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

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

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

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

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

Topic	**Action**
General Highlights from January 2008 HOSC meeting reviewed and no changes were requested.	Highlights approved.
Biennial Review I. <u>Kidney stone line movement</u> Smits presented a proposal to combine the two current kidney stone lines into one line, and add urinary tract codes from one additional line. This change would serve to consolidate the urinary tract stones onto one line. Line 418 would be consolidated into line 376. The changes were accepted as outlined in the meeting materials with the following changes: a) whether 593.89 (other specified disorder of kidney or ureter) had obstructive ureteral codes). Further investigation found several obstructive diagnoses under this code; it will therefore remain on Line 187 (Ureteral stricture or obstruction) b) 50392-50395 to be added to Line 187, as these procedures were appropriate to this line c) Remove 50590 (Lithotripsy) from Line 187 as it is no longer necessary to be on that line once all urinary tract calculi ICD-9 codes were removed II. <u>Allergy conditions</u>	1) Urinary tract stone line consolidation: changes accepted as outlined in the meeting materials, except a) 50392-50395 added to Line 187 and 50590 removed from Line 187. 2) Allergy conditions: no movement of allergy conditions on the list, no addition of any allergy treatments to lines that do not currently have such treatments. Smits to work with Medical Directors to see if there are any barriers to patient access to allergist care for conditions paired with such care. Smits also to research chronic and recurrent urticaria and bring back recommendations to the next HOSC meeting.

Testimony heard from Dr. Coutin and Dr. Hassett, from the state allergy association The major issue outlined by the Allergist was that the number of visits and types of treatments allowed for patients with Allergists is limited by many health plans. Saha noted that it is not the HSC's place to come between a specialty society and health plans. OHP covers allergy treatments for asthma; it is up to the plans to determine how to administer this benefit. Saha noted that urticaria, which covers a range of diagnoses from minor to major, is currently not covered due to its location on Line 559 (Symptomatic urticaria). Some of the more severe forms of this diagnosis might have evidence for coverage. Smits pointed out that if evidence was found for adding coverage for severe forms of urticaria, then these diagnosis codes could be moved to another line, such as Line 341 (Angioneurotic edema) as part of an interim modification. It was decided that Smits will research chronic and recurrent urticaria and bring back recommendations to the next HOSC about possible movement of these diagnoses higher on the list and, if moved, what treatments are effective and should be paired with this diagnosis. The decision was to bring the Allergist concerns to the OHP Medical Directors meeting in June and work with the plans to facilitate allergist treatments where indicated on the Prioritized List and determine if there are any barriers to patient access of these services which must be addressed. Allergy conditions were not moved on the list, and no new allergy treatment procedures were added to any line. The HOSC requested that if the Allergy association had any evidence that interventions for allergic conditions reduces or prevents downstream issues, the HOSC would like to have this information brought to them for consideration for adding additional allergy treatments to the list where appropriate. III. <u>Fibromyalgia</u> The HOSC heard testimony from Dr. Bennett, a rheumatologist at OHSU who reported multiple conflicts of interest, including funding from Merck, Berringer, Pfizer, and other pharmaceutical companies. Dr. Bennett testified about the prevalence of fibromyalgia, its affects on quality of life, and the high health care utilization of fibromyalgia patients. He then reviewed accepted treatments. Jennifer Wagner from the DHS and the Governor's office also spoke as an advocate	3) Fibromyalgia: no line movement. No change in current treatment coverage. 4) Constipation in children: no change in current coverage. 5) Gastroparesis: no change in current coverage 6) Autism/dementia line splint: Line 210 (Chronic organic mental disorders including dementias) will be split into two lines: Line 210 (Chronic organic mental disorders including dementias) and Line 211 (Autism spectrum disorders; Treatment: medical/psychotherapy). Both lines will hold all the CPT codes current on Line 210. These treatment codes will be re-evaluated at a later time. Referral to Guideline regarding health and behavior assessment codes will be removed from both lines.

