna); birthweight below 1500 g; bacterial meningitis; hyperbilirubinemia requiring exchange transfusion; or severe perinatal asphyxia (Apgar scores of 0-3, absence of spontaneous respirations for 10 minutes, or hypotonia at 2 hours of age).

HR4 Children with increased exposure to sunlight

HR5 Children living in areas with inadequate water fluoridation (less than 0.7 parts per million).

HR6 Parents with alcohol and/or drug use. Children with history of intrauterine addiction. Physical and behavioral indicators: hypertension, gastritis, esophagitis, hematological disorders, poor nutritional status, cardiac, arrhythmias, neurological disorders, intrauterine growth retardation, mood swings, difficulty concentrating, inappropriateness, irritability or agitation, depression, bizarre behavior, abuse and neglect, behavior problems.

HR7 Having a: chronically mentally ill parent; substance abusing parent; mother who began parenting as a teen. Living at or below poverty. Being, in the judgment of a MH professional, depressed. Having: parents involved in criminal behavior; experienced an out-of-home placement(s), multiple moves, failed adoption(s). Being homeless. Having: suffered physical, emotional or sexual abuse, or severe neglect; a chronic health problem in the family; an absence of a family support system. Being substance affected at birth. Behavior problems in child care/preschool.

HR8 HIV positive mother or previously tested positive.

TABLE 3
Ages 7-12*

Leading Causes of Death:
- Motor vehicle crashes
- Injuries (nonmotor vehicle)
- Congenital anomalie
- Leukemia
- Homicide
- Heart disease

Screening

- Height and weight
- Blood pressure
- Guidelines for referral (See Checklists)
- Sexual abuse/ practices

HIGH RISK GROUPS
- TUBERCULIN SKIN TEST (PPD) (HR1)
- FAS, FAE, DRUG AFFECTED (HR4)

This list of preventive services is not exhaustive. Clinicians may wish to add other preventive services on a routine basis after considering the patient's medical history and other individual circumstances. Examples of target conditions include:
- Developmental disorders
- Scoliosis
- Behavioral and learning disorders
- Parent/family dysfunction

Patient & Parent Counseling

Diet and Exercise
- Fat (esp. saturated fat), cholesterol, sweets and between-meal snacks, sodium
- Caloric balance
- Selection of exercise program

Injury Prevention
- Safety belts
- Smoke detector
- Storage of firearms, drugs, toxic chemicals, matches
- Bicycle safety helmets

Dental Health
- Regular tooth brushing and dental visits

Mental Health/ Chemical Dependency
Parental education regarding:
- Child development
- Attachment/bonding
- Behavior management
- Special needs of a child due to:
  - Familial disruption
  - Health problems
  - Temperament incongruence with parent
  - Minority group status/cultural conflict
- Increased well-child visits (HR4)
- Targeted case management, as indicated (2)
- Referral for MHCD services

Substance Use
- Tobacco: Discussion of health hazards (HR4,HR5)
- Alcohol/inhalants/ other drugs: Discussion of health hazards
- Referral for abuse

HIGH RISK GROUPS
- SHARING/USING UNSTERILIZED NEEDLES AND SYRINGES (HR7)

Sexual Practices
- Sexual development and behavior(1)
- Sexually transmitted diseases: partner selection, condoms
- Unintended pregnancy and contraceptive options

Other Primary Preventive Measures

HIGH RISK GROUPS
- SKIN PROTECTION FROM ULTRAVIOLET LIGHT (HR2)

Chemoprophylaxis

HIGH RISK GROUPS
- FLUORIDE SUPPLEMENTS (HR3)

Remain Alert For:
- Vision disorders
- Diminished hearing
- Dental decay, malalignment, mouth breathing
- Abnormal bereavement
- Suicide risk factors (HR6)
- Signs of child abuse or neglect

*Because of the lack of data and differing risk profiles, the scheduling of visits and the frequency of the individual preventive services listed in this table are left to clinical discretion.

1. Often best performed with the involvement of parents.
2. As defined in Ancillary Services.

HR1 Household members of persons with tuberculosis or others at risk for close contact with the disease; recent immigrants or refugees from countries in which tuberculosis is common (e.g., Asia, Africa, Central and South America, Pacific Islands); family members of migrant workers; residents of homeless shelters; or persons with certain underlying medical disorders.

HR2 Children with increased exposure to sunlight.

HR3 Children living in areas with inadequate water fluoridation (less than 0.7 parts per million).

HR4 Household members with history of alcohol and/or drug abuse or dependency. Physical and behavioral indicators: hypertension, gastritis, esophagitis, hematological disorders, poor nutritional status, cardiac, arrhythmias, neurological disorders, intrauterine growth retardation, mood swings, difficulty concentrating, inappropriateness, irritability or agitation, depression, bizarre behavior, conflicts with family or friends, abuse and neglect, behavior problems.

HR5 Having a: chronically mentally ill parent; substance abusing parent; mother who began parenting as a teen. Living at or below poverty. Being, in the judgment of a MH professional, suicidal and/or depressed. Having parents involved in criminal behavior; experienced an out-of-home placement(s), multiple moves, failed adoption(s). Being homeless. Having: suffered physical, emotional or sexual abuse, or severe neglect; a chronic health problem in the family; a mental or emotional disorder and is in juvenile justice system; an absence of a family support system. Being substance affected at birth. Behavior problem in child care/school.

