MINUTES
HEALTH SERVICES COMMISSION
January 27, 2005

***Members Present*:** Eric Walsh, MD, Chair; Daniel Mangum, DO; Andrew Glass, MD; Somnath Saha, MD; Donalda Dodson, RN, MPH; Kathy Savicki, LCSW; Dan Williams; Ellen Lowe (arrived 11:40 a.m.); Bryan Sohl, MD, Susan McGough (via teleconferencing, Dr. Sohl arrived 11:22, a.m. and Ms. McGough arrived 11:36 a.m.).

Staff Present: Darren Coffman; Alison Little, MD, MPH; Laura Lanssens.

Also Attending: Chris Barber, RN, Tom Turek, MD and Marcia Becker-Mehr, Office of Medical Assistance Programs (OMAP); Kelly Wright, Mark Rutstein, MD,MBA, and Kristina Frank, AMGEN; Robert Buckendorf, PhD, Oregon Speech & Hearing Association; John White, PhD, OTR/L, Pacific University-School of Occupational Therapy; Robert Love, OTR/L, Providence Portland Medical Center; Blaise Scollard, PsyD, CCC; Janice Cockrell, MD, Emanuel Hospital & Pediatric Rehabilitation.

I. Call to Order

Dr. Eric Walsh, Chair, called the Health Services Commission (HSC) meeting to order at 11:21 a.m. in room 111 of the Clackamas Community College Wilsonville Training Center, 29353 Town Center Loop East, Wilsonville, Oregon. Darren Coffman called roll.

II. Therapy Guidelines

Dr. Alison Little referred the HSC to the documentation within the Therapy Guidelines section of the packet. Dr. Little proposed that the guidelines for the chronic and acute therapies be combined into one guideline and exclude limits on swallowing disorders. Dr. Little explained that she had combined the chronic and acute therapies into one because otherwise a limit of two therapy visits for a stroke patient would apply as soon as they were discharged from the hospital.

There was discussion about connecting the guideline to a diagnosis. Dr. Glass brought up that fact that many times there is no diagnosis given by the therapist. Usually it is a description of the speech and articulation problems, a description of school behavior, or how the individual is functioning at home. Kathy Savicki expressed the concern about the need to have the guideline be able to distinguish where the impairment is small, but broad enough for those with a real disability.

Dr. Walsh wondered why the acute stage of treatment extended to six months, with the potential for a huge number of visits should the patient be seen everyday. An example

of a young child with a severe head injury was given, where even more than six months of visits may be needed after leaving the hospital. Dr. Walsh explained to the therapists that the HSC is looking to manage a perceived over-utilization of visits. He challenged the therapists to go through the articles they sent and find where it states that a certain number of visits are better than another number. Also he explained that the HSC is looking for specificity, and the articles only had antidotal evidence. The HSC needs to see evidence of the utility of different types of treatment and the appropriate frequency of that treatment. Furthermore, Dr. Walsh requested that the therapists establish a gradation of severity for specific diagnoses to which guidelines can be attached.

The therapists said they do not have evidence that a certain number of visits gives a better outcome than another amount, but they do have evidence that children improve on standard scores or on functional outcomes after treatment. The concerns are not for the children with mild articulation issues but rather to provide for the children under the age of two that have autism, cerebral palsy and other severe disabilities. They said there is a critical learning period for communication skills for children under age two (e.g. reciprocity).

It was noted that inpatient stays were considered acute with an unlimited number of visits available, but they wanted patients seen in a skilled nursing facility (SNF) to be exempt from the limits as well. Dr. Little clarified that they are acute facilities, but as it is being implemented now, SNF patients are subjected to limits. That was a decision that OMAP said they made because there was not a clear direction from the HSC.

Dr. Saha mentioned that it would be useful to the HSC to have a list of diagnoses, with a recommended approach supported by evidence for the acute phase and the chronic phase of each disease. The therapists replied that there is a need for standard outcome measures across all fields of therapy so that they could measure progress. Dr. Janice Cockrell pointed out that there is difficulty in using such measurements in children due to their natural development. There are good adult outcomes available; however for children there does not appear to be a minimum "dose". In pediatrics, much of the treatment involves educating the family so that they can follow through with a home treatment program. Dr. Cockrell's concern is cutting back on treatment visits when there are periods of rapid development that should be occurring in childhood -- below the age of three and at puberty. Dr. Cockrell recognizes that the diagnosis of developmental delay is a problem as the etiology of the delay needs to be known before the patient's management can be determined.

Ms. Savicki asked if stringent guidelines could be crafted for children with minor problems because they would be the easiest to manage. Upon discussion the HSC concluded that the diagnostic system does not delineate disease severity. Upon review of the literature, however, it was pointed out that there are some qualification schemes, including a seven-level language skill qualification. The Commission asked if they could provide a list of important diagnostic codes that should be exempt from the guidelines and a grading system to be used for follow-up visits to determine when a patient's progress becomes stationary. Again the HSC urged the therapists to present the best

evidence-based approaches. The therapists replied that they understood there was a need for management of these services and they would be happy to supply the requested information. Furthermore, they would promote good treatment notes and charts that show whether or not the patient is making progress, whether there is follow through on the treatment plan, and whether the patient can act independently. Ms. Savicki said she thought it would be best to look at simple things that would allow the managed care systems to manage these services, such as the level of disability and the level of progress.

The therapists asked if the HSC could modify the guideline for age two and under that would provide speech pathologists some visits for evaluation. Dr. Little mentioned that she was still struggling with importance of visits for children from age 0-2 years because the one study dealing with the treatment of young children had an average age of 3-1/2 years and it showed no significance between treatment and control groups. A separate commentary on services for this age group was unclear as to whether the children received hearing aids and/or speech therapy.

Marcia Becker-Mehr, from OMAP, informed the HSC that evaluations are not prior authorized. OMAP would not know the age of the individual as claims get processed, therefore evaluations are currently covered for children of any age.

Ms Savicki was concerned about the cost impact of restoring services. Mr. Coffman explained the changes that went into effect in October 2004 were a reduction in service and they were felt to be within the allowable boundaries of fiscal impact because the restoration of services would still be at a lower level than what they were prior to October 1, 2004.

The subject of dysphagia was brought up and whether there should be a limit of visits attached. Dr. Little explained that she felt the results of not treating it are costly, and it appears that it is not being abused in the same way as speech therapy.

There was a motion to accept Dr. Little's draft to remove swallowing disorders from the current set of visit limits while the HSC continues to work on the other aspects of the guideline.

Prior to a second to the motion, Dr. Mangum said he was concerned about the teenagers with head injuries having enough visits. Three months seemed too short in a nursing home setting because recovery time from a head injury can be significant. He further stated that 6 months could even be relatively short in that situation. He did not want to withhold care by sticking with the guideline as it is. Ms. Savicki suggested adding a clause to the guideline stating that it does not apply to an individual in a skilled nursing facility for rehabilitation purposes. Dr. Mangum agreed with the concept, however noted that it would also allow for individuals that have less acute problems to receive ongoing therapy.

MOTION: Remove limits on visits for the evaluation and treatment of swallowing disorders from the current guideline. MOTION CARRIES: 9-0, Ayes: Walsh, Mangum, Glass, Saha, Dodson, Savicki, Williams, Lowe, Sohl. Abstention: McGough.

MOTION: Have no limits apply to therapies in a setting of inpatient hospital care, inpatient rehabilitation units, and skilled nursing facilities with the primary purpose of rehabilitation. MOTION CARRIES: 10-0.

After some discussion, Dr. Walsh clarified that the HSC still has concerns with therapy visits for 0-2 year olds, the current distribution of limits by age, and the fact that the current guideline covers all severity levels with one set of limits. Dr. Walsh asked the therapists to work with the HSC to set sensible limits with specific guidelines.

The therapists mentioned that the federal government does not mandate services for children under 36 months. Therefore these children rely on the state for these services and given Oregon's financial situation, these services are being decimated.

MOTION: Give four visits for speech therapy to those less than 3 years of age. MOTION CARRIES: 9-0, Ayes: Walsh, Mangum, Glass, Saha, Dodson, Savicki, Williams, Lowe, Sohl. Abstention: McGough.

See Attachment A for the rehabilitation therapy guidelines after the approved modifications .

III. Chair's Report

Dr. Eric Walsh reported that he met with one of the vice presidents of OHSU with regard to using the Prioritized List as a way of giving free or sliding scale services to individuals who are not insured or do not qualify for the Oregon Health Plan. This would be a way to seed the waters so all of the hospitals in Portland will have a methodology in which they can provide unreimbursed or under-reimbursed care.

The OHSU Department of Family Medicine has taken two of four clinics and turned the Richmond clinic (39th and Division SE) into a federally qualified health center look-alike and the Scappoose clinic into a rural health center. In fact, OHSU is the only Medicaid provider in Columbia County. From 2002 to 2005, the Department of Family Medicine has increased the number of Medicaid clients that are served by ten percent. Most of the other health care facilities are doing the opposite. OHSU can do this by receiving cost-based reimbursements. Dr. Walsh just learned that the Richmond Health Center is the largest federally qualified health center in the state of Oregon. Dr. Walsh was happy to report good news on the health care front.

IV. OHP Update

Darren Coffman informed the HSC that Dr. Goldberg was unable to attend. However, Dr. Goldberg wanted Mr. Coffman to convey to the HSC that the Benchmark Report has been well received. There will be the prospect for more discussion once PwC and OMAP have finished their report explaining the differences between the OHP reimbursement rates and the benchmark rates.
The HSC should not expect any more significant changes in the Oregon Health Plan beyond what has been seen in the Governor's budget. This elimination of dental and vision services for adults was an attempt to make cuts in the OHP to account for the cost increases for the biennium. At the same time, Dr. Goldberg is hearing about some attempts to find ways to buy back a portion of these benefits. The current stance within the Legislature is certainly much different than it was two years, when there was a focus of attention on the OHP. The general perception is that if the State is able to sustain some level of OHP Standard at 24,000 eligibles, combined with the 10,000 lives covered by FHIAP, it appears Oregon will be able to maintain the federal waiver. At the present time Oregon is still looking at getting down to the level of 24,000 OHP Standard eligibles by June 30, 2005 through attrition alone rather than disenrollment.

Ellen Lowe mentioned that the Medicaid national caseload is increasing significantly, which is a direct result of the poverty level. This should be reflected in rising OHP Plus populations and costs. Ellen Lowe shared with the HSC some insight on the 73rd Oregon Legislative Assembly. For example, there is a coalition that is being put together to look at the "tobacco tax". Ms. Lowe is one of the members of the coalition. This group is looking at an increase in tax from ten to thirty-five cents per pack. It will need to pass the legislature with a 3/5ths majority as a tax bill, and most likely will need 2/3rds of the votes to override an expected veto from the Governor.

Kathy Savicki mentioned that Barney Speight, OMAP Administrator, has put together two workgroups dealing with cost-savings. Ms Savicki requested that the HSC receive copies of the materials. She also mentioned that she heard that FHIAP is now receiving applications from the unemployed. The waiting list is gone and FHIAP is taking individuals as well as group enrollees. It is becoming a back-door way for the poor to purchase subsidized insurance, using private policies. She thinks it might become the new "Standard" plan.

V. Approval of Minutes (December 10, 2004)

Dr. Dan Mangum asked for a correction on page 5, regarding his comment. Change "…is no money available" to "…are limited funds available". Also change the spelling "anticdotal" to "anecdotal".

MOTION: Accept the December 10, 2004 Minutes with the changes requested by Dr. Mangum. MOTION CARRIES: 9-0, Ayes: Walsh, Mangum, Glass, Saha, Dodson, Savicki, Williams, Lowe, Sohl. Abstention: McGough.

VI. Director's Report

Darren Coffman updated the HSC with regards to commission vacancies. There is one appointment imminent. He is looking at being more instrumental in replacing the commissioners that have expired second terms, which is beyond the period of time the Governor wishes commission and board members to serve.

VII. Medical Director's Report

Dr. Alison Little did not have a Medical Director's Report.

VIII. Report from the MHCD Subcommittee

As Donalda Dodson was out of state at the time of the meeting, Kathy Savicki reported in her stead. Ms. Savicki explained that Dr. David Pollack is doing work nationally around the integration of primary care and behavioral health delivery systems, with the core strategies involving the co-location of behavioral health providers in primary care settings. With regard to primary care providers, there would be a co-location of them into the mental and behavioral health settings. This physical co-location has a physical consultation and a varied intervention triage strategy. There is a group whose focus is starting pilot programs here in Oregon, with the emphasis on the federally qualified health clinics that serve many of those that used to be on OHP Standard. There is a strong position paper regarding this program and the MHCD Subcommittee should be receiving copies in the near future.

Ms. Savicki went on to report that the Subcommittee will be taking a second look at what the HSC has done with incorporating evidence-based practice through an update from staff, with an eye toward what the Office of Mental Health and Addiction Services is producing. Her feeling is that this topic will be an informational discussion and that no action on the part of the Subcommittee may be necessary. In her opinion, there are plenty of strategies that allow for mental health & chemical dependency to be managed, but they don't translate well onto the Prioritized List.

IX. Report from Health Outcomes Subcommittee

Erythropoietin

Dr. Dan Mangum said that the Health Outcomes Subcommittee had accepted some changes to the erythropoietin (EPO) guideline to include treatment in the setting of chronic renal failure, either with or without dialysis. He said Amgen representatives want other changes made but have yet to provide compelling information to do so.

In the use of EPO for Jehovah's Witnesses, the OSU College of Pharmacy did a revue that included its use pre-surgery. Dr. Bryan Sohl indicated there are new guidelines that suggest when EPO should be provided to Jehovah's Witnesses in an obstetrical setting, particularly in the case of pre-eclampsia when a large amount of blood loss is expected. His hospital is looking at it from a perspective of all surgeries at risk of high blood loss. Dr. Little noted the College of Pharmacy found the cost for EPO per case in pre-surgery was almost $3,000 compared to $168 per unit of transfused blood. They did not find evidence to support widespread use of this practice and recommended it be looked at on a case-by-case basis.

Dr. Sohl wondered if such a guideline could legally be limited to just Jehovah's Witnesses. Dr. Tom Turek could not understand the justification for potentially treating all women undergoing planned C-sections. Dr. Sohl did not think that was an issue as he as never had a patient other than a Jehovah's Witness who would refuse blood. Dr. Sohl believes guidelines from ACOG are too liberal, but believes reasonable ones could be developed. However, he recognizes that it is such a rare case (one has never come to OMAP's attention) that maybe the decision should be left up to the attending physician, with payment decisions made by Dr. Turek in the case of FFS and the managed care plans otherwise. Dr. Sohl will forward an article on this issue to Dr. Little and Dr. Turek for possible consideration at a future meeting.

MOTION: Accept the changes to the EPO guideline adding chronic renal failure with or without dialysis as an indication for treatment. MOTION CARRIES: 10-0.

See Attachment B for the EPO guideline as modified.

Transplant algorithm

Will be discussed in the methodology discussion later in the agenda.

Outstanding New CPT/HCPCS Codes

No action is required on codes for negative wound pressure therapy, wearable defibrillator, and a procedure for end-stage glaucoma as the decisions made at the last meeting appear correct after reviewing further material.

Recommendations for handling the other new codes were briefly presented and then voted on separately. The following actions were taken.

MOTION: Add brachytherapy (CPT 19296 & 19298) to Line 228, Cancer of Breast, Treatable. MOTION CARRIES: 10-0.

It is being recommended not to add colonoscopy with ultrasound to the List (put on Non-OHP Services List), as ultrasound is only used to stage rectal cancers. It was discovered, however, that this appropriate pairing did not appear on the List.

MOTION: Add flexible sigmoidoscopy with endoscopic ultrasound examination (CPT 45341) to Line 273 (Cancer Of Colon, Rectum, Small Intestine And Anus, Where Treatable). MOTION CARRIES: 10-0.

It was decided to leave the code for endobronchial ultrasound on the Non-OHP Services List for now, as the literature was not conclusive that therapy would change as a result of its usage. However there it is planned to ask for someone to give expert testimony on this at a future meeting.

No action was taken on the testing of central auditory function and it will be left on the Non-OHP Services List. Testimony received said that these were no longer being done as there is no effective treatment for the disorders of central auditory function that it is used to diagnose.

The subcommittee is recommending that the treatment of tinnitus be moved down lower, since there is no effective treatment other than possibly an anti-depressant.

MOTION: Move tinnitus (ICD-9-CM 388.30-388.32) from line 511, Hearing Loss - Over Age of Five, to Line 721, Sensory Organ Conditions With No Effective Treatment or No Treatment Necessary. MOTION CARRIES: 10-0.

MOTION: Add osteoplastic reconstruction of dorsal spine (CPT 63295) to higher spinal deformity line (Line 327): 10-0.

Other miscellaneous code changes

A document that detailed additional straightforward coding recommendations was reviewed. The only departure from recommending the entire set of changes was that subcommittee does not want to add codes for umbilical and midline hernias to Line 6 as they don't carry the same risk of incarceration in children. Mr. Coffman also mentioned additional changes involving dental procedures, in which the retreatment of root canals for bicuspid and posterior teeth were being moved down, and codes for the incision and drainage of abscesses of the mouth were being added.

MOTION: Adopt the additional coding changes to the Prioritized List recommended by the Health Outcomes Subcommittee as documented in Attachment C (Note: the coding changes discussed in the previous section are also included in this document). MOTION CARIES: 10-0.

MOTION: Adopt OHSU guidelines (see Attachment D) on the appropriate placement of cochlear implants to be associated with the corresponding lines (303 & 513). MOTION CARIES: 10-0.

Finally, a document produced by Dr. Little detailed changes being recommended to the hepatitis lines since some codes representing conditions where treatment was

appropriate where on the non-funded line. While all other coding changes being made at the meeting represented interim modifications to the List to be implemented April 1, 2005, the changes involving hepatitis will be made effective with the implementation of the 2005-07 list because of potential financial implications.

MOTION: Make changes to the placement of chronic hepatitis and hepatitis with coma as shown in Attachment E. MOTION CARIES: 9-0, Ayes: Walsh, Mangum, Glass, Saha, Dodson, Savicki, Williams, Lowe, McGough. Abstention: Sohl.

X. Draft 2005-07 Biennial Report to Governor and the 73rd Legislature

Mr. Coffman said that the biennial report is about 95% completed and should be ready to go to the printer toward the end of February. He said it will still be bulky, but will be over 100 pages less than the 2003 report as ORS no longer directs us to include PricewaterhouseCooper's report on the actuarial pricing of the list. This is because 2003 legislature directed the HSC to conduct their own actuarial pricing of OHP services in developing the benchmark rates.

Mr. Coffman also wondered about the inclusion of the 100+ pages involving the condition and treatment indexes to the report. After some thought towards taking them out, it was finally decided to keep them in, particularly since the legislators and laypeople might find them of use.

