Minutes
HEALTH SERVICES COMMISSION
January 25, 2007

Members Present: Daniel Mangum, DO, Chair; Bryan Sohl, MD; Susan McGough; Lisa Dodson, MD (left at 1:15 pm); Kevin Olson, MD (left at 2:15 pm); Kathryn Weit; Leda Garside, RN, BSN; Dan Williams.

Members Absent: Somnath Saha, MD, MPH; Bruce Abernethy.

Staff Present: Darren Coffman; Kathleen Weaver, MD, Dorothy Allen.

Also Attending: Ariel Smits, MD, MPH; Chris Kirk, MD, OHP Medical Directors; Wally Shaffer, MD, and Caroline Price, Division of Medical Assistance Programs (DMAP); Stephanie Davis and Ed Fischer, Mercer Government Human Services Consulting.

I. Call to Order

Dr. Dan Mangum, Chair, called the Health Services Commission (HSC) meeting to order at 11:21 a.m. in room 117A at Meridian Park Hospital, Community Health Education Center, 19300 SW 65th Avenue, Tualatin, Oregon. Mr. Darren Coffman called the roll.

Dr. Mangum introduced Dr. Ariel Smits, who will be joining the Health Services Commission staff as Medical Director in February, 2007. Dr. Smits shared that she went to medical school at Washington University in St. Louis, has completed two residency programs with OHSU, in preventive medicine and family medicine. She also has a Master of Public Health from Portland State University.

II. Approval of Minutes (December 8, 2006)

MOTION: To approve the December 8, 2006 minutes without corrections: MOTION CARRIES: 8-0.

III. Chair's Report

Dr. Mangum deferred his report in lieu of discussing the recommendations of the Health Outcomes Subcommittee.

IV. Director's Report

Mr. Coffman reports that staff from DMAP along with he and Dr. Smits will shortly be meeting with CMS to discuss the bottom-line ramifications of the 07-09 prioritized list in terms of changes to the OHP Plus benefit package.

While he was examining some codes that moved from a funded to non-funded positions or vice versa, he noted some potential issues involving the treatment for laryngeal stenosis and laryngeal spasm. Mr. Coffman asked if these conditions ought to be placed somewhere on the list besides on line 535, PARALYSIS OF VOCAL CORD OR LARYNX? Dr. Mangum suggested that the Commission look at the methodology to see if these conditions are placed appropriately. Dr. Lisa Dodson shared that the spasms are being treated effectively with botox.

MOTION: To move the laryngeal stenosis and laryngeal spasm codes to line 385, DYSTONIA. MOTION CARRIES: 8-0.

Mr. Coffman noted that Dr. Jeanene Smith was recently confirmed by the Senate and is now the officially appointed OHPR Administrator. Also, Tina Edlund has been appointed as OHPR's Deputy Administrator.

There are ongoing discussions with DHS which may affect the timing of the HSC staff providing coding changes for yearly technical corrections and the new/deleted codes each year. Mr. Coffman is recommending that the technical corrections be submitted with the ICD-9-CM revisions, rather than with the CPT-4 codes, to balance the workload.

A draft of the biennial report will be sent to the Commission as soon as it is ready for review.

V. Report from OHP Standard Benefit Design Workgroup

Dr. Mangum reports that he, Dr. Saha and Mr. Coffman have been attending the OHP Standard Benefit Design Workgroup. There has been discussion regarding the reorganized list being used to draw a second funding line so that savings could be used to expand services to the thousands of low-income Oregonians who have no insurance. Voiced opposition urged that the coverage should not be expanded by cutting services.

Mr. Coffman spoke about House Bill 2174, which calls for a second line to be drawn to define OHP Standard Benefits. It has been read into the record and assigned to a health care committee for review. However, recent developments seem to indicate that the bill will not move forward, based in part on the discussions of this workgroup and its inability to gain consensus from the major stakeholders involved (representation from hospitals, health plans, nurses, medical associations, county mental health).

By moving the funding line up to 300 for OHP Standard, making it a significantly reduced benefit package, only 4,000 – 5,000 more enrollees could be added. For this small increase in enrollees, it did not seem enough of an effect to the workgroup to justify the loss of benefits the currently covered population would endure. Furthermore, the additional administrative burden the health plans would need to bear to go through the process would be prohibitive.

VI. Report from Health Outcomes Subcommittee

A. Bariatric surgery

Dr. Mangum reported that there was a lengthy discussion regarding the placement of bariatric surgery. Previous discussions yielded a consensus on the following points:

1. Sufficient evidence regarding the efficacy of bariatric surgery is available to support the movement of bariatric surgery to a higher ranking on the Prioritized List.

2. The large number of beneficiaries who would qualify and potentially seek bariatric surgery exceeds short term budgetary allotment. Focusing on the subpopulation with patients with BMI > 35 and type II diabetes is appropriate.

3. Coverage will be initiated as an add-on to the benefits covered for the diagnosis of type II diabetes.

4. Surgical care should be provided at those Oregon centers which have been designated as bariatric surgery Centers of Excellence or anticipate certification during 2008 (Legacy Good Samaritan, OHSU, and Sacred Heart in Eugene). These centers will be expected to maintain and report outcomes data specific to the OHP population.

Dr. Mangum shared some concerns brought forward by a representative of the OHP Medical Directors. There is alarm that this procedure may be seen by those who perform it as a money-maker, with new centers opening and advertisements on television. There also seems to be unease about overall outcomes and a strong unease regarding where approving this surgery for OHP patients might lead. A large number of OHP patients will meet the narrow surgical criteria of those with a BMI > 35 and type II diabetes. There were concerns expressed regarding covering costs for these procedures.

The Subcommittee discussed which bariatric procedure should be covered, gastric bypass or lap-banding. Type II diabetes seems to be resolved 80% of the time when a gastric bypass is preformed as compared to the 40-50% with lap-banding, though the risk of complication is lower. After discussion, the members agreed to leave the choice up to the physicians performing the surgery.

Mr. Dan Williams inquired about the cost of the two procedures. Dr. Kathy Weaver informed the group that gastric bypass costs around $30,000 while lap-banding is about $15,000.

The HOSC reviewed the HRC's Recommended Patient Eligibility Criteria and modified it to limit the surgery to patients with type II diabetes with a body-mass index (BMI) of 35 and greater and to test for smoking cessation and illicit drug use (See Attachment A).

Coding recommendations: Add bariatric surgery codes to line 33, TYPE II DIABETES MELLITUS (CPT-4 codes 43644-43645, 43846-43848, and 43770-43774). Surgical revision codes will be placed on the complications line.

Dr. Mangum stated that bariatric surgery is being added only as a pilot project. DHS and HSC commented that Medicaid rules require statewide coverage of benefits unless otherwise waived, but it would represent a benefit limited to a specific subpopulation. The Public Employee's Benefit Board) PEBB will provide outcomes data on its enrollees to the Commission when it becomes available.

MOTION: To approve the bariatric surgery recommendations as proposed by the HOSC: MOTION CARRIES: 8-0.

VII. Mercer Presentation on Preliminary 2008-09 OHP Benchmark Rates

Ms. Stephanie Davis and Mr. Ed Fischer, Mercer Government Human Services Consulting, were introduced. The goal of the project is to develop cost benchmarks to best estimate the cost to providers to deliver services or, in cases where this is impossible, to develop a proxy of cost. Last biennium's report showed that DME and pharmacy providers were being reimbursed at or above their cost, much higher than other providers.

Mr. Fischer addressed some preliminary findings and high level observations. A goal of this report is to discover if there are provider reimbursement inequities, with some providers being reimbursed at a higher percentage of their true costs than others. Mercer looked at data sources and status by service category for hospitals, physicians, prescription drugs, dental, mental health, DME/supplies, chemical dependency and other services. Data will be trended-forward from the 2004 data, taking into account DMAP fee-schedule increases that took place after 2004.

Mr. Fischer explained that the 2007 report will be an update of the previous publication, including an executive level summary, a description of the methodology and a broad overview of the implications the data reveals.

He explained their *average market reimbursement approach*, the methodology by which the average physician unit costs was assessed. Preliminary results for hospitals seem to indicate that the hospital reimbursement is at a lower percentage than the previous

report indicated, while physician reimbursement stayed largely the same. Prescription drug reimbursement appears to have increased.

Mr. Fischer explained that reimbursement of services at the provider's cost takes into account employee and physical salary as well as business overhead.

Mr. Coffman reported that the Actuarial Advisory Committee will be meeting with Mercer at the end of the month. He urged the commissioners to contact him with any concerns or comments.

VIII. Other Business

No other business was offered at this time.

IX. Public Comment

No public comment was offered at this time.

X. Adjournment

Dr. Mangum adjourned the meeting of the Health Services Commission at 3:10 p.m.

ATTACHMANT A

HSC Approved Patient Eligibility Criteria for Bariatric Surgery Approved on 1/25/07

1. Age ≥ 18
2. BMI ≥ 35 with co-morbid type II diabetes
3. Participate in the following four evaluations and meet criteria as described.
    a. Psychosocial evaluation: (Conducted by a licensed mental health professional)
        i. Evaluation to assess compliance with post-operative requirements.
        ii. No current abuse or dependence of substances, including alcohol, illicit drugs, and nicotine. Must be free of abuse or dependence during a six-month observation period immediately preceding surgery. Testing will be conducted within one month of the surgery to confirm abstinence.
        iii. No mental or behavioral disorder that may interfere with postoperative outcomes *
        iv. Patient with previous psychiatric illness must be stable for at least 6 months.
    b. Medical evaluation: (Conducted by OHP primary care provider)
        i. Pre-operative physical condition and mortality risk assessed with patient found to be an appropriate candidate.
        ii. Maximize medical control of diabetes, hypertension, or other co-morbid conditions.
        iii. Female patient not currently pregnant with no plans for pregnancy for at least 2 years post-surgery. Contraception methods reviewed with patient agreement to use effective contraception through 2nd year post-surgery.
    c. Surgical evaluation: (Conducted by a licensed bariatric surgeon associated with program**)
        i. Patient found to be an appropriate candidate for surgery at initial evaluation and throughout a six-month observation period while continuously enrolled on OHP.
        ii. Received counseling by a credentialed expert on the team regarding the risks and benefits of the procedure*** and understands the many potential complications of the surgery (including death) and the realistic expectations of post-surgical outcomes.
        iii. If the patient is found to no longer be an appropriate candidate for surgery for any reason listed in these criteria during the six-month observation period, a new six-month observation period will be required to precede surgery once surgical candidacy has been re-established.
    d. Dietician evaluation: (Conducted by licensed dietician)
        i. Evaluation of adequacy of prior dietary efforts to lose weight
        ii. Counseling in dietary lifestyle changes
4. Participate in additional evaluations: (Conducted after completion of medically supervised weight reduction program)
        i. Post-surgical attention to lifestyle, an exercise program and dietary changes and understands the need for post-surgical follow-up with all applicable professionals (e.g. nutritionist, psychologist/psychiatrist, exercise physiologist or physical therapist, support group participation, regularly scheduled physician follow-up visits).

* Many patients (>50%) have depression as a co-morbid diagnosis that, if treated, would not preclude their participation in the bariatric surgery program.

** All surgical services including evaluation are to be performed at a center of excellence for bariatric surgery as recognized by Medicare.

*** Only Roux-en-Y gastric bypass and laparoscopic adjustable gastric banding are allowed options.

Minutes
HEALTH SERVICES COMMISSION
June 28, 2007

Members Present: Somnath Saha, MD, MPH, Chair Pro Tem; Bruce Abernethy; Lisa Dodson, MD; Kevin Olson, MD; Leda Garside, RN, BSN; Dan Williams; Rodney McDowell, MSW, LCSW.

Members Absent: Daniel Mangum, DO; Kathryn Weit; Susan McGough.

Staff Present: Darren Coffman; Ariel Smits, MD, MPH; Nathan Hierlmaier, MPH.

Also Attending: Chris Kirk, MD, OHP Medical Directors; Wally Shaffer, MD, Caroline Price, RN, and Celeste Symonette, RN, Division of Medical Assistance Programs (DMAP); Ruth Medak, MD, Health Resources Commission (HRC) Obesity MedTAP; David Pass, MD, HRC Director.

I. Call to Order

Dr. Somnath Saha, Chair Pro Tem, called the Health Services Commission (HSC) meeting to order at 12:10 p.m. in room 117B&C at Meridian Park Hospital, Community Health Education Center, 19300 SW 65th Avenue, Tualatin, Oregon. Mr. Darren Coffman called the roll.

Dr. Saha welcomed Mr. Rodney McDowell to the commission. Mr. McDowell shared that he is a clinical services manager for a behavioral health organization in the Columbia Gorge, covering Wasco, Hood River, Sherman and Gilliam counties. He is a Licensed Clinical Social worker.

Mr. Coffman stated that Dr. Bryan Sohl has resigned his commission post; the May Health Outcomes Subcommittee meeting was his last.