HR6 In family with or experiencing recent divorce, separation, unemployment, depression, alcohol or other drug abuse, serious medical illness, recent bereavement, sexual and physical abuse, or living alone.

HR7 Intravenous drug users.

TABLE 4
Ages 13-18*

Leading Causes of Death:
- Motor vehicle crashes
- Homicide
- Suicide
- Injuries (nonmotor vehicle)
- Heart disease

Screening

History
- Prescription and over-the-counter drug abuse
- Dietary intake
- Physical activity
- Tobacco
- Sexual abuse/ practices
- Alcohol/inhalants/ drug use

Physical Exam
- Height and weight
- Blood pressure
- Guidelines for referral (See Checklists)

HIGH RISK GROUPS
- COMPLETE SKIN EXAM (HR1)
- CLINICAL TESTICULAR EXAM (HR2)
- COMPLETE ORAL CAVITY (HR18)
- FAE, FAS, DRUG AFFECTED (HR16)

Laboratory/ Diagnostic Procedures

HIGH RISK GROUPS
- RUBELLA ANTIBODIES (HR3)
- VDRL/RPR (HR4)
- CHLAMYDIA TESTING (HR5)
- GONORRHEA CULTURE (HR6)
- COUNSELING AND TESTING FOR HIV (HR7)
- TUBERCULIN SKIN TEST (PPD) (HR8)
- HEARING (HR9)
- PAPANICOLAOU SMEAR (HR10)(1)

Patient and/or Parent Counseling

Diet and Exercise
- Fat (esp. saturated fat), cholesterol, sodium, iron(2), calcium(2)
- Caloric balance
- Selection of exercise program
- Eating disorders

Substance Use
- Tobacco: Discussion of health hazards
- Alcohol/inhalants/ other drugs: Discussion of health hazards
  - Driving/other dangerous activities while using drugs and alcohol
  - Referral for abuse

HIGH RISK GROUPS
- SHARING/USING UNSTERILIZED NEEDLES AND SYRINGES (HR12)

Sexual Practices
- Sexual development and behavior(3)
- Sexually transmitted diseases: partner selection, condoms
- Unintended pregnancy and contraceptive options

Injury Prevention
- Safety belts
- Safety helmets
- Violent behavior(4)
- Firearms(4)
- Smoke detector

Dental Health
- Regular tooth brushing, flossing, dental visits

Mental Health and Chemical Dependency
Parent education regarding:
- Behavior management
- Adolescent development
- Special needs of a child due to:
  - Familial disruption
  - Health problems
  - Minority groups status/cultural conflict
- Increased well-child visits (HR17)
- Targeted case management, as indicated (6)
- Referral for MHCD services

Other Primary Preventive Measures

HIGH RISK GROUPS
- DISCUSSION OF HEMOGLOBIN TESTING (HR13)
- SKIN PROTECTION FROM ULTRAVIOLET LIGHT (HR14)

Immunizations & Chemoprophylaxis

- Tetanus-diphtheria (Td) booster(5)

HIGH RISK GROUPS
- FLUORIDE SUPPLEMENTS (HR15)

This list of preventive services is not exhaustive. Clinicians may wish to add other preventive services on a routine basis after considering the patient's medical history and other individual circumstances. Examples of target conditions include:
- Scoliosis
- Developmental disorders
- Behavioral and learning disorders

Remain Alert For:
- Tooth decay, malalignment, gingivitis
- Signs of child abuse or neglect
- Abnormal bereavement
- Suicide risk factors (HR11)
- Depressive symptoms

*One visit is required for immunizations. Because of lack of data and differing patient risk profiles, the scheduling of additional visits and the frequency of the individual preventive services listed in this table are left to clinical discretion.

1. Every 1-3 years. 2. For females. 3. Often best performed early in adolescence and with the involvement of parents. 4. Especially for males. 5. Once between ages 14 and 16. 6. As defined in Ancillary Services.

TABLE 4 - Ages 13-18	High Risk Groups

HR1 Persons with increased recreational or occupational exposure to sunlight, a family personal history of skin cancer, or clinical evidence of precursor lesions (e.g., dysplastic nevi, certain congenital nevi).

HR2 Males with a history of cryptorchidism, or orchiopexy, or testicular atrophy.

HR3 Females of childbearing age lacking evidence of immunity.

HR4 Persons who engage in sex with multiple partners in areas in which syphilis is prevalent, prostitutes, or contacts of persons with active syphilis.

HR5 Persons who attend clinics for sexually transmitted diseases; attend other high risk health care facilities (e.g., adolescent and family planning clinics); or have other risk factors for chlamydial infection (e.g., multiple sexual partners or a sexual partner with multiple sexual contacts).

HR6 Persons with multiple sexual partners or a sexual partner with multiple sexual contacts, sexual contacts of persons with culture-proven gonorrhea, or persons with a history of repeated episodes of gonorrhea.

HR7 Persons seeking treatment for sexually transmitted diseases; homosexual and bisexual men; past or present intravenous (IV) drug users; persons with a history of prostitution or multiple sexual partners; women whose past or present sexual partners were HIV infected, bi-sexual, or IV drug users; persons with long-term residence or birth in an area with high prevalence of HIV infection; or persons with a history or transfusion between 1978 and 1985.

HR8 Household members of persons with tuberculosis or others at risk for close contact with the disease; recent immigrants or refugees from countries in which tuberculosis is common (e.g., Asia, Africa, Central and South America, Pacific Islands); family members of migrant workers; residents of homeless shelters; or persons with certain underlying medical disorders.