XI. Methodology for Modifying the Prioritized List

Mr. Coffman directed the Commission to the latest version of the prioritization methodology appearing in their packets. A single change has been made since they last viewed this document. At the last meeting, the Commission reworded the second endpoint on the right-hand side of the methodology algorithm from "Do not add, move, or remove from List" to "Move, remove or do not add to List" for the purpose of clarity. At this time the Commission reviewed the documentation on the prioritization methodology in its entirety. It was recommended that "Move" be added as an option to the upper right-hand endpoint for a treatment determined not to be effective.

MOTION: Accept the prioritization methodology description, including the methodology algorithm as modified, for inclusion in the 2003 biennial report. MOTION CARIES: 10-0.

XII. Other Business

It was decided that the next meetings for the HOSC and the HSC will be scheduled for Thursday, April, 28, 2005 and Thursday, July 7, 2005. For both dates, the meetings will be held in Room 117A of the Meridian Park Hospital, Community Health Education Center.

XIII. Public Comment

No further comment was offered at this time.

XIV. Adjournment

Dr. Walsh adjourned the meeting of the Health Services Commission at 3:15 p.m.

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Eric Walsh, MD, Chair

ATTACHMENT A

Revised Guideline for Rehabilitative Therapies

GUIDELINE NOTE 1, SPEECH, OCCUPATIONAL, AND PHYSICAL THERAPY

On Lines 1, 19, 21, 24, 26, 29, 31, 35, 37, 38, 40, 42, 52, 89, 95, 96, 97, 98, 101, 102, 103, 104, 105, 106, 112, 113, 114, 115, 132, 133, 134, 136, 143, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 165, 168, 175, 177, 180, 191, 198, 199, 209, 215, 219, 216, 240, 241, 248, 261, 264, 286, 287, 288, 289, 290, 294, 299, 313, 318, 319, 323, 324, 325, 330, 336, 371, 374, 375, 382, 383, 384, 388, 441, 454, 455, 456, 469, 470, 471, 483, 484, 485, 486, 498, 516, 517, 518, 519, 522, 568, 584, 589, 594, 645, 646, 685

Physical, occupational and speech therapy, and cardiac and vascular rehabilitation, are covered for ~~these~~ diagnoses ~~when~~ paired with the respective CPT codes, depending on medical necessity, for up to 3 months after the initiation of the therapies. Thereafter, the following number of combined physical and occupational therapy visits are allowed per year, depending on medical necessity:

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

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

- Age < 3: 4
- Age 3-7: 24
- Age 8-12: 12
- Age > 12: 2

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

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

ATTACHMENT B

Revised Guideline for Erythropoietin

GUIDELINE NOTE 2, ERYTHROPOIETIN

On Lines 2, 4, 27, 118, 119, 120, 122, 123, 124, 125, 137, 140, 166, 178, 182, 183, 193, 194, 195, 196, 200, 201, 212, 213, 222, 227, 228, 229, 231, 232, 233, 234, 235, 236, 237, 249, 250, 252, 265, 273, 274, 275, 276, 277, 278, 279, 280, 314, 329, 349, 445, 446, 500, 501, 502, 503, 693

1. Indicated for anemia (Hgb < 10gm/dl or Hct < 30%) induced by cancer chemotherapy, in the setting of myelodysplasia, or chronic renal failure, with or without dialysis.
   A. Endogenous erythropoietin levels of < 200 IU/L are required for treatment, except in chronic renal failure.
   B. Reassessment should be made after 8 weeks of treatment. If no response, treatment should be discontinued. If response is demonstrated, EPO should be titrated to maintain a level between 10 and 12.

2. Indicated for anemia (Hgb < 10gm/dl or Hct < 30%) associated with HIV/AIDS.
   A. An endogenous erythropoietin level < 500 IU/L is required for treatment, and patient may not be receiving zidovudine (AZT) > 4200 mg/week.
   B. Reassessment should be made after 8 weeks of treatment. If no response, treatment should be discontinued. If response is demonstrated, EPO should be titrated to maintain a level between 10 and 12.

ATTACHMENT C

Interim Modifications of Prioritized List of Health Services Approved on January 27, 2005 for Implementation April 1, 2005.

Diagnosis: CERVICAL VERTEBRAL DISLOCATIONS/FRACTURES, OPEN OR CLOSED; OTHER VERTEBRAL DISLOCATIONS/FRACTURES, OPEN; SPINAL CORD INJURIES WITH OR WITHOUT EVIDENCE OF BERTEBRAL INJURY
Treatment: MEDICAL AND SURGICAL TREATMENT
Line: 113

ADD 733.13 Pathologic fracture of vertebrae

Diagnosis: COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
Treatment: MEDICAL AND SURGICAL TREATMENT
Line: 148

DELETE 26055 TENDON SHEATH INCISION (E.G., FOR TRIGGER FINGER)

Diagnosis: CRUSH INJURIES: TRUNK, UPPER LIMBS, LOWER LIMB INCLUDING BLOOD VESSELS
Treatment: SURGICAL TREATMENT
Line: 149

ADD 29130 APPLICATION OF FINGER SPLINT, STATIC

Diagnosis: CANCER OF BREAST, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL(See Guideline Notes 2,3 and 12)
Treatment: MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY, RADIATION THERAPY AND BREAST RECONSTRUCTION (See Coding Specification Below)
Line: 228

ADD 19296 BRACHYTHERAPY ON DATE SEPARATE FROM PARTIAL MASTECTOMY
ADD 19298 BRACHYTHERAPY CONCURRANT WITH PARTIAL MASTECTOMY

Diagnosis: CANCER OF COLON, RECTUM, SMALL INTESTINE AND ANUS, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL
Treatment: MEDICAL AND SURGICAL TREATMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY
Line: 273

ADD 45341 SIGMOIDOSCOPY, FLEXIBLE; WITH ENDOSCOPIC ULTRASOUND EXAMINATION

Diagnosis: COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
Treatment: MEDICAL AND SURGICAL TREATMENT
Line: 299

ADD 21501 INCISION AND DRAINAGE, DEEP ABSCESS OR HEMATOMA, SOFT TISSUE OF NECK OR THORAX

Interim Modifications of Prioritized List of Health Services Approved on January 27, 2005 for Implementation April 1, 2005. (Cont'd)

Diagnosis: SPINAL DEFORMITY, CLINICALLY SIGNIFICANT
Treatment: MEDICAL AND SURGICAL THERAPY
Line: 327

ADD 63295 OSTEOPLASTIC RECONSTRUCTION OF DORSAL SPINE ELEMENTS

Diagnosis: DENTAL CONDITIONS (EG. INFECTIONS)
Treatment: URGENT AND EMERGENT DENTAL SERVICES
Line: 359

ADD D7511 I&D ABSCESS OF INTRAORAL SOFT TISSUE, COMPLICATED
ADD D7521 I&D ABSCESS OF EXTRAORAL SOFT TISSUE, COMPLICATED

Diagnosis: FRACTURE OF SHAFT OF BONE, CLOSED
Treatment: OPEN OR CLOSED REDUCTION
Line: 469

DELETE 733.13 Pathologic fracture of vertebrae

Diagnosis: DISLOCATION/DEFORMITY OF ELBOW, HAND, ANKLE, FOOT, JAW, CLAVICLE AND SHOULDER
Treatment: SURGICAL TREATMENT
Line: 484

DELETE 26055 TENDON SHEATH INCISION (E.G., FOR TRIGGER FINGER)

Diagnosis: CLOSED DISLOCATIONS/FRACTURES OF NON-CERVICAL VERTEBRAL COLUMN WITHOUT SPINAL CORD INJURY
Treatment: MEDICAL AND SURGICAL TREATMENT
Line: 485

ADD 733.13 Pathologic fracture of vertebrae

Diagnosis: FRACTURE OF JOINT, CLOSED (EXCEPT HIP)
Treatment: OPEN OR CLOSED REDUCTION
Line: 486

ADD 27827 OPEN TREATMENT OF FRACTURE OF WEIGHT-BEARING ARTICULAR SURFACE/PORTION OF DISTAL TIBIA WITH INT/EXT FIXATION, TIBIA ONLY

Diagnosis: NON-MALIGNANT OTITIS EXTERNA
Treatment: MEDICAL THERAPY
Line: 504

ADD 69020 DRAINAGE EXTERNAL AUDITORY CANAL, ABSCESS

Proposed Interim Modification of Prioritized List of Health Services Reviewed on January 27, 2005 for Implementation April 1, 2005 (Cont'd).

Diagnosis: DENTAL CONDITIONS (EG. DENTAL CARIES, FRACTURED TOOTH)
Treatment: BASIC RESTORATIVE
Line: 507

ADD	D2391	Resin based composite restoration, one surface, posterior
ADD	D2392	Resin based composite restoration, two surfaces, posterior
ADD	D2393	Resin based composite restoration, three surfaces, posterior
ADD	D2394	Resin based composite restoration, four or more surfaces, posterior
ADD	D3430	Retrograde filling

Diagnosis: HEARING LOSS – OVER AGE OF FIVE
Treatment: MEDICAL THERAPY INCLUDING HEARING AIDS
Line: 511

DELETE	388.30	Tinnitus, unspecified
DELETE	388.31	Subjective tinnitus
DELETE	388.32	Objective tinnitus

Diagnosis: PERIPHERAL NERVE ENTRAPMENT
Treatment: MEDICAL AND SURGICAL TREATMENT
Line: 537

DELETE	26055	TENDON SHEATH INCISION (E.G., FOR TRIGGER FINGER)

Diagnosis: SPINAL DEFORMITY, NOT CLINICALLY SIGNIFICANT
Treatment: ARTHRODESIS/REPAIR/RECONSTRUCTION, MEDICAL THERAPY
Line: 611

ADD	63050	LAMINOPLASTY, CERVICAL, W/SPINAL CORD DECOMPRESSION, 2/> VERTEBRAL SEGMENTS
ADD	63051	LAMINOPLASTY, CERVICAL, W/SPINAL CORD DECOMPRESS, 2/> VERTEBRAL SEGMENTS W/POST BONE RECONSTRUCT
ADD	63295	OSTEOPLASTIC RECONSTRUCTION OF DORSAL SPINE ELEMENTS

Diagnosis: SENORY ORGAN CONDITIONS WITH NO EFFECTIVE TREATMENT OR NO TREATMENT NECESSARY
Treatment: EVALUATION
Line: 721

ADD	388.30	Tinnitus, unspecified
ADD	388.31	Subjective tinnitus
ADD	388.32	Objective tinnitus

ATTACHMENT D

Approved Guidelines for Cochlear Implants

GUIDELINE NOTE 16, COCHLEAR IMPLANTS, AGE 5 OR UNDER

On Line 303

Children will be considered candidates for cochlear implants if the following criteria are met:

a) Profound sensorineural hearing loss in both ears
b) Child has reached the age of 1
c) Receive little or no useful benefit from hearing aids
d) No medical contraindications
e) High motivation and appropriate expectations (both child, when appropriate, and family)

GUIDELINE NOTE 30, COCHLEAR IMPLANTS, OVER AGE 5

On Line 513

Children will be considered candidates for cochlear implants if the following criteria are met:

a) Profound sensorineural hearing loss in both ears
b) Child is under the age of 19
c) Receive little or no useful benefit from hearing aids
d) No medical contraindications
e) High motivation and appropriate expectations (both child, when appropriate, and family)

Postlinguistic adults will be considered candidates for cochlear implants if the following criteria are met:

a) Severe-to-profound sensorineural hearing loss in both ears
b) Hearing loss acquired after learning oral speech and language development
(postlinguistic hearing loss)
c) Receive limited benefit from appropriately fit hearing aids; i.e., scores of 40% or less on sentence recognition test in the best-aided listening condition
d) No medical contraindications

Prelinguistic adults will be considered candidates for cochlear implants if the following criteria are met:

a) Profound sensorineural hearing loss in both ears
b) Hearing loss acquired before learning speech and language (prelinguistic hearing loss)
c) Receive no benefit from hearing aids
d) No medical contraindications
e) A desire to be a part of the hearing world

ATTACHMENT E

Changes to 2005-07 Prioritized List Involving the Treatment of Hepatitis

10/1/04 Line	Code	Code description	10/1/05 Line
603	070.0	Viral hepatitis A with hepatic coma	329
603	070.1	Viral hepatitis A without mention of hepatic coma	No Change
603	070.20	Viral hepatitis B with hepatic coma, acute or unspecified, without mention of hepatitis delta	329
603	070.21	Viral hepatitis B with hepatic coma, acute or unspecified, with hepatitis delta	329
603	070.22	Viral hepatitis B with hepatic coma, chronic, without mention of hepatitis delta	329
603	070.23	Viral hepatitis B with hepatic coma, chronic, with hepatitis delta	329
603	070.30	Viral hepatitis B without mention of hepatic coma, acute or unspecified, without mention of hepatitis delta	No Change
603	070.31	Viral hepatitis B without mention of hepatic coma, acute or unspecified, with hepatitis delta	No Change
332	070.32	Viral hepatitis B without mention of hepatic coma, chronic, without mention of hepatitis delta	No Change
603	070.33	Viral hepatitis B without mention of hepatic coma, chronic, with hepatitis delta	329
603	070.41	Acute or unspecified hepatitis C with hepatic coma	329
603	070.42	Hepatitis delta without mention of active hepatitis B disease with hepatic coma	329
603	070.43	Hepatitis E with hepatic coma	329
603	070.44	Chronic hepatitis C with hepatic coma	329
603	070.49	Other specified viral hepatitis with hepatic coma	329
332	070.51	Acute or unspecified hepatitis C without mention of hepatic coma	No Change
603	070.52	Hepatitis delta without mention of active hepatitis B disease or hepatic coma	329
603	070.53	Hepatitis E without mention of hepatic coma	No Change
332	070.54	Chronic hepatitis C without mention of hepatic coma	No Change
603	070.59	Other specified viral hepatitis without mention of hepatic coma	No Change
603	070.6	Unspecified viral hepatitis with hepatic coma	329
603	070.70	Unspecified viral hepatitis C without hepatic coma	No Change
603	070.71	Unspecified viral hepatitis C with hepatic coma	329
603	070.9	Unspecified viral hepatitis without mention of hepatic coma	No Change
30	572.2	Hepatic coma	438
30	572.3	Portal hypertension	438
30	572.8	Other sequelae of chronic liver disease	438

MINUTES
HEALTH SERVICES COMMISSION
April 28, 2005

Members Present: Eric Walsh, MD, Chair; Daniel Mangum, DO; Bryan Sohl, MD; Eric Walsh, MD; Andrew Glass, MD; Leda Garside, RN; Daniel Williams; Susan McGough; Kathy Savicki, LCSW.

Members Absent: Somnath Saha, MD; Ellen Lowe.

Staff Present: Darren Coffman; Alison Little, MD, MPH; Laura Lanssens.

Also Attending: Chris Barber, RN, and Kathy Kirk, RN, Office of Medical Assistance Programs (OMAP); Robert Buckendorf, PhD, Oregon Speech & Hearing Association; Blaise Scollard, PsyD, CCC, Kaiser Permanente; Janice Cockrell, MD, Emanuel Hospital & Pediatric Rehabilitation; Anita Asmussen, Legacy; Bruce Goldberg, Oregon Health Policy & Research (via telephone conferencing).

I. Call to Order

Dr. Eric Walsh, Chair, called the Health Services Commission (HSC) meeting to order at 12:30 p.m. in Room 117A of the Meridian Park Hospital, Community Health Education Center, 19300 SW 65th Avenue, Tualatin Oregon. Darren Coffman called roll.

II. OHP Update

Due to his scheduling demands, Dr. Bruce Goldberg was moved up in the agenda. He commented that there was nothing remarkable to report from the legislative front at this time. He said that the House and Senate were still coming to an agreement on what State budget will look like. In regards to the Oregon Health Plan, there is little in the way of new policy being created. Bills of note would:

- eliminate premiums for those at or below 10% FPL, which passed a Senate committee and is now before Ways and Means.
- add back the vision and dental benefits cut in the Governor's budget
- mandate mental health parity, which passed out of Senate and probably be part of the legislative end-game.
- mandate water fluoridation for many of the state's water districts, which passed out of the House and was just heard in Senate committee the previous day
- address obesity & child health, eliminating school vending machines that sell pop
- improve quality/decrease costs through rate regulation
- bring transparency through the publication of financial and clinical data

Dr. Goldberg said that OHP issues were being dwarfed by increasing uninsurance rates and federal level cuts to Medicaid. Ms. Savicki had heard that caseloads for OHP Plus and nursing homes were up significantly and wondered how this would affect the budget? Dr. Goldberg replied that this was true but that most of the resulting financial impact had already been figured into budget during the last rebalance and therefore is reflected in the Governor's budget. He indicated that new calculations would be made in May and that the increase in the nursing home caseload was potentially more of a problem.

Dr. Walsh then asked if the OHP population was decreasing to the enrollment numbers necessary to stay under budget? Dr. Goldberg said that yes, OHP Standard is now just below 30,000 and on its way down to 25,000 on the pace anticipated. He added that the total population for OHP continues to remain over 400,000, with probably around 350,000 of that in OHP Plus. Ms. Savicki noted that there is now some incentive to move from OHP Standard to OHP Plus through disability qualification in order to receive a richer benefit package.

II. Approval of Minutes (January 27, 2005)

MOTION: Accept the January 27, 2005 Minutes with the following changes: 1) page 7, paragraph 1, second sentence, change "pre-eclampsia" to "placenta previa" and 2) page 8, paragraph 2, second sentence, remove the word "there." MOTION CARRIES: 9-0.

III. Chair's Report

Dr. Walsh reported that he did not have a chair's report.

IV. Director's Report

Darren Coffman reported that Dr. Bruce Goldberg is shadowing Erinn Kelley-Siel in preparation for her maternity leave which will begin sometime in May. During that period he will be spending most of his time in the Governor's office and Dr. Jeanene Smith will take over most of the administrative duties with OHPR.

Mr. Coffman reminded the HSC that at the last meeting they had wanted to be kept up-to-date on the progress of the DHS workgroups that Barney Speight was organizing. He directed them to a handout in the packet which indicated the Cost Drivers Workgroup has identified areas for work and will likely meet over the next several months. The Administrative Efficiencies Workgroup is still deliberating about critical areas for future efforts and should complete their work by June 2005.

Mr. Coffman announced that this would be the last meeting for Andy Glass and Kathy Savicki. Andy is to be replaced by Kevin Olson, MD, an oncologist from Tualatin, and Kathy will be replaced by Laurie Theodorou, LCSW, a social worker from Medford. The vote on their confirmation before the full Senate is expected in the next few days. Pending final confirmation, the July 7th meeting will also be the first for Kathryn Weit, a consumer representative from Eugene. She will be taking the vacancy left by Jono Hildner. Mr. Coffman said that a second new consumer representative may be confirmed by the July meeting to take Ellen Lowe's place.