II. Approval of Minutes (January 25, 2007)

MOTION: To approve the January 25, 2007 minutes without corrections: MOTION CARRIES: 7-0.

III. Chair Pro Tem's Report

Dr. Saha deferred the report in lieu of a presentation from the Health Resources Commission on their study of the non-surgical management of obesity.

IV. Non-Surgical Management of Obesity

Dr. Ruth Medak, a member of the Health Resources Committee, was introduced. Dr. Medak presented the MedTAP report on the medical management of obesity.

This study is an assessment of literature for non-surgical treatment of obesity. The topic stirs strong feelings so there is more than just dry evidence presented.

Obesity is an epidemic sweeping United States; Oregon has a 24% obesity rate and it is getting notably worse. Assessment of health habits point to poor eating and lack of exercise, as well as genetic predisposition, as factors. Adults and children both participate in these poor health habits.

The key questions addressed in the report are:

- What is the evidence for the effectiveness of non-surgical treatments (pharmacological, dietary, behavioral, and/or physical activity) in improving objective outcomes for obesity such as sustained weight loss; waist/hip ratio; diabetes prevention, improvement or reversal; hyperlipidemia; hypertension; cardiovascular disease; mortality; obstructive sleep apnea; metabolic syndrome; or non-alcoholic fatty liver disease (NAFLD)?
- What is the evidence for the effectiveness of a combination of non-surgical treatments?
- What are the adverse effects associated with non-surgical treatments in patients?
- Are there any subgroups of patients in which the effectiveness of non-surgical treatments are paramount?
- What is the evidence for effectiveness of non-surgical treatments in prevention of weight gain for children and adults?
- What is the effectiveness and cost-effectiveness of treatments of obesity measured in $/QALY (quality adjusted life-years)?

Effectiveness of non-surgical treatments

The report includes a table comparing the effectiveness of weight loss medications and medications for which weight loss is a side effect. The weigh loss results are similar for each medication, all being low. Also compared are results of dietary, behavior and physical activity.

In studies of large groups, there is no evidence of long-term sustained weight loss in the non-surgical treatments of obesity, each yielding around 5 kg (≈11 lbs) of sustained weight loss. Within the groups, smaller subsets have better results; 20% of people will sustain greater than or equal to 10% weight less for more than a year. Further, Dr. Medak explained that, in the study of obesity, methods that keep patients from simply gaining more weight can be seen as a good result.

Dr. Saha interjected that small impacts on individuals can have large implications at a population level for highly prevalent diseases.

Dr. Sohl suggested that waist circumference might be a better indicator for obesity than BMI (Body Mass Index). Dr. Medak quickly agreed, sharing that very fit, very muscular individuals with high weight may have a high BMI but not be obese at all. Waist-to-hip ratio is the best indicator of abdominal obesity, but is currently not the standard measure.

Evidence for the effectiveness of a combination of non-surgical treatments

Successful patients utilize multiple modalities to achieve and maintain weight loss. Those who include exercise and behavior therapy add approximately 2 kg (≈4.5 lbs) each to weight loss.

Adverse effects associated with non-surgical treatments in patients

Gallstones, gout and hair loss are common adverse effects of medication.

Subgroups of patients in which the effectiveness of non-surgical treatments are paramount

The strongest evidence is for a positive impact with individuals with risk factors such as cardiac issues, diabetes and metabolic syndrome. Weight loss by any means improves metabolic control. A diabetes prevention study was perhaps the most promising, yielding an average weight loss of 7%, sustained for 3 years. The study was not intensive, urging moderate exercise and diet.

Effectiveness of non-surgical treatments in prevention of weight gain for children and adults

A multi-pronged approach of medication, diet, exercise and behavioral counseling/intervention (with contact more than once a month for three months), in concert with family support produces small but sustainable results.

Effectiveness and cost-effectiveness of treatments of obesity measured in $/QALY

The data on cost-effectiveness came from non-US studies; seem to suggest cost savings, especially in the prevention of diabetes.

There are many non-pharmacologic programs, such as supervised, medically supervised, semi-supervised and lay supervised programs, which produce similar outcomes. Very low calorie diets initially reduce more weight than low calorie diets;

however many people regain the weight. To sustain the loss, patients need maintenance and continued support.

This report comes to some conclusions but not clear recommendations; however, it is clear that the cost of doing nothing is too high.

Dr. Saha opened up the commissioner's discussion of this topic by stating that the interest in this subject is high; treating and preventing obesity moved to line #8 on the Prioritized List of Health Services during this year's biennial review. The commission has made its decisions regarding bariatric surgery and is now deciding the proper non-surgical treatments to include on this line.

Medication

It appears that while prescriptions are effective there are physical side effects and the weight comes back when medication is ceased. When used to treat obesity, as a chronic condition, therapy for the next 10 to 20 years will be expensive and may be found in the future to cause intractable harm.

Dr. Lisa Dodson commented that no single therapy works alone. Dr. Kevin Olson wondered, outside of creating a health care delivery system such as models that work in the treatment of diabetes, which is not the purview of the commission, how can we structure benefits to achieve weight loss goals? Busy doctors tend only to have time to write prescriptions.

Dr. Saha stated the larger impact may start with broader approaches to this issue, by educating children. Staying with the issue at hand, prescription studies extend at most to 4.5 years so their long term safety is not known. For the time being, until there is better longitudinal evidence (15 to 20 year studies), medications should not be covered.

Non-pharmacologic therapy

Intensive multi-modal therapy has been shown to be effective in weigh loss and management. The commission discussed allowing services from lay providers, though current guidelines require those receiving Medicaid dollars be licensed and hold current provider agreements with DMAP; Oregon Administrative Rules (OARs) could be re-written to allow reimbursement to lay providers. There are existing billing codes for health and behavior assessment and intervention as well as education and training which could be utilized.

Should OHP pay for weight-loss centers such as Weight Watchers or Jenny Craig? Dr. Chris Kirk shared that some private health plans reimburse members for successful completion. Quality and professionalism are variable within the lay provider realm; selecting one over the other might indicate that the state is endorsing a commercial provider.

In summary, the commission would like to encourage obesity management by covering services for intensive counseling of nutrition and exercise, limited to health care professionals.

Ms. Celeste Symonette offered that DMAP is developing an RFP designed to mimic Washington's model, expanding the current disease management program by examining risk profile, which would include obesity. This would encompass group visits, self-management education and training.

Dr. Saha summarized that the commission should review and add the proper billing codes as well as write guidelines defining both intensive intervention and maintenance.

V. Legislative Update

Dr. Jeanene Smith reports that Senate Bill 329 (the Healthy Oregon Act) was signed into law by the Governor today. This bill sets up a planning process to build broad health care reform, largely based on the Bates/Westlund proposed legislation and the work of the Health Policy Commission (HPC). The HPC completed a report just before the session concluded that outlines the initial roadmap to broader health reform.

This legislation sets up the Oregon Health Fund Board and will be closely connected with OHPR; current commissions and committee personnel will also be staffing new subcommittees. A Benefits Subcommittee is forming that that will work with the HSC, utilizing the work this commission has been doing over the past years. A status report from this subcommittee is due in February, which will look at how the list might be applied to a commercial population. Work will begin once the Oregon Health Fund Board is staffed. The new board will propose a plan for a new health care system to the next legislative session.

Dr. Saha shared that he and Mr. Coffman have been involved with the Public Employees' Benefit Board (PEBB), discussing how PEBB might use the prioritized list as an option for state employee benefits. Dr. Smith, also a PEBB board member, said that PEBB has expressed interest in running a pilot program using this commission's work to offer benefits to state employees.

Dr. Saha asked for volunteers to continue exploring this possibility in defining an essential benefit package called for under SB 329. Mr. Bruce Abernethy, Dr. Lisa Dodson and Ms. Leda Garside volunteered. Dr. Kirk and Dr. Wally Shaffer will also be involved.

Dr. Smith thanked the commission for their work on the Benchmark report and reported the news that there is no budget for further studies.

Dr. Smith also reported that House Bill 2918 passed, which directs the Health Resources Commission (HRC) to study the evidence-based research on treatments for pervasive developmental disorders (PDD) and developmental delay. The bill ensures

that insurance companies cannot discriminate against those with PDD for other covered services. The HRC hope to complete their review of autism by early spring. This bill's passage does not affect the prioritized list.

The Healthy Kids bill has been referred to the citizens for a vote to amend the constitution to raise the cigarette tax to expand children's health care in Oregon. If it passes in November, the plan will be implemented by July, 2008. There is concern from the tobacco lobby; however the Governor is committed to covering kids.

VI. Director's Report

Mr. Coffman introduced Nathan Hierlmaier, a research analyst who has been working as Health Services Commission staff since January. Mr. Hierlmaier has been handling some of the technical aspects of the commission's work.

Recently, Mr. Coffman traveled to Madison, Wisconsin as part of a team with Dr. Alison Little and Mr. Mark Gibson from the Office of Evidence-Based policy, to meet with Wisconsin's Medicaid staff, who are seriously considering implementing an expansion program for childless adults using a prioritized list.

He noted that today's signing of Senate Bill 329 makes the HSC staff now DHS employees, as a part of the bill directs a migration of the OHPR office to DHS. This organizational change does not affect the function of the Health Services Commission.

HSC staff recently met with the OHP Contractors to discuss a realistic timing for changes related to new CPT codes. Codes will continue to be reviewed by the Commission in December and will be finalized at the January meeting. Though the official notice will be sent after that meeting, the proposed changes involving these codes will be posted on the HSC website for contractors to view before January 1st. Technical changes and corrections will be given every six months.

VII. Medical Director's Report

Dr. Ariel Smits reports that she is working on examining where the procedure codes fall on the list in a number of areas, which is extensive and may take some time. She is also involved in a series of DHS meetings discussing the delivery of mental health services. She and Mr. Coffman have been invited to participate in a program which is looking at the delivery of preventive services for children in the state, through CDRC, with DHS focusing on screening for children with the potential for developmental disabilities.

VIII. Report from Health Outcomes Subcommittee (HOSC)

Dr. Saha reported the subjects discussed and recommendations made at the morning's HOSC meeting.

Treatments for pseudotumor cerebri/benign intracranial hypertension: This means increased pressure inside the cranium mimicking a tumor in the brain. This condition had been prioritized to a low line on the list and not covered; the provider community asked to have it reviewed. This is a treatable condition with neurologists and ophthalmologists have a role in it. The subcommittee researched the condition and evidence, making it clear that the condition should be covered. A congenital form of the same condition appears on line 86.

Recommended action:

1) Delete code 348.2 from line 701
2) Rename line 86 "Encephalocele, hydrocephalus, and benign intracranial hypertension"
3) Change treatment description for line 86 to "Medical and surgical treatment"
4) Add the following CPT codes to line 86: 31294, 62270, 67570, 92002, 92004, 92012, 92014, 92081, 92082, 92083 and 92250

Spinal surgery: There were some inconsistencies on the spinal surgery lines. As an example, some approaches were covered; others were not, though unintentional.

Recommended action:

Add and delete certain CPT codes relating to spinal surgery from certain lines as outlined in Attachment A.

Wound debridement/cesarean post-op debridement: A wound care provider shared that they were unable to bill for cesarean wound complications because it can't be coded with 998.83 (non-healing surgical wound) in the 6 week post-partum period.

Recommended action:

1) Add CPT codes 11040-11044 to lines 145 and 296
2) Add 674.1 and 674.3 to line 145
3) Remove 674.1 and 674.3 from line 54

Surgical treatment of pancreatitis: The surgical codes for placement of pancreatic drains for acute pancreatitis were inappropriately placed.

Recommended action:

1) Add 48000, 48001, 48020, 48120 to line 330
2) Change name of line 330 to "Medical and Surgical Treatment"
3) Delete 48000 from line 77, 48105 from line 326, 48000 from line 671
4) Add 48020 and 48120 to line 671
5) Add 48000 to line 257

Surgical treatment of secondary hyperparathyroidism: patients with kidney disease sometimes develop this condition. This condition exists only on the dialysis line. Moving the diagnosis code to the appropriate line allows the treatment to be covered.

Recommended action:

1) Add 588.81 to line 440
2) Delete 588.81 from line 247
3) Add 60500 to line 274
4) Delete 60512 from line 319

Capsule endoscopy: This is an expensive new technology whereby an encapsulated camera is swallowed, allowing the small intestine's image to be captured, an area that neither the upper and lower endoscopy can reach. Good evidence was found for use in diagnosis of obscure GI bleeding thought to be of GI origin and of Crohn's disease, when upper and lower endoscopy have not yielded a diagnosis. Given the lack of evidence in this tool's usefulness in diagnosing and screening of colon cancer and esophageal conditions, the members wish to add a guideline with its use.