HR9 Persons exposed regularly to excessive noise in recreational or other settings.

HR10 Females who are sexually active or (if the sexual history is thought to be unreliable) aged 18 or older.

HR11 In family with or experiencing recent divorce, separation, unemployment, depression, alcohol or other drug abuse, serious medical illness, living alone, recent bereavement, sexual or physical abuse.

HR12 Intravenous drug users.

HR13 Persons of Caribbean, Latin American, Asian, Mediterranean, or African decent.

HR14 Persons with increased exposure to sunlight

HR15 Persons living in areas with inadequate water fluoridation (less than 0.7 parts per million).

HR16 Household members with history of alcohol and/or drug abuse or dependency. Early onset of alcohol and/or drug dependency. 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.

HR17 Having a: chronically mentally ill parent; substance abusing parent; mother who began parenting as a teen. Living at or below poverty. Being, in the judgment of a MH professional, suicidal and/or depressed. Having: parents involved in criminal behavior; experienced an out-of-home placement(s), multiple moves, failed adoption(s). Being homeless. Having suffered physical, emotional or sexual abuse, or severe neglect. Having a: chronic health problem in the family; a mental or emotional disorder and is in juvenile justice system; an absence of a family support system. Being substance affected at birth. Behavioral problems in school.

HR18 Persons with exposure to tobacco or excessive amounts of alcohol or those suspicious symptoms or lesions detected through self examination.

TABLE 5
Ages 19-39*

Leading Causes of Death:
- Motor vehicle crashes
- Homicide
- Suicide
- Injuries (nonmotor vehicle)
- Heart disease

Screening

History
- Dietary intake
- Physical activity
- Tobacco use
- Sexual practices
- Alcohol/drug use (HR28)
- Prescription and over-the-counter drug abuse

Physical Exam
- Height and weight
- Blood pressure

Brief Mental Status Exam with assessment of mood

HIGH RISK GROUPS
- COMPLETE ORAL CAVITY EXAM (HR1)
- PALPATION FOR THYROID NODULES (HR2)
- CLINICAL BREAST EXAM (HR3)
- CLINICAL TESTICULAR EXAM (HR4)
- COMPLETE SKIN EXAM (HR5)

Laboratory/ Diagnostic Procedures
- Nonfasting total blood cholesterol
- Papanicolaou smear(1)

HIGH RISK GROUPS
- FASTING PLASMA GLUCOSE (HR6)
- RUBELLA ANTIBODIES (HR7)
- VDRL/RPR (HR8)
- URINALYSIS FOR BACTERIURIA (HR9)
- CHLAMYDIAL TESTING (HR10)
- GONORRHEA CULTURE (HR11)
- COUNSELING AND TESTING FOR HIV (HR12)
- HEARING (HR13)
- TUBERCULIN SKIN TEST (PPD) (HR14)
- ELECTRO-CARDIOGRAM (HR15)
- MAMMOGRAM (HR3)
- COLONOSCOPY (HR16)

Counseling

Diet and Exercise
- Fat (esp. saturated fat), cholesterol, sodium, iron(2), calcium(2)
- Caloric balance
- Selection of exercise program
- Eating disorders (2)

Substance Use
- Tobacco: Discussion of health hazards
- Alcohol/other drugs: Discussion of health hazards
  - Driving/other dangerous activities while using drugs and alcohol
  - Referral for abuse

HIGH RISK GROUPS
- SHARING/USING UNSTERILIZED NEEDLES AND SYRINGES (HR18)

Sexual Practices
- Sexual behavior
- Sexually transmitted diseases: partner selection, condoms, anal intercourse
- Unintended pregnancy and contraceptive options
- HIV diagnosed

Injury Prevention
- Safety belts
- Safety helmets
- Violent behavior(3)
- Firearms(3)
- Smoke detector
- Smoking near bedding or upholstery

HIGH RISK GROUPS
- BACK-CONDITIONING EXERCISES (HR19)
- PREVENTION OF CHILDHOOD INJURIES (HR20)
- FALLS IN THE ELDERLY (HR21)

Dental Health
- Regular tooth brushing, flossing, dental visits

Other Primary Preventive Measures

HIGH RISK GROUPS
- DISCUSSION OF HEMOGLOBIN TESTING (HR22)
- SKIN PROTECTION FROM ULTRAVIOLET LIGHT (HR23)

Immunizations

- Tetanus-diphtheria (Td) booster(4)

HIGH RISK GROUPS
- HEPATITIS B VACCINE (HR24)
- PNEUMOCOCCAL VACCINE (HR25)
- INFLUENZA VACCINE (5) (HR26)
- MEASLES-MUMPS-RUBELLA VACCINE (HR27)

This list of preventive services is not exhaustive. Clinicians may wish to add other preventive services on a routine basis after considering the patient's medical history and other individual circumstances. Examples of target conditions include:
- Chronic obstructive pulmonary disease
- Hepatobiliary disease
- Bladder cancer
- Endometrial disease
- Travel-related illness
- Occupational illness and injuries

Remain Alert For:
- Depressive symptoms (HR29)
- Suicide risk factors (HR17)
- Abnormal bereavement
- Malignant skin lesions
- Tooth decay, gingivitis
- Signs of physical abuse (HR30)

*The frequency of the individual preventive services listed in this table is left to clinical discretion, except as indicated in other footnotes.