for pain patients. She stressed how important this issue was from both patients and providers prospective. Smits reviewed the current evidence on effectiveness of various treatments for fibromyalgia. DMAP input on restrictions for treatment for fibromyalgia was elicited. Shaffer noted that the PA for Neuronin is being eliminated, but a PA was being instituted for Lyrica. HOSC members briefly discussed whether the HSC would need to make a guideline regarding treatments covered for fibromyalgia if fibromyalgia is moved above current funding line. Olson pointed out that the HSC covers office visits and most medications for the coverage of fibromyalgia currently, despite the placement of fibromyalgia below the current funding line. Shaffer responded that in FFS Medicaid, fibromyalgia is a below the line diagnosis and therefore providers are not paid for office visits for this diagnosis. Saha pointed out that the evidence for effectiveness of the current medications is not strong; therefore coverage of such medications would not be evidence based. Gubler raised concerns that prevalence of the disease outstrips the disease prevalence (i.e. fibromyalgia is overdiagnosed). Dr. Bennett did not feel that fibromyalgia is overdiagnosed, and noted that most Rheumatologists and Physiatrists, as well as well educated primary care physicians, are able to make the diagnosis. Dodson wondered what would the HSC move below the line to make room for moving fibromyalgia above the line. McKelvey pointed out that the major benefit of moving fibromyalgia is access to medications, and the evidence for the effectiveness of these medications is lacking. Olson agreed and stated that the HSC needed to keep the bar high, otherwise the HSC will have many arguments about other conditions with weak effectiveness that should be covered. The final decision was to maintain fibromyalgia on its current line with no guideline or other change.	

IV. Constipation in children The HOSC heard a brief presentation from Dr. Byrne of OHSU pediatric GI regarding the cost-effectiveness of covering constipation in children. Discussion centered around why children would be singled out for treatment as a special population. Gubler argued that there was higher burden of disease in the elderly. Dodson agreed that constipation/encopresis is a problem in the adult/elderly population Other discussion centered around whether coverage of constipation in children would really reduce costs (from prevention of downstream problems). McKelvey felt that moving constipation above the line will result in increased referrals to GI and possibly higher costs. Discussion also occurred regarding the poor evidence for effectiveness of treatments for constipation. Olson argued that the HSC needs evidence for some effective treatments to move this, which is not currently there. Dodson concurred that there was no compelling new evidence for moving constipation in kids into the funded region. Saha requested that Byrne be given the opportunity to send us evidence of effectiveness of treatment and then readdress at a future HSC meeting. Coffman noted that the HSC could move constipation as a non-biennial review item in the future if evidence is found. Decision: no change in coverage for constipation in children. If Dr. Byrne or other expert comes forward with evidence of effectiveness of treatment, then the HSC would readdress at a future meeting. V. Gastroparesis Smits reviewed a request to move coverage of gastroparesis, and the evidence for various treatments for this condition. There was general consensus that there was no good evidence for the effectiveness of any treatment. No change to current coverage was recommended. recommended VI. Autism/dementia line split Smits brought forward a late agenda item submitted by the Mental Health and Chemical Dependency Subcommittee. The recommendation was to move autism diagnoses off the line that holds dementia diagnoses. The treatments for both of these conditions need to be reviewed, but such a review was thought to be best done after the HRC completes its report on	