Recommended action: Add 91110 to lines 194 [Ulcers, GI Hemorrhage; Surgical Treatment] and 293 [Regional Enteritis, Idiopathic Proctocolitis, Ulceration of Intestine; Medical And Surgical Treatment] with the following guideline:

1) Wireless capsule endoscopy is covered for diagnosis of
    a. Obscure GI bleeding suspected to be of small bowel origin with iron deficiency anemia or documented GI blood loss
    b. Suspected Crohn's disease with prior negative work up
2) Wireless capsule endoscopy is not covered for
    a. Colorectal cancer screening
    b. Confirmation of lesions of pathology normally within the reach of upper or lower endoscopes (lesions proximal to the ligament of Treitz or distal to the ileum)
3) Wireless capsule endoscopy is covered only when the following conditions have been met:
    a. Prior studies must have been performed and been non-diagnostic
    b. GI bleeding: Upper and lower endoscopy
    c. Suspected Crohn's disease: Upper and lower endoscopy, small bowel follow through
    d. Radiological evidence of lack of stricture
    e. Only covered once during any episode of illness
    f. FDA approved devices must be used
    g. Patency capsule should not be used prior to procedure

Add 91111 [Esophageal use of wireless capsule endoscopy] to never covered list.

Bariatric surgery guideline changes: Required completion of weight loss program and cessation of illicit drugs and nicotine were discussed. See Attachment B for revised guideline.

Comfort care wording changes: There was a misconception that the intent of the commission was to only provide comfort care if a patient was given less than a six month prognosis, which would fall under hospice care. The intent is that comfort care be provided to all patients given a terminal prognosis. Dr. Smits, Dr. Shaffer and Mr.

Coffman will work on a solution with all interested Medical Directors and plan to propose a solution at the August meeting.

Percutaneous vertebroplasty guideline: This procedure may be employed to accelerate healing of cracked vertebrae. Evidence shows that patients are significantly improved during the first 6 weeks, over those treated conservatively. After 6 weeks, there is no difference in outcomes.

Recommended action: Adopt the guideline, as follows.

Vertebroplasty is included on line 112, Vertebral Fracture, under the following criteria:

1) Must be performed within the first 6 weeks after fracture
   a. Acute nature of fracture must be documented by MRI, X-ray or other modality
2) None of the following may be present:
   a. Coagulation disorder
   b. Underlying vertebral infection
   c. Severe cardiopulmonary disease
   d. Extensive vertebral destruction (>50% of height)
   e. Neurological symptoms related to spinal compression
   f. Lack of surgical back up for emergency decompression
3) Must document
   a. Pain is caused by non healing vertebral fracture
   b. Vertebral height is not more than 50% collapsed
   c. Procedure is not performed on a prophylactic basis
   d. Risks of open surgical approach are greater than risks of percutaneous approach

The following issues corrected condition/treatment pairings and housekeeping items:

Pinning of closed fracture: Add 20650 and 20670 to line 460

Thoracic vascular repair: Add 33320-33331, 33880-33891and 35211-35272 to line 114

PET scans for colon and testicular cancer:

1) Add line 191 and line 270 to Guideline Note 4 list of lines
2) Remove line 119 from Guideline Note 4 list of lines
3) Add 78811-78816 to line 191 and line 270
4) Add reference to Guideline Note 4 to titles of lines 191 and 270
5) Remove reference to Guideline Note 4 from line 119

V codes: ICD-9-CM codes are for various needs, immunization, personal history, family history, status codes. Dr. Smits reviewed V-codes in the range V01-V049 (see Attachment C)

The HOSC suggests all the changes are approved with the exception of the codes for a personal and family history of cancer, which are tabled until the August meeting. Also

tabled are codes V62.0 and V58.69, which have been used extensively and are seemingly costly.

Lymphedema is a condition where there is disruption of the flow of lymph through the lymphatic system in the legs or arms, typically due to surgery. This is currently on a non-funded line and the commission was asked to review this placement. Dr. David Pass from the Health Resources Commission spoke to the HOSC about this issue. He spoke about complex decompressive therapy (CDT), which is a combination of exercise, compressive massage and bandaging, and appears to be effective in reducing the amount of edema.

Dr. Smits and Dr. Pass will draft a guideline for review at the August meeting.

Recommendations from the May 3, 2007 HOSC meeting:

Unspecified Otitis Media: Delete from Chronic Otitis Media line 530: 382.9 (unspecified otitis media)

Cleft palate repair:: Add to line 110 (Cleft Palate With Airway Obstruction) and line 377 (Cleft Lip/Palate): 15732 Muscle flap pharyngoplasty

Croup: Add to croup line 16: 94640 - Inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes

Fluoride treatment: Add to line 298 (preventive dental services): 520.3 (mottled teeth).

Pelvic ring fracture: Add to line 474 (surgical repair of pelvic fracture): 805.6 (sacral fracture)

Chronic mesenteric ischemia: Add to line 293 to pair with 557.1 (chronic mesenteric ischemia): 35471 (percutaneous transluminal balloon angioplasty, renal or visceral artery) and 37205 (transcatheter placement of intravascular stent)

Routine pairings:

-721.42 (lumbar spondylosis with myelopathy) with 97530 (therapeutic activities, 15 min) and 97535 (self care/home management training) on line 324 (spinal deformities, clinically significant).

-883.2 (open wound of finger(s) with tendon involvement) and 881.20 (open wound of elbow, forearm, and wrist with tendon involvement) with 97110 (therapeutic procedure, 15 min) on line 375 (deep open wound).

-540.1 (acute appendicitis with peritoneal abscess) on line 12 (appendicitis) with 99231, 99232, 99233 (in hospital aftercare).

-146.0 (malignant neoplasm of oropharynx-tonsil) with 21557 (radical dissection of tumor) on line 234 (cancer of oral cavity).

-161.1 (malignant neoplasm of larynx-supraglottis) with 21555 (excision of tumor) and 60220 (total thyroid lobectomy) on line 234 (cancer of oral cavity)

-871.3 (open wound of eyeball) with 65101 (enucleation of eye) on line 396 (purulent endophthalmitits)

-Remove from line 234 (cancer of oral cavity): 20955, 20956, 20957 (bone graphs to low extremity areas)

Central pain syndrome: Add ICD-9 code 338.0 central pain syndrome to the stoke line 284

Ventricular Assist Device: Add VAD guideline #10 to Line 154. "Ventricular Assist Devices are only included on this line as a bridge to cardiac transplantation."

Cochlear stimulator: Place CPT codes 69714 and 69715 on lines 299 and 499; delete from lines 300 and 501

Tunneled catheter: Move CPT codes 36589 and 36590 to ancillary services list from line 145

Chronic anemia codes: Add to line 170 and remove from line 171: 285.21 - Anemia in chronic kidney disease, 285.22 - Anemia in neoplastic disease, 285.29 - Anemia of other chronic disease

Skin graft for urinary anomalies: Remove CPT codes from line 99: 15576 - Formation of skin flap transferred to eyelid, nose, ears, lips, intraoral areas; 15630 - Delayed flap to those sites to eyelid, nose, ears, lips, intraoral areas; 15732 - Skin flap to head or neck; 15734 - Skin flap to upper extremity

Tendon repair/ foot wound: Add CPT code to line 375: 28208 - Repair of tendon of foot, extensor

Intrathecal pump codes: Add to lines 140 and 216: 62360 - Implantation of intrathecal pump; 62361 - Implantation of intrathecal pump, non reprogrammable pump;
Add to line 216: 62362 - Implantation of intrathecal pump, programmable pump
Add to line 216, 333, 574, and 578: 62367 - Electronic analysis of intrathecal pump; 62368 - Electronic analysis of intrathecal pump with reprogramming
Add to line 333: 95990 - Refilling and maintenance of intrathecal pump; 95991 - Refilling and maintenance of intrathecal pump administered by a physician

Mr. Coffman stated that all these changes will be included in the interim modifications for implementation October 1, 2007, with the exception of the bariatric surgery

guideline. That particular guideline will be incorporated to the new list effective January 1, 2008.

MOTION: To approve the recommendations of the HOSC: MOTION CARRIES: 7-0.

IX. Report from Mental Health Care & Chemical Dependency (MHCD) Subcommittee

The MHCD Subcommittee met February 21, 2007 and are scheduled to meet again in July. The subcommittee was to discuss services for autism and autism spectrum disorders. As it happened that topic was also being discussed in the legislature. As HB 2918 has passed, the subcommittee tabled their review until after the Health Resources Commission's report is released.

Dr. Dodson reported that the subcommittee answered the HOSC's concerns regarding CPT codes 96150-96155 (behavioral health assessment and intervention). These services are not aimed at the individual with psychiatric conditions that are new or unrelated (comorbid) to other physical health conditions, but rather those individuals with chronic health conditions for whom psychosocial treatments would be useful in the management of that illness in dealing with their adjustment issues. This would involve a complementary part of the overall care of the patient that could be provided by a behavioral care specialist in the primary care setting. These services would likely be from a Master's-level Qualified Mental Health Provider (QMHP) working in an integrated primary care setting and likely be the responsibility of the FCHPs. This includes psychologists, social workers and nurses. The services could involve psycho-education, support, and motivational services that could also be provided in a group setting.

Dr. Saha proposed that staff work with the subcommittee to review the chronic disease lines which these codes should be added to and report back with this list of proposed additions to the prioritized list.

X. Report from OHP Standard Benefit Design Workgroup

The last meeting of this group was held in February, 2007. From that meeting, it was suggested that HSC staff work with the OHP medical directors to examine how private health plans are handing the management of diagnostic and other "line zero" services.

Another workgroup was formed consisting of HSC staff, Dr. Shaffer and the DHS Actuarial Services Unit. The new group met yesterday and outlined some of the approaches they may want to take regarding line zero, including looking at some services that could be moved to lines on the prioritized list; suggesting some services where guidelines are appropriate, and the institution of prior authorization where

appropriate. The new group will continue to meet regularly, though the OHP Standard Benefit Design Workgroup is now defunct.

XI. Report from Actuarial Advisory Committee (AAC)

The AAC met on January 31, 2007. The report on the Benchmark Rate Study was subsequently released in February. Mr. Coffman presented the report's findings to the OHP contractors and had one legislative inquiry. There did seem to be interest in the report this year but is unaware of any difference it made in the legislator's deliberation.

As Dr. Smith reported earlier, there is no funds budgeted for this report in the new biennium.

XII. Other Business

No other business was offered at this time.

XIII. Public Comment

No public comment was offered at this time.

XVI. Adjournment

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

Spinal Fusion (Arthrodesis)

CPT Code	Description	Line 112	Line 140	Line 208	Line 231	Line 324	Line 460	Line 474	Line 546	Line 593
22532	Lateral extracavitary technique, thoracic	**X**	**X**	**X**	**X**	**X**		X		
22533	Lateral extracavitary technique, lumbar	**X**	**X**	**X**	**X**	**X**		X		
22534	Lateral extracavitary technique, thoracic or lumbar, each add'l segment	**X**	**X**	**X**	**X**	**X**		X		
22548	Anterior transoral approach, occiput-C2	X	X	X	X	X		**X**	X	
22554	Anterior approach, cervical	X	X	X	X	X		**X**	X	X
22556	Anterior approach, thoracic	X	X	X	X	X		**X**	X	X
22558	Anterior approach, lumbar	X	X	X	X	X		**X**	X	X
22585	Anterior approach, lumbar, each additional interspace	X	X	X	X	X		**X**	X	X
22590	Posterior approach, occiput-C2	X	**X**	**X**	**X**	X		**X**	**X**	X
22595	Posterior approach, C1-C2	X	**X**	**X**	**X**	X		**X**	**X**	X
22600	Posterior approach, cervical	X	**X**	X	**X**	X		**X**	**X**	X
22610	Posterior approach, thoracic	X	**X**	X	**X**	X	~~X~~	**X**	**X**	X
22612	Posterior approach, lumbar	X	**X**	X	**X**	X	~~X~~	**X**	**X**	X
22614	Posterior approach, lumbar, each additional vertebral segment	X	**X**	X	**X**	X	~~X~~	**X**	**X**	X
22630	Posterior interbody technique, lumbar	X	**X**	**X**	**X**	X		**X**	**X**	X
22632	Posterior interbody technique, lumbar, each additional interspace	X	**X**	**X**	**X**	X		**X**	**X**	X
22800	Posterior, for spinal deformity, up to 6 vertebral segments	**X**	**X**	**X**	**X**	X		**X**	**X**	X
22802	Posterior, for spinal deformity, 7 to 12 vertebral segments	X	**X**	**X**	**X**	X		**X**	**X**	X
22804	Posterior, for spinal deformity, 13 or more vertebral segments	**X**	**X**	**X**	**X**	X		**X**	**X**	X
22808	Anterior, for spinal deformity, 2-3 vertebral segments	**X**	X	**X**	**X**	X		**X**	**X**	X
22810	Anterior, for spinal deformity, 4-7 vertebral segments	**X**	**X**	**X**	**X**	X		**X**	**X**	X
22812	Anterior, for spinal deformity, 8 or more vertebral segments	**X**	**X**	**X**	**X**	X		**X**	**X**	X
22818	Kyphectomy, single or 2 segments	**X**	**X**	**X**	**X**	X		**X**	**X**	X
22819	Kyphectomy, 3 or more segments	**X**	**X**	**X**	**X**	X		**X**	**X**	X