1. Every 1-3 years. 2. For women. 3. Especially for young males. 4. Every 10 years. 5. Annually.

HR1 Persons with exposure to tobacco or excessive amounts of alcohol, or those with suspicious symptoms or lesions detected through self-examination.
HR2 Persons with a history of upper-body irradiation.
HR3 Women aged 35 and older with a family history of premenopausally diagnosed breast cancer in first-degree relative.
HR4 Men with a history of cryptorchidism, or orchiopexy, or testicular atrophy.
HR5 Persons with family or personal history of skin cancer, increased occupational or recreational exposure to sunlight, or clinical evidence of precursor lesions (e.g., dysplastic nevi, certain nevi).
HR6 The markedly obese, persons with a family history of diabetes, or women with a history of gestational diabetes.
HR7 Women lacking evidence of immunity.
HR8 Prostitutes, persons who engage in sex with multiple partners in areas in which syphilis is prevalent, or contacts of persons with active syphilis.
HR9 Persons with diabetes.
HR10 Persons who attend clinics for sexually transmitted diseases; attend other high risk health care facilities (e.g., adolescent and family planning clinics); or have other risk factors for chlamydial infection (e.g., multiple sexual partners or a sexual partner with multiple sexual contacts, age less than 20).
HR11 Prostitutes, persons with multiple sexual partners or a sexual partners with multiple contacts, sexual contacts of persons with culture-proven gonorrhea, or persons with a history of repeated episodes of gonorrhea.
HR12 Persons seeking treatment for sexually transmitted diseases; homosexual and bisexual men; past or present intravenous (IV) drug users; persons with a history of prostitution or multiple sexual partners; women whose past or present sexual partners were HIV infected, bi-sexual, or IV drug users; persons with long-term residence or birth in an area with high prevalence of HIV infection; or persons with a history or transfusion between 1978 and 1985.
HR13 Persons exposed regularly to excessive noise.
HR14 Household members of persons with tuberculosis or others at risk for close contact with the disease (e.g., staff of tuberculosis clinics, shelters for the homeless, nursing homes, substance abuse treatment facilities, dialysis units, correctional institutions); recent immigrants or refugees from countries in which tuberculosis is common; migrant workers; residents of nursing homes, correctional institutions, or homeless shelters; or persons with certain underlying medical disorders (e.g., HIV infection).
HR15 Men who would endanger public safety were they to experience sudden cardiac events (e.g., commercial airline pilots).
HR16 Persons with a family history of familial polyposis coli or cancer family syndrome.
HR17 Recent divorce, separation, unemployment, depression, alcohol or other drug abuse, serious medical illness, living alone, or recent bereavement.
HR18 Intravenous drug users.
HR19 Persons at increased risk for low back injury because of past history, body configuration, or type of activities.
HR20 Persons with children in the home or automobile.
HR21 Persons with older adults in the home.
HR22 Young adults of Caribbean, Latin American, Asian, Mediterranean, or African decent.
HR23 Persons with increased exposure to sunlight.
HR24 Homosexually active men, intravenous drug users, recipients of some blood products, or persons in health-related jobs with frequent exposure to blood or blood products.
HR25 Persons with medical conditions that increase the risk of pneumococcal infection (e.g., chronic cardiac or pulmonary disease, sickle cell disease, nephrotic syndrome, Hodgkin's disease, asplenia, diabetes mellitus, alcoholism, cirrhosis, multiple myeloma, renal disease, or conditions associated with immunosuppression).
HR26 Residents of chronic care facilities or persons suffering from chronic cardiopulmonary disorders, metabolic diseases (including diabetes mellitus), hemoglobinopathies, immunosuppression, or renal dysfunction.
HR27 Persons born after 1956 who lack evidence of immunity to measles (receipt of live vaccine on or after first birthday, laboratory evidence of immunity, or a history of physician-diagnosed measles).
HR28 Persons 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.
HR29 In 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.
HR30 In women: contusions or minor lacerations to the face, head, neck, breast, or abdomen; primary complaints of chronic headaches, abdominal pains, sexual dysfunction, recurrent vaginal infections, joint pains, muscle aches, sleep disorders, eating disorders. Assessment includes psycho-social history, history of sexual or physical abuse, alcohol and drug usage in household, current living arrangement and safety concerns. Referrals may be needed for shelters and for mental health, chemical dependency and legal services.

TABLE 6
Ages 40-64*

Leading Causes of Death:
- Heart disease
- Lung cancer
- Cerebrovascular disease
- Breast cancer
- Colorectal cancer
- Obstructive lung disease

Screening

History
- Dietary intake
- Physical activity
- Tobacco
- Sexual practices
- Alcohol/drug use (HR29)
- Prescription and over-the-counter drug abuse

Physical Exam
- Height and weight
- Blood pressure
- Clinical breast exam(1)

Brief Mental Status Exam with assessment of mood

HIGH RISK GROUPS
- COMPLETE SKIN EXAM (HR1)
- COMPLETE ORAL CAVITY EXAM (HR2)
- PALPATION FOR THYROID NODULES (HR3)
- AUSCULTATION FOR CAROTID BRUITS (HR4)

Laboratory/ Diagnostic Procedures
- Nonfasting total blood cholesterol
- Papanicolaou smear(2)
- Mammogram(3)