the effectiveness of treatments for autism. The HOSC agreed to the proposed line split as a placeholder, and will readdress treatment options for these conditions at a later date.	
Guidelines I. <u>Prevention tables</u> Smits presented recommendations for updates to the Prevention Tables based on USPSTF recommendations since 2004. There was some discussion about whether BRCA testing should have an upper age limit. However, the recommendation was only for referral for genetic counseling, and it was pointed out that older women would have the limited benefits of this testing in their case discussed at that time. The recommendations were accepted as outlined in the meeting materials. II. <u>Cervical dysplasia</u> Smits presented a new guideline which adopts the ASCCP guidelines for management of cervical dysplasia. McKelvey raised concerns about adding a guideline which refers to a specific date of the ASCCP guideline, which this guideline is expected to change. Coffman stated that the Attorney General's office has specified that the Prioritized List must refer to an actual document, not a changing guideline. HSC staff will be cognizant of monitoring for new ASCCP guidelines and bringing new guidelines back to the HSC when they are available to keep the HSC guideline current. The subcommittee approved the new guideline, with HSC to bring back any new changes as they become available. III. <u>Chronic otitis media</u> Smits presented an updated guideline for chronic otitis media. Discussion centered around having a consistent wording in the guideline, to refer to the condition as "chronic nonsuppurative otitis media with effusion" whereever chronic otitis media, effusion or other term was used. Also, the subcommittee wanted to clarify that hearing testing and ear tubes should only be done for bilateral chronic otitis media, not unilateral. Dr. McKelvey stressed that chronic otitis media with effusion did not include acute otitis media that has failed one or more courses of antibiotics. This condition should be treated with antibiotics. There was discussion about whether the "total of 4-6 months" prior to surgery was after first diagnosis of the effusion or after hearing testing. The HOSC decided it was after diagnosis of the effusion. The group accepted the guideline changes as amended.	I. Prevention tables: changes accepted as outlined in the meeting materials. II. Cervical dysplasia: a guideline for Line 31 (cervical dysplasia) was adopted. "Work up and treatment of cervical dysplasia should follow the American Society for Cervical Colposcopy and Pathology guidelines as published in the American Journal of Obstetrics & Gynecology, October 2007." III. Chronic otitis media: guideline was changed to read GUIDELINE NOTE 51, CHRONIC OTITIS MEDIA *Line 493* <u>Antibiotic and other medication therapy are not indicated for children with bilateral chronic nonsuppurative otitis media.</u> ~~Observation OR antibiotic therapy are treatment options for children with effusion that has been present less than 4 to 6 months and at any time in children without a 20-decibel hearing threshold level or worse in the better-hearing ear.~~ <u>Children with bilateral chronic nonsuppurative otitis media present for 3 months or longer or with language delay, learning problems, or significant hearing loss at any time should have hearing testing. Children with bilateral chronic nonsuppurative otitis media who are not at risk should be reexamined at 3- to 6-month intervals until the effusion is no longer present, significant</u>

IV. Tonsillectomy Smits reviewed recommendations to update the tonsillectomy guideline to reflect stricter standards for infectious indications and allow for tonsillectomy for treatment of pediatric obstructive sleep apnea. The HOSC members discussed the use of tonsillectomy for OSA, reviewed data on the rates of tonsillectomy in the Medicaid population, and reviewed expert input. The decision was to accept the changes to the guideline as recommended, with deletion of the 4th category entirely (rather than an alternate modification which was suggested). The sleep apnea guideline was changed to reflect that surgery is second line for adults, but not for children. V. Bariatric surgery Smits introduced several concerns raised by DMAP and the health plans regarding the bariatric surgery guideline. The subcommittee felt that the first proposed change, which added a clarifying footnote to the guideline, was simply an administrative clarification and accepted this change with minimal discussion. The second proposed change was rejected, which would have added coverage for bariatric surgery with obesity as the primary diagnosis and diabetes as the secondary diagnosis to Line 8, Obesity (rather than the current coverage only on the diabetes line with diabetes as the primary diagnosis and obesity as the secondary diagnosis). The general discussion centered around the fact that the limited number of surgery centers would quickly learn how to code the diagnoses to get reimbursement and that therefore this change was not needed. The third proposed change was to explicitly add medical marijuana use as a contraindication. This change was also rejected, with discussion centering around the group's sense that the Centers of Excellence would best decide whether medical marijuana use made a patient a poor surgical candidate. The outcomes of bariatric surgery are being tracked, and if medical marijuana use is found to be associated with poor outcomes, then the subcommittee will readdress whether to add this as a contraindication. Lap band refills coverage approved as recommended VI. VAD guideline Deferred to August meeting VII. PET scan Deferred to August meeting	hearing loss is identified, or structural abnormalities of the eardrum or middle ear are suspected. For the child who has had bilateral chronic nonsuppurative otitis media and who has a bilateral hearing deficiency diagnosed by formal audiometry testing ~~(defined as a 20-decibel hearing threshold level or worse in the better hearing ear)~~, bilateral myringotomy with tube insertion recommended after a total of 4 to 6 months of bilateral effusion with a documented bilateral hearing deficit. Adenoidectomy is an appropriate surgical treatment for bilateral chronic nonsuppurative otitis media ~~serous otitis media with persistent effusion~~ in children over 3 ~~4~~ years with their second set of tubes. First time tubes are not an indication for an adenoidectomy. III. Tonsillectomy **GUIDELINE NOTE 27, SLEEP APNEA** *Line 211* Surgery for sleep apnea for adults is only covered after documented failure of both CPAP and an oral appliance. **GUIDELINE NOTE 36, TONSILLECTOMY** *Line 392* Tonsillectomy is an appropriate treatment in a case with: 1) Five ~~three~~ documented attacks of strep tonsillitis in a year or 3 documented attacks of strep tonsillitis in two consecutive years where an attack is considered a positive culture/screen and where ~~10~~