~~X~~=REMOVE FROM LIST
X=LEAVE ON LIST
X=ADD TO LIST

Line 112: CERVICAL VERTEBRAL DISLOCATIONS/FXS, OPEN OR CLOSED; OTHER VERTEBRAL DISLOCATIONS/ FXS, OPEN; SPINAL CORD INJURIES WITH OR WITHOUT EVIDENCE OF VERTEBRAL INJURY
Line 140: DISORDERS OF SPINE WITH NEUROLOGIC IMPAIRMENT
Line 208: CHRONIC OSTEOMYELITIS
Line 231: CANCER OF BONES, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL
Line 324: SPINAL DEFORMITY, CLINICALLY SIGNIFICANT
Line 460: CLOSED FRACTURE OF EXTREMITIES
Line 474: CLOSED DISLOCATIONS/FXS OF NON-CERVICAL VERTEBRAL COLUMN W/O SPINAL CORD INJURY
Line 546: BENIGN NEOPLASM BONE AND ARTICULAR CARTILAGE INCLUDING OSTEOID OSTEOMAS; BENIGN NEOPLASM OF CONNECTIVE AND OTHER SOFT TISSUE
Line 593: SPINAL DEFORMITY, NOT CLINICALLY SIGNIFICANT

Spinal instrumentation

CPT	Description	Line 112	Line 131	Line 140	Line 145	Line 208	Line 214	Line 296	Line 324	Line 474
22840	Posterior non-segmental instrumentation	X		X		**X**	X		X	**X**
22841	Internal spinal fixation by wiring of spinous processes	X		**X**		**X**	X		X	X
22842	Posterior segmental instrumentation; 3-6 vertebral segments	X		**X**		X	X		X	X
22843	Posterior segmental instrumentation; 7-12 vertebral segments	X		**X**		X	X		X	X
22844	Posterior segmental instrumentation; 13 or more vertebral segments	X		**X**		X	X		X	X
22845	Anterior instrumentation; 2-3 vertebral segments	X		X		X	X		X	**X**
22846	Anterior instrumentation; 4-7 vertebral segments	X		**X**		X	X		X	**X**
22847	Anterior instrumentation; 8 or more vertebral segments	X		**X**		X	X		X	**X**
22848	Pelvic fixation other than sacrum	X		**X**		**X**			X	**X**
22849	Reinsertion of spinal fixation device	X	~~X~~	**X**	X		X	X	X	**X**
22850	Removal of posterior nonsegmental instrumentation	X	~~X~~	**X**	X		X	X	X	**X**
22851	Application of intervertebral biomechanical devices to vertebral defect or interspace	X	~~X~~	X		X	X		X	**X**
22852	Removal of posterior segmental instrumentation	X	~~X~~	**X**	X		X	X	X	**X**
22855	Removal of anterior instrumentation	X	~~X~~	X	X		X	X	X	**X**

~~X~~=REMOVE FROM LIST
X=LEAVE ON LIST
X=ADD TO LIST

Line 112: CERVICAL VERTEBRAL DISLOCATIONS/ FRACTURES; OTHER VERTEBRAL DISLOCATIONS/ FRACTURES, OPEN; SPINAL CORD INJURIES
Line 131: OPEN FRACTURE OF EXTREMITIES
Line 140: DISORDERS OF SPINE WITH NEUROLOGIC IMPAIRMENT
Line 145: COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
Line 208: CHRONIC OSTEOMYELITIS
Line 214: INTRASPINAL AND INTRACRANIAL ABSCESS
Line 296: COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
Line 324: SPINAL DEFORMITY, CLINICALLY SIGNIFICANT
Line 474: CLOSED DISLOCATIONS/FRACTURES OF NON-CERVICAL VERTEBRAL COLUMN W/O SPINAL CORD INJURY

HSC Approved Patient Eligibility Criteria for Bariatric Surgery Approved on 6/28/07

Bariatric surgery for obesity is included on Line 33, TYPE II DIABETES, under the following criteria:

1. Age ≥ 18
2. BMI ≥ 35 with co-morbid type II diabetes
3. Participate in the following four evaluations and meet criteria as described.

A. Psychosocial evaluation: (Conducted by a licensed mental health professional)

- **i. Evaluation to assess compliance with post-operative requirements.**
- **ii. No current abuse of or dependence on alcohol. Must remain free of abuse of or dependence on alcohol during a six-month observation period immediately preceding surgery. No current use of nicotine or illicit drugs and must remain abstinent from their use during the six-month observation period. Testing will be conducted within one month of the surgery to confirm abstinence from nicotine and illicit drugs.**
- **iii. No mental or behavioral disorder that may interfere with postoperative outcomes[1].**
- **iv. Patient with previous psychiatric illness must be stable for at least 6 months.**

B. Medical evaluation: (Conducted by OHP primary care provider)

- **i. Pre-operative physical condition and mortality risk assessed with patient found to be an appropriate candidate.**
- **ii. Maximize medical control of diabetes, hypertension, or other co-morbid conditions.**
- **iii. Female patient not currently pregnant with no plans for pregnancy for at least 2 years post-surgery. Contraception methods reviewed with patient agreement to use effective contraception through 2nd year post-surgery.**

C. Surgical evaluation: (Conducted by a licensed bariatric surgeon associated with program[2])

- **i. Patient found to be an appropriate candidate for surgery at initial evaluation and throughout a six-month observation period while continuously enrolled on OHP.**
- **ii. Received counseling by a credentialed expert on the team regarding the risks and benefits of the procedure[3] and understands the many potential complications of the surgery (including death) and the realistic expectations of post-surgical outcomes.**
- **iii. If the patient is found to no longer be an appropriate candidate for surgery for any reason listed in these criteria during the six-month observation period, a new six-month observation period will be required to precede surgery once surgical candidacy has been re-established.**

D. Dietician evaluation: (Conducted by licensed dietician)

- **i. Evaluation of adequacy of prior dietary efforts to lose weight. *If no or inadequate prior dietary effort to lose weight, must undergo 6 month medically supervised weight reduction program.***
- **ii. Counseling in dietary lifestyle changes**

4. Participate in additional evaluations: ~~*(Conducted after completion of medically supervised weight reduction program)*~~

- **i. Post-surgical attention to lifestyle, an exercise program and dietary changes and understands the need for post-surgical follow-up with all applicable professionals (e.g. nutritionist, psychologist/psychiatrist, exercise physiologist or physical therapist, support group participation, regularly scheduled physician follow-up visits).**

[1] Many patients (>50%) have depression as a co-morbid diagnosis that, if treated, would not preclude their participation in the bariatric surgery program.
[2] All surgical services including evaluation are to be performed at a center of excellence for bariatric surgery as recognized by Medicare.
[3] Only Roux-en-Y gastric bypass and laparoscopic adjustable gastric banding are approved for inclusion.

ATTACHMANT C

V Code Review
V01-V49

Question: Which V codes should appear on the list and which line(s) should they appear on?

Question source: HOSC, HSC staff, medical directors

Process:

1) List reviewed and V codes currently on list and their current location(s) determined
2) DHS consulted, status of each V code in DHS system determined
3) Samaritan Health System coders met with HSC staff; suggestions given for V code inclusion and placement
4) Proposal for inclusion/non inclusion of codes started by Medical Director

Recommendations:

1) Immunizations (V01-V06):
    a. Add
        i. V04.5, rabies vaccination, to lines 141 and 181 (preventive services)
            1. Recommended by Oregon Veterinary Association for certain animal bites
        ii. V05.4, varicella vaccination, to lines 141 and 181 (preventive services)
            1. On CDC recommended vaccine schedule
    b. Remove
        i. V06.9, vaccination with unspecified combined vaccine, from lines 141 and 181 (preventive services)
            1. Nonspecific
    c. Add to never covered list
        i. Travel vaccinations
            1. V03.0, V03.1, V04.4, V06.0, V06.2 (cholera, typhoid-paratyphoid, yellow fever, alone or with other)
        ii. Contact with smallpox (V01.3)
            1. Want notification if smallpox suspected
        iii. Non-specific vaccination codes: V01.9, V05.9, V06.8
        iv. Vaccinations not on current CDC vaccine schedule
            1. V03.3, V03.4, V04.1, V04.7, V05.2 (plague, tularemia, smallpox, common cold, leishmaniasis)

2) Miscellaneous 1 (V07-V08)
    a. Add
        i. V07.2, prophylactic immunotherapy including Rhogam, to pregnancy line 54 (maternity care)
    b. Remove
        i. V07.4 (Need for prophylactic postmenopausal hormone replacement therapy) from line 181 (preventive care)

1. USPSTF Guideline from 2005 recommends against prophylactic use of HRT for prevention of any condition in post-menopausal women; risks outweigh benefits

c. Add to never covered list
   i. Non specific immunotherapy codes (V07.39, V07.8, V07.9)

3) Personal history (V09-V15)
   a. Add
      i. V15.88 (history of falls) to line 181 (preventive services)
         1. Fall prevention is recommended screening and intervention in the over 65 population per screening table in List
   b. Add to never covered list
      i. V10-V15.7 (personal history of disease)
         1. Secondary use only per Samaritan
         2. Should put code for disease screening (i.e. colon cancer screening) first, and personal history (i.e. history of colon cancer) as secondary code
   c. Note: V09, V13.61, V14, and V15 codes other than V15.88 are secondary only codes per CMS

4) Family history (V16-V19)
   a. Add
      i. V18.9 (family history of genetic disease) to diagnostic line
   b. Remove
      i. All codes V16-V19 currently on list
         1. Currently on lines 141 and 181 (preventive services)
         2. Secondary only codes per Samaritan
         3. Should put code for disease screening (i.e. colon cancer screening) first, and family history (i.e. family history of colon cancer) as secondary code
   c. Add to never covered list
      i. V18.51, V18.59 (Family history of colon polyps, other digestive disorders)

5) Maternal/child (V20-39)
   a. Add
      i. V23.2 (pregnancy with history of abortion) to line 54 (maternity care)
         1. Thoroughness
      ii. V26.3 (genetic testing codes) to diagnostic list
      iii. V29 codes (“rule out” infant codes) to diagnostic list
   b. Add to never covered list
      i. V26.0-V26.2 (infertility codes)
      ii. V26.8, V26.9, V39 (nonspecific codes)
   c. Note: V21, V22.2, V26.5, V27 are secondary only codes per CMS

6) Behavioral/special senses (V40-V41)
   a. Add V40-V41 to never covered list
      i. Samaritan: not used

ii. DHS: not allowable as primary code

7) Status (V42-V49)
    a. Remove
        i. Secondary codes per CMS
            1. V42.0 from lines 108, 109, 435
            2. V43.1 from line 406
            3. V43.3 from lines 147, 195, 310, 316
    b. Add to never covered list
        i. V43.22, V45-V49
        ii. Samaritan: these codes are secondary
    c. Note: V42, V43 (except V43.22), V44, V45 (except V45.7), V46.0, V46.2, V46.8 are secondary codes only per CMS

Note: all secondary only codes should be added to never covered list

Minutes

HEALTH SERVICES COMMISSION
August 23, 2007

Members Present: Dan Mangum, DO; Somnath Saha, MD, MPH; Lisa Dodson, MD; Leda Garside, RN, BSN; Dan Williams; Rodney McDowell, MSW, LCSW; Kathryn Weit.

Members Absent: Bruce Abernethy; Kevin Olson, MD; Susan McGough.

Staff Present: Darren Coffman; Ariel Smits, MD, MPH; Nathan Hierlmaier, MPH; Dorothy Allen.

Also Attending: Jon Pelkey, Wally Shaffer, MD, Caroline Price, RN, and Celeste Symonette, RN, DMAP; Sean Kolmer, OHPR; Amy Goodall and Claudia Black, OMA; Betsy Earls, Kaiser Permanente; Dayna Steringer, Providence Health Plan; David Pollack, MD, OHSU; Barney Speight, Oregon Health Fund Board; Susan Murray, Multnomah County Health Dept.; Gil Munoz, Virginia Garcia Clinic.

I. Call to Order

Dr. Dan Mangum, Chair, called the Health Services Commission (HSC) meeting to order at 11:30 a.m. in room 117B&C at Meridian Park Hospital, Community Health Education Center, 19300 SW 65th Avenue, Tualatin, Oregon. Mr. Darren Coffman called the roll.

II. Oregon Health Fund Board Update

Mr. Barney Speight introduced himself and reported that the seven Oregon Health Fund Board (OHFB) members have been nominated by the Governor and are awaiting confirmation.