HIGH RISK GROUPS
- FASTING PLASMA GLUCOSE (HR5)
- VDRL/RPR (HR6)
- URINALYSIS FOR BACTERIURIA (HR7)
- CHLAMYDIAL TESTING (HR8)
- GONORRHEA CULTURE (HR9)
- COUNSELING AND TESTING FOR HIV (HR10)
- TUBERCULIN SKIN TEST (PPD) (HR11)
- HEARING (HR12)
- ELECTRO-CARDIOGRAM (HR13)
- FECAL OCCULT BLOOD/ SIGMOIDOSCOPY (HR14)
- FECAL OCCULT BLOOD/COLONOSCOPY (HR15)
- BONE MINERAL CONTENT (HR16)

Counseling

Diet and Exercise
- Fat (esp. saturated fat), cholesterol, complex carbohydrates, fiber, sodium, iron, calcium(4)
- Caloric balance
- Selection of exercise program

Substance Use
- Tobacco: Discussion of health hazards
- Alcohol/other drugs: Discussion of health hazards
  - Driving/other dangerous activities while using drugs and alcohol
  - Referral for abuse

HIGH RISK GROUPS
- SHARING/USING UNSTERILIZED NEEDLES AND SYRINGES (HR19)

Sexual Practices
- Sexual behavior orientation
- Sexually transmitted diseases: partner selection, condoms, anal intercourse
- Unintended pregnancy and contraceptive options
- HIV diagnosed

Injury Prevention
- Safety belts
- Safety helmets
- Smoke detector
- Smoking near bedding or upholstery

HIGH RISK GROUPS
- BACK-CONDITIONING EXERCISES (HR20)
- PREVENTION OF CHILDHOOD INJURIES (HR21)
- FALLS IN THE ELDERLY (HR22)

Dental Health
- Regular tooth brushing, flossing, dental visits

Other Primary Preventive Measures

HIGH RISK GROUPS
- SKIN PROTECTION FROM ULTRAVIOLET LIGHT (HR23)
- DISCUSSION OF ASPIRIN THERAPY (HR24)
- DISCUSSION OF ESTROGEN REPLACEMENT THERAPY (HR25)

Immunizations

- Tetanus-diphtheria (Td) booster(5)

HIGH RISK GROUPS
- HEPATITIS B VACCINE (HR26)
- PNEUMOCOCCAL VACCINE (HR27)
- INFLUENZA VACCINE (HR28)(6)

This list of preventive services is not exhaustive. Clinicians may wish to add other preventive services on a routine basis after considering the patient's medical history and other individual circumstances. Examples of target conditions
- Chronic obstructive pulmonary disease
- Hepatobiliary disease
- Bladder cancer
- Endometrial disease
- Travel-related illness
- Occupational illness and injuries

Remain Alert For:
- Depressive symptoms (HR30)
- Suicide risk factors (HR17)
- Abnormal bereavement
- Signs of physical abuse or neglect (HR31)
- Peripheral arterial disease (HR18)
- Tooth decay, gingivitis

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*The frequency of the individual preventive services listed in this table is left to clinical discretion.

1. Annually for women. 2. Every 1-3 years for women. 3. Every 1-2 years for women beginning at age 50 (age 35 for those at increased risk). 4. For women. 5. Every 10 years. 6. Annually.

HR1 Persons with family or personal history of skin cancer, increased occupational or recreational exposure to sunlight, or clinical evidence of precursor lesions (e.g., dysplastic nevi, certain nevi).

HR2 Persons with exposure to tobacco or excessive amounts of alcohol, or those with suspicious symptoms or lesions detected through self-examination.

HR3 Persons with a history of upper-body irradiation.

HR4 Persons with risk factors for cerebrovascular or cardiovascular disease (e.g., hypertension, smoking, CAD, atrial fibrillation, diabetes) or those with neurologic symptoms (e.g., transient ischemic attacks) or a history of cerebrovascular disease).

HR5 The markedly obese, persons with a family history of diabetes, or women with a history of gestational diabetes.

HR6 Prostitutes, persons who engage in sex with multiple partners in areas in which syphilis is prevalent, or contacts of persons with active syphilis.

HR7 Persons with diabetes.

HR8 Persons who attend clinics for sexually transmitted diseases; attend other high risk health care facilities (e.g., adolescent and family planning clinics); or have other risk factors for chlamydial infection (e.g., multiple sexual partners or a sexual partner with multiple sexual contacts).

HR9 Prostitutes, persons with multiple sexual partners or a sexual partners with multiple contacts, sexual contacts of persons with culture-proven gonorrhea, or persons with a history of repeated episodes of gonorrhea.

HR10 Persons seeking treatment for sexually transmitted diseases; homosexual and bisexual men; past or present intravenous (IV) drug users; persons with a history of prostitution or multiple sexual partners; women whose past or present sexual partners were HIV infected, bisexual, or IV drug users; persons with long-term residence or birth in an area with high prevalence of HIV infection; or persons with a history or transfusion between 1978 and 1985.

HR11 Household members of persons with tuberculosis or others at risk for close contact with the disease (e.g., staff of tuberculosis clinics, shelters for the homeless, nursing homes, substance abuse treatment facilities, dialysis units, correctional institutions); recent immigrants or refugees from countries in which tuberculosis is common (Asia, Africa, Central and South America, Pacific Islands); migrant workers; residents of nursing homes, correctional institutions, or homeless shelters; or persons with certain underlying medical disorders (e.g., HIV infection).

HR12 Persons exposed regularly to excessive noise.

HR13 Men with two or more cardiac risk factors (high blood cholesterol, hypertension, cigarette smoking, diabetes mellitus, family history of CAD); men who would endanger public safety were they to experience sudden cardiac events (e.g., commercial airline pilots); or sedentary or high risk males planning to begin a vigorous exercise program.