Mr. Coffman then asked Leda Garside, who has replaced Donalda Dodson, to introduce herself. She indicated that she is the ¡Salud! Services Coordinator for Tuality Healthcare and in that role she helps OHP clients on a daily basis. She looks forward to working with the Commission on their very important task.

V. Medical Director's Report

Dr. Alison Little reported that she had been sent to Chicago to represent Oregon in a meeting of 15 states to explore a collaborative effort in using evidence-based medicine in making health policy for state Medicaid programs. One option would be to have the Center for Evidence-Based Policy at OHSU put together statements using established evidence-based research. The other option would be to create brand new evidence-based reviews, similar to what they do on the collaborative effort involving prescription drugs now. When asked what the states would find useful, Dr. Little suggested a process to deal with the new CPT and ICD-9-CM codes each year. It was clear to her that Oregon is farther along with the use of evidence-based research than most states.

Dr. Little wonder what the HSC thought of establishing an advisory group made up of representatives of the specialty societies that could be used to obtain feedback regarding new codes and the biennial review. The comments were positive, but Dr. Walsh and Dr. Glass thought another method would be to link with the graduate programs in order to gain access to data that can be used for decision making.

VI. Report from the Mental Health Care & Chemical Dependency Subcommittee

Kathy Savicki reported that Darren Coffman provided the Subcommittee with an orientation of the HSC's prioritization process, beginning with an overview of the 1989 legislation and ending with an update of the recent changes that incorporate the consideration of a service's clinical effectiveness, using evidence-based research, and cost-effectiveness.

VII. Report from Health Outcomes Subcommittee

For the benefit for the newest member, Leda Garside, Dr. Daniel Mangum explained the Health Outcomes Subcommittee's process for reviewing changes to the Prioritized List. The coding changes are placed into one of fourteen different categories, with the categories having lower numbers being those that will likely require the most discussion. There will not necessarily be representation from all fourteen types of changes during any one particular meeting, so some category numbers will not show up on the reports of the proposed changes being reviewed. Dr. Mangum proceeded to outline the changes discussed at the morning's meeting.

MOTION: Accept the changes to the Prioritized List identified in Attachment A. MOTION CARRIES: 9-0.

Dr. Mangum indicated there was a discussion on the prioritization of mast cell tumors. This is a rare disorder that can be quite benign or behave like cancers and be very significant. The Subcommittee concluded that the low number of cases doesn't warrant a guideline but they will ask Kevin Olson when he comes on if he has any input.

The Subcommittee also discussed artificial discs. These may become a substitute for back fusion, but only in the cases where there is no neurological involvement, which are current placed below the funding line. It was decided not to place this service on the list at this time. The Subcommittee still wants to see information on cost, which they will consider along with a new National Institute for Clinical Evidence (NICE) review.

Dr. Mangum said that Amgen representatives requested two modifications to the erythropoietin (EPO) guideline. The first is the elimination of a requirement to measure blood EPO levels cancer patients. The Subcommittee did not see adequate information as to whether it is not needed, but thought that this test is not currently being performed, so agree with its removal from the guideline. Amgen also continued with their request to increase the hemoglobin level at which to initiate medication – at 11 gm/dl instead of 10 gm/dl. The Subcommittee found nothing provided to support that claim and what was provided was in the way of industry articles. Also left unanswered was the question of who owns the data. If Amgen does, they would have the ability to withhold any negative information.

MOTION: Remove section 1.A of the EPO guideline, which requires the measurement of EPO levels in cancer patients. MOTION CARRIES: 9-0.

Dr. Mangum reported that the Subcommittee discussed the treatment of macular degeneration, a fairly uncommon condition that leads to blindness. The "wet type" of macular degeneration (about 25%) is the only type with any treatment available. There are three subtypes with two treatment options. Macugen is a new drug that costs about $10,000 – 12,000 per year that can treat all three subtypes. The second option is photodynamic therapy, which is only shown to be effective for the predominately classic subtype but is about half the cost. Neither treatment is remarkably effective (there are

no head-to-head comparisons) but they are better than nothing. The average age of onset of the wet type of macular degeneration is 72, so the fiscal impact on the OHP population will not be significant.

MOTION: Add a guideline to Line 409 that includes photodynamic therapy for the treatment of the predominantly classic subtype of macular degeneration and Macugen for the treatment of the occult and minimally classic subtypes. MOTION CARRIES: 9-0.

Finally, Dr. Mangum said that OMAP was indicating difficulty implementing the intent of the coverage of ventricular assist devices (VADs). While Commission minutes indicate the HSC's intent to only have these be covered as a bridge to transplant, they would like to see a guideline attached to the List to make it clear.

MOTION: Remove CPT codes 33979 and 33980 from Line 264 (ACUTE AND SUBACUTE ISCHEMIC HEART DISEASE, MYOCARDIAL INFARCTION) and add to Line 172 (HEART FAILURE). Add a guideline to Line 172 that reads, "Ventricular assist devices are only included on this line as a bridge to cardiac transplantation." MOTION CARRIES: 9-0.

All changes to the Prioritized List discussed today will be combined with any approved at the July 7th meeting for implementation on October 1, 2005.

IX. Therapy Guidelines

Dr. Little said that the only remaining issue regarding the rehabilitative therapy guidelines was a request from providers/advocates to increase the number of visits for children of age 0-3 from 4 to 24. She indicated she had contacted the person recommended by Donalda Dodson and included the articles she suggested in the meeting packet.

Ms. Savicki indicated that the MHCD Subcommittee is monitoring the need to change codes on the List related to services for 0-3 year olds. She thought that there should be health plan representation on the DHS committee working on coding issues involving early interventions for young children.

Dr. Buckendorf suggested the use of a standardized test to qualify for treatment. It was cautioned that this wouldn't be able to stand alone as a measure of progress because it wouldn't address all areas of communication. Perhaps three or more out of about ten available measures would need to be employed to address as many areas as possible. Marsha Becker-Mehr suggested putting together a workgroup to look at the possible use of one or more standardized measurements to help identify those kids that would benefit the most from treatment.

It was acknowledged that family follow-through is a big issue and few visits are necessary when the family is engaged. Those in the audience identified autism and

craniofacial deformities as examples of cases where additional visits at an early age where additional visits would be warranted. Dr. Walsh again wondered where the evidence was to justify this level of treatment.
Susan McGough reminded everyone that there are appeal processes in place that can be used in the cases of unusual circumstances.

MOTION: Change the number of speech therapy visits for 0-3 year olds from 4 to 24. This will make the number of speech therapy visits the same a PT/OT for all age ranges. Create a table in the guideline to separate the two groups of therapies so that it is apparent that the limits apply to each group separately. Also, add an example of when six additional visits are allowed to include "the case of rapid growth/development." MOTION CARRIES: 9-0.

X. Developing Work Plan for 2005-07

Darren Coffman briefly noted that the July meeting will be devoted to establishing a work plan for the Commission for the next biennium, when the full compliment of new members will be present.

XI. Public Comment

No further comment was offered at this time.

XII. Other Business

Darren Coffman presented plaques to Dr. Glass and Ms. Savicki in recognition of their 12 and 10 years of service on the Commissioners, respectively. Plaques will also be given to Donalda Dodson and Ellen Lowe at a later date.

XIII. Adjournment

Dr. Walsh adjourned the meeting of the Health Services Commission at 3:17 p.m. The next HSC meeting is scheduled for Thursday, July 7, 2005, in Room 117A of the Meridian Park Hospital, Community Health Education Center, 19300 SW 65th Avenue, Tualatin, Oregon.

_____
Eric Walsh, MD, Chair

ATTACHMENT A

Potential Interim Modifications to the List for 10/1/05 Implementation

2) Non-pairings: discussion required

67208 Destruction of localized lesion of retina, cryotherapy, diathermy
67210 Destruction of localized lesion of retina, photocoagulation

Omission	*Provider*	
ADD	193	CANCER OF EYE AND ORBIT, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL

67221 Destruction of localized lesion of choroid, photodynamic therapy
67225 Destruction of localized lesion of choroid, photodynamic therapy, second eye at single session

Error	*Provider*	
DELETE	389	DIABETIC AND OTHER RETINOPATHY
ADD	409	DEGENERATION OF MACULA AND POSTERIOR POLE

3) Inappropriate pairings: discussion required

369.9 Unspecified visual loss

Error	*OMAP - MD*	*non-specific code, excluded by OMAP historically*
DELETE	446	DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE LEVEL OF INDEPENDENCE IN SELF-DIRECTED CARE CAUSED BY CHRONIC CONDITIONS THAT CAUSE NEUROLOGICAL DYSFUNCTION

4) Previously discussed issues

Add Guideline Note 7

Evidence-based	*HSC Staff*	
ADD	304	GENERALIZED CONVULSIVE OR PARTIAL EPILEPSY WITHOUT MENTION OF IMPAIRMENT OF CONSCIOUSNESS

11) Non-pairings: straightforward

V45.13 Aftercare for healing traumatic fracture of hip

Omission	*OMAP - MD*	*Add V codes for ortho aftercare to fracture lines*
ADD	131	OPEN FRACTURE OF EXTREMITIES
ADD	177	FRACTURE OF HIP, CLOSED

V54.01 Encounter for removal of internal fixation device
V54.09 Other aftercare involving internal fixation device

Omission	*OMAP - MD*	*Add V codes for ortho aftercare to fracture lines*
ADD	112	CERVICAL VERTEBRAL DISLOCATIONS/FRACTURES, OPEN OR CLOSED; OTHER VERTEBRAL DISLOCATIONS/FRACTURES, OPEN; SPINAL CORD INJURIES WITH OR WITHOUT EVIDENCE OF VERTEBRAL INJURY
ADD	113	FRACTURE OF PELVIS, OPEN AND CLOSED
ADD	131	OPEN FRACTURE OF EXTREMITIES
ADD	177	FRACTURE OF HIP, CLOSED
ADD	460	CLOSED FRACTURE OF EXTREMITIES (EXCEPT TOES)

V54.02 Encounter for lengthening/adjustment of growth rod
V54.10 Aftercare for healing traumatic fracture of arm, unspecified
V54.11 Aftercare for healing traumatic fracture of arm, upper arm
V54.12 Aftercare for healing traumatic fracture of arm, lower arm
V54.14 Aftercare for healing traumatic fracture of leg, unspecified
V54.15 Aftercare for healing traumatic fracture of upper leg
V54.16 Aftercare for healing traumatic fracture of lower leg

Omission	*OMAP - MD*	*Add V codes for ortho aftercare to fracture lines*
ADD	131	OPEN FRACTURE OF EXTREMITIES
ADD	460	CLOSED FRACTURE OF EXTREMITIES (EXCEPT TOES)

V54.17 Aftercare for healing traumatic fracture of vertebrae

Omission	*OMAP - MD*	*Add V codes for ortho aftercare to fracture lines*
ADD	112	CERVICAL VERTEBRAL DISLOCATIONS/FRACTURES, OPEN OR CLOSED; OTHER VERTEBRAL DISLOCATIONS/FRACTURES, OPEN; SPINAL CORD INJURIES WITH OR WITHOUT EVIDENCE OF VERTEBRAL INJURY

V54.19 Aftercare for healing traumatic fracture of other bone

Omission	*OMAP - MD*	*Add V codes for ortho aftercare to fracture lines*
ADD	113	FRACTURE OF PELVIS, OPEN AND CLOSED
ADD	215	FRACTURE OF RIBS AND STERNUM, OPEN
ADD	342	FRACTURE OF FACE BONES; INJURY TO OPTIC AND OTHER CRANIAL NERVES
ADD	539	CLOSED FRACTURE OF GREAT TOE

V54.20 Aftercare for healing pathologic fracture of arm, unspecified
V54.21 Aftercare for healing pathologic fracture of upper arm
V54.22 Aftercare for healing pathologic fracture of lower arm
V54.23 Aftercare for healing pathologic fracture of hip
V54.24 Aftercare for healing pathologic fracture of leg, unspecified
V54.25 Aftercare for healing pathologic fracture of upper leg
V54.26 Aftercare for healing pathologic fracture of lower leg
V54.27 Aftercare for healing pathologic fracture of vertebrae

Omission	*OMAP - MD*	*Add V codes for ortho aftercare to fracture lines*
ADD	460	CLOSED FRACTURE OF EXTREMITIES (EXCEPT TOES)

V54.29 Aftercare for healing pathologic fracture of other bone

Omission	*OMAP - MD*	*Add V codes for ortho aftercare to fracture lines*
ADD	113	FRACTURE OF PELVIS, OPEN AND CLOSED
ADD	215	FRACTURE OF RIBS AND STERNUM, OPEN
ADD	342	FRACTURE OF FACE BONES; INJURY TO OPTIC AND OTHER CRANIAL NERVES
ADD	539	CLOSED FRACTURE OF GREAT TOE

V54.81 Aftercare following joint replacement

Omission	*OMAP - MD*	*Add V codes for ortho aftercare to fracture lines*
ADD	177	FRACTURE OF HIP, CLOSED
ADD	333	NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS
ADD	370	RHEUMATOID ARTHRITIS, OSTEOARTHRITIS, OSTEOCHONDRITIS DISSECANS, AND ASEPTIC NECROSIS OF BONE
ADD	472	DISLOCATION/DEFORMITY KNEE AND HIP
ADD	507	MALUNION AND NONUNION OF FRACTURE

33240 Insertion of cardioverter-defibrillator pulse generator

Omission *OMAP - MD*

ADD 145 COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT

58554 Laparoscopy, surgical, with vaginal hysterectomy for uterus >250 gms with removal of tubes/ovaries

Omission *Provider*

ADD 509 UTERINE PROLAPSE; CYSTOCELE

58940 Oophorectomy, partial or total, unilateral or bilateral

Omission *OMAP - MD* *Pair with 633.20*

ADD 56 ECTOPIC PREGNANCY

92506 Evaluation of speech, language, voice, communication, auditory processing or aural rehab status
92507 Treatment of speech, language, voice, communication or auditory processing disorder, individual
92508 Treatment of speech, language, voice, communication or auditory processing disorder, group
92607 Evaluation for prescription for speech-generating augmentative and alternative communication device; first
92608 Evaluation for prescription for speech-generating augmentative and alternative communication device; each add'l 30 minutes
92609 Evaluation for prescription for speech-generating augmentative and alternative communication device; including programming and modification

Omission *Client/Advocate*

ADD 237 CANCER OF ORAL CAVITY, PHARYNX, NOSE AND LARYNX, TREATABLE

12) New codes: similar to existing

78811 Tumor imaging, postitron emission tomography, limited area

78814 Tumor imaging, postitron emission tomography, with concurrent CT for attenuation correction and anatomical localization; limited area

New CPT Code	*OMAP - HPU*	
ADD	27	HODGKIN'S DISEASE
ADD	119	HODGKIN'S DISEASE
ADD	122	NON-HODGKIN'S LYMPHOMAS
ADD	123	NON-HODGKIN'S LYMPHOMAS
ADD	137	MALIGNANT MELANOMA OF SKIN, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL
ADD	272	CANCER OF LUNG, BRONCHUS, PLEURA, TRACHEA, MEDIASTINUM AND OTHER RESPIRATORY ORGANS, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL
ADD	304	GENERALIZED CONVULSIVE OR PARTIAL EPILEPSY WITHOUT MENTION OF IMPAIRMENT OF CONSCIOUSNESS

78812 Tumor imaging, postitron emission tomography, skull base to mid-thigh

78813 Tumor imaging, postitron emission tomography, whole body

78815 Tumor imaging, postitron emission tomography, with concurrent CT for attenuation correction and anatomical localization; skull base to mid-thigh

78816 Tumor imaging, postitron emission tomography, with concurrent CT for attenuation correction and anatomical localization; whole body

New CPT Code	*OMAP - HPU*	
ADD	27	HODGKIN'S DISEASE
ADD	119	HODGKIN'S DISEASE
ADD	122	NON-HODGKIN'S LYMPHOMAS
ADD	123	NON-HODGKIN'S LYMPHOMAS
ADD	137	MALIGNANT MELANOMA OF SKIN, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL
ADD	272	CANCER OF LUNG, BRONCHUS, PLEURA, TRACHEA, MEDIASTINUM AND OTHER RESPIRATORY ORGANS, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL

14) Deletion of invalid codes

78810 Tumor imaging, postitron emission tomography, metabolic evaluation

Obsolete	*OMAP - HPU*	
DELETE	27	HODGKIN'S DISEASE
DELETE	119	HODGKIN'S DISEASE
DELETE	122	NON-HODGKIN'S LYMPHOMAS
DELETE	123	NON-HODGKIN'S LYMPHOMAS
DELETE	137	MALIGNANT MELANOMA OF SKIN, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL
DELETE	272	CANCER OF LUNG, BRONCHUS, PLEURA, TRACHEA, MEDIASTINUM AND OTHER RESPIRATORY ORGANS, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL

MINUTES
HEALTH SERVICES COMMISSION
July 7, 2005

***Members Present*:** Eric Walsh, MD, Chair; Daniel Mangum, DO; Somnath Saha, MD; Dan Williams; Ellen Lowe; Susan McGough; Bryan Sohl, MD (via teleconferencing); Leda Garside, RN, BSN; Kevin Olson, MD; Laurie Theodorou, LCSW; Kathryn Weit.

Staff Present: Darren Coffman; Alison Little, MD, MPH; Dorothy Allen.

Also Attending: Chris Barber, RN, and Thomas Turek, MD, Office of Medical Assistance Programs (OMAP); Chris Kirk, MD, Oregon Health Plan Medical Directors; Rick Wopat, MD, Medical Director, Samaritan Health Services; Diane Lund, Oregon Heath Forum; Bruce Goldberg, MD, Oregon Health Policy & Research (OHPR).

I. Call to Order

Dr. Eric Walsh, Chair, called the Health Services Commission (HSC) meeting to order at 11:13 a.m. in Room 117A of the Meridian Park Hospital, Community Health Education Center, 19300 SW 65th Avenue, Tualatin, Oregon. Darren Coffman called roll.

II. Introduction of New Members

New Commission members, Dr. Kevin Olson, Laurie Theodorou and Kathryn Weit were introduced and asked to speak about their background.

Kathryn Weit shared that she works with for the Oregon Council on Developmental Disabilities and became involved in the disability community because her son has disabilities.

Dr. Kevin Olson said that he has testified before the Commission on many times over the years and is involved in other leadership issues regarding oncology.

Laurie Theodorou is with the Jackson County Mental Health Department, where she focuses on providing services for young children. She is also involved in integrating community services.

At Dr. Eric Walsh's suggestion, the established members briefly shared some of their background.

III. Approval of Minutes (April 28, 2005)

MOTION: Accept the April 28, 2005 Minutes with no changes. MOTION CARRIES: 11-0.