VIII. Pharmacy medication management DMAP has worked with the Oregon Board of Pharmacy to draft a refined guideline for pharmacy medication management. The subcommittee raised concerns about whether the proposed guideline is rigorous enough. Dodson also raised the concern that there should be a specific "or" placed between the alternate qualifications in requirement #2. Smits to check with statewide pharmacy experts, obtain documentation about required school of pharmacy training on medication management which have been required since 2003.	~~days of continuous~~ an appropriate course of antibiotic therapy has been completed; 2) Peritonsillar abscess unresponsive to medical management and drainage documented by surgeon, unless surgery performed during acute stage ~~Second occurrence of peritonsillar abscess, or if first abscess, has to be drained under general anesthesia;~~ 3) ~~Airway obstruction with presence of right ventricular hypertrophy or cor-pulmonale; and/or,~~ Moderate or severe obstructive sleep apnea (OSA) in children 18 and younger, or mild OSA in children with daytime symptoms and/or other indications for surgery. For children 3 and younger or for children with significant co-morbidities, OSA must be diagnosed by nocturnal polysomnography. For children older than 3 who are otherwise healthy, OSA must be diagnosed by either nocturnal polysomnography, use of a validated questionnaire (such as the Pediatric Sleep Questionnaire or OSA 18), or consultation with a Sleep Medicine specialist. 4) ~~4+ tonsils, which result in obstruction of breathing, swallowing and/or speech~~ Other recommended changes: Add Guideline #36 to lines 49 (Cleft palate), 84 (Deep abscesses [includes peritonsillar abscesses]), 211 (Sleep Apnea), and 565 (Chronic diseases of tonsils and adenoids) IV. Bariatric surgery A footnote was added to the current guideline: "**[4]The patient must meet criteria #1 and #2, and be referred by the**

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

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HEALTH OUTCOMES SUBCOMMITTEE
Clackamas Community College
Wilsonville, Oregon
January 10, 2008
8:00-11:30

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

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

Also Attending: Wally Shaffer MD, DMAP; Caroline Price RN, DMAP; Celeste Symonette, DMAP; Chris Kirk, MD, OHP Medical Directors; Dr. Kevin Wei, OHSU Cardiology; Tina Kitchen, MD, Office of Development and Disabilities Services