HR14 Persons aged 50 and older who have first degree relatives with colorectal cancer; a personal history of endometrial, ovarian, or breast cancer; or a previous diagnosis of inflammatory bowel disease, adenomatous polyps, or colorectal cancer.

HR15 Persons with a family history of familial polyposis coli or cancer family syndrome.

HR16 Perimenopausal women at increased risk for osteoporosis (e.g., Caucasian race, bilateral oophorectomy before menopause, slender build) and for whom estrogen replacement therapy would otherwise not be recommended.

HR17 Recent divorce, separation, unemployment, depression, alcohol or other drug abuse, serious medical illness, living alone, or recent bereavement.

HR18 Persons over age 50, smokers, or persons with diabetes mellitus.

HR19 Intravenous drug users.

HR20 Persons at increased risk for low back injury because of past history, body configuration, or type of activities.

HR21 Persons with children at home or automobile.

HR22 Persons with older adults in the home.

HR23 Persons with increased exposure to sunlight.

HR24 Men who have risk factors of myocardial infarction (e.g., high blood cholesterol, smoking, diabetes mellitus, family history of early onset CAD) and who lack a history of gastrointestinal or other bleeding problems, and other risk factors for bleeding or cerebral hemorrhage.

HR25 Perimenopausal women at increased risk for osteoporosis (e.g., Caucasian, low bone mineral content, bilateral oophorectomy before menopause or early menopause, slender build) and who are without known contraindications (e.g., history of undiagnosed vaginal bleeding, active liver disease, thromboembolic disorders, hormone-dependent cancer).

HR26 Homosexually active men, intravenous drug users, recipients of some blood products, or persons in health related jobs with frequent exposure to blood or blood products.

HR27 Persons with medical conditions that increase the risk of pneumococcal infection (e.g., chronic cardiac or pulmonary disease, sickle cell disease, nephrotic syndrome, Hodgkin's disease, asplenia, diabetes mellitus, alcoholism, cirrhosis, multiple myeloma, renal disease or conditions associated with immunosuppression).

HR28 Residents of chronic care facilities or persons suffering from chronic cardiopulmonary disorders, metabolic diseases (including diabetes mellitus), hemoglobinopathies, immunosuppression, or renal dysfunction.

HR29 Persons 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, behavior problems, secretiveness or vagueness about personal or medical history.

HR30 In 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.

HR31 In women: contusions or minor lacerations to the face, head, neck, breast, or abdomen; primary complaints of chronic headaches, abdominal pains, sexual dysfunction, recurrent vaginal infections, joint pains, muscle aches, sleep disorders, eating disorders. Assessment includes psycho-social history, history of sexual or physical abuse, alcohol and drug usage in household, current living arrangement and safety concerns. Referrals may be needed for shelters and for mental health, chemical dependency and legal services.

TABLE 7
Age 65 and Over*

Leading Causes of Death:
- Heart disease
- Cerebrovascular disease
- Obstructive lung disease
- Pneumonia/influenza
- Lung cancer
- Colorectal cancer

Screening

History
- Prior symptoms of transient ischemic attack
- Dietary intake
- Physically activity
- Tobacco
- Functional status at home
- Alcohol/drug use (HR17)
- Prescription and over-the-counter drug abuse

Physical Exam
- Height and weight
- Blood pressure
- Visual acuity
- Hearing and hearing aids
- Clinical breast exam(1)

Brief Mental Status Exam with assessment of mood

HIGH RISK GROUPS
- AUSCULTATION FOR CAROTID BRUITS (HR1)
- COMPLETE SKIN EXAM (HR2)
- COMPLETE ORAL CAVITY EXAM (HR3)
- PALPATION FOR THYROID NODULES (HR4)

Laboratory/ Diagnostic Procedures
- Nonfasting total blood cholesterol
- Dipstick urinalysis
- Mammogram(2)
- Thyroid function tests(3)

HIGH RISK GROUPS
- FASTING PLASMA GLUCOSE (HR5)
- TUBERCULIN SKIN TEST (HR6)
- ELECTRO-CARDIOGRAM (HR7)
- PAPANICOLAOU SMEAR (4) (HR8)
- FECAL OCCULT BLOOD/ SIGMOIDOSCOPY (HR9)
- FECAL OCCULT BLOOD/COLONOSCOPY (HR10)

Counseling

Diet and Exercise
- Fat (esp. saturated fat), cholesterol, complex carbohydrates, fiber, sodium, iron, calcium(3)
- Caloric balance
- Selection of exercise program

Substance Use
- Tobacco: Discussion of health hazards
- Alcohol/other drugs: Discussion of health hazards
  - Driving/other dangerous activities while using drugs and alcohol
  - Referral for abuse

Injury Prevention
- Prevention of falls
- Safety belts
- Smoke detector
- Smoking near bedding or upholstery
- Hot water heater temperature
- Safety helmets

HIGH RISK GROUPS
- PREVENTION OF CHILDHOOD INJURIES (HR12)

Dental Health
- Regular dental visits, tooth brushing, flossing

Other Primary Preventive Measures
- Glaucoma testing by eye specialist

HIGH RISK GROUPS
- DISCUSSION OF ESTROGEN REPLACEMENT THERAPY (HR13)
- DISCUSSION OF ASPIRIN THERAPY (HR14)
- SKIN PROTECTION FROM ULTRAVIOLET LIGHT (HR15)