IV. Chair's Report

Dr. Eric Walsh welcomed the new members and noted that the strength of the Commission rests in the diverse mix of physicians and non-physicians that serve.

Dr. Walsh noted that the Commission meetings are public meetings that are recorded and the proceedings are public record. He spoke about the importance of following the rules for public meetings, such as having motions to approve the actions of the Commission.

Dr. Walsh spoke about his interactions with colleagues and the sense in the provider community that "the Oregon Health Plan is dead." He shared that as a member of the Commission he finds such opinions bothersome and feels that the Oregon Health Plan is not dead and the principles behind the plan are more alive than ever. He related that with the budget restrictions taking place now is the time to be more creative, proactive and evidence-based than ever in terms of what works.

The Commission has been focusing on evidence-based research in providing direction to the Oregon Health Plan and continues to seek new and innovative ways to deliver these much needed services to the qualifying citizens of Oregon.

V. Director's Report

Darren Coffman reported that, at this time, the Legislature has yet to assign any new tasks to the Health Services Commission, a departure from past sessions.

Mr. Coffman spoke about a memo from Barney Speight, Administrator, Office of Medical Assistance Programs, and Bruce Goldberg, MD, Administrator, Office of Oregon Health Policy and Research. The memo summarizes a report from PricewaterhouseCoopers that compares the results of the Department of Human Services per capita cost development to the benchmark analysis. The memo may have caused some confusion to the Legislature and a second memo is being drafted to clear up additional questions the first one has generated.

Missing from the report is data from managed care prescription drugs, which is considered proprietary information and not subject to disclosure. A question was posed by Dr. Walsh, to the attending guests, as to why managed care prescription drug information is proprietary. Dr. Thomas Turek, Office of Medical Assistance Programs

(OMAP), explained that new contracts are now in place that allows OMAP access to the data. The report pre-dates these contracts.

Mr. Coffman stated that Mercer attempted to survey the managed care plans for their prescription costs and received responses from two of the fourteen companies contacted. Mercer did not use this data due to lack of response.

A Service Award plaque was presented to Ms. Ellen Lowe for her fifteen years of service on the Commission.

VI. Medical Director's Report

Dr. Alison Little welcomed the new Commissioners and, at the suggestion of Mr. Coffman, shared her background.

VII. Report from the Mental Health Care & Chemical Dependency Subcommittee

The Mental Health Care & Chemical Dependency Subcommittee met on June 15, 2005. Darren Coffman reported that the subcommittee first corrected some minor coding issues before hearing a report on the Medicare Modernization Act.

The report focused on how the Medicare Modernization Act will impact clients with dual eligibility with a particular focus on those who are receiving mental health and chemical dependency services.

Those currently enrolled in a Managed Care Plan will be automatically enrolled and those in a Fee for Service Plan will have random pharmacy assignments. OHP clients with dual eligibility will have the option to change pharmacies on a monthly basis.

Mr. Coffman stated that all but three of the Fully Capitated Health Plans (FCHPs) are applying to become Medicare Advantage Plans. Enrollment starts October 15, in anticipation of a January 1, 2006 start up date.

Ellen Lowe commented that fielding calls from clients to address questions raised by the first letter sent regarding the Medicare Modernization Act is resource intensive, some calls taking up to thirty-five minutes to complete.

Mr. Coffman indicated the Subcommittee also heard a report from Mr. Ralph Summers, Office of Mental Health and Addiction Services, on implementing and tracking the use of evidence-based practices within mental health services. The Subcommittee will bring forward evidence based recommendations as they are identified.

The next meeting will include a report outlining a new coding system for early mental health services for children zero to five years of age. The current coding system does

not work well because often times the services are provided to the child individually, rather than the parent or family.

Dr. Walsh commented that he would like to continue the tradition of having a Commission member also be involved with the Mental Health Care & Chemical Dependency Subcommittee.

VIII. Report from Health Outcomes Subcommittee

Dr. Daniel Mangum reviewed with the Commission the Subcommittee's technical correction recommendations from their discussion of the document "Potential Interim Modifications to the List for 10/1/05 Implementation." He clarified that the Sub-committee does NOT recommend adopting the changes in the report pertaining to benign tremor or cracked nipple, as both were felt to be conditions which can cause significant discomfort or disability, and for which there are effective, inexpensive treatments.

The Subcommittee discussed congenital hydrocele and whether or not this condition should be treated as a hernia. The consensus was there is no evidence to suggest adverse outcomes from not repairing hydroceles, hence no change is recommended.

Regarding umbilical hernia, Dr. Mangum explained that in addition to adding CPT code 49580 to Line 606, this code, as well as 49585, will be deleted from Line 6, as they pertain to repair of reducible umbilical hernias. He also clarified that ICD-9-CM code 259.5 should be added to Line 485, not Line 163 as printed in the report, and that ICD-9-CM codes 291.82 and 292.85 should be added to Line 610 rather than Line 260.

Dr. Mangum explained that mast cell disorders are a complex set of diseases with unclear coding. The Subcommittee recommends clarification of the coding by attaching a guideline to Line 714, specifying that mast cell disorders limited to the skin will be prioritized to this line.

Genetic counseling was discussed, and given the uncertain benefits and potentially high cost, the Subcommittee recommends doing additional research before these codes are added to the list. Dr. Mangum noted that guidelines will likely be necessary. Because the 4th digit code, V26.3, is already on Line 53, the Subcommittee recommends that this code be removed, particularly since the new HCPCS code S0265, genetic counseling under physician supervision, will be added to Line 54, Pregnancy.

Artificial disks were discussed, and Dr. Mangum related that long-term outcome data were lacking, hence the Subcommittee recommends not adding this code to the List.

MOTION: To accept the HOSC's recommendations. MOTION CARRIES: 11-0.

Additional recommendations were reviewed with the Commission from the document entitled "Addendum to Recommended Interim Modifications for Review on 7/7/05."

- S0613, Clinical breast exam without pelvic exam – Dr. Little noted that the USPSTF recommends screening mammography with or without clinical breast exam (level B), while clinical breast exam alone carries an I recommendation. Commission recommendation is to add to line 181.
- S2900, Surgical techniques requiring use of robot surgical system – there was discussion about the cost of this technology, and whether it should instead be placed on the non-covered services List. Dr. Olson explained that robotics often allow for a less invasive surgery, and can expand the indications for certain procedures. Recommendation is to add to Ancillary Services, with the understanding that this code will undergo case by case review by OMAP.
- S0265, Genetic Counseling, under physician supervision, each 15 minutes – recommendation to add to Line 54. The subcommittee asked Dr. Little to bring additional research to the next meeting.
- 97001, Physical therapy evaluation; 97002, Physical therapy re-evaluation; 97003, Occupational therapy evaluation; 97004, Occupational therapy re-evaluation; 97012, Application of modality: traction, mechanical; 97014, Application of modality: electrical stimulation; 97022, Application of modality: whirlpool; 97032, Application of modality: electrical stimulation (requiring one-on-one contact); 97110, Therapeutic procedure: therapeutic exercises, range of motion; 97112, Therapeutic procedure: neuromuscular re-education; 97113, Therapeutic procedure: aqua therapy; 97116, Therapeutic procedure: gait training; 97124, Therapeutic procedure: massage; 97140, Manual therapy techniques; 97150, Therapeutic procedures, group – recommendation is to add to line 521 to pair with carpal tunnel syndrome.

MOTION: To accept the recommendations as written. MOTION CARRIES: 11-0.

IX. OHP Update

Dr. Bruce Goldberg reported that this legislative session has not produced many changes, however a number of budgetary issues have been addressed. For example, although dental care did not make the Governor's recommended budget, it appears that service will be restored in both the House and the Senate budgets. Vision services remain unfunded. Further, there has been legislation proposed that will eliminate co-payments for the poorest OHP clients, those falling below 10% of the FPL, and to restore the six-month grace period for premium payments. Other services experiencing cuts in the Governor's Recommended Budget include home care enrollment and Temporary Assistance to Needy Families (TANF). Senate Bill 289 will open roadside food stands to WIC clients.

Ms. Lowe commented that this session's budget process did not lend itself to in-depth discussions, therefore the legislature may not have a full understanding of the impacts cuts might have. She further added that restoring the 10-cent tobacco tax could mean

as much as $79 M. She also noted that separating vision and dental services was a violation of OHP's principles.

Dr. Goldberg commented that the Medicare Modernization Act has the potential to cause chaos upon implementation and mentioned that clients are penalized 1% for not enrolling in a timely manner.

Dr. Somnath Saha asked for the status on the fluoride bill. Dr. Goldberg related that the bill is still in the Senate and it faces strong opposition from the environmental community.

X. Review of Bylaws

Dr. Walsh tabled discussion of the Bylaws for a future meeting.

XI. Alternative Strategies for Defining OHP Standard Benefit Package – A presentation by Dr. Rick Wopat

Synopsis of presentation:

The primary objective of the Oregon Health Plan (OHP) is to promote health. The strategy of the OHP is to increase the number of Oregonians with access to basic health care by focusing spending on more effective services and by using funds more wisely. This achieves our ability to "ration services, not people."

In recent years, budget constraints have necessitated reducing the number of Oregonians with access to OHP, by closing enrollment and by reducing the number insured by attrition.

Potential solutions include: raise more money for OHP; eliminate OHP Standard; reduce the Federal Poverty Level (FPL) to qualify for OHP Standard; create a more focused benefit package for OHP Standard and offer the benefits to more Oregonians.

A benefit package that focuses on effective prevention may provide the highest benefit and return on dollars invested in health care for those up to 100% FPL. Examples of services falling into this category: immunizations; reproductive services including birth control and preconception counseling; and, screening for certain chronic conditions.

Those found to have certain chronic conditions (diabetes, chronic severe depression, congestive heart failure, schizophrenia, asthma, etc) would qualify for a broader range of services. Examples of proposed conditions not covered: osteoarthritis; dysthymic disorder (mild depression); chronic headaches; and, fibromyalgia.

New lines on the Prioritized List of Health Services may need to be added. Dr. Wopat further suggested that two funding lines be established, one for OHP Plus and a new line for the prevention focused model for OHP Standard.

Suggested next steps are to develop a methodology, complete a financial model, involve stakeholders, discuss pilot projects rather than a statewide implementation, include this proposal in the new waiver application and consider legislative implications.

XII. Developing Work Plan for 2005-07

Darren Coffman shared that the next biennial review of the Prioritized List of Health Services should be completed by May, 2006. The provider community's input will be solicited for specific areas, yet to be determined. The timeline to review the list is subject to the upcoming Medicaid Waiver renewal process and suggested that perhaps work on a prevention/chronic disease management focused list could be included.

XIII. Other Business

Dr. Walsh suggested that a smaller group be formed to discuss a more prevention focused list, with meetings in August and October. Commission members were asked to contact Dr. Little and Darren Coffman with names of others who might like to participate.

MOTION: Form a work group to study the proposal presented by Dr. Wopat. MOTION CARRIES: 11-0.

XIV. Public Comment

No further comment was offered by the public at this time.

XV. Adjournment

Dr. Walsh adjourned the meeting of the Health Services Commission at 2:45 p.m.

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Eric Walsh, MD, Chair

MINUTES
HEALTH SERVICES COMMISSION
September 22, 2005

***Members Present*:** Eric Walsh, MD, Chair; Daniel Mangum, DO; Somnath Saha, MD; Dan Williams; Ellen Lowe; Leda Garside, RN, BSN; Kevin Olson, MD; Laurie Theodorou, LCSW.

Members Absent: Bryan Sohl, MD; Susan McGough; Kathryn Weit.

Staff Present: Darren Coffman; Alison Little, MD, MPH; Dorothy Allen.

Also Attending: Kipp Bajaj, Central City Concern; Chris Kirk, MD, Marion Polk Community Health Plan (MPCHP); Thomas Turek, MD, Kathy Kirk, and Chris Barber, Office of Medical Assistance Program; Gary Hosstetter, Oregon Primary Care Association (OPCA); Kassie Clarke; Bruce Goldberg, MD, Office of Health Policy & Research

I. Call to Order

Dr. Eric Walsh, Chair, called the Health Services Commission (HSC) meeting to order at 12:39 p.m. in Room 117A of the Meridian Park Hospital, Community Health Education Center, 19300 SW 65th Avenue, Tualatin, Oregon. Darren Coffman called roll.

II. Approval of Minutes (July 7, 2005)

Ms. Laurie Theodorou recommended a change to the Mental Health Care & Chemical Dependency Subcommittee report to amend a paragraph to read: "The next meeting will include a report outlining a new coding system for early mental health services for children zero to five years of age. The current coding system does not work well because often times the services are provided to the child individually, rather than the parent or family."

Dr. Daniel Mangum noted where his name had been misspelled.

MOTION: Accept the July 7, 2005 Minutes with changes. MOTION CARRIES: 8-0.

III. Chair's Report

Dr. Walsh deferred his report until later in the agenda, when the Prioritization Principles Workgroup is discussed.

IV. Director's Report

Mr. Darren Coffman reported that International Classifications of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) is supposedly going to be published in the Federal Register in October 2006, putting implementation as early as October 2008. This will increase the number of billing codes from approximately 18,000 to around 45,000. The Mental Health Care & Chemical Dependency Subcommittee will act as a pilot to re-map their line items from ICD-9-CM to ICD-10-CM.

V. Medical Director's Report

Dr. Alison Little shared that both she and Ms. Ellen Lowe will be speaking on Friday, September 23, 2005 at the Citizens Health Care Working Group on the "Oregon Story." Former Governor John Kitzhaber will also be speaking.

VI. Report from the Mental Health Care & Chemical Dependency Subcommittee

The Subcommittee met September 21, 2005. Mr. Coffman reported that the group has been discussing the challenges of coding services for children aged zero to five years-old. A workgroup has been looking at the early childhood mental health diagnostic system that does not currently adequately describe the services provided.

Mr. Coffman reported that he has been keeping the Subcommittee informed about the potential reprioritization of the list. They will be interested in the impact on the placement of mental health and chemical dependency services under such a revised model.

VII. Report from Health Outcomes Subcommittee

Dr. Daniel Mangum reviewed with the Commission the Subcommittee's technical correction recommendations from their discussion of the document "Recommended Interim Modifications for Review on 9/22/05" (see Attachment A).. The Subcommittee recommended acceptance of the report, with the following changes:

- Do not add ICD-9-CM code 996.87 to Line 435, Diabetes Mellitus with end stage renal disease.
- Eliminate Line 607 at the time of the next biennial review. Change Line 529 title to "Anal Fissure; Anal Fistula", and change first sentence of guideline to read, "Surgery for chronic anal fissure is covered when one or more of the following are present:"

MOTION: To accept the HOSC's recommendations with the changes as stated. MOTION CARRIES: 8-0.

A provider letter regarding ENT considerations was reviewed by the Subcommittee and the Guideline Note 26, Sinus Surgery, was revised to read as follows:

Sinus surgery indicated in <u>one or more</u> the following circumstances <u>(1-7)</u>:

1. **4 or more episodes of acute rhinosinusitis in one year**
2. **Failure of medical therapy of chronic sinusitis including ALL of the following:**
   - **Several courses of antibiotics**
   - **Trial of inhaled and/or oral steroids**
   - **Allergy assessment and treatment when indicated**

   AND one or more of the following:
   - **Findings of obstruction or active infection on CT scan**
   - ~~**Obstructive symptoms due to polyposis that persist or recur after steroid treatment**~~
   - **Symptomatic mucocele**
   - **Negative CT scan but significant disease found on nasal endoscopy**
3. **~~Bilateral extensive and massive obstructive n~~Nasal polyposis causing or contributing to sinusitis ~~with complications~~**
4. **Complications of sinusitis including subperiosteal or orbital abscess, Pott's puffy tumor, brain abscess or meningitis**
5. **Invasive or allergic fungal sinusitis**
6. **Tumor of nasal cavity or sinuses**
7. **CSF rhinorrhea**

<u>MOTION: To accept the HOSC's recommended changes to the sinus surgery guideline. MOTION CARRIES: 8-0</u>.

The Subcommittee also discussed adenoidectomy in conjunction with ear tubes in children less than 4 years of age. There is reasonable evidence of additional effectiveness of adenoidectomy based on the NEJM article, a Cochrane review and the Gates study, and there appears to be a 6 decibel hearing improvement at 12 months. However, the Subcommittee finds that the evidence that this improvement affects long-term outcomes (language development, school performance) is lacking. It was pointed out that adenoidectomy with a second set of tubes for children over 4 is currently covered.

Discussion of genetic testing has been tabled until an algorithm is defined. Dr. Walsh outlined one which Dr. Little will refine for the December meeting.

Dr. Mangum noted that acupuncture is currently on the following lines: HIV, tobacco cessation, three substance abuse lines and comfort care. There was a discussion about the evidence showing that acupuncture for tobacco cessation is not effective. At the next meeting, the full Cochrane review will be obtained to determine if the HOSC should recommend that acupuncture be removed from the tobacco cessation line.

Other disease categories were reviewed including chronic and acute pain, dental pain and osteoarthritis. Many of the categories are for conditions below the funded line. The Subcommittee has decided to not investigate further, with the exception of tobacco cessation.

VIII. OHP Update

Dr. Bruce Goldberg shared with the committee highlights of legislation that affects the Oregon Health Plan (OHP) including:

- A proposed cut to dental care was restored by the Legislature for OHP Plus.
- Premium co-pay policy changes – The Legislature eliminated premiums for clients at or below 10% of the Federal Poverty Level (FPL). Clients who pay premiums will now have up to six months to meet their premium costs.
- Vision benefits were cut.
- Cuts were made to hospital reimbursement and over-the-counter medications.
- Though mental health parity has always been covered by OHP, this past session, parity passed for all other fully-insured group health plans, advancing health care in this state.
- A bill passed making it easier for retired physicians to volunteer at clinics, particularly at safety net clinics.

Dr. Goldberg shared that there is currently a proposal, sent to the Medicaid Commission for scoring, to use the Oregon prioritized list nationally, saving $50 billion over 10 years, covering an additional 2.5 million adults.

Dr. Goldberg noted that the recent disaster, Hurricane Katrina, is likely to have an impact on Medicare. Ms. Ellen Lowe commented that the disaster may effect the roll-out of the Medicare Modernization Act. Dr. Goldberg mentioned that there is a proposal to delay the Medicare prescription drug program by a year, using the cost savings for disaster relief.

Dr. Goldberg gave an overview of the Mercer benchmark rate study for the benefit of the new commissioners:

> The HSC was charged with developing a benchmark standard for OHP payment for all services (mental health, chemical dependency, doctors, hospitals, medications, etc.). Each provider holds the belief that they are underpaid for their services. The Mercer study was conducted to establish an appropriate benchmark for provider payments. Most services were found to be reimbursed at 50-70% of cost. A PricewaterhouseCoopers report then gave insight as to where and why current reimbursement differs from the benchmark rates.