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

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

information which can distinguish myocarditis from CAD. In this type of case, it can prevent cardiac catheterization. Other testing would not be as definitive. He stated that MRI is becoming the gold standard for determining cardiac viability, particularly prior to CABG or other revascularization or stenting procedures. He testified that better knowledge of cardiac viability have better outcomes after CABG. Patients with cardiomyopathy with question about viability being considered for CABG are very helpful. Saha was concerned about inappropriate use and cost. Kirk thought that restricting payment might facilitate further discussion between consultants. Saha felt that the best compromise would be to place on congenital lines and allow prior authorization for FCHPs. Smits suggested having experts come and testify. Saha would like experts to testify on when this test would be effective and not abused. He suggested having Cardiology input to help craft guidelines to guide utilization to cover only those indications which are cost effective and improve outcomes. Smits brought up an issue that arose with the cardiac MRI codes. The old codes become obsolete and the new codes are not yet in the DMAP system. Symonette indicated that the HSC decision today can be implemented in a few days.	
ECHO with contrast Dr. Wei provided testimony about the uses and indications for ECHO with contrast. He testified that the addition of contrast would reduce the use of further imaging studies, reduce the number of non-diagnostic studies, and improve outcomes. Saha raised concerns about whether non-diagnostic studies are from operator issues or from need for contrast. Dr. Wei replied that contrast actually improves reading regardless of the readers experience level. Adds $120 to the cost of the ECHO. Dr. Wei felt that adding contrast reduces "patient through-put" and therefore is not likely to be abuse. Stress ECHOs are more likely to need contrast due to more difficulty to obtain stress images. Dr. Mangum stated that he did not think that contrast was community standard. He asked whether adding contrast improves outcomes. Saha asked for which signs or symptoms would require contrast ECHO to be on the Diagnostic list. Wei replied that not allowing diagnostic use would penalize patients. Use of contrast for ECHOs with patients with soft tissue issues (obesity, etc.) is especially helpful.	C8923, C8924, C8927, and C8928: place on the Diagnostic List with the following guideline: "Need for contrast should be assessed and if indicated implemented at the time of the original ECHO and not as a separate procedure." Place ECHO with contrast for congenital anomalies (C8921, C8922, C8926) on congenital cardiac anomaly lines (74, 77, 94, 95, 98, 99, 116, 117, 123, 140, 142, 149, 185, 193, 195, 237, 247, 274, 279, 673).

Saha asked about the use of this technology for stroke. Wei replied that contrast was not very useful in stoke cases. Looking for a patent foramen ovale utilizes no cost agitated saline. Kirk states that ECHO with contrast is frequently billed after a billing for an ECHO in the community. He recommended that the HSC only allow billing for one type of ECHO. He stated that if a facility did not have the ability to read an ECHO at the time of initial patient contract or did not have the ability to do a contrast ECHO, then the plans could authorize a follow-up ECHO which would be likely to occur in the next day to weeks. Dr. Wei indicated that most techs who read ECHOs can be trained to determine whether a scan is adequate and could use contrast for those which are no adequate. Dr. Wei indicated that the community only has a 1% rate of using contrast for ECHOs and that the payment for contrast generally does not result in profit, just coverage for the cost. Kirk wondered if ECHO with contrast would avoid the cost of a cardiac MRI. Saha suggested putting this on the Diagnostic List and following it to see if it is an issue. Kirk suggested taking to the Medical Directors for input. Symonette suggested putting in a guideline that only one test can be billed (ECHO or ECHO with contrast). Saha wanted to restrict use of contrast to the time of the original ECHO, rather than as a separate study. Saha felt that this could be a guideline: "Need for contrast should be assessed and if indicated implemented at the time of the original ECHO and not as a separate procedure." No time interval would be in place to allow for ECHOs to be done at a separate site if the original site did not have the ability to do contrast.	
Telephone and Email consultation guideline CPT codes for these types of visits were approved in December. The Commission was presented with a draft guideline for there use based on a guideline from Providence Health Plans. Discussion centered around who can bill these codes. MD, NP, PA should be included. The group debated allowing RNs to bill. Symonette recommended including RNs, as they provide valuable patient access. Kitchen indicated the importance of RNs for care management services.	Guideline adopted as follows: **Guideline XX Telephone and Email Consultations** Telephone and email consultations are a covered service only when the following criteria are met: 1) Patient must have a pre-existing relationship with the provider as demonstrated by at least one prior office visit within the past 12 months. 2) E-visits must be provided by a physician or licensed provider within their scope of practice.