Immunizations
- Tetanus-diphtheria (Td) booster(5)
- Influenza vaccine(1)
- Pneumococcal vaccine

HIGH RISK GROUPS
- HEPATITIS B VACCINE (HR16)

This list of preventive services is not exhaustive. Clinicians may wish to add other preventive services on a routine basis after considering the patient's medical history and other individual circumstances. Examples of target conditions include:
- Chronic obstructive pulmonary disease
- Hepatobiliary disease
- Bladder cancer
- Endometrial disease
- Travel-related illness
- Occupational illness and injuries

Remain Alert For:
- Depression symptoms including preoccupation with somatic complaints (HR18)
- Suicide risk factors (HR11)
- Abnormal bereavement
- Changes in cognitive function
- Medications that increase risk of falls
- Signs of physical abuse or neglect (HR19)
- Malignant skin lesions
- Peripheral arterial disease
- Tooth decay, gingivitis, teeth lose
- Polypharmacy, expecially multiple interacting drugs

*The frequency of the individual preventive services listed in this table is left to clinical discretion.

1. Annually. 2. Every 1-2 years for women until age 75, unless pathology detected. 3. For women. 4. Every 1-3 years. 5. Every 10 years.

HR1 Persons with risk factors for cerebrovascular or cardiovascular disease (e.g., hypertension, smoking, CAD, atrial fibrillation, diabetes) or those with neurologic symptoms (e.g., transient ischemic attacks) or a history of cerebrovascular disease).

HR2 Persons with family or personal history of skin cancer, or clinical evidence of precursor lesions (e.g., dysplastic nevi, certain congenital nevi), or those with increased occupational or recreational exposure to sunlight.

HR3 Persons with exposure to tobacco or excessive amounts of alcohol, or those with suspicious symptoms or lesions detected through self-examination.

HR4 Persons with a history of upper body irradiation.

HR5 Markedly obese, persons with a family history of diabetes, or women with a history of gestational diabetes.

HR6 Household members of persons with tuberculosis or others at risk for close contact with the disease (e.g., staff of tuberculosis clinics, shelters for the homeless, nursing homes, substance abuse treatment facilities, dialysis units, correctional institutions); recent immigrations or refugees from countries in which tuberculosis is common (e.g., Asia, Africa, Central and South America, Pacific Islands); migrant workers; residents of nursing homes, correctional institutions, or homeless shelters; or persons with certain underlying medical disorders (e.g., HIV infection).

HR7 Men with two or more cardiac risk factors (high blood cholesterol, hypertension, cigarette smoking, diabetes mellitus, family history of CAD); men who would endanger public safety were they to experience sudden cardiac events (e.g., commercial airline pilots); or sedentary or high risk males planning to begin a vigorous exercise program.

HR8 Women who have not had previous documented screening in which smears have been consistently negative.

HR9 Persons with a first degree relatives with colorectal cancer; a personal history of endometrial, ovarian, or breast cancer; or a previous diagnosis of inflammatory bowel disease, adenomatous polyps, or colorectal cancer.

HR10 Persons with a family history of familial polyposis coli or cancer family syndrome.

HR11 Recent divorce, separation, unemployment, depression, alcohol or other drug abuse, serious medical illness, living alone, or recent bereavement.

HR12 Persons with children in the home or automobile.

HR13 Women at increased risk for osteoporosis (e.g., Caucasian, low bone mineral content, bilateral oophorectomy before menopause or early menopause, slender build) and who are without know contraindicators (e.g., history of undiagnosed vaginal bleeding, active liver disease, thromboembolic disorders, hormone-dependent cancer).

HR14 Men who have risk factors for myocardial infarction (e.g., high blood cholesterol, smoking, diabetes mellitus, family history of early onset CAD) and who lack a history of gastrointestinal or other bleeding problems, or other risk factors for bleeding or cerebral hemorrhage.

HR15 Persons with increased exposure to sunlight.

HR16 Homosexually active men, intravenous drug users, recipients of some blood products, or persons in health related jobs with frequent exposure to blood or blood products.

HR17 Persons 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, behavior problems, secretiveness or vagueness about personal or medical history.

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HR19 In women: contusions or minor lacerations to the face, head, neck, breast, or abdomen; primary complaints of chronic headaches, abdominal pains, sexual dysfunction, recurrent vaginal infections, joint pains, muscle aches, sleep disorders, eating disorders. Assessment includes psycho-social history, history of sexual or physical abuse, alcohol and drug usage in household, current living arrangement and safety concerns. Referrals may be needed for shelters and for mental health, chemical dependency and legal services.

DRAFT

Checklist for Adolescents with Alcohol and Other Drug Problems*

A child using any drug beyond nicotine, alcohol and marijuana should be referred to a treatment provider for assessment. A child using three or more drugs (licit or illicit) should automatically be referred. A child who first uses drugs (licit or illicit) before age 13 should be referred. A child who answers "yes" to any of the "high risk" questions should be referred.