Dr. Goldberg reported that although the benchmark study showed that durable medical equipment (DME) was already at a near-cost reimbursement, the Legislature directed monies toward a higher rate of reimbursement for those services. When asked why, Dr. Goldberg reminded the Commission that sometimes decisions made at that level may be more influenced by the political realm than by research and evidence.
Dr. Goldberg suggested that the Commission be more visible to the Legislature during the next legislative session.

IX. Report from the Prioritization Principles Workgroup - Eric Walsh

Dr. Walsh reported that the Prioritization Principles Workgroup met twice since the last HSC meeting to discuss the ideas behind the presentation made by Dr. Rick Wopat on July 7, 2005. The presentation challenged the HSC to rethink the organization of the list to potentially offer coverage to more people, with a differently conceived package focused on preventive services and the management of certain fatal chronic illnesses.

The workgroup consisted of healthcare and economy experts, some of whom currently sit on the HSC. The first meeting was on August 11, 2005. Dr. Walsh reported that meeting's discussion involved a wide range of topics, including other state's plans, cash accounts and hospitals' potential resistance to a plan that may not cover hospital expenses.

At the second meeting, September 12, 2005, the workgroup examined the underlying principles of the Oregon Health Plan from it's inception to today. They discussed whether the HSC should take a comprehensive global look at the list with the view of changing the priorities to reflect things that effect populations more than individuals. It was also pointed out how money is being used to buy health insurance rather than treat disease. The overwhelming consensus of the workgroup was that this is something the HSC should investigate.

Dr. Walsh read the Prioritization Principles Workgroup's proposed recommendation to the Health Services Commission:

> "The Prioritization Principles Workgroups recommends that the Health Services Commission re-examine the Prioritized List to see if priorities that emphasize prevention and chronic disease management would result in a greater benefit to the population being served by OHP, given the allocations currently allotted by the legislature."

Dr. Walsh reviewed the document "OHP Principles and Policy Objectives" with the commission, pointing out relevant principle statements from the earliest discussions in 1987 through the 2004 Health Values Survey, supporting Oregonian's desire for health care that provides a basic benefit to the largest number of uninsured. The data also shows that Oregonians value prevention.

The workgroup discussed, in general terms, re-prioritizing the list by moving prevention and chronic disease management up towards the top. The idea is to have one list with two funding lines; the first line capturing a smaller benefit package (OHP Standard) than the second line, which would encompass more services for those who are categorically eligible for Medicaid (OHP Plus).

Dr. Mangum noted the difficulties of cost-containment with diagnostic procedures, often called "Line Zero," which are paid for in their entirety whether or not the condition diagnosed is covered. Mr. Coffman stated that the list of covered diagnostic procedures could differ between OHP Plus and OHP Standard. He also said that diagnostic procedures could be specifically added to the list where separately appropriate.

Ms. Lowe shared her concerns around excluding acute/fatal diseases from coverage. Dr. Saha noted that there are currently in excess of 125,000 Oregonians that are getting no coverage at all.

Dr. Walsh asked the Commission if the Original 17 Categories of Health Services still make sense in today's environment and noted the categories could be reordered to focus on prevention and chronic disease management. The Commission agreed and asked Mr. Coffman and Dr. Little to provide the current prioritized list of health services, each line with its 17 category designation, to review before the next meeting. The Commissioners will bring their notated lists to the next meeting.

X. Discussion of Process For Upcoming Biennial Review

Dr. Walsh spoke about the upcoming Biennial Review and felt that the topic should be the prioritization principles that are being developed. A random sample of physicians will receive a survey questionnaire. Dr. Little will have sample questions ready for the next meeting.

XI. Review of Bylaws

Dr. Walsh tabled discussion of the bylaws for a future meeting.

XII. Other Business

No other business was identified at this time.

XIII. Public Comment

No further comment was offered by the public at this time.

XIV. Adjournment

Dr. Walsh adjourned the meeting of the Health Services Commission at 3:15 p.m.

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Eric Walsh, MD, Chair

HEALTH SERVICES COMMISSION
Clackamas Community College
Wilsonville Training Center, Room 218
Wilsonville, Oregon
December 8, 2005

***Members Present*:** Eric Walsh, MD, Chair; Daniel Mangum, DO; Somnath Saha, MD; Dan Williams; Ellen Lowe; Kevin Olson, MD; Laurie Theodorou, LCSW; Bryan Sohl, MD; Susan McGough (via phone); Kathryn Weit; Leda Garside, RN, BSN (arrived at 1:53 pm).

Guests: Dr. Cedric Hayden, Hayden Family Dentistry Group; Chris Barber, Office of Medical Assistance Program; Chris Kirk, MD, MVIPA; Jeanene Smith, MD, Office of Health Policy & Research; Tina Kitchen, DHS; Ann Uhler, MHCD Subcommittee; Hasina Squires, Government Relations Strategies; Rachel Solotaroff, Portland VA Medical Center; Devan Kansagara, Portland VA Medical Center; Doris Cameron-Minard, NAMI OR; Steven Duffin, Capitol Dental Care; Tim Boehm, Capitol Dental Care

I. Call to Order

Dr. Eric Walsh, Chair, called the Health Services Commission (HSC) meeting to order at 12:58 p.m. in room 218 of the Clackamas Community College Training Center located at 29353 Town Center Loop East, Wilsonville, Oregon 97070. Darren Coffman called roll.

II. Approval of Minutes (September 22, 2005)

MOTION: Accept the September 22, 2005 minutes without correction. MOTION CARRIES: 10:0.

III. Chair's Report

Dr. Walsh deferred his report until later in agenda.

IV. Director's Report

Mr. Coffman reported that the staff is currently putting together a Request for Proposal (RFP) for the benchmark rate study. The HSC is charged with establishing benchmark rates for the Oregon Health Plan and must report to the Legislature every two years.

The next report is due August 1, 2006. The initial thought was to benchmark to Medicare rates but further investigation makes that seem unlikely. The information would take months to gather and would not be as complete as would be needed. Especially due to news from State Purchasing that the RFP process is taking up to six months.

To stay within budget and the time constraints, Mr. Coffman proposed using the current methodology and data from 2001-03 and trending those numbers forward for the new report. This would allow us more time and the ability to add current program changes.

MOTION: Empower the staff to initiate the RFP, trending forward the 2001-03 benchmark rates. MORTION CARRIES: 10-0.

Mr. Coffman yielded the floor to Dr. Som Saha.

Dr. Saha stated that looking into reprioritization is innovative, much like the original OHP, where most of the analysis of that program was done retrospectively or "post-hoc." Dr. Saha proposes that the Commission do some policy ethnography that will be useful to other states as they examine their own Medicaid plans. As the Commission is undertaking this now, it seems reasonable to plan prospectively to do an evaluation of the effect the changes may have on the population. Dr. Saha suggests collecting data before and after the changes and volunteered to lead this effort.

Dr. Walsh asked Dr. Saha to write a one-page proposal for the Commission to evaluate.

V. Medical Director's Report

With Dr. Turek's departure, Dr. Alison Little reports that she will be helping to fill that role until that position is filled.

VI. OHP Update

Office of Health Policy & Research Acting Director Dr. Jeanene Smith reported that the OHP2 Waiver is up for renewal. The Medicaid Advisory Committee (MAC) is getting regular updates from the Oregon Medical Assistance Program (OMAP) and has seen Dr. Rick Wopat's presentation regarding possible reprioritization of the list. The timing is such that we will have to apply for the new waiver under the current model. If it is decided to make program/prioritization changes, amendments will have to be submitted.

VII. Report from the MHCD Subcommittee

Mr. Coffman reported that the Subcommittee met in November and continued their discussion of ICD-9-CM/DSM-4 codes, which don't apply well to mental health care services for the 0-5 years of age population. The subcommittee is recommending adding "Not Otherwise Specified" (NOS) codes with guidelines limiting the use to patients ages 0-5. The Office of Mental Health and Addiction Services are looking at those guidelines.

Other services being looked at are bereavement issues and parent/child relational issues that currently are coded with specific "V" Codes, which upon further investigation are not valid, as they are not appropriate for primary diagnosis. A full set of recommendations will be forthcoming in January.

VIII. Report from Health Outcomes Subcommittee

Dr. Dan Mangum gave a report on testimony heard testimony from Dr. Mark Nichols OHSU/Planned Parenthood, regarding Essure, a FDA approved hysteroscopic sterilization device, for which general anaesthesia is not required. The long-term failure rate is 2.6 per 1000 (cumulative for 5 years), which is better than tubal ligation. OMAP will provide data regarding average costs of tubal ligation statewide over the previous six months to a year, to be reviewed at the January meeting.

Dr. Mangum reviewed for the Commission the Subcommittee's discussion and recommendations from the documents entitled "Recommended Interim Modifications for Review on 12/8/05" and "Recommended Interim Modifications for Review on 12/8/05 II" (see Attachments A and B). All changes were recommended for approval to the Health Services Commission except, or in addition to, the following:

- 50592 Ablation, renal tumors, RFA - Add to NON-OHP services List.
- 33548: Surgical ventricular restoration procedure - Add to NON-OHP services List.
- 33880-33891, 75956-75959: Endovascular AAA Repair - Recommend addition but the subcommittee will review at the next meeting after more research.
- 46505: Chemodenervation of internal anal sphincter - Add to NON-OHP services List.
- 61630-61642: Intracranial angioplasty/stent placement - Do not add to list at this time, but review at next meeting.
- 77421: Stereotactic X-ray guidance for localization of target volume for delivery of RT - Add to NON-OHP services List.
- 91022: Duodenal motility study - Add to NON-OHP services List.
- 98960-98962: Patient education by non-physician - No action taken, will be discussed at next meeting with additional information from plans, and financial impact from OMAP.
- G0110-G0116: Pulmonary rehab - No action taken, will be discussed at next meeting with additional information from plans on the current provision of these services.
- 01965: Anesthesia for incomplete or missed abortion - Add to ancillary list.
- 15040-15366: Skin grafting and dermal substitutes - No action taken, Dr. Little will solicit input from plastic surgery on these codes, consider again at the next meeting.
- 99051: Services provided during regularly scheduled evening, weekend or holiday hours - The Commission engaged in extensive discussion regarding the fairness of additional reimbursement, and the affect of this incentive on access. Approximate additional payment is $12.00 Per RBRVS. Decision: 99051 should be added to all medical therapy lines.

- 99053: Services provided between 10 PM - 8 AM at 24-hour facility - Keep on non-OHP services list.
- 99060: Services provided on an emergency basis out of the office which disrupt scheduled office services - Add to all medical lines.
- 76376-87900, 88384-89049: Various X-ray and lab procedures – No action at this time. Dr. Little will provide additional information at the next Commission meeting.
- 96101-96120: Psychological and neuropsych testing - Confer with MHCD Subcommittee before taking action.
- 90714: Td, preservative free, for use in age >7 - No action at this time. Dr. Little will gather cost comparisons to the prior vaccine for next meeting.
- S2114: Tenodesis of biceps - Place on non-OHP services list, NOT Line 504.
- S2117: Subtalar arthroereisis - Add to PAC-5 list, not Lines 446, 556, 557, 571 with intention being that the device procedure would be non-covered, the other procedure would be covered.
- ICD-9-CM 931: Foreign body in ear - Recommend this line be moved at the time of the biennial review, with revision of Line titles.
- 62272: Spinal puncture, therapeutic - Add to Line 86 to pair with normal pressure hydrocephalus, 331.3, in addition to Line 31.

Venous angioplasty was discussed at the request of a radiology group. As it appears that long term outcomes are poor, do not add 35476 to Lines 39, 145 and 669.

MOTION: To accept the HOSC's recommendations. MOTION CARRIES: 11-0.

Acupuncture for Tobacco Cessation and Genetic Testing will be discussed at future meetings, after additional research is completed.

IX. Biennial Review of Prioritized List

Biennial Review Letters

The Commission reviewed the draft Biennial Review letters and made editing suggestions. Additionally, the receiver's list should be expanded to include executive directors of safety net clinics, health plan directors, hospital executives, representatives of the disabilities community, mental health community, dental community and other patient advocates as a way of informing them that the Commission is reviewing the Prioritized List of Health Services. This would be an initial step in gauging the stakeholder community's reaction to proposed changes to covered services.

Dr. Little will incorporate the suggestions and send the new letter to the Commissioners for review before the mailing currently slated for early January.

Prioritized List Discussion

Dr. Walsh reviewed the goals and objectives of the Oregon Health Plan, highlighting:
- Definition of basic level of health care
- Increased access to health care

- Prevention & primary care should be guaranteed even when resources are limited
- Reduce cost shift of uncompensated hospital care
- Rank health services from the most important to least important, not necessarily the most life saving treatment to the least life saving
- Public outreach input mentioned prevention and primary care as top priorities

Mr. Coffman reviewed the results of the Commission's reprioritization homework that was given to the Commissioners at the September 21, 2005 meeting. Please see Attachment C.

Four Commissioners gave their input in the format requested. Mr. Coffman pointed out there was general agreement on the ranking of the first five categories as well as the last four from those respondents.

Dr. Walsh urged the Commissioners who have not had a chance to respond to please send their thoughts to Mr. Coffman and the discussion will be continued at the January meeting.

X. Other Business

No other new business was brought forward at this time.

XI. Public Comment

No further comment was offered at this time.

XII. Adjournment

Dr. Walsh adjourned the meeting of the Health Services Commission at 3:40 p.m.

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Eric Walsh, MD, Chair

Recommended Interim Modifications for Review on 12/8/05

1) New codes: discussion required

22523 Percutaneous vertebral augmentation (kyphoplasty); thorasic
22524 Percut+-*aneous vertebral augmentation (kyphoplasty); lumbar
22525 Percutaneous vertebral augmentation (kyphoplasty); each add'l thorasic or lumbar
77422 High energy neutron radiation treatment delivery; single treatment area, no or simple blocks
77423 High energy neutron radiation treatment delivery; 1 or more isocenters with blocking and/or wedge

New CPT Code HSC Staff previously considered with new HCPCS code in 5/2004

ADD TO NON-OHP SERVICES LIST

28890 Extracorporeal shock wave, high energy, performed by physician, req anaesthesia, involving plantar fascia
43770 Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric band
43771 Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric band
43772 Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric band
43773 Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric band
43774 Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric band and port
43886 Gastric restrictive procedure, open; revision of SQ port component only
43887 Gastric restrictive procedure, open; removal of SQ port component only
43888 Gastric restrictive procedure, open; removal and replacement of SQ port component only
50250 Ablation, open, one or more renal mass lesions, cryosurgical
50592 Ablation, percutaneous, one or more renal tumors, unilateral, radiofrequency

New CPT Code HSC Staff

ADD TO NON-OHP SERVICES LIST

45990 Anorectal exam, surgical, requiring anesthesia, diagnostic

New CPT Code HSC Staff
ADD TO DIAGNOSTIC LIST

45499 Unlisted laparoscopy procedure, rectum
51999 Unlisted laparoscopic procedure, bladder
New CPT Code HSC Staff
ADD TO PAC-5 LIST

90649 Human papilloma virus vaccine, types 6,11,16,18, 3 dose schedule
New CPT Code HSC Staff not FDA approved yet
ADD TO NON-OHP SERVICES LIST

90736 Zoster vaccine, live, for SC injection
New CPT Code HSC Staff
ADD TO ANCILLARY SERVICES LIST

33548 Surgical ventricular restoration procedure
New CPT Code HSC Staff
ADD 261 ACUTE AND SUBACUTE ISCHEMIC HEART DISEASE, MYOCARDIAL INFARCTION

33880 Endovascular repair of descending thorasic aorta; involving coverage of L subclavian artery origin initial endoprosthesis plus extensions to celiac artery origin
33881 Endovascular repair of descending thorasic aorta; not involving coverage of L subclavian artery origin initial endoprosthesis, plus extensions to celiac artery origin
33883 Placement of proximal extension prosthesis for endovascular repair of descending thorasic aorta, initial
33884 Placement of proximal extension prosthesis for endovascular repair of descending thorasic aorta, each add'l extension
33886 Placement of distal extension prosthesis delayed after endovascular repair of descending thorasic aorta
33889 Open subclavian to carotid artery transposition performed in conjunction with endovascular repair of descending thorasic aorta, by neck incision, unilateral
33891 Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision
75956 Endovascular repair of descending thorasic aorta; involving coverage of L subclavian artery origin initial endoprosthesis plus extensions to celiac artery origin, radiologic supervision and interp **(cont'd on next page)**

75957 Endovascular repair of descending thorasic aorta; not involving coverage of L subclavian artery origin initial endoprosthesis, plus extensions to celiac artery origin, radiologic supervision and interp

75958 Placement of proximal extension prosthesis for endovascular repair of descending thorasic aorta, radiologic supervision and interp

75959 Placement of distal extension prosthesis delayed after endovascular repair of descending thorasic aorta, radiologic supervision and interp

New CPT Code	*HSC Staff*	*pair with 746.85, coronary artery anomaly*
ADD	21	DISSECTING OR RUPTURED AORTIC ANEURYSM
ADD	24	NON-DISSECTING ANEURYSM WITHOUT RUPTURE

46505 Chemodenervation of internal anal sphincter

New CPT Code	*HSC Staff*	
ADD	529	CHRONIC ANAL FISSURE; ANAL FISTULA

46710 Repair of ileoanal pouch fistula/sinus, pouch advancement; transperineal approach

46712 Repair of ileoanal pouch fistula/sinus, pouch advancement; combined transperineal transabdominal approach

New CPT Code	*HSC Staff*	
ADD	293	REGIONAL ENTERITIS, IDIOPATHIC PROCTOCOLITIS, ULCERATION OF INTESTINE

61630 Balloon angioplasty, intracranial, percutaneous

61635 Transcatheter placement of intravascular stent, intracranial, including angioplasty, if performed

New CPT Code	*HSC Staff*	*pair with 434, occlusion of cerebral arteries, and 433 occ/stenosis of precerebral arteries*
ADD	245	OCCLUSION AND STENOSIS OF PRECEREBRAL ARTERIES
ADD	284	STROKE

61640 Balloon dilation of intracranial vasospasm, percutaneous; initial vessel

61641 Balloon dilation of intracranial vasospasm, percutaneous; each add'l vessel in same vascular family

61642 Balloon dilation of intracranial vasospasm, percutaneous; each add'l vessel in diff vascular family

New CPT Code	*HSC Staff*	*pair with 435, transient cerebral ischemia*
ADD	267	TRANSIENT CEREBRAL ISCHEMIA