Shaffer brought up concerns about paying for these codes and their budget impact. Suggested that these codes should be included in the biennial review to allow the actuaries to analyze the effects on cost. Dodson stated that she did not see much risk of abuse for these codes. Recommended adding and then seeing if any issues arise. Symonette suggested putting these codes on a "watch list." Other codes could be added for further review. The proposed guideline was altered to include examples of included and non-included services. RNs were added to the list of providers who can bill for these services.	3) Documentation should model SOAP charting; must include patient history, provider assessment, and treatment plan; follow up instructions; be adequate so that the information provided supports the assessment and plan; must be retained in the patient's medical record and be retrievable. 4) Telephone and email consultations must involve permanent storage (electronic or hard copy) of the encounter. 5) Telephone and email consultations must meet HIPAA standards for privacy. 6) There needs to be a patient-clinician agreement of informed consent for E-visits by email. This should be discussed with and signed by the patient and documented in the medical record. Examples of Covered Telephone and Email Visits: 1. Extended counseling when person-to-person contact would involve an unwise delay. 2. Treatment of relapses that require significant investment of provider time and judgment. 3. Counseling and education for patients with complex chronic conditions. Examples of Non Covered Email and Telephone Consultation: 1. Prescription renewal. 2. Scheduling a test. 3. Scheduling an appointment. 4. Reporting normal test results. 5. Requesting a referral. 6. Follow up of medical procedure to confirm stable condition, without indication of complication or new condition. 7. Brief discussion to confirm stability of chronic problem and continuity of present management.
Pharmacy Medication Management codes The HOSC adopted CPT codes covering pharmacy medication management at their December meeting and requested a guideline addressing the qualifications of a pharmacist who could perform these services. Smits presented input from the School of Pharmacy and a guideline based on North Carolina requirements for certifying pharmacists. Mangum felt that certifying pharmacists should be a state or	Guideline adopted as follows: **Guideline XXX Pharmacist Medication Management** Pharmacy medication management services are covered when provided by a pharmacist who has: 1) A current and unrestricted license to practice as a pharmacist in Oregon 2) One of the following qualifications:

pharmacy board function. Shaffer stated that this type of certification would be a whole new area for DMAP. Dodson agreed that this type of regulation could be done by the board of pharmacy by administrative rules. Olson agreed that the HSC should refer this to the board of pharmacy. Kirk stated that the health plans still need to credential pharmacists for billing. Symonette indicated that DMAP has limited ability to credential pharmacists; she felt it was more appropriate to have Board of Pharmacy do any necessary certification. Saha stressed that the HSC want this service paid only in context of medical home. Shaffer pointed out that other states use pharmacists for polypharmacy management and other situations outside the medical home. Discussion centered around requiring these services to be done by referral from a provider and that a consult note return to that referring provider.	a. Certification from the Board of Pharmaceutical Specialties b. Certified Geriatric Practitioner c. Completion of an accredited residency program with two years of clinical experiences approved by the Boards, d. Holds the academic degree of Doctor of Pharmacy and has three years of clinical experience approved by the Boards and has completed a American Council on Pharmaceutical Education (ACPE) approved certificate program in the area of practice e. Has successfully completed the course of study and holds the academic degree of Bachelor of Science in Pharmacy and has five years of clinical experience approved by the Boards and has completed two ACPE approved certificate programs with at least one program in the area of practice 3) Services must be provided based on referral from a physician or licensed provider. 4) Documentation must be provided for each consultation and must reflect collaboration with the physician or licensed provider. Documentation should model SOAP charting; must include patient history, provider assessment, and treatment plan; follow up instructions; be adequate so that the information provided supports the assessment and plan; must be retained in the patient's medical record and be retrievable.
Epidural steroid injections Epidural steroid injection procedures were not on the Prioritized List, ancillary list, diagnostic list, nor never covered list, except 62280 and 62281 which were on the Ancillary List. The HSC had asked Smits to bring information back to them about placement recommendations. Smits presented information from Dr. David Sibell, and expert in Pain Medicine, regarding coverage of epidural steroid injections. Kitchen wanted to make sure that placing these codes only on suggested lines would not this restrict baclofen epidural injections. Symonette indicated that it would not. Kirk pointed out that OHP patients can't go to pain clinics,	62280-62282 were added to the Review List for use for comfort care only. 62310-62311 were placed on the Never Covered list. 62318-62319 were added to the Review List for use for inpatient indications only. 64479-64480 were placed on the Never Covered list.

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

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

The HOSC discussed procedures which have been recently adopted which they would like to follow utilization. DMAP has offered to put utilization data on these codes on a quarterly basis, and monitor for changes in utilization. If there are dramatic changes seen, these codes will come back to the HOSC/HSC for further discussion.	placed on the "Watch List:" •Vertebroplasty •Surgical treatment of obesity •Non-surgical treatment/nutrition counseling for obesity •Telephone and email consultation •Pharmacy medication management •Behavior and assessment codes