The OHFB will be reliant upon the work on the HSC as well as the Health Policy Commission (HPC) and the Medicaid Advisory Committee (MAC) to complete the work assigned to the Board by the Legislature. The fundamental charter of the Board is to develop a comprehensive plan to further 12 goals that are stated in SB 329, including greater access through existing programs, developing an essential benefit package (or packages) for future programs and reforming the delivery system to move towards long-term sustainability.

The appropriation given to do this work is $1.2 million general fund and $1.8 million federal funds; small compared to the awesome amount of work required.

There will be five committees, staffed mostly by the Oregon Health Policy & Research employees:

The *Federal Law/Policy Committee*, by July 31, 2008, is to submit a report to the congressional delegation that outlines where federal policy inhibits the state of Oregon from moving towards universal health care. This committee will work independently from the other four groups. SB 329 specifies that there will be hearings held in the five congressional districts and hearings held in Washington, DC.

The *Finance Committee* will consist of the HPC members and other stakeholders. Their work will be, in part, to examine the recommendations of the HPC Roadmap to Reform report, investigate an insurance exchange model that has been implemented by Massachusetts and identify additional revenue approaches.

The *Delivery System Reform Committee* has a very broad charge, including tasks to improve quality and transparency information, as well as examining provider reimbursement reform to rebuild primary care the health delivery fabric of Oregon, focusing on concepts like medical home models and incentivizing health information technology towards a community delivery system.

The *Eligibility & Enrollment Committee* will, among other things, be responsible for looking at public subsidies, outreach planning, preserving employer and employee choice and streamlining enrollment procedures. This group will consist of members of the Medicaid Advisory Committee (MAC) who provided the frame work for the Healthy Kid's Initiative.

The *Benefits Committee* will be substantially composed of HSC members. SB 329 calls for a 'defined set of essential health services' as 'identified by the Health Services Commission using the methodology in ORS 414.720, or an alternative methodology.' This work, according to the bill, could be wholly delegated to the HSC; however, as the HSC has ongoing work to do for the Oregon Health Plan, the OHFB will enlist the assistance of a set of committed, interested parties. The Committee will start with the framework of the Prioritized List of Health Services to determine what constitutes a minimum essential benefits package, including what is covered, limitations, exclusions and cost-sharing.

The legislation lays out milestones for the OHFB's work, including an initial report that is due February 1, 2008 to the 2008 interim 30-day legislative session. During the summer of 2008, five to seven public meetings will be held across the state to get public input. Then, on or before October 1, 2008, the OHFB must present a full comprehensive plan to include any recommended legislation.

Mr. Dan Williams asked, as Oregon has been down the reform road before with very modest success, is there a greater likelihood of success this time? Mr. Speight stated he is hopeful but not naïve. There are some current environmental characteristics that are encouraging, such as support from the business community. There is a real

concern in the Washington and Oregon business communities with the current system and its lack of sustainability. Most Americans do not want a government run system, though are not opposed to health care linked to employment. The purchasing community is looking for a greater predictability of costs. There is the hope that this legislation may be able to help reduce the difference between Medical Cost Inflation and the Consumer Price Index in next 5-10 years by half. Though there is a lack of consensus on what next steps to take, hopefully the work of the OHFB will provide direction.

Dr. Mangum expressed concern over the definition of essential benefits. Though the Prioritized List seems to be a logical way to determine essential services, little money is saved by moving the funding line higher on the list. Mr. Speight explained he doesn't believe there is a simple answer. The real cost savings may come from delivery system reform.

Dr. Lisa Dodson stated, with this round of reforms, we are facing a new factor which hasn't occurred before; a huge physician and nurse workforce shortage, especially in the rural areas. Many practitioners are opting out of providing broad spectrum care. Mr. Speight indicated that there is a workgroup on workforce issues under the Delivery System Committee. He shared that this group will be making policy recommendations to formulate a 10 year plan, including funding for programs to educate high school students in preparation for health care jobs.

Dr. Som Saha asked for clarification of the phrase "define essential services." The list is designed as a way to prioritize health services from most important to least, based in part by public input. The line is to determine what can be afforded, not what was essential. Essential service values have not been vetted in a public forum. Mr. Speight agreed and asked the commissioners to feel comfortable with departing from their normal work involving the list and to consider alterative methodologies.

III. Health and Behavior Assessment Codes (96150 Series)

Mr. Coffman introduced Dr. David Pollack, Gil Munoz and Susan Murray, who were present to address the commissioner's questions on the use of the health and behavior assessment CPT codes. Mr. Coffman noted that this issue was first presented for consideration in December 2006 and most recently discussed at the June 2007 meeting. These codes are currently not on the list.

Dr. Pollack began by stating that these are a component of an essential set of services that need to be done to better provide behavioral health services in a primary care setting. The future of effective health care has to include integrated care, not to preclude or replace appropriate specialty care in specialty care settings. Further, this kind of care is not being integrated due to financial barriers that dictate which services can be provided to whom in what setting. Today, we are addressing one component of integrated services that is appropriate for the primary care setting.

This recommendation is to endorse a set of codes that allows co-located behavioral health specialists who are working in a primary care setting to work with a patient who has been referred by the primary care provider. The primary diagnosis would be a condition other than mental health.

Mr. Gil Munoz, Executive Director of the Virginia Garcia Memorial Health Center, discussed how beneficial this environment is for patients who suffer from chronic conditions who also have psychosocial issues and may be disorganized mentally. Having behavioral health specialists on site may help determine why a particular stroke patient with mental health issues is missing their medication and employ other techniques to help them adhere to their treatment.

Ms. Susan Murray, Multnomah County Health Department, stressed that these codes are not used to treat and bill mental illness. This is about appropriate, evidence-based interventions for treating physical illnesses. The evidence shows that behavior interventions work, resulting in significantly fewer ED visits, hospitalizations, and outpatient medical office visits.

Motion: Place CPT codes 96150-96155 on the Prioritized List as shown in Attachment A, using CMS's guidelines. MOTION CARRIES: 7-0.

IV. Approval of Minutes (June 28, 2007)

MOTION: To approve the June 28, 2007minutes without corrections. MOTION CARRIES: 7:0

V. Chair's Report

Dr. Mangum waived his report.

VI. Director's Report - Darren Coffman

Mr. Coffman mentioned that there is currently a physician membership vacancy and, in January, there will be a second physician vacancy along with a consumer representative vacancy. The Senate will confirm appointees in February, 2008. For the physician positions we are looking for representation of a DO (statutorily) and a general surgeon or OBGYN.

The Line Zero Workgroup which is working with the managed care plans appears to be making some progress. Mr. Coffman will give a detailed report at the next HSC meeting.

VII. Medical Director's Report

Dr. Ariel Smits waived her report.

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

The MHCD Subcommittee met in July. The members reviewed the Health and Behavior Assessment Codes which were approved earlier in today's meeting.

The group discussed and recommends adding multi-systemic therapy code (H2033) to lines 184 (Abuse or Dependence of Psychoactive Substance), 264 (Oppositional Defiant Disorder) and 371 (Conduct Disorder, Age 18 and Under). Further, they recommend adding code 90847 (family psychotherapy. conjoint with patient present) to line 547 (Sexual Dysfunction).

MOTION: To add mental health procedure codes H2033 (to lines 184, 264, and 371) and 90847 (to line 547) as recommended. MOTION CARRIES: 7-0.

IX. Report from the Health Outcomes Subcommittee

Dr. Saha reported the subjects discussed and recommendations made at the morning's HOSC meeting.

New ICD-9-CM and HCPCS code placement – make changes to the list as indicated in Attachment B with the following exceptions:

- Place code 488 (Avian flu) on line 652 (Other Viral Infections, Excluding Pneumonia Due To Respiratory Syncytial Virus In Persons Under Age 3).
- Do not add codes 389.13 (Neural hearing loss, unilateral) and 389.17 (Sensory hearing loss, unilateral) to line 300 (Sensorineural Hearing loss – age 5 or under) and line 501 (Sensorineural Hearing loss – over age five) as cochlear implants are only covered for bilateral hearing loss.
- Place code 624.0 (Dystrophy of vulva), including all valid fifth-digit codes, on line 223 (Vulvar dystrophy).

Laparoscopic surgery **-** HOSC recommendation is to include laparoscopic surgery when the equivalent open procedure code is on the list and to remove laparoscopic CPT codes on inappropriate lines. The surgeons will decide which approach to use. The following recommendations involve the use of laparoscopic codes for abdominal conditions.

Laparoscopic Surgery: Esophagus

- Add code 43280 - Laparoscopic Nissen to line 475 (Achalasia, Non-Neonatal)

- Add code 43289 - Unlisted laparoscopic procedure, esophagus to line 98 (Congenital Anomalies of Upper Alimentary Tract, Excluding Tongue)

Laparoscopic Surgery: Spleen

- Add code 38120 - Laparoscopy, splenectomy to line 13 (Ruptured Spleen) and line 173 (Hereditary Anemias, Hemoglobinopathies, And Disorders Of The Spleen)

Laparoscopic Surgery: Stomach

- Add code 43280 - Laparoscopic Nissen to line 194 (Ulcers, Gi Hemorrhage)
- Delete code 43651 and 43652 - Laparoscopy; transaction of vagus nerves, truncal from line 194
- Delete code 43653 - Laparoscopy, gastrostomy, without construction of gastric tube (Stamm procedure) from line 51 (Deformities Of Head And Compound/Depressed Fractures Of Skull)

Laparoscopic Surgery: Pancreas

- Add code 49320 - Laparoscopy, abdomen, peritoneum, and omentum, diagnostic, with or without collection of specimen(s) by brushing or washing to line 33 (Neoplasms Of Islets Of Langerhans) and line 490 (Cancer Of Pancreas).
- Add code 49321 - Laparoscopy, surgical, with biopsy to line 33 (Neoplasms Of Islets Of Langerhans) and line 490 (Cancer Of Pancreas).
- Add code 49322 - Laparoscopy, surgical, with aspiration of cyst or cavity to line 257 (Cyst And Pseudocyst Of Pancreas).
- Add code 49324 - Laparoscopy, surgical, with insertion of intraperitoneal cannula or catheter to line 33 (Neoplasms Of Islets Of Langerhans), line 257 (Cyst And Pseudocyst Of Pancreas) and line 490 (Cancer Of Pancreas).
- Add code 49325 - Laparoscopy, surgical, with revision of intraperitoneal cannula or catheter to line 33 (Neoplasms Of Islets Of Langerhans), line 257 (Cyst And Pseudocyst Of Pancreas) and line 490 (Cancer Of Pancreas).

Laparoscopic surgery: Liver

- Add code 47560 - Laparoscopy, surgical, with guided transhepatic cholangiography, without bx to line 155 (Disorders Of Bile Duct).
- Add code 47561 - Laparoscopy, surgical, with guided transhepatic cholangiography, with biopsy to line 155 (Disorders Of Bile Duct).
- Add code 47563 - Laparoscopic cholecystecomy with cholangiography to line 155 (Disorders Of Bile Duct).
- Add code 47564 - Laparoscopic cholecystecomy with exploration of common bile duct to line 155 (Disorders Of Bile Duct).
- Add code 47570 - Laparoscopic cholecystoenterostomy to line 155 (Disorders Of Bile Duct).
- Add code 47579 - Unlisted laparoscopy procedure, biliary tract to line 155 (Disorders Of Bile Duct).
- Add code 49321 - Laparoscopy, surgical, with biopsy to line 30 (Liver Abscess).

- Add code 49322 - Laparoscopy, surgical, with aspiration of cyst or cavity to line 30 (Liver Abscess).

Laparoscopic Surgery: Other Abdominal

- Delete code 49324 - Laparoscopy, surgical, with insertion of intraperitoneal cannula or catheter, permanent from line 249 (Poisoning By Ingestion, Injection, and Non-Medicinal Agents) and line 311 (Type II Diabetes Mellitus).
- Delete code 49325 - Laparoscopy, surgical, with revision of intraperitoneal cannula or catheter, permanent from line 249 (Poisoning By Ingestion, Injection, and Non-Medicinal Agents) and line 311 (Type II Diabetes Mellitus).
- Delete code 49326 - Laparoscopy, surgical, with omentopexy from line 249 (Poisoning By Ingestion, Injection, and Non-Medicinal Agents) and line 311 (Type II Diabetes Mellitus).

Laparoscopy: Hernias

- Add line 49659 - Unlisted laparoscopy procedure, hernoplasty, herniorrhaphy, herniotomy to line 6 (Complicated Hernia Defined as Being Incarcerated And Having Symptoms Of Obstruction And/Or Gangrene; Uncomplicated Hernia In Children Under Age 18) and line 606 (Uncomplicated Hernia).

Laparoscopic Surgery: Miscellaneous Abdominal

- Delete code 49324 - Laparoscopy, surgical, with insertion of intraperitoneal cannula or catheter from line 2 (Type I Diabetes Mellitus) and line 311 (Type II Diabetes Mellitus).
- Delete code 49325 - Laparoscopy, surgical, with revision of intraperitoneal cannula or catheter from line 2 (Type I Diabetes Mellitus) and line 311 (Type II Diabetes Mellitus).
- Delete code 49326 -Laparoscopy, surgical, with omento pexy from line 2 (Type I Diabetes Mellitus) and line 311 (Type II Diabetes Mellitus).