64650 Chemodenervation of eccrine glands; both axillae
64653 Chemodenervation of eccrine glands; other areas

New CPT Code HSC Staff

ADD	651	DISORDERS OF SWEAT GLANDS

77421 Stereotactic X-ray guidance for localization of target volume for the delivery of radiation therapy

New CPT Code HSC Staff

ADD	137	MALIGNANT MELANOMA OF SKIN, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL
ADD	190	CANCER OF THYROID, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL
ADD	193	CANCER OF EYE & ORBIT, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL
ADD	224	CANCER OF SOFT TISSUE, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL
ADD	231	CANCER OF BONES, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL
ADD	234	CANCER OF ORAL CAVITY, PHARYNX, NOSE AND LARYNX, WHERE TREATMENT WILL RESULT IN A
ADD	272	CANCER OF LUNG, BRONCHUS, PLEURA, TRACHEA, MEDIASTINUM AND OTHER RESPIRATORY ORGANS,
ADD	274	CANCER OF ENDOCRINE SYSTEM, EXCLUDING THYROID, WHERE TREATMENT WILL RESULT IN A
ADD	277	CANCER OF BRAIN AND NERVOUS SYSTEM, WHERE TREATMENT WILL RESULT IN A GREATER THAN
ADD	346	CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA, WHERE TREATMENT WILL RESULT IN A
ADD	488	CANCER OF ESOPHAGUS, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR

91022 Duodenal motility (manometric) study

New CPT Code HSC Staff

ADD TO ALL GI LINES

95873 Electrical stimulation for guidance in conjunction with chemodenervation
95874 Electrical EMG for guidance in conjunction with chemodenervation

New CPT Code HSC Staff

ADD	333	NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS
ADD	344	DYSTONIA (UNCONTROLLABLE)

98960 Education and training for patient self-management by qualified, nonphysician healthcare professional using standardized curriculum, face-to-face, each 30 minutes, individual **(cont'd on next page)**

98961 Education and training for patient self-management by qualified, nonphysician healthcare professional using standardized curriculum, face-to-face, each 30 minutes, 2-4 patients
98962 Education and training for patient self-management by qualified, nonphysician healthcare professional using standardized curriculum, face-to-face, each 30 minutes, 5-8 patients

New CPT Code	*HSC Staff*	
ADD	2	TYPE I DIABETES MELLITUS
ADD	156	ASTHMA
ADD	172	HEART FAILURE

3) Non-pairings: discussion required

35476 Transluminal balloon angioplasty, percutaneous, venous

Omission	*Provider*	*to pair with 453.8 venous thrombosis, other specified*
ADD	39	BUDD-CHIARA SYNDROME, AND OTHER VENOUS EMBOLISM AND THROMBOSIS
ADD	145	COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
ADD	669	VARICOSE VEINS OF LOWER EXTREMITIES WITHOUT ULCER OR INFLAMMATION

G0110 NETT pulmonary rehabilitation; education/skills training, individual
G0111 NETT pulmonary rehabilitation; education/skills training, group
G0112 NETT pulmonary rehabilitation; nutritional guidance, initial
G0113 NETT pulmonary rehabilitation; nutritional guidance, subsequent
G0114 NETT pulmonary rehabilitation; psychosocial consultation
G0115 NETT pulmonary rehabilitation; psychological testing
G0116 NETT pulmonary rehabilitation; psychosocial counselling

Omission	*Provider*	
ADD	281	CHRONIC OBSTRUCTIVE PULMONARY DISEASE

11) Non-pairings: straightforward

Revise cochlear implant guideline (Guideline Note 32)

Provider *remove unnecessary criteria saying child must be at least one year old*

REVISE 501 SENSORINEURAL HEARING LOSS, OVER AGE 5

33608 Repair of complex cardiac anomaly other than pulmonary atresia with VSD by construction or replacement of conduit from right or left ventricle to pulmonary artery

Non-Pairing *OMAP - MD* *to pair with 747.3, anomalies of pulmonary artery*

ADD 102 TETRALOGY OF FALLOT

33660 Repair of incomplete or partial atrioventricular canal (ostium primum ASD), with or without atrioventricular valve repair

Non-Pairing *OMAP - MD* *to pair with 745.61, other endocardial cushion defects*

ADD 95 ATRIAL SEPTAL DEFECT, PRIMUM
ADD 105 OTHER AND UNSPECIFIED ENDOCARDIAL CUSHION DEFECTS

12) New codes: similar to existing

01965 Anaesthesia for incomplete or missed abortion procedures
01966 Anaesthesia for induced abortion procedures

New CPT Code *HSC Staff*

ADD 297 TERMINATION OF PREGNANCY

15040 Harvest of skin for tissue cultured skin autograft, 100sq cm or less
15340 Tissue cultured allogeneic skin substitute, first 25 sq cm or less
15341 Tissue cultured allogeneic skin substitute, each add'l 25 sq cm
15420 Xenograft skin (dermal) for temp wound closure, face, hands, feet, etc; first 100 sq cm or less
15421 Xenograft skin (dermal) for temp wound closure, face, hands, feet, etc; each add'l 100 sq cm **(cont'd on next page)**

15430 Acellular xenograft implant; first 100 sq cm or less
15431 Acellular xenograft implant; each add'l 100 sq cm

New CPT Code	*HSC Staff*	
ADD	40	BURN, PARTIAL THICKNESS GREATER THAN 30% OF BODY SURFACE OR WITH VITAL SITE; FULL THICKNESS WITH VITAL SITE, LESS THAN 10% OF BODY SURFACE
ADD	99	CONGENITAL ANOMALIES OF URINARY SYSTEM
ADD	137	MALIGNANT MELANOMA OF SKIN, TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL
ADD	146	CRUSH INJURIES: TRUNK, UPPER LIMBS, LOWER LIMB INCLUDING BLOOD VESSELS
ADD	162	BURN FULL THICKNESS GREATER THAN 10% OF BODY SURFACE
ADD	196	BURN, PARTIAL THICKNESS WITHOUT VITAL SITE, 10-30% OF BODY SURFACE
ADD	224	CANCER OF SOFT TISSUE, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL
ADD	296	COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
ADD	303	BILATERAL ANOMALIES OF EXTERNAL EAR WITH IMPAIRMENT OF HEARING
ADD	346	CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL
ADD	350	CHRONIC ULCER OF SKIN
ADD	360	CONDITIONS INVOLVING EXPOSURE TO NATURAL ELEMENTS (EG. LIGHTNING STRIKE, HEATSTROKE)
ADD	375	DEEP OPEN WOUNDS
ADD	556	DEFORMITIES OF UPPER BODY AND ALL LIMBS
ADD	660	SEBORRHEIC KERATOSIS, DYSCHROMIA, VASCULAR DISORDERS, SCAR CONDITIONS, & FIBROSIS OF SKIN

15110 Epidermal autograft, trunk, arms, legs; first 100sq cm
15111 Epidermal autograft, trunk, arms, legs; each add'l 100sq cm
15130 Dermal autograft, trunk, arms, legs; first 100sq cm
15131 Dermal autograft, trunk, arms, legs; each add'l 100sq cm
15150 Tissue cultured epidermal authograft, trunk, arms, legs, first 25 sq cm or less
15151 Tissue cultured epidermal authograft, trunk, arms, legs, each add'l 1 sq cm to 75sq cm
15152 Tissue cultured epidermal authograft, trunk, arms, legs, each add'l 100 sq cm
15170 Acellular dermal replacement, trunk, arms, legs; first 100 sq cm or less
15171 Acellular dermal replacement, trunk, arms, legs; each add'l 100 sq cm or less
15300 Allograft skin for temporary wound closure, trunk, arms, legs; first 100 sq cm or less
15301 Allograft skin for temporary wound closure, trunk, arms, legs; each add'l 100 sq cm (cont'd on next page)

15330 Acellular dermal allograft, trunk, arms, legs; first 100 sq cm or less
15331 Acellular dermal allograft, trunk, arms, legs; each add'l 100 sq cm or less
15360 Tissue cultured allogeneic dermal substitute, trunk, arms, legs; first 100 sq cm or less
15361 Tissue cultured allogeneic dermal substitute, trunk, arms, legs; each add'l 100 sq cm

New CPT Code	*HSC Staff*	
ADD	40	BURN, PARTIAL THICKNESS GREATER THAN 30% OF BODY SURFACE OR WITH VITAL SITE; FULL THICKNESS WITH VITAL SITE, LESS THAN 10% OF BODY SURFACE
ADD	137	MALIGNANT MELANOMA OF SKIN, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL
ADD	146	CRUSH INJURIES: TRUNK, UPPER LIMBS, LOWER LIMB INCLUDING BLOOD VESSELS
ADD	162	BURN FULL THICKNESS GREATER THAN 10% OF BODY SURFACE
ADD	196	BURN, PARTIAL THICKNESS WITHOUT VITAL SITE, 10-30% OF BODY SURFACE
ADD	224	CANCER OF SOFT TISSUE, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL
ADD	296	COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
ADD	346	CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL
ADD	350	CHRONIC ULCER OF SKIN
ADD	360	CONDITIONS INVOLVING EXPOSURE TO NATURAL ELEMENTS (EG. LIGHTNING STRIKE, HEATSTROKE)
ADD	375	DEEP OPEN WOUNDS
ADD	556	DEFORMITIES OF UPPER BODY AND ALL LIMBS
ADD	660	SEBORRHEIC KERATOSIS, DYSCHROMIA, AND VASCULAR DISORDERS, SCAR CONDITIONS, AND FIBROSIS OF SKIN

15115 Epidermal autograft, face, hands, feet, etc; first 100sq cm
15116 Epidermal autograft, face, hands, feet, etc; each add'l 100sq cm
15135 Dermal autograft, face, hands, feet, etc; first 100sq cm
15136 Dermal autograft, face, hands, feet, etc; each add'l 100sq cm
15155 Tissue cultured epidermal authograft, face, hands, feet, etc; first 25 sq cm or less
15156 Tissue cultured epidermal authograft, face, hands, feet, etc; each add'l 1 sq cm to 75sq cm
15157 Tissue cultured epidermal authograft, face, hands, feet, etc; each add'l 100 sq cm
15175 Acellular dermal replacement, face, hands, feet, etc; first 100 sq cm or less
15176 Acellular dermal replacement, face, hands, feet, etc; each add'l 100 sq cm or less
15320 Allograft skin for temporary wound closure, face, hands, feet, etc; first 100 sq cm or less (cont'd on next page)

15321 Allograft skin for temporary wound closure, face, hands, feet, etc; each add'l 100 sq cm
15335 Acellular dermal allograft, face, hands, feet, etc; first 100 sq cm or less
15336 Acellular dermal allograft, face, hands, feet, etc; each add'l 100 sq cm or less
15365 Tissue cultured allogeneic dermal substitute, face, hands, feet, etc; first 100 sq cm or less
15366 Tissue cultured allogeneic dermal substitute, face, hands, feet, etc; each add'l 100 sq cm

New CPT Code HSC Staff

ADD	40	BURN, PARTIAL THICKNESS GREATER THAN 30% OF BODY SURFACE OR WITH VITAL SITE; FULL THICKNESS WITH VITAL SITE, LESS THAN 10% OF BODY SURFACE
ADD	99	CONGENITAL ANOMALIES OF URINARY SYSTEM
ADD	137	MALIGNANT MELANOMA OF SKIN, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL
ADD	146	CRUSH INJURIES: TRUNK, UPPER LIMBS, LOWER LIMB INCLUDING BLOOD VESSELS
ADD	162	BURN FULL THICKNESS GREATER THAN 10% OF BODY SURFACE
ADD	196	BURN, PARTIAL THICKNESS WITHOUT VITAL SITE, 10-30% OF BODY SURFACE
ADD	224	CANCER OF SOFT TISSUE, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL
ADD	296	COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
ADD	303	BILATERAL ANOMALIES OF EXTERNAL EAR WITH IMPAIRMENT OF HEARING
ADD	346	CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL
ADD	350	CHRONIC ULCER OF SKIN
ADD	360	CONDITIONS INVOLVING EXPOSURE TO NATURAL ELEMENTS (EG. LIGHTNING STRIKE, HEATSTROKE)
ADD	375	DEEP OPEN WOUNDS
ADD	660	SEBORRHEIC KERATOSIS, DYSCHROMIA, VASCULAR DISORDERS, SCAR CONDITIONS, & FIBROSIS OF SKIN

22010 Incision and drainage, open, of deep abscess, posterior spine; cervical, thorasic
22015 Incision and drainage, open, of deep abscess, posterior spine; lumbar, sacral

New CPT Code HSC Staff pair with 730.08, osteomyelitis of spine

ADD	35	ACUTE OSTEOMYELITIS
ADD	214	INTRASPINAL AND INTRACRANIAL ABSCESS
ADD	351	ABSCESS AND CELLULITIS, NON-ORBITAL

32503 Resection of apical lung tumor, including chest wall resection, without chest wall reconstruction
32504 Resection of apical lung tumor, including chest wall resection, with chest wall reconstruction

New CPT Code HSC Staff pair with 162.3, malig neoplasm of lung, upper lobe

ADD	272	CANCER OF LUNG, BRONCHUS, PLEURA, TRACHEA, MEDIASTINUM AND OTHER RESPIRATORY ORGANS, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL

33507 Repair of anomalous aortic origin of coronary artery by unroofing or translocation

New CPT Code HSC Staff pair with 746.85, coronary artery anomaly

ADD	100	CORONARY ARTERY ANOMALY

33768 Anastamosis, cavopulmonary, second superior vena cava

New CPT Code HSC Staff use with 33478

ADD	97	SUBVALVULAR AORTIC STENOSIS, RIGHT VENTRICULAR INFUNDIBULAR OBSTRUCTION AND OTHER SPECIFIED ANOMALIES OF HEART
ADD	145	COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
ADD	149	BULBUS CORDIS ANOMALIES AND ANOMALIES OF CARDIAC SEPTAL CLOSURE: DOUBLE OUTLET RIGHT VENTRICLE
ADD	151	COMMON VENTRICLE
ADD	321	MULTIPLE VALVULAR DISEASE
ADD	367	HYPOPLASTIC LEFT HEART SYNDROME
ADD	368	CONGENITAL PULMONARY VALVE STENOSIS

33925 Repair of pulmonary artery arborization anomalies by unifocalization; without CPB
33926 Repair of pulmonary artery arborization anomalies by unifocalization; with CPB

New CPT Code HSC Staff

ADD	102	TETRALOGY OF FALLOT (TOF)
ADD	152	CONGENITAL PULMONARY VALVE ATRESIA

36598 Contrast injection for radiologic evaluation of existing central venous access device

New CPT Code HSC Staff

ADD TO ANCILLARY SERVICES LIST

37184 Primary percutaneous transluminal mechanical thrombectomy,non-coronary, arterial, incl. intraprocedural pharmacologic thrombolytic injection; first vessel

37185 Primary percutaneous transluminal mechanical thrombectomy,non-coronary, arterial, incl. intraprocedural pharmacologic thrombolytic injection; all subsequent vessels

37186 Secondary percutaneous transluminal mechanical thrombectomy,non-coronary, arterial, incl. intraprocedural pharmacologic thrombolytic injection;provided in conjunction with another percutaneous

New CPT Code	*HSC Staff*	
ADD	29	ARTERIAL EMBOLISM/THROMBOSIS: ABDOMINAL AORTA, THORACIC AORTA
ADD	345	ATHEROSCLEROSIS, AORTIC AND RENAL
ADD	366	ATHEROSCLEROSIS, PERIPHERAL

37187 Percutaneous transluminal mechanical thrombectomy,vein, incl. intraprocedural pharmacologic thrombolytic injection

37188 Percutaneous transluminal mechanical thrombectomy,vein, incl. intraprocedural pharmacologic thrombolytic injection; repeat treatment on subsequent day

New CPT Code	*HSC Staff*	
ADD	39	BUDD-CHIARI SYNDROME, AND OTHER VENOUS EMBOLISM AND THROMBOSIS
ADD	211	PHLEBITIS AND THROMBOPHLEBITIS, DEEP

37718 Ligation, division and stripping, short saphenous vein

37722 Ligation, division and stripping, long saphenous vein from saphenofemoral junction to knee or below

New CPT Code	*HSC Staff*	
ADD	350	CHRONIC ULCER OF SKIN
ADD	669	VARICOSE VEINS OF LOWER EXTREMITIES WITHOUT ULCER OR INFLAMMATION

44180 Laparoscopy, surgical, enterolysis

New CPT Code	*HSC Staff*	
ADD	23	INTUSSCEPTION, VOLVULUS, INTESTINAL OBSTRUCTION, AND FOREIGN BODY IN STOMACH, INTESTINES, COLON, AND RECTUM
ADD	558	PERITONEAL ADHESION

44186 Laparoscopy, surgical; jejunostomy for decompression or feeding

New CPT Code HSC Staff

ADD	23	INTUSSCEPTION, VOLVULUS, INTESTINAL OBSTRUCTION, AND FOREIGN BODY IN STOMACH, INTESTINES, COLON, AND RECTUM
ADD	77	CONGENITAL ANOMALIES OF DIGESTIVE SYSTEM AND ABDOMINAL WALL EXCLUDING NECROSIS; CHRONIC INTESTINAL PSEUDO-OBSTRUCTION
ADD	216	NEUROLOGICAL DYSFUNCTION IN BREATHING, EATING, SWALLOWING, BOWEL, OR BLADDER CONTROL CAUSED BY CHRONIC CONDITIONS

44187 Laparoscopy, surgical; ileostomy or jejunostomy, non-tube

New CPT Code HSC Staff

ADD	23	INTUSSCEPTION, VOLVULUS, INTESTINAL OBSTRUCTION, AND FOREIGN BODY IN STOMACH, INTESTINES, COLON, AND RECTUM
ADD	77	CONGENITAL ANOMALIES OF DIGESTIVE SYSTEM AND ABDOMINAL WALL EXCLUDING NECROSIS; CHRONIC INTESTINAL PSEUDO-OBSTRUCTION
ADD	216	NEUROLOGICAL DYSFUNCTION IN BREATHING, EATING, SWALLOWING, BOWEL, OR BLADDER CONTROL CAUSED BY CHRONIC CONDITIONS
ADD	270	CANCER OF COLON, RECTUM, SMALL INTESTINE AND ANUS, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL
ADD	293	REGIONAL ENTERITIS, IDIOPATHIC PROCTOCOLITIS, ULCERATION OF INTESTINE

44188 Laparoscopy, surgical, colostomy or skin-level cecostomy

New CPT Code HSC Staff

ADD	23	INTUSSCEPTION, VOLVULUS, INTESTINAL OBSTRUCTION, AND FOREIGN BODY IN STOMACH, INTESTINES, COLON, AND RECTUM
ADD	77	CONGENITAL ANOMALIES OF DIGESTIVE SYSTEM AND ABDOMINAL WALL EXCLUDING NECROSIS; CHRONIC INTESTINAL PSEUDO-OBSTRUCTION
ADD	216	NEUROLOGICAL DYSFUNCTION IN BREATHING, EATING, SWALLOWING, BOWEL, OR BLADDER CONTROL CAUSED BY CHRONIC CONDITIONS
ADD	256	DIVERTICULITIS OF COLON
ADD	270	CANCER OF COLON, RECTUM, SMALL INTESTINE AND ANUS, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL
ADD	271	CANCER OF CERVIX, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL
ADD	293	REGIONAL ENTERITIS, IDIOPATHIC PROCTOCOLITIS, ULCERATION OF INTESTINE