Initial Information Questions

1. Have you used alcohol or other drugs before? [ ] Yes [ ] No
   If so, which ones? _____
   _____
   _____

2. At what age did you begin using these drugs? _____
3. How recent is your use of these drugs? _____

High Risk-Questions

4. Do you use alcohol or other drugs to "cheer up" or change the way you feel when you are in a bad mood?
   [ ] Yes [ ] No Comment _____
   _____

5. Do you sometimes use more than you thought you would? [ ] Yes [ ] No
   Comment _____
   _____

6. Have you tried to cut back or stop using? [ ] Yes [ ] No
   Comment _____
   _____

7. Have you had a memory loss, loss of consciousness, hallucinations or an accident as a result of your use?
   [ ] Yes [ ] No
   Comment _____

8. Have you considered or attempted suicide? [ ] Yes [ ] No
   Comment _____

9. Have you intentionally hurt yourself or others while using? [ ] Yes [ ] No
   Comment _____

*Developed by the Office of Alcohol and Drug Abuse Programs, Department of Human Resources, State of Oregon, 1991

DRAFT

Checklist for Mental Health Referral*

Date _____
Child's Name _____ Birthdate _____
Medicaid # _____
Medicheck Provider's Name _____
Agency _____

Instruction: Circle those behaviors that apply. Please refer to the Mental Health Checklist Manual for complete instructions. Please refer a child for mental health evaluation where indicated.

1. FEELINGS
Circle all that apply

a. restless
b. sad
c. guilty
d. euphoric
e. irritable
f. feels out of control
g. sullen
h. fearful
i. lonely
j. cries excessively
k. cries too little
l. anxious
m. angry
n. self critical

Is a problem indicated?
0 No
1 Yes
2 Unknown

2. BEHAVIOR
Circle all that apply

a. impulsive
b. fire setter
c. problems at school
d. threatens/harms others
e. overactive
f. suicidal
g. sexually acts out
h. sexually preoccupied
i. steals
j. tortures animals
k. self-destructive
l. lies
m. substance abuser
n. destroys property
o. refuses to talk
p. compulsive
q. listless

Is a problem indicated?
0 No
1 Yes
2 Unknown

3. SOCIAL INTERACTIONS
Circle all that apply

a. withdraws
b. may cling excessively
c. difficulty making and keeping friends
d. failure to respond socially (infants)
e. aggressive
f. defiant
g. argues excessively
h. inattentive
i. acts young
j. victimized
k. disobedient; may involve legal violations

Is a problem indicated?
0 No
1 Yes
2 Unknown

4. THINKING
Circle all that apply

a. frequently confused
b. daydreams excessively
c. out of touch with reality
d. distracted
e. bizarre ideation
f. mistrustful
g. obsessive
h. delusional
i. blames others
j. frequent memory loss
k. problem concentrating, paying attention
l. suicidal ideation

Is a problem indicated?
0 No
1 Yes
2 Unknown

5. PHYSICAL PROBLEMS
Circle all that apply

a. wets bed
b. wets during day
c. soils pants
d. frequent stomachaches
e. low weight/weight loss or gain
f. vomits or uses laxatives
g. problems eating (poor appetite, nausea, eats non-foods)
h. frequent headaches
i. lacks energy
j. problems sleeping (nightmares, sleep-walking)

Is a problem indicated?
0 No
1 Yes
2 Unknown

Other problems including history of maltreatment or trauma:

1. _____
2. _____
3. _____
4. _____
5. _____

*Developed by Mental Health and Developmental Disability Services Division, Department of Human Resources, State of Oregon, 1991

EXPANDED DEFINITION OF ANCILLARY SERVICES

Ancillary Services

- **Ambulatory surgery center** services
- **Outpatient hospital** services
- **Inpatient hospital** services [NOTE: OMAP should remove day limits currently in effect for adults and General Assistance recipients.]
- **Laboratory** services
- **Radiology and imaging** services
- **Prescription drugs** (to include outpatient, inpatient, intravenous, enteral therapy and limited over-the-counter drugs)
- **Medical supplies and equipment** prescribed by the practitioner (e.g., prosthetic devices wheelchairs, respirators, ventilators, apnea monitors, diabetic testing strips, ostomy supplies, oxygen and related equipment, and ophthalmic materials)
- **Physical therapy**
- **Occupational therapy**
- **Speech and language therapy**
- **Hearing therapy and aids**
- **Vision therapy and aids**
- **Transportation, meals, lodging and daycare** necessary for recipients to access covered services
- **Personal care** services (e.g., health care aide services)
- **Home health** services (i.e., skilled nursing, home health aide, speech/occupational/physical therapy, and equipment and supplies provided through a certified Home Health Agency)
- **Private duty nursing** services

- **Anesthesia** services

- **Therapeutic and diagnostic injections**

- **Hospice services** [NOTE: OMAP is to establish a hospice program with appropriate restrictions. The program should include outpatient and residential components.]

- **Nutritional counseling** (e.g., diabetic counseling, counseling for improved pregnancy outcomes)

- **Rehabilitation services** for spinal cord or head injury

- **Case management services** covered, now or in the future, by OMAP as a part of the traditional Medicaid program. Case management is defined as services that are designed to obtain health care services necessary to maintain an optimal level of physical and emotional development and health. Case management includes a comprehensive, ongoing assessment of needs (including support services, such as medical, social and educational), plus the development and implementation of a detailed plan of services and related activities. Examples of case management services include:

  - **Maternity Case Management:** Expansion of the prenatal service package to include management of other non-medical services which address social, economic and nutritional factors.

  - **Targeted Case Management:** Management targeted at special groups which can be identified by age, type or degree of disability, illness or condition. Examples of groups which could be targeted are pregnant women, at-risk/vulnerable children, individuals with catastrophic illness or injury such as AIDS or cancer patients, individuals with developmental disorders, and individuals with chronic mental illness.