Dr. Smits will review gynecologic, arthroscopic, vascular and other surgical areas where laparoscopic approaches are used and bring back recommendations to the next HOSC meeting.

<u>Discography</u> – remove codes 62290 and 62291 from lines 140 (Disorders of Spine with Neurologic Impairment), 324 (Spinal Deformity, Clinically Significant) and from the Diagnostic List and add to Never Covered list.

<u>Non-Pairings Requiring Discussion</u>

Line 138, Multiple Endocrine Neoplasia (MEN)

- Delete ICD-9 codes 193 (Malignant neoplasm of thyroid gland), 198.4 (Secondary malignant neoplasm of other parts of nervous system), and 237.4 (Neoplasm of other and unspecified endocrine glands)
- Add new ICD-9 codes: 258.01 (MEN I), 258.02 (MEN IIa), and 258.03 (MEN IIb)

- Add CPT codes: 60500-60505 (parathyroidectomy), 60540-60545 (adrenalectomy), 60650 (laproscopic adrenalectomy), 60699 (unlisted procedure, endocrine system), 99201-99215 (office visits), 99221-99233 (hospital visits), and 99241-99255 (consultation)
- Change treatment description to “Medical and Surgical Treatment”

Line 365, Congenital hydronephrosis

- Add CPT codes 50220, 50225, 50234, 50236, & 50240 (nephrectomy) and 50600 & 50605 (ureterotomy)

Lines 122 (Non-Hodgkin’s lymphomas), 190 (Cancer of thyroid), 225 (Cancer of breast), 274 (Cancer of endocrine system, excluding thyroid), and 456 (Lymphadenitis)

- Remove lymph node biopsy CPT codes (38500, 38505, 38510, 38520, 38525, 38530) and add to Never Covered list.

Guidelines

The guideline change recommendations shown in Attachment C for Comfort/Palliative Care, Vertebroplasty, Non-Surgical Treatment of Obesity and Lymphedema were discussed and accepted.

Add to line 694 (Lymphedema) - 97110 (therapeutic procedure and exercises), 97530 (therapeutic activities, use of dynamic activities to improve function), and 97760 (orthotics management and training).

DMAP Issues

Mediastinoscopy/ganglion cyst excision:

- Remove code 39400 (mediastinoscopy) from line 272 (Lung Cancer) and place on Diagnostic List. Remove code 20612 (aspiration and/or injection of ganglion cyst) from line 505 (Disorders of Shoulder); keep on line 662 (Ganglion Cysts).

V-Codes

Recommend suggested placements for V-codes as noted in Attachment D, except:

- V62.9 (Other psychological or physical stress, NEC), V57 (Encounter for physical and occupational therapy) and V58.6 (Long-term (current) use of medications) referred to the Line Zero Task Force for recommendations on placement.
- V53.4 (Fitting and adjustment of orthodontics) not placed on Line 377 (Cleft palate); placed on lower orthodontic line 707.
- More information required on V53.5 (Fitting and adjustment of other intestinal appliance) and V53.02 (Fitting and adjustment of neuropacemaker for brain or peripheral nerves); staff asked to research these codes further and bring information to next meeting.
- V53.09 (Fitting and adjustment of other devices related to nervous system and special senses); staff requested to research what appropriate lines for this code, such as epilepsy, cerebral palsy, and similar lines, and bring back suggestions for next meeting.

- V55.7 (attention to artificial vagina-cosmetic) placed on line 464 rather than Never Covered list.
- V58.5 (Orthodontics aftercare) placed on line 707 (orthodontic line) rather than cleft palate line.

Immunizations
Remove vaccination CPT codes from the ancillary list and place on lines 141 (Preventive Services, Birth to 10 Years of Age), 181 (Preventive Services with Proven Effectiveness, Over Age Of 10), 375 (Deep Open Wound) or Never Covered list as written in Attachment E.

MOTION: To approve the recommendations of the HOSC. MOTION CARRIES: 7-0.

X. Health Fund Board Discussion

The Prioritized List is about treating conditions based on values given to categories of service and the OHFB is looking for a "basic benefit" package. The group shared their concerns about how that might work. Defining what essential health care benefits are will be a monstrous issue to tackle. Dr. Saha mentioned the remarks heard during the public meetings held by the HSC recently which stressed the need to "fix the delivery system."

XI. Other Business

No other business was offered at this time.

XII. Public Comment

No public comment was offered at this time.

XIII. Adjournment

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

ATTACHMENT A

PLACEMENT OF BEHAVIORAL HEALTH ASSESSMENT CODES

Addition of CPT codes 96150-96154	
Lines	**Condition type**
2, 44, 107, 117, 120, 139, 156, 165, 172, 173, 174, 188, 189, 198, 206, 211, 250, 251, 254, 256, 259, 261, 265, 266, 269, 280, 281, 292, 293, 304, 310-314, 316, 319, 320, 327, 329, 335, 336, 338, 345, 347, 350, 358, 369, 374, 376, 390, 395, 423, 432, 438, 440-442, 450, 458, 459, 461, 465, 466, 475, 477, 478, 483, 484, 487, 493, 499, 501, 503, 510, 511, 515, 522, 529	Chronic disease
4, 163, 175, 246, 247	Renal dialysis
14, 35, 130, 167, 168, 171, 202, 203, 208, 305, 306, 379, 381, 445	Chronic infections (TB, HIV, etc.)
27, 33, 118, 122, 134, 137-138, 190-193, 209, 224-226, 228-234, 270-277, 326, 346, 488-491	Cancer
40, 162, 196	Burns
54	Maternity care
106, 108, 109, 124, 127, 154, 176, 197, 433-436	Organ transplant
112, 140, 214, 324	Spinal cord injury/abscess
1, 31, 51, 136, 283, 284, 455, 467	Injuries to the nervous system (concussion, stroke, etc.)
620	Medical obesity
216, 333, 446, 447	Disability lines
237-238,322	Amputation of limb
182	Tobacco dependence
218, 297, 457	TAB/SAB related
262	Terminal illness
Addition of CPT code 96154 only (Family assessment/intervention)	
Lines	**Condition type**
59, 60, 63-70, 74, 77, 78, 80, 83, 84, 86, 87, 94-99, 101-106, 201	Newborn issues requiring parental training/assessment

1) New codes: discussion required

258.01 Multiple endocrine neoplasia [MEN] type I
258.02 Multiple endocrine neoplasia [MEN] type IIA
258.03 Multiple endocrine neoplasia [MEN] type IIB

New ICD-9 Code	*HSC Staff*	*Parent ICD-9-CM code already appear on this line.*
ADD	138	MULTIPLE ENDOCRINE NEOPLASIA

9) New codes: straightforward pairing

058.10 Roseola infantum
058.11 Roseola infantum due to human herpes virus 6
058.12 Roseola infantum due to human herpes virus 7
079.83 Parvovirus B19

New ICD-9 Code	*HSC Staff*	
ADD	652	OTHER VIRAL INFECTIONS, EXCLUDING PNEUMONIA DUE TO RESPIRATORY SYNCYTIAL VIRUS IN PERSONS UNDER AGE 3

488 Influenza due to identified avian influenza virus

New ICD-9 Code	*HSC Staff*	
ADD	444	ARTHROPOD-BORNE VIRAL DISEASES

789.51 Malignant ascites
789.59 Other ascites

New ICD-9 Code	*HSC Staff*
ADD TO SIGNS & SYMPTOMS LIST	

Q4089 Rhophylac injection

New HCPCS Code		*HSC Staff*
ADD	54	PREGNANCY

S0180 Etonogestral implant system

New HCPCS Code		*HSC Staff*
ADD	53	BIRTH CONTROL

S2066 Breast GAP flap reconstruction
S2067 Breast "stacked" DIEP/GAP
S2068 Breast DIEP or SIEA flap

New HCPCS Code		*HSC Staff*
ADD	225	CANCER OF THE BREAST

S3800 Genetic testing for ALS

New HCPCS Code	*HSC Staff*
ADD TO DIAGNOSTIC LIST	

S9152 Speech therapy, re-evaluation

New HCPCS Code		*HSC Staff*
ADD	1	SEVERE/MODERATE HEAD INJURY
ADD	26	ACUTE BACTERIAL MENINGITIS
ADD	31	SUBARACHNOID AND INTRACEREBRAL HEMORRHAGE/HEMATOMA;
ADD	40	BURN, PARTIAL THICKNESS GREATER THAN 30% OF BODY SURFACE OR WITH VITAL SITE;
ADD	51	DEFORMITIES OF HEAD AND COMPOUND/DEPRESSED FRACTURES OF SKULL
ADD	145	COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
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	234	CANCER OF ORAL CAVITY, PHARYNX, NOSE AND LARYNX,
ADD	258	ACUTE POLIOMYELITIS
ADD	283	INTRACEREBRAL HEMORRHAGE
ADD	284	STROKE

S9152 Speech therapy, re-evaluation (cont'd)

ADD	296	COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
ADD	377	CLEFT PALATE AND/OR CLEFT LIP
ADD	432	GUILLAIN-BARRE SYNDROME
ADD	447	NEUROLOGICAL DYSFUNCTION IN COMMUNICATION CAUSED BY CHRONIC CONDITIONS

12) New codes: similar to existing

040.41 Infant botulism
040.42 Wound botulism

New ICD-9 Code		*HSC Staff*
ADD	199	BOTULISM

058.21 Human herpes virus 6 encephalitis
058.29 Other human herpes virus encephalitis

New ICD-9 Code		*HSC Staff*
ADD	203	HERPES ZOSTER; HERPES SIMPLEX WITH NEUROLOGICAL AND OPHTHALMOLOGICAL COMPLICATIONS

058.81 Human herpes virus 6 infection
058.82 Human herpes virus 7 infection
058.89 Other human herpes virus infection

New ICD-9 Code		*HSC Staff*
ADD	614	HERPES SIMPLEX WITHOUT COMPLICATIONS, EXCLUDING GENITAL HERPES

200.3 Marginal zone lymphoma
200.4 Mantle cell lymphoma
200.5 Primary central nervous system lymphoma
200.6 Anaplastic large cell lymphoma
200.7 Large cell lymphoma
202.7 Peripheral T cell lymphoma **(cont'd on next page)**

The following 5th digit codes have been added to each of the 4th digit codes 200.3-200.7 and 202.7:

0 Unspecified site, extranodal and solid organ sites
1 Lymph nodes of head, face, and neck
2 Intrathoracic lymph nodes
3 Intra-abdominal lymph nodes
4 Lymph nodes of axilla and upper limb
5 Lymph nodes of inguinal region and lower limb
6 Intrapelvic lymph nodes
7 Spleen
8 Lymph nodes of multiple sites

New ICD-9 Code		*HSC Staff*	*Parent ICD-9-CM codes already appear on these lines.*
ADD	122	NON-HODGKIN'S LYMPHOMAS/MEDICAL THERAPY, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY	
ADD	123	NON-HODGKIN'S LYMPHOMAS/BONE MARROW TRANSPLANT	
ADD	674	MEDICAL CONDITIONS WHERE TREATMENT OF THE CONDITION WILL NOT RESULT IN A 5% 5-YEAR SURVIVAL	

233.30 Carcinoma in situ, unspecified female genital organ
233.31 Carcinoma in situ,vagina
233.32 Carcinoma in situ,vulva
233.39 Carcinoma in situ, other female genital organ

New ICD-9 Code		*HSC Staff*	*Parent ICD-9-CM code already appear on this line.*
ADD	229	CANCER OF VAGINA, VULVA AND OTHER FEMALE GENITAL ORGANS, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL	

255.41 Glucocorticoid deficiency
255.42 Mineralocorticoid deficiency

New ICD-9 Code		*HSC Staff*	*Parent ICD-9-CM code already appear on this line.*
ADD	9	ADDISON'S DISEASE	

284.81 Red cell aplasia (acquired)(adult)(with thymoma)
284.89 Other specified aplastic anemias

New ICD-9 Code	*HSC Staff*	*Parent ICD-9-CM code already appear on these lines.*
ADD	121	OTHER SPECIFIED APLASTIC ANEMIAS
ADD	170	ANEMIAS DUE TO DISEASE OR TREATMENT AND OTHER APLASTIC ANEMIAS; MYELODYSPLASIA AND MYELODYSPLASTIC SYNDROME

288.66 Bandemia

New ICD-9 Code	*HSC Staff*
ADD TO SIGNS & SYMPTOMS LIST	

315.34 Speech and language developmental delay due to hearing loss

New ICD-9 Code	*HSC Staff*	*Parent ICD-9-CM code already appear on this line.*
ADD	447	NEUROLOGICAL DYSFUNCTION IN COMMUNICATION CAUSED BY CHRONIC CONDITIONS