44213 Laparoscopy, surgical, mobilization of splenic flexure in conjunction with partial colectomy (use with 44204)

New CPT Code HSC Staff

ADD	23	INTUSSCEPTION, VOLVULUS, INTESTINAL OBSTRUCTION, AND FOREIGN BODY IN STOMACH, INTESTINES, COLON, AND RECTUM
ADD	77	CONGENITAL ANOMALIES OF DIGESTIVE SYSTEM AND ABDOMINAL WALL EXCLUDING NECROSIS; CHRONIC INTESTINAL PSEUDO-OBSTRUCTION
ADD	126	ACUTE VASCULAR INSUFFICIENCY OF INTESTINE
ADD	216	NEUROLOGICAL DYSFUNCTION IN BREATHING, EATING, SWALLOWING, BOWEL, OR BLADDER CONTROL CAUSED BY CHRONIC CONDITIONS
ADD	256	DIVERTICULITIS OF COLON
ADD	270	CANCER OF COLON, RECTUM, SMALL INTESTINE AND ANUS, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL
ADD	293	REGIONAL ENTERITIS, IDIOPATHIC PROCTOCOLITIS, ULCERATION OF INTESTINE

44213 Laparoscopy, surgical, mobilization of splenic flexure in conjunction with partial colectomy (use with 44204)

ADD	488	CANCER OF ESOPHAGUS, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL
ADD	523	RECTAL PROLAPSE
ADD	558	PERITONEAL ADHESION

44227 Laparoscopy, surgical; closure of enterostomy, large or small intestine, with resection and anastomosis

New CPT Code HSC Staff

ADD	3	PERITONITIS AND RETROPERITONEAL INFECTIONS
ADD	10	INJURY TO INTERNAL ORGANS
ADD	77	CONGENITAL ANOMALIES OF DIGESTIVE SYSTEM AND ABDOMINAL WALL EXCLUDING NECROSIS; CHRONIC INTESTINAL PSEUDO-OBSTRUCTION
ADD	256	DIVERTICULITIS OF COLON
ADD	270	CANCER OF COLON, RECTUM, SMALL INTESTINE AND ANUS, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL
ADD	293	REGIONAL ENTERITIS, IDIOPATHIC PROCTOCOLITIS, ULCERATION OF INTESTINE
ADD	296	COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT

45395 Laparoscopy, surgical; proctectomy, complete, combined abdominoperineal, with colostomy

New CPT Code HSC Staff

ADD	77	CONGENITAL ANOMALIES OF DIGESTIVE SYSTEM AND ABDOMINAL WALL EXCLUDING NECROSIS; CHRONIC INTESTINAL PSEUDO-OBSTRUCTION
ADD	270	CANCER OF COLON, RECTUM, SMALL INTESTINE AND ANUS, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL

45397 Laparoscopy, surgical; proctectomy, combined abdominoperineal pull-through procedure, with creation of colonic reservoir, with diverting enterostomy

New CPT Code HSC Staff

ADD	77	CONGENITAL ANOMALIES OF DIGESTIVE SYSTEM AND ABDOMINAL WALL EXCLUDING NECROSIS; CHRONIC INTESTINAL PSEUDO-OBSTRUCTION
ADD	293	REGIONAL ENTERITIS, IDIOPATHIC PROCTOCOLITIS, ULCERATION OF INTESTINE

45400 Laparoscopy, surgical; proctopexy

New CPT Code HSC Staff

ADD	523	RECTAL PROLAPSE

45402 Laparoscopy, surgical; proctopexy, with sigmoid resection

New CPT Code HSC Staff

ADD	270	CANCER OF COLON, RECTUM, SMALL INTESTINE AND ANUS, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL

50382 Removal and replacement of internally dwelling ureteral stent, percutaneous
50384 Removal of internally dwelling ureteral stent, percutaneous
50387 Removal and replacement of externally accessible transnephric ureteral stent
50389 Removal of nephrostomy tube

New CPT Code HSC Staff

ADD	290	URINARY FISTULA
ADD	359	URINARY TRACT CALCULUS
ADD	362	CALCULUS OF BLADDER OR KIDNEY
ADD	364	URETERAL STRICTURE OR OBSTRUCTION; HYDRONEPHROSIS; HYDROURETER

57295 Revison of prosthetic vaginal graft, vaginal approach

New CPT Code HSC Staff

ADD 464 CONGENITAL ABSENCE OF VAGINA

95251 Ambulatory continuous glucose monitoring of interstitial tissue fluid via SC sensor up to 72 hours; physician interpretation and report

New CPT Code HSC Staff

ADD 2 TYPE I DIABETES MELLITUS

99051 Services provided in the office during regularly scheduled evening, weekend or holiday office hours, in addition to basic service
99053 Services provided between 10PM and 8AM at 24 hour facility, in addition to basic service
99060 Services provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service

New CPT Code HSC Staff

ADD TO NON-OHP SERVICES LIST

90779 Unlisted therapuetic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion

New CPT Code HSC Staff

ADD TO PAC-5 LIST

92626 Evaluation of auditory rehab status; first hour
92627 Evaluation of auditory rehab status; each add'l 15 minutes
92630 Auditory rehab; pre-lingual hearing loss
92633 Auditory rehab; post-lingual hearing loss

New CPT Code HSC Staff

ADD TO ALL SPEECH THERAPY LINES

97760 Orthotic management and training, upper extremity, lower extremity or trunk, each 15 minutes
97761 Prosthetic training, upper or lower extremity, each 15 minutes
97762 Checkout for orthotic/prosthetic use, established patient, each 15 minutes

New CPT Code HSC Staff

ADD TO ALL PT LINES

96401 Chemotherapy administration, SC or IM, non-hormonal anti-neoplastic
96402 Chemotherapy administration, SC or IM, hormonal anti-neoplastic
96409 Chemotherapy administration, IV, push technique, single or initial substance
96411 Chemotherapy administration, IV, push technique, each add'l substance
96413 Chemotherapy administration, infusion technique, up to 1 hour, single or initial substance
96415 Chemotherapy administration, infusion technique, each add'l hour, 1 to 8 hours
96416 Chemotherapy administration, infusion technique, initiation of prolonged infusion requiring use of portable or implantable pump
96417 Chemotherapy administration, infusion technique, each add'l sequential infusion, up to 1 hour
96521 Refilling and maintenance of portable pump
96522 Refilling and maintenance of implantable pump or resevoir for drug delivery, systemic
96523 Irrigation of implanted venous access device for drug delivery systems
New CPT Code HSC Staff
ADD TO ALL ONCOLOGY LINES

58110 Endometrial sampling performed in conjunction with colposcopy
76376 3D rendering with interp and report of CT, MRI, US or other tomographic modality; not requiring image postprocessing on an independent workstation
76377 3D rendering with interp and report of CT, MRI, US or other tomographic modality; requiring image postprocessing on an independent workstation
80195 Therapuetic drug assay; sirolimus
82271 Blood, occult, by peroxidase activity (guiac); other sources (than feces)
82272 Blood, occult, by peroxidase activity (guiac); feces, single specimen (eg, from digital rectal exam)
83037 Hemoglobin, glycosylated, by device cleared by FDA for home use
83631 Lactoferrin, fecal; quantitative
83695 Lipoprotein, blood; high resolution fractionation and quantitation of lipoprotiens, including subclasses
83700 Lipoprotein, blood; electrophoretic separation and quantitation
83701 Lipoprotein, blood; high resolution fractionation and quantitation of lipoproteins incl. lipoprotein subclasses when performed
83704 Lipoprotein, blood; quantitation of lipoprotein particle numbers and lipoprotein particle subclasses
83900 Molecular diagnostics; amplification of patient nucleic acid, multiplex, first two nucleic acid sequences
83907 Molecular diagnostics; lysis of cells prior to nucleic acid extraction
83908 Molecular diagnostics; signal amplification of patient nucleic acid, each nucleic acid sequence (cont'd on next

page)

83909	**Molecular diagnostics; separation and identification by high resolution technique**
83914	**Mutation identification by enzymatic ligation or primer extension, single segment, each segment**
86200	**Cyclic citrullinated peptide, antibody**
86355	**B cells, total count**
86357	**Natural killer cells, total count**
86367	**Stem cells, total count**
86480	**Tuberculosis test, cell mediated immunity measurement of gamma interferon antigen response**
86923	**Compatability test each unit; electronic**
86960	**Volume reduction of blood or blood products, each unit**
87209	**Smear, primary source with determination; complex special stain for ova and parasites**
87900	**Infectious agent drug susceptibility phenotype prediction using regularly updated genotypic bioinformatics**
88333	**Pathologic consultation during surgery; cytologic exam, first site**
88334	**Pathologic consultation during surgery; cytologic exam, each add'l site**
88384	**Array-based evaluation of multiple molecular probes; 11-50 probes**
88385	**Array-based evaluation of multiple molecular probes; 51-250 probes**
88386	**Array-based evaluation of multiple molecular probes; 251-500 probes**
89049	**Caffiene halothane contracture test for malignant hyperthermia susceptibility**
95865	**Needle EMG; larynx**
95866	**Needle EMG; hemidiaphram**
96101	**Psychological testing with interp and report, per hour of psychologist or physician time, both face-to-face and interp/prep time**
96102	**Psychological testing with interp and report, with qualified health care professional interp and report, administered by technician, per hour of technician time face-to-face**
96103	**Psychological testing with interp and report, administered by computer, with qualified health care professional interp and report**
96116	**Neurobehavioral status exam, per hour of psychologist or physician time, both face-to-face and interp/prep**
96118	**Neuropsychological testing, per hour of psychologist or physician time, both face-to-face and interp/prep**
96119	**Neuropsychological testing, with qualified health care professional interp and report, administered by technician, per hour of technician time face-to-face**
96120	**Neuropsychological testing, administered by computer, with qualified health care professional interp and**

New CPT Code HSC Staff

ADD TO DIAGNOSTIC LIST

90714 Tetanus and diptheria toxoids, adsorbed, for use in individuals 7 years and older
90760 Intravenous infusion, hydration; initial, up to 1 hour
90761 Intravenous infusion, hydration; each add'l hour, up to 8 hours
90765 Intravenous infusion, for therapy, prophylaxis or diagnosis; initial, up to 1 hour
90766 Intravenous infusion, for therapy, prophylaxis or diagnosis; each add'l hour, up to 8 hours
90767 Intravenous infusion, for therapy, prophylaxis or diagnosis; add'l sequential infusion, up to 1 hour
90768 Intravenous infusion, for therapy, prophylaxis or diagnosis; concurrent infusion
90772 Therapuetic, prophylactic or diagnostic injection, SC or IM
90773 Therapuetic, prophylactic or diagnostic injection; intra-arterial
90774 Therapuetic, prophylactic or diagnostic injection; IV push, single or initial substance
90775 Therapuetic, prophylactic or diagnostic injection; IV push, each add'l sequential push
99143 Moderate sedation services provided by same physician performing service that the sedation supports, requiring presence of observer to monitor patient status; under 5 years, first 30 minutes
99144 Moderate sedation services provided by same physician performing service that the sedation supports, requiring presence of observer to monitor patient status; 5 years or older, first 30 minutes
99145 Moderate sedation services provided by same physician performing service that the sedation supports, requiring presence of observer to monitor patient status; each add'l 15 minutes
99148 Moderate sedation services provided by physician other than the one performing service that the sedation supports; under 5 years, first 30 minutes
99149 Moderate sedation services provided by physician other than the one performing service that the sedation supports; 5 years or older, first 30 minutes
99150 Moderate sedation services provided by physician other than the one performing service that the sedation supports; each add'l 15 minutes

New CPT Code HSC Staff

ADD TO ANCILLARY SERVICES LIST

99300 Subsequent neonatal intensive care, per day, for recovering infant (body weight 2501-5000 grams)
99304 Initial nursing facility care, detailed or comprehensive, low complexity
99305 Initial nursing facility care, comprehensive, moderate complexity
99306 Initial nursing facility care, comprehensive, high complexity
99307 Subsequent nursing facility care, problem focused, straightforward
99308 Subsequent nursing facility care, expanded problem focused, low complexity
99309 Subsequent nursing facility care, detailed, moderate complexity **(cont'd on next page)**

99310 Subsequent nursing facility care, comprehensive, high complexity
99318 Annual nursing facility assessment, detailed, comprehensive, low-moderate complexity
99324 Domicilary or rest home visit, new, problem focused, straightforward
99325 Domicilary or rest home visit, new, expanded problem focused, low complexity
99326 Domicilary or rest home visit, new, detailed, moderate complexity
99327 Domicilary or rest home visit, new, comprehensive, moderate complexity
99328 Domicilary or rest home visit, new, comprehensive, high complexity
99334 Domicilary or rest home visit, established, problem focused, straightforward
99335 Domicilary or rest home visit, established, expanded problem focused, low complexity
99336 Domicilary or rest home visit, established, detailed, moderate complexity
99337 Domicilary or rest home visit, established, comprehensive, mod-high complexity
99339 Individual physician supervision of pateint (not present) in home, domicilary or rest home requiring complex/multidisciplinary care modalities, care plan oversight within calendar month, 15-29 minutes
99340 Individual physician supervision of pateint (not present) in home, domicilary or rest home requiring complex/multidisciplinary care modalities, care plan oversight within calendar month, 30 minutes or more

New CPT Code	*HSC Staff*
ADD	ALL MEDICAL THERAPY LINES

14) Deletion of invalid codes

15342 Application of bilaminate skin substitute/neodermis; 25 sq cm
15343 Application of bilaminate skin substitute/neodermis; each add"l 25 sq cm

Deleted Code	*HSC Staff*	
DELETE	40	BURN, PARTIAL THICKNESS GREATER THAN 30% OF BODY SURFACE OR WITH VITAL SITE; FULL THICKNESS WITH VITAL SITE, LESS THAN 10% OF BODY SURFACE
DELETE	99	CONGENITAL ANOMALIES OF URINARY SYSTEM
DELETE	137	MALIGNANT MELANOMA OF SKIN, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL
DELETE	162	BURN FULL THICKNESS GREATER THAN 10% OF BODY SURFACE
DELETE	196	BURN, PARTIAL THICKNESS WITHOUT VITAL SITE, 10-30% OF BODY SURFACE
DELETE	350	CHRONIC ULCER OF SKIN
DELETE	375	DEEP OPEN WOUNDS

15350 Application of allograft skin; 100 sq cm or less

Deleted Code	*HSC Staff*	
DELETE	40	BURN, PARTIAL THICKNESS GREATER THAN 30% OF BODY SURFACE OR WITH VITAL SITE; FULL THICKNESS WITH VITAL SITE, LESS THAN 10% OF BODY SURFACE
DELETE	99	CONGENITAL ANOMALIES OF URINARY SYSTEM
DELETE	137	MALIGNANT MELANOMA OF SKIN, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL
DELETE	162	BURN FULL THICKNESS GREATER THAN 10% OF BODY SURFACE
DELETE	196	BURN, PARTIAL THICKNESS WITHOUT VITAL SITE, 10-30% OF BODY SURFACE

15350 Application of allograft skin; 100 sq cm or less

DELETE	296	COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
DELETE	346	CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL
DELETE	350	CHRONIC ULCER OF SKIN
DELETE	360	CONDITIONS INVOLVING EXPOSURE TO NATURAL ELEMENTS (EG. LIGHTNING STRIKE, HEATSTROKE)
DELETE	375	DEEP OPEN WOUNDS
DELETE	555	ATROPHY OF EDENTULOUS ALVEOLAR RIDGE

15351 Application of allograft skin; each add'l 100 sq cm

Deleted Code	*HSC Staff*	
DELETE	40	BURN, PARTIAL THICKNESS GREATER THAN 30% OF BODY SURFACE OR WITH VITAL SITE; FULL THICKNESS WITH VITAL SITE, LESS THAN 10% OF BODY SURFACE
DELETE	99	CONGENITAL ANOMALIES OF URINARY SYSTEM
DELETE	137	MALIGNANT MELANOMA OF SKIN, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL
DELETE	162	BURN FULL THICKNESS GREATER THAN 10% OF BODY SURFACE
DELETE	196	BURN, PARTIAL THICKNESS WITHOUT VITAL SITE, 10-30% OF BODY SURFACE
DELETE	296	COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
DELETE	350	CHRONIC ULCER OF SKIN
DELETE	375	DEEP OPEN WOUNDS

15810 Salabrasion; 20 sq cm or less
15811 Salabrasion; over 20 sq cm

Deleted Code	*HSC Staff*	
DELETE	660	SEBORRHEIC KERATOSIS, DYSCHROMIA, AND VASCULAR DISORDERS, SCAR CONDITIONS, AND FIBROSIS OF SKIN

16010 Dressings and/or debridement, initial or subsequent, under anaesthesia; small
16015 Dressings and/or debridement, initial or subsequent, under anaesthesia; medium or large

Deleted Code	*HSC Staff*	
DELETE	40	BURN, PARTIAL THICKNESS GREATER THAN 30% OF BODY SURFACE OR WITH VITAL SITE; FULL THICKNESS WITH VITAL SITE, LESS THAN 10% OF BODY SURFACE

16010 Dressings and/or debridement, initial or subsequent, under anaesthesia; small
16015 Dressings and/or debridement, initial or subsequent, under anaesthesia; medium or large

DELETE	162	BURN FULL THICKNESS GREATER THAN 10% OF BODY SURFACE
DELETE	196	BURN, PARTIAL THICKNESS WITHOUT VITAL SITE, 10-30% OF BODY SURFACE
DELETE	360	CONDITIONS INVOLVING EXPOSURE TO NATURAL ELEMENTS (EG. LIGHTNING STRIKE, HEATSTROKE)
DELETE	632	MINOR BURNS

21493 Closed treatment of hyoid fracture; without manipulation
21494 Closed treatment of hyoid fracture; with manipulation
31585 Treatment of closed laryngeal fracture; without manipulation
31586 Treatment of closed laryngeal fracture; with closed manipulative reduction

Deleted Code	*HSC Staff*	
DELETE	15	DEEP OPEN WOUND OF NECK, INCLUDING LARYNX; FRACTURE OF LARYNX OR TRACHEA, OPEN

32520 Resection of lung, with chest wall resection

Deleted Code	*HSC Staff*	
DELETE	272	CANCER OF LUNG, BRONCHUS, PLEURA, TRACHEA, MEDIASTINUM AND OTHER RESPIRATORY ORGANS, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL
DELETE	291	ANEURYSM OF PULMONARY ARTERY