331.5 Idiopathic normal pressure hydrocephalus (INPH)

New ICD-9 Code	*HSC Staff*
ADD	86 ENCEPHALOCELE; CONGENITAL HYDROCEPHALUS

359.21 Myotonic muscular dystrophy
359.22 Myotonia congenital
359.23 Myotonic chondrodystrophy
359.24 Drug induced myotonia
359.29 Other specified myotonic disorder

New ICD-9 Code	*HSC Staff*	*Parent ICD-9-CM code already appear on these lines.*
ADD	216	NEUROLOGICAL DYSFUNCTION IN BREATHING, EATING, SWALLOWING, BOWEL, OR BLADDER CONTROL CAUSED BY CHRONIC CONDITIONS
ADD	333	NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS
ADD	446	DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE LEVEL OF INDEPENDENCE IN SELFDIRECTED
ADD	447	NEUROLOGICAL DYSFUNCTION IN COMMUNICATION CAUSED BY CHRONIC CONDITIONS

364.81 Floppy iris syndrome
364.89 Other disorders of iris and ciliary body

New ICD-9 Code	*HSC Staff*	*Parent ICD-9-CM code already appear on this line.*
ADD	402	EXOPHTHALMOS AND CYSTS OF THE EYE AND ORBIT

388.45 Acquired auditory processing disorder
389.05 Conductive hearing loss, unilateral
389.06 Conductive hearing loss, bilateral

New ICD-9 Code	*HSC Staff*	*Parent ICD-9-CM codes already appear on these lines.*
ADD	299	HEARING LOSS - AGE 5 OR UNDER
ADD	499	HEARING LOSS - OVER AGE OF FIVE

389.13 Neural hearing loss, unilateral
389.17 Sensory hearing loss, unilateral

New ICD-9 Code	*HSC Staff*	*Parent ICD-9-CM code already appear on these lines.*
ADD	299	HEARING LOSS - AGE 5 OR UNDER
ADD	300	SENSORINEURAL HEARING LOSS - AGE 5 OR UNDER
ADD	499	HEARING LOSS - OVER AGE OF FIVE
ADD	501	SENSORINEURAL HEARING LOSS - OVER AGE OF FIVE

389.20 Mixed hearing loss, unspecified
389.21 Mixed hearing loss, unilateral
389.22 Mixed hearing loss, bilateral

New ICD-9 Code	*HSC Staff*	*Parent ICD-9-CM code already appear on these lines.*
ADD	299	HEARING LOSS - AGE 5 OR UNDER
ADD	499	HEARING LOSS - OVER AGE OF FIVE
ADD	582	CONDUCTIVE HEARING LOSS

414.2 Chronic total occlusion of coronary artery

New ICD-9 Code	*HSC Staff*	*Parent ICD-9-CM code already appear on these lines.*
ADD	154	CONGESTIVE HEART FAILURE, CARDIOMYOPATHY, TRANSPOSITION OF GREAT VESSELS, HYPOPLASTIC LEFT HEART SYNDROME
ADD	261	ACUTE AND SUBACUTE ISCHEMIC HEART DISEASE, MYOCARDIAL INFARCTION

415.12 Septic pulmonary embolism

New ICD-9 Code	*HSC Staff*	*Parent ICD-9-CM code already appear on this line.*
ADD	285	ACUTE PULMONARY HEART DISEASE AND PULMONARY EMBOLI

423.3 Cardiac tamponade

New ICD-9 Code	*HSC Staff*	*Parent ICD-9-CM code already appear on this line.*
ADD	111	MYOCARDITIS (NONVIRAL), PERICARDITIS (NONVIRAL) AND ENDOCARDITIS

440.4 Chronic total occlusion of artery of the extremities

New ICD-9 Code	*HSC Staff*	
ADD	44	PERIPHERAL VASCULAR DISEASE, LIMB THREATENING INFECTIONS, AND VASCULAR COMPLICATIONS
ADD	366	ATHEROSCLEROSIS, PERIPHERAL

449 Septic arterial embolism

New ICD-9 Code	*HSC Staff*	
ADD	338	DISORDERS OF ARTERIES, OTHER THAN CAROTID OR CORONARY

525.71 Osseointegration failure of dental implant
525.72 Post-osseointegration biological failure of dental implant
525.73 Post-osseointegration mechanical failure of dental implant
525.79 Other endosseous dental implant failure

New ICD-9 Code	*HSC Staff*	
ADD	707	DENTAL CONDITIONS (EG. ORTHODONTICS)

569.43 Anal sphincter tear (healed) (old)

New ICD-9 Code	*HSC Staff*	*Incontinence due to old tear is 787.6*
ADD	704	GASTROINTESTINAL CONDITIONS WITH NO EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY

624.0 Dystrophy of vulva

New ICD-9 Code	*HSC Staff*	*New 5th digit codes are being split out across two lines.*
DELETE	223	DYSTROPHY OF VULVA IN A GREATER THAN 5% 5-YEAR SURVIVAL

624.01 Vulvar intraepithelial neoplasia I [VIN I]
624.02 Vulvar intraepithelial neoplasia II [VIN II]

New ICD-9 Code	*HSC Staff*	
ADD	229	CANCER OF VAGINA, VULVA AND OTHER FEMALE GENITAL ORGANS, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL

624.09 Other dystrophy of vulva

New ICD-9 Code	*HSC Staff*	
ADD	223	DYSTROPHY OF VULVA IN A GREATER THAN 5% 5-YEAR SURVIVAL

629.82 Acquired absence of both uterus and cervix
629.83 Acquired absence of uterus, with remaining cervical stump
629.84 Acquired absence of cervix with remaining uterus

New ICD-9 Code	*HSC Staff*	*Parent ICD-9-CM code already appear on this line.*
ADD	698	GENITOURINARY CONDITIONS WITH NO EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY

664.60 Anal sphincter tear complicating delivery, not associated with third-degree perineal laceration, unspecified as to episode of care or not applicable.
664.61 Anal sphincter tear complicating delivery, not associated with third-degree perineal laceration,
664.64 Anal sphincter tear complicating delivery, not associated with third-degree perineal laceration,

New ICD-9 Code	*HSC Staff*	
ADD	54	PREGNANCY

733.45 Aseptic necrosis of bone, jaw

New ICD-9 Code	*HSC Staff*	*Parent ICD-9-CM code already appear on this line.*
ADD	370	RHEUMATOID ARTHRITIS, OSTEOARTHRITIS, OSTEOCHONDRITIS DISSECANS, AND ASEPTIC NECROSIS OF BONE

787.20 Dysphagia, unspecified
787.21 Dysphagia, oral phase
787.22 Dysphagia, oropharyngeal phase
787.23 Dysphagia, pharyngeal phase
787.24 Dysphagia, pharyngoesophageal phase
787.29 Other dysphagia

New ICD-9 Code	*HSC Staff*	*Parent ICD-9-CM code already appear on this line.*
ADD	216	NEUROLOGICAL DYSFUNCTION IN BREATHING, EATING, SWALLOWING, BOWEL, OR BLADDER CONTROL CAUSED BY CHRONIC CONDITIONS

Approved modified Statement of Intent; also approved deletion of comfort care and futile care lines on current list.

Statement of Intent #1

Comfort/Palliative Care

It is the intent of the Commission that comfort/palliative care treatments for patients with ~~terminal conditions/illnesses (defined~~ with an illness with <5% expected 5 year survival~~)~~ be a covered service. Comfort/palliative care includes the provision of services or items that give comfort to and/or relieve symptoms for such patients ~~with a terminal illness~~. There is no intent to limit comfort/palliative care services according to the expected length of life (e.g., six months) for ~~the~~ such patients ~~with terminal illness~~, except as specified by Oregon Administrative Rules.

It is the intent of the Commission to not cover ~~This category of care does not include services that are~~ diagnostic, ~~curative,~~ or curative care for the primary illness or care focused on active treatment of the primary illness ~~condition~~ which are intended to prolong life or alter disease progression for patients with <5% expected 5 year survival.

Examples of comfort/palliative care include:
1) Medication for symptom control and/or pain relief .
2) In-home, day care services, and hospice services as defined by DMAP
3) Medical equipment (such as wheelchairs or walkers) determined to be medically ~~necessary~~ appropriate for completion of basic activities of daily living ~~for a reasonable length of time~~
4) Medical supplies (such as bandages and catheters) determined to be medically ~~necessary~~ appropriate for management of symptomatic complications ~~of the terminal condition~~ or as required for symptom control.
5) Services under ORS 127.800-127.897 (Oregon Death with Dignity Act), to include but not be limited to the attending physician visits, consulting physician confirmation, mental health evaluation and counseling, and prescription medications.

Examples of services which are not covered include:

1) Chemotherapy or surgical interventions with the primary intent to prolong life or alter disease progression

Medical equipment or supplies which will not benefit the patient for a reasonable length of time

New Guideline for Vertebroplasty amended to read:

Vertebroplasty is included on line 112, Vertebral Fracture, under the following criteria:

1) Must be performed within the first 6 weeks after fracture
   a. Acute nature of fracture must be documented by MRI, Xray or other modality
2) None of the following may be present:
   a. Coagulation disorder
   b. Underlying vertebral infection
   c. Severe cardiopulmonary disease
   d. Extensive vertebral destruction (>50% of height)
   e. Neurological symptoms related to spinal compression
   f. Lack of surgical back up for emergency decompression
3) Must document
   a. Disabling pain caused by non healing vertebral fracture
   b. Vertebral height is not more than 50% collapsed
   c. Procedure is not performed on a prophylactic basis
   d. Risks of open surgical approach are greater than risks of percutaneous approach
   e. Analgesic therapy fails to control pain or the risks of analgesic therapy outweigh the benefits

Guideline Note 4: Non-Surgical Treatment of Obesity; Line 6

Medical treatment of obesity includes intensive counseling on nutrition and exercise, provided by health care professionals. Intensive counseling is defined as face to face contact more than monthly. Visits are not to exceed more than once per week. Pharmacological treatments are not intended to be included as a treatment on this line. See also Guideline Note 57.

2. CPT code changes for line 8 (Obesity) of the 2007-2009 list approved as noted in meeting document.

The following guideline for Lymphedema Treatment (Line 296) was accepted:

Lymphedema treatments are covered when medically appropriate. These services will only be covered when provided by a licensed practitioner who is certified by, or participating in the certification or training process for, one of the accepted lymphedema training certifying organizations. The only accepted certifying organization at this time is LANA (Lymphology Association of North America; http://www.clt-lana.org).

ATTACHMENT D

V CODE REVIEW

Question: Which V codes should appear on the list and which line(s) should they appear on?

Question source: HOSC, HSC staff, medical directors

General principles

1) If codes can be placed on 5 or fewer lines and appropriate lines can be identified, then place on list
2) If codes would be appropriately placed on >5 lines, then place on ancillary list
    a. Multiple lines causes potential actuarial problems
    b. Placement on multiple lines is labor intensive
3) If codes are not used or are inappropriate therapy, then place on never covered list
4) If code has high abuse potential or may be inappropriate care, the research the issue and bring for discussion in necessary

Follow up from June review:

1) Immunizations (V01-V06):
    a. Recommendations for placement of vaccine CPT/HCPCS codes on immunization recommendation document

2) Miscellaneous 1 (V07-V08)
    a. Review V07.4 (Need for prophylactic postmenopausal hormone replacement therapy)
        i. Currently on line 181 (preventive care >10 years)
        ii. USPSTF Guideline from 2005 recommends against prophylactic use of HRT for prevention of any condition in post-menopausal women; risks outweigh benefits
        iii. NEJM June 21, 2007:
            1. WHI: Estrogen-Alone Trial show that younger postmenopausal women who take estrogen-alone hormone therapy have significantly less buildup of calcium plaque in their arteries compared to their peers who did not take hormone therapy.
            2. National Heart, Lung, and Blood Institute (NHLBI): “These findings do not alter the current recommendations that when hormone therapy is used for menopausal symptoms, it should only be taken at the smallest dose and for the shortest time possible, and hormone therapy should never be used to prevent heart disease." June 20, 2007
        iv. Recommend placing V07.4 on never covered list
            1. Menopausal symptom treatment can be applied to line 485 (Menopausal management) with ICD-9 627.2 (menopause)
                a. Office visit codes on line

3) Personal history (V09-V15)
    a. Review V10
        i. V10 codes are invalid as primary codes per CMS
        ii. Olson coder: used as secondary only
        iii. Recommend placing on never covered list
    b. Review V12
        i. V12 codes are invalid as primary codes per CMS
        ii. Olson coder: V12.72 secondary only
        iii. DHS: minimal billings
        iv. Recommend placing on never covered list

4) Family history (V16-V19)
    a. Review V16 to determine use for cancer screening/care
        i. Olson coder: V16 malignant series used as secondary codes only
        ii. DHS: minimal billings
        iii. Recommend placing on never covered list