32522 Resection of lung, with chest wall reconstruction, without prosthesis

Deleted Code	*HSC Staff*	
DELETE	224	CANCER OF SOFT TISSUE, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5 YEAR SURVIVAL
DELETE	272	CANCER OF LUNG, BRONCHUS, PLEURA, TRACHEA, MEDIASTINUM AND OTHER RESPIRATORY ORGANS, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL
DELETE	291	ANEURYSM OF PULMONARY ARTERY

32525 Resection of lung, with major chest wall reconstruction, with prosthesis

Deleted Code	*HSC Staff*	
DELETE	272	CANCER OF LUNG, BRONCHUS, PLEURA, TRACHEA, MEDIASTINUM AND OTHER RESPIRATORY ORGANS, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL
DELETE	291	ANEURYSM OF PULMONARY ARTERY

33918 Repair of pulmonary atresia with VSD by unifocalization of pulmonary arteries; without CPB
33919 Repair of pulmonary atresia with VSD by unifocalization of pulmonary arteries; with CPB

Deleted Code	*HSC Staff*	
DELETE	152	CONGENITAL PULMONARY VALVE ATRESIA
DELETE	291	ANEURYSM OF PULMONARY ARTERY

37720 Ligation, division and complete stripping of short or long saphenous veins

Deleted Code	*HSC Staff*	
DELETE	211	PHLEBITIS AND THROMBOPHLEBITIS, DEEP
DELETE	350	CHRONIC ULCER OF SKIN
DELETE	669	VARICOSE VEINS OF LOWER EXTREMITIES WITHOUT ULCER OR INFLAMMATION

37730 Ligation, division and complete stripping of short and long saphenous veins

Deleted Code	*HSC Staff*	
DELETE	350	CHRONIC ULCER OF SKIN

42325 Fistulization of sublingual salivary cyst **(cont'd on next page)**

42326 Fistulization of sublingual salivary cyst; with prosthesis

Deleted Code	*HSC Staff*	
DELETE	349	SIALOADENITIS, ABSCESS, FISTULA OF SALIVARY GLANDS
DELETE	543	SIALOLITHIASIS, MUCOCELE, DISTURBANCE OF SALIVARY SECRETION, OTHER AND UNSPECIFIED DISEASES OF SALIVARY GLANDS

43638 Gastrectomy, partial, proximal, including esophagogastrotomy, with vagotomy

Deleted Code	*HSC Staff*	
DELETE	77	CONGENITAL ANOMALIES OF DIGESTIVE SYSTEM AND ABDOMINAL WALL EXCLUDING NECROSIS; CHRONIC INTESTINAL PSEUDO-OBSTRUCTION
DELETE	194	ULCERS, GI HEMORRHAGE
DELETE	276	CANCER OF STOMACH, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL

43639 Gastrectomy, partial, proximal, including esophagogastrotomy, with vagotomy, with pyloroplasty or pyloromyotomy

Deleted Code	*HSC Staff*	
DELETE	194	ULCERS, GI HEMORRHAGE

44200 Laparoscopy, surgical, enterolysis

Deleted Code	*HSC Staff*	
DELETE	23	INTUSSCEPTION, VOLVULUS, INTESTINAL OBSTRUCTION, AND FOREIGN BODY IN STOMACH, INTESTINES, COLON, AND RECTUM
DELETE	77	CONGENITAL ANOMALIES OF DIGESTIVE SYSTEM AND ABDOMINAL WALL EXCLUDING NECROSIS; CHRONIC INTESTINAL PSEUDO-OBSTRUCTION
DELETE	256	DIVERTICULITIS OF COLON
DELETE	431	FUNCTIONAL AND MECHANICAL DISORDERS OF THE GENITOURINARY SYSTEM INCLUDING BLADDER OUTLET OBSTRUCTION
DELETE	558	PERITONEAL ADHESION

44201 Laparoscopy, surgical, jejunostomy (for feeding or decompression)

Deleted Code	*HSC Staff*	
DELETE	77	CONGENITAL ANOMALIES OF DIGESTIVE SYSTEM AND ABDOMINAL WALL EXCLUDING NECROSIS; CHRONIC INTESTINAL PSEUDO-OBSTRUCTION

44239 Unlisted laparoscopy procedure, rectum

Deleted Code	*HSC Staff*	
DELETE	621	MORBID OBESITY

92510 Aural rehab following cochlear implant, with or without speech processor programming

Deleted Code	*HSC Staff*	
DELETE	300	SESORINEURAL HERING LOSS - AGE 5 OR UNDER (See Guideline Note 17)
DELETE	501	SESORINEURAL HERING LOSS - OVER AGE OF FIVE (See Guideline Note 32)

76375 Coronal, sagittal, multiplanar, oblique, 3D or holographic reconstr of CT, MRI or other tomographic modality
78160 Plasma radioiron disappearance rate
78162 Radioiron oral absorption
78170 Radioiron red cell utilization
78172 Chelatable iron for estimation of total body iron
78445 Venous thrombosis study
82273 Blood, occult, by peroxidase activity (guiac); other sources (than feces)
83715 Lipoprotien, blood; electrophoretic separation and quantitation
83716 Lipoprotien, blood; high resolution fractionation and quantitation of lipoprotiens including lipoprotien
86064 B cells, total count
86379 Natural killer cells, total count
86585 Tuberculosis, tine test
86587 Stem cells, total count
90780 Intravenous infusion for therapy/diagnosis, administered by physician; up to 1 hour
90781 Intravenous infusion for therapy/diagnosis, administered by physician; each add'l hour up to 8 hours
90782 Therapuetic, prophylactic or diagnostic injection, SC or IM
90783 Therapuetic, prophylactic or diagnostic injection; intra-arterial
90784 Therapuetic, prophylactic or diagnostic injection, intravenous
90788 Therapuetic, prophylactic or diagnostic injection, IM injection of antibody
90799 Unlisted therapuetic, prophylactic or diagnostic injection
96100 Psychological testing with interp and report, per hour
96115 Neurobehavioral status exam with interp and report, per hour
96117 Neuropsychological testing battery, with interp and report, per hour

Deleted Code	*HSC Staff*
DELETE FROM DIAGNOSTIC LIST	

90939 Hemodialysis access flow study to determine blood flow in grafts and AV fistulae by an indicator dilution method, hook up; transcutaneous measurement and disconnection

Deleted Code HSC Staff

DELETE FROM ALL RENAL LINES AND LINE 163 (DISORDERS OF FLUID, ELECTROLYTE, AND ACID-BASE BALANCE)

92330 Prescription, fitting, and supply of ocular prosthesis, with medical supervision of adaptation

92335 Prescription of ocular prosthesis and direction of fitting and supply by independent technician

Deleted Code HSC Staff

DELETE FROM ALL EYE LINES

96400 Chemotherapy administration, SC or IM, with or without local anaesthesia

96408 Chemotherapy administration, IV; push technique

96410 Chemotherapy administration, infusion technique, up to 1 hour

96412 Chemotherapy administration, infusion technique, 1 to 8 hours, each add'l hour

96414 Chemotherapy administration, infusion technique, initiation of prolonged infusion requiring use of portable or implantable pump

96520 Refilling and maintenance of portable pump

96530 Refilling and maintenance of implantable pump or resevoir for drug delivery, systemic

96545 Provision of chemotherapy agent

Deleted Code HSC Staff

DELETE FROM ALL ONCOLOGY LINES

97504 Orthotic fitting and training, upper extremity, lower extremity or trunk, each 15 minutes

97520 Prosthetic training, upper or lower extremity, each 15 minutes

Deleted Code HSC Staff

DELETE FROM ALL PHYSICAL THERAPY LINES

92390 Supply of spectacles, except prosthesis for aphakia and low vision aids

92391 Supply of contact lenses, except prosthesis for aphakia

92393 Supply of ocular prosthesis

92395 Supply of permanent prosthesis for aphakia; spectacles

92396 Supply of permanent prosthesis for aphakia; contact lenses

97703 Checkout for orthotic/prosthetic use, established patient, each 15 minutes

99141 Sedation with or without analgesia; IV, IM or inhalation **(cont'd on next page)**

99142 Sedation with or without analgesia; oral, rectal or intranasal

Deleted Code *HSC Staff*

DELETE FROM ANCILLARY SERVICES LIST

99261 Follow up inpatient consultation, problem focused, low complexity
99262 Follow up inpatient consultation, expanded problem focused, moderate complexity
99263 Follow up inpatient consultation, detailed, high complexity
99271 Confirmatory consultation, problem focused, straight-forward
99272 Confirmatory consultation, expanded problem focused, straightforward
99273 Follow up inpatient consultation, detailed, low complexity
99274 Follow up inpatient consultation, comprehensive, moderate complexity
99275 Follow up inpatient consultation, comprehensive, high complexity
99301 E&M nursing facility assessment, detailed, comprehensive, low complexity
99302 E&M nursing facility assessment, detailed, comprehensive, mod-high complexity
99303 E&M nursing facility assessment, comprehensive, comprehensive, high complexity
99311 Subsequent nursing facility care, problem focused, problem focused, low complexity
99312 Subsequent nursing facility care, expanded problem focused, moderate complexity
99313 Subsequent nursing facility care, detailed, moderate-high complexity
99321 Domicilory or rest home visit, new, problem focused, low complexity
99322 Domicilary or rest home visit, new, expanded problem focused, moderate complexity
99323 Domicilary or rest home visit, new, detailed, high complexity
99331 Domicilary or rest home visit, established, problem focused, low complexity
99332 Domicilary or rest home visit, established, expanded problem focused, moderate complexity
99333 Domicilary or rest home visit, established, detailed, high complexity

Deleted Code *HSC Staff*

DELETE ALL MEDICAL THERAPY LINES

90871 Electroconvulsive therapy; multiple seizures, per day
92392 Supply of low vision aide
97020 Application of modality to one or more areas; microwave
99052 Services requested between 10PM and 8AM, in addition to basic service
99054 Services requested on Sundays and holidays, in addition to basic service

Deleted Code *HSC Staff*

DELETE FROM NON-OHP SERVICES LIST

Recommended Interim Modifications for Review on 12/8/05 II

1) New codes: discussion required

S2114 Arthroscopy, shoulder, surgical; tenodesis of biceps

New HCPCS Code *HSC Staff*

ADD	504	DISRUPTIONS OF THE LIGAMENTS AND TENDONS OF THE ARMS AND LEGS, EXCLUDING KNEE, GRADES II AND III

S2117 Arthroereisis, subtalar

New HCPCS Code *HSC Staff* *pair with 736.79 Other acquired deformities of ankle and foot*

ADD	446	DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE LEVEL OF INDEPENDENCE IN SELF-DIRECTED CARE CAUSED BY CHRONIC CONDITIONS
ADD	556	DEFORMITIES OF UPPER BODY AND ALL LIMBS
ADD	557	DEFORMITIES OF FOOT
ADD	571	CAVUS DEFORMITY OF FOOT; FLAT FOOT; POLYDACTYLY AND SYNDACTYLY OF TOES

2) Inappropriate pairings: discussion required

931 Foreign body in ear

Move *Provider* *move from Line 532 Cerumen impaction*

ADD	492	NON-MALIGANT OTITIS EXTERNA
DELETE	532	CERUMEN IMPACTION; FOREIGN BODY IN EAR AND NOSE

10) Inappropriate pairings: straightforward

H0037 Community psychiatric supportive treatment program, per diem

Not Indicated *OMHAS*

DELETE	502	SOMATIZATION DISORDER; SOMATOFORM PAIN DISORDER; PREMENSTRUAL TENSION SYNDROMES

11) Non-pairings: straightforward

26591 Repair, intrinsic muscles of hand

Non-Pairing OMAP - MD pair with 883.2 open wound finger with tendon

ADD 375 DEEP OPEN WOUND

61580 Craniofacial approach to anterior cranial fossa; extradural, including lateral rhinotomy, ethmoidectomy, sphenoidectomy, without maxillectomy or orbital exenteration

61581 Craniofacial approach to anterior cranial fossa;extradural, including lateral rhinotomy, ethmoidectomy, sphenoidectomy, maxillectomy, orbital exenteration

61582 Craniofacial approach to anterior cranial fossa; extradural, including unilateral or bifrontal craniotomy, elevation of frontal lobe, osteotomy of base of anterior cranial fossa

61583 Craniofacial approach to anterior cranial fossa; intradural, including unilateral or bifrontal craniotomy, elevation or resection of frontal lobe, osteotomy of base of anterior cranial fossa

61584 Orbitocranial approach to anterior cranial fossa, extradural, including supraorbital ridge osteotomy and elevation of frontal/temporal lobes; without orbital exenteration

61585 Orbitocranial approach to anterior cranial fossa, extradural, including supraorbital ridge osteotomy and elevation of frontal/temporal lobes; with orbital exenteration

61586 Bicoronal, transzygomatic and/or LeFort I osteotomy approach to anterior cranial fossa with or without internal fixation, without bone graft

61590 Infratemporal pre-auricular approach to middle cranial fossa, with or without disarticulation of mandible, including parotidectomy, craniotomy, decompression and/or mobilization of facial nerve and petrous carotid artery

61591 Infratemporal post-auricular approach to middle cranial fossa, including mastoidectomy, resection of sigmoid sinus, with or without decompression and/or mobilization of contents of auditory canal or petrous

61592 Orbitocranial zygomatic approach to middle cranial fossa including osteotomy of zygoma, craniotomy and extra- or intradural elevation of temporal lobe

61595 Transtemporal approach to posterior cranial fossa, jugular foramen or midline skull base, including mastoidectomy, decompression of sigmoid sinus and/or facial nerve, with or without mobilization

61596 Transcochlear approach to posterior cranial fossa, jugular foramen or midline skull base, including labyrinthectomy, decompression, with or without mobilization of facial nerve or petrous carotid artery (cont'd)

61597 Transcondylar approach to posterior cranial fossa, jugular foramen or midline skull base, including occipital condylectomy, mastoidectomy, resection of C1-C3 vertebral bodies, decompression of vertebral artery, with or without mobilization

61598 Transpetrosal approach to posterior cranial fossa, clivus or foramen magnum, including ligation of superior petrosal sinus and/or sigmoid sinus

Non-Pairing	*Provider*	*pair with 225.2 benign neoplasm of brain*
ADD	136	BENIGN NEOPLASM OF BRAIN

62272 Spinal puncture, therapeutic, for drainage of CSF

Non-Pairing	*OMAP - MD*	*pair with 430 subarachnoid hemorrhage*
ADD	31	SUBARACHNOID AND INTRACEREBRAL HEMORRHAGE/HEMATOMA; COMPRESSION OF BRAIN

67710 Severing of tarsorrhaphy

Non-Pairing	*OMAP - MD*	*pair with 374.46 blepharophimosis*
ADD	519	PTOSIS (ACQUIRED) WITH VISION IMPAIRMENT

12) New codes: similar to existing

S2068 Breast reconstruction with deep inferior epigastric perforator flap, including micorvascular anastomosis and closure of donor site, unilateral

New HCPCS Code	*HSC Staff*	
ADD	225	CANCER OF BREAST, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL

S2075 Laparoscopy, surgical; repair incisional or ventral hernia

S2076 Laparoscopy, surgical; repair umbilical hernia

S2077 Laparoscopy, surgical; implantation of mesh or other prosthesis for incisional or ventral hernia repair

New HCPCS Code	*HSC Staff*	
ADD	6	COMPLICATED HERNIA WITH OBSTRUCTION AND/OR GANGRENE; UNCOMPLICATED HERNIA IN CHILDREN
ADD	606	UNCOMPLICATED HERNIA IN ADULTS AGE 18 AND OVER

S2078 Laparoscopic supracervical hysterectomy, with or without removal of tubes and/or ovaries

New HCPCS Code	*HSC Staff*	
ADD	458	MENSTRUAL BLEEDING DISORDERS
ADD	471	UTERINE LEIOMYOMA

S2079 Laparoscopic esophagomyotomy (Heller type)

New HCPCS Code	*HSC Staff*	
ADD	475	ACHALASIA, NON-NEONATAL

13) Non-pairings: MHCD services

H0018 Short-term residential treatment without room and board, per diem

Omission	*OMHAS*	
ADD	301	POST TRAUMATIC STRESS DISORDER

H0019 Long-term residential treatment without room and board, per diem

Omission	*OMHAS*	
ADD	301	POST TRAUMATIC STRESS DISORDER
ADD	419	BORDERLINE PERSONALITY DISORDER
ADD	420	SCHIZOTYPAL PERSONALITY DISORDER

Attachment C

A	B	C	D	μ	E	F	% Served	Old	Title
0				0	4**			0	**Diagnostic Services**
1	1	2	1	1.25		1	Moderate	2	**Maternity Care**, including more disorders of the newborn
2	2	1	2	1.75		1	Many	4	**Preventative Care for Children**
5	4	3	4	4		1	Many	9	**Proven Effective Preventive Care for Adults**
4	3	5	6	4.5	2	1	Many	6	**Reproductive Services**, excludes maternity and infertility services
3	5	6	5	4.75	1*	1*	Moderate	5	**Chronic Fatal**, treatment improves life span and quality of life *(Chronic Illness, Life-threatening)*
10	11	4	3	7		2	Many	8	**Preventive Dental Care**, adults and children *(Split out?)*
6	6	8	9.5	7.38		1*	Few	1	**Acute Fatal**, treatment prevents death with full recovery *(Acute Illness or Injury, Life-threatening)*
7	7	9	9.5	8.13		1*	Few	3	**Acute Fatal**, treatment prevents death without full recovery *(Acute Illness or Injury, Life-threatening)*
8	9	11	7.5	8.88		1*	Few	10	**Acute Nonfatal**, treatment causes return to previous health state *(Acute Illness or Injury, Not Life-threatening)*
11	8	10	11	10		1	Few	7	**Comfort Care**
9	10	12	12.5	10.9	3*	1/2*	Moderate	11	**Chronic Nonfatal**, one-time treatment improves quality of life *(Chronic Illness, Not Life-threatening)*
12	13	7	12.5	11.1	3*	1/2*	Moderate	13	**Chronic Nonfatal**, repetitive treatment improves quality of life *(Chronic Illness, Not Life-threatening)*
13	12	13	7.5	11.4		1*	Few	12	**Acute Nonfatal**, treatment without return to previous health state *(Acute Illness, Not Life-threatening)*
14	14	14	14	14		3	Few	14	**Acute Nonfatal**, treatment expedites recovery of self-limiting conditions
15	15	15	--	15			Few	15	**Infertility Services**
16	16	16	--	16		--	Many	16	**Less Effective Preventative Care for Adults**
17	17	17	--	17		3	Few	17	**Fatal or Nonfatal**, treatment causes minimal or no improvement in quality of life

* Selected lines
** With restrictions