5) Status (V42-V49)
    a. Review V43.1
        i. DHS: minimal billings
        ii. Recommend placing on never covered list

6) Secondary only codes
    a. Not to be used as primary codes per CMS, but approximately $10 million associated with these codes for last biennium
    b. V62.9 (other psychological or physical stress, NEC) which has $7.3 million associated with it per DMAP
        i. Used for case management per DMAP
            1. Targeted case management ($3.5 million)
            2. Crisis intervention ($2.3 million)
            3. Residential care, NOS ($1.4 million)
        ii. Need more information, for discussion only
    c. V58.69 (Long-term (current) use of other medications) which has $1.2 million associated with it per DMAP
        i. Used for medication monitoring (lab work for serum levels, adverse effects, medication injections)
        ii. Place on ancillary list

<u>New code review: V01-V49</u>

1) Several new codes added by CMS
    a. Add to line 53 (Birth Control)
        i. V25.04 (Counseling in natural family planning to avoid unwanted pregnancy), V26.41 (Procreative counseling and advice using natural family planning), V26.49 (Other procreative management, counseling and advice)

b. Place on never covered list
    i. V12.53, V12.54, V13.22, V16.52, V17.40-V17.49, V18.11, V18.19 (personal and family history codes), V26.81, V26.89 (infertility codes), V49.89 (Dual sensory impairment)
    ii. Similar codes placed on never covered list during June review

V Code Review for V50-V58

1) Surgery (V50-V55)
    a. Cosmetic surgery (V50-V51)
        i. Keep
            1. V50.2 (Elective circumcision) on line 587 (Redundant pupice)
                a. Medically indicated circumcision on other lines
                    i. Mechanical disorders of GI system, Line 431
                    ii. Phimosis, Line 535
            2. V50.41-V50.42 (Prophylactic breast/ovary removal) on lines 225 (Breast cancer), 181 (Adult preventive services)
        ii. Add to never covered list
            1. V50.0, V50.1, V50.3, V50.8, V50.9, V51
                a. Cosmetic procedures with no medical indication
            2. V50.4, V50.49
                a. Non-specific codes
    b. Fitting and adjustment artificial body part (V52)
        i. Add to never covered list
            1. V52 (fitting and adjustment of artificial body parts)
                a. DMAP: minimal billings
                b. Most appear to be cosmetic
    c. Fitting and adjustment, device (V53)
        i. Add to specific lines
            1. V53.01 (Fitting and adjustment of cerebral ventricular (communicating) shunt)
                a. Line 86 (Hydrocephalus with shunt treatment)
            2. V53.1 (Fitting and adjustment of spectacles and contact lenses)
                a. Line 497 (Disorders of refraction)
            3. V53.2 (Fitting and adjustment of hearing aid)
                a. Lines 299 and 499 (Hearing impairment lines)
            4. V53.31-V53.39 (Cardiac devices)
                a. Add to cardiac lines with CPT codes for pacemaker and/or defibrillator
            5. V53.4 (Fitting and adjustment of orthodontics)
                a. Line 377 (Cleft palate)
            6. V53.6 (fitting and adjustment of urinary device)
                a. Line 431 (Urinary tract obstruction)

7. V55.5 (Attention to cystostomy)
    a. Lines 99, 216, 431
    b. All have cystostomy CPT codes
8. V55.6 (Attention to other artificial opening of urinary tract)
    a. Lines 99, 216, 431
    b. All have cystostomy CPT codes

ii. Add to ancillary list
1. V53.5 (fitting and adjustment of other intestinal appliance)
    a. Appropriate lines: 23, 57, 77, 216, 270, 293, 296 (>5)
        i. Have CPT codes for ileostomy or colostomy or similar
2. V53.7 (fitting and adjustment of orthopedic device)
3. V53.8(fitting and adjustment of wheelchair)
4. V53.02 (fitting and adjustment of neuropacemaker for brain or peripheral nerves)
    a. Many types of diseases treated with this: back pain, complex regional pain syndrome, etc**.**

iii. Add to never covered list
1. Non specific codes
    a. V53.0, V53.3, V53.90, V53.99

iv. Need discussion
1. V53.09 (Fitting and adjustment of other devices related to nervous system and special senses)
    a. $240,000 DMAP billings
    b. Used for treatments for epilepsy, chorea, “unspecified quadriplegia,” cerebral palsy, etc.
    c. Also used of low back pain treatment ($30,000 per DMAP)
        i. See Excel supplemental document

d. Surgical aftercare (V54)
i. Keep codes currently assigned to lines
1. On appropriate lines

ii. Add to never covered list
1. Non specific codes: V54.1, V54.2, V54.8, V54.89, V54.9

e. Attention to artificial opening (V55)
i. Add to ancillary list
1. V55.0-V55.4
    a. All have >5 possible appropriate lines

ii. Add to never covered list
1. V55.7 (attention to artificial vagina-cosmetic)
2. V55.8, V55.9--nonspecific

2) Other procedure (V56-V58)
a. Add
i. Dialysis catheters (V56) to dialysis lines (4, 163, 175, 246, 247)
ii. V58.5 (Orthodontics aftercare) to line 377 (cleft palate)

b. Add to ancillary list
    i. V58.0, V58.1 (radiotherapy, chemotherapy)
        1. Huge billings through DMAP ($15 million)
        2. Per CMS guidelines, should be coded first before underlying dx
    ii. V58.3, V58.4 (attention to dressings/sutures, etc.)
    iii. V58.7, V58.8 (various type of aftercare)
    iv. V58.6 (laboratory monitoring for medication use)
        1. Cannot be used as primary codes per CMS
        2. Lots of billing through DMAP ($10 million)
        3. See discussion above in follow up section part 6
c. Add to never covered list
    i. V58.11, V58.12 (Encounter for antineoplastic chemotherapy, Encounter for immunotherapy for neoplastic condition)
        1. Not used per DMAP
    ii. V58.2 (Blood transfusion, without reported diagnosis)
        1. Not used per DMAP
    iii. V58.9—non specific code
d. Need more info/discussion
    i. PT/OT (V57)
        1. $10.3 million in DMAP billings
        2. Concerns
            a. Should providers use ICD-9 code for underlying condition?
            b. Concern for use in circumventing the PT/OT guideline
            c. V57.89 is being used for room and board for rehab facilities ($1.5 million)—is this appropriate?
            d. Significant increase in usage since implementation of PT/OT guidelines
        3. Add to never covered list?
    ii. V58.0, V58.1 (radiotherapy, chemotherapy)
        1. Huge billings through DMAP ($15 million)
        2. Per CMS guidelines, should be coded first before underlying dx

ATTACHMENT E

IMMUNIZATION CPT CODE REVIEW

CPT/ HCPCS Code	Description	Line 141	Line 181	Line 375	Never Covered
90465	Immunization administration, injection, <8 years of age, first injection, with physician counseling	**X**			
90466	Immunization administration, injection, <8 years of age, additional injection, with physician counseling	**X**			
90467	Immunization administration, oral or intranasal, <8 years of age, first administration, with physician counseling	**X**			
90468	Immunization administration, oral or intranasal, <8 years of age, each add'l administration, with physician counseling	**X**			
90471	Immunization administration, injection, first injection	X	X		
90472	Immunization administration, injection, each add'l injection	X	X		
90473	Immunization administration, oral or intranasal, first administration	X	X		
90474	Immunization administration, oral or intranasal, each add'l administration	X	X		
90476	Adenovirus vaccine, type 4, oral				**X**
90477	Adenovirus vaccine, type 7, oral				**X**
90581	Anthrax vaccine				**X**
90585	BCG vaccine for TB				**X**
90586	BCG vaccine for bladder cancer				**X**
90632	Hepatitis A vaccine, adult		**X**		
90633	Hepatitis A vaccine, pediatric/adolescent-2 dose schedule	**X**	**X**		
90634	Hepatitis A vaccine, pediatric/adolescent-3 dose schedule	**X**	**X**		
90636	Hepatitis A-Hepatitis B vaccine, adult		**X**		
G00010	Administration of hepatitis B vaccine	**X**	**X**		
90645	Hib vaccine, HbOC conjugate	**X**			
90646	Hib vaccine, PRP-D conjugate	**X**			
90647	Hib vaccine, PRP-OMP conjugate	**X**			
90648	Hib vaccine, PRP-T conjugate	**X**			
90649	HPV vaccine	**X**	**X**		
90655	Influenza virus vaccine, preservative free, 6-35 months	**X**			
90656	Influenza virus vaccine, preservative free, 3 years and older	**X**	**X**		

ATTACHMENT E

IMMUNIZATION CPT CODE REVIEW

CPT/ HCPCS Code	Description	Line 141	Line 181	Line 375	Never Covered
90657	Influenza virus vaccine, 6-35 months	X			
90658	Influenza virus vaccine, 3 years and older	X	X		
90660	Influenza virus vaccine, intranasal	X	X		
G0008	Administration of influenza vaccine	X	X		
90665	Lyme disease vaccine				X
90669	Pneumococcal conjugate vaccine, <5 years	X			
90675	Rabies vaccine, intramuscular			X	
90676	Rabies vaccine, intradermal			X	
90680	Rotavirus vaccine	X			
90690	Typhoid vaccine, live, oral				X
90691	Typhoid vaccine, Vi, intramuscular				X
90692	Typhoid vaccine, H-P, subcutaneous				X
90693	Typhoid vaccine, AKD, subcutaneous (military only)				X
90698	DTap-Hib-IPV vaccine	X			
90700	DTaP, <7	X			
90701	DTaP, 7 and older	X	X		
90702	dT, <7	X			
90703	Tetanus toxoid	X	X		
90704	Mumps vaccine	X	X		
90705	Measles vaccine	X	X		
90706	Rubella vaccine	X	X		
90707	MMR vaccine	X	X		
90708	Measles and rubella vaccine	X	X		
90710	MMR and varicella vaccine	X	X		
90712	Poliovirus vaccine, oral				X
90713	Poliovirus vaccine, injection	X	X		
90714	Td, preservative free, 7 and older	X	X		
90715	TDaP, 7 and older		X		
90716	Varicella vaccine	X	X		
90717	Yellow fever vaccine				X
90718	Td, 7 and older	X	X		
90719	Diphtheria toxoid	X	X		
90720	DTP-Hib vaccine	X			
90721	DTaP-Hib vaccine	X			
90723	DTaP-HepB-IPV vaccine	X	X		
90725	Cholera vaccine				X
90727	Plague vaccine				X
90732	Pneumoccoccal vaccine, 2 years and older	X	X		
G0009	Administration of pneumococcal vaccine	X	X		

ATTACHMENT E

IMMUNIZATION CPT CODE REVIEW

CPT/ HCPCS Code	Description	Line 141	Line 181	Line 375	Never Covered
90733	Meningococcal vaccine, any groups	X	X		
90734	Meningococcal vaccine, serogroups A,C,Y and W-135	X	X		
90735	Japanese encephalitis vaccine				X
90736	Zoster vaccine		X		
90740	Hepatitis B vaccine, dialysis or immunosuppressed patient, 3 dose schedule	X	X		
90743	Hepatitis B vaccine, adolescent, 2 dose schedule		X		
90744	Hepatitis B vaccine, pediatric/adolescent, 3 dose schedule	X	X		
90746	Hepatitis B vaccine, adult		X		
90747	Hepatitis B vaccine, dialysis or immunosuppressed patient, 4 dose schedule	X	X		
90748	HepB-Hib vaccine	X			
90740	Unlisted vaccine/toxoid	X	X		

Line 141: PREVENTIVE SERVICES, BIRTH TO 10 YEARS OF AGE
Line 181: PREVENTIVE SERVICES WITH PROVEN EFFECTIVENESS, OVER AGE OF 10
Line 375: DEEP OPEN WOUNDS

IV. Non-Surgical Management of Obesity

Dr. Ruth Medak, a member of the Health Resources Committee, was introduced. Dr. Medak presented the MedTAP report on the medical management of obesity.

This study is an assessment of literature for non-surgical treatment of obesity. The topic stirs strong feelings so there is more than just dry evidence presented.

Obesity is an epidemic sweeping United States; Oregon has a 24% obesity rate and it is getting notably worse. Assessment of health habits point to poor eating and lack of exercise, as well as genetic predisposition, as factors. Adults and children both participate in these poor health habits.

The key questions addressed in the report are:

- What is the evidence for the effectiveness of non-surgical treatments (pharmacological, dietary, behavioral, and/or physical activity) in improving objective outcomes for obesity such as sustained weight loss; waist/hip ratio; diabetes prevention, improvement or reversal; hyperlipidemia; hypertension; cardiovascular disease; mortality; obstructive sleep apnea; metabolic syndrome; or non-alcoholic fatty liver disease (NAFLD)?
- What is the evidence for the effectiveness of a combination of non-surgical treatments?
- What are the adverse effects associated with non-surgical treatments in patients?
- Are there any subgroups of patients in which the effectiveness of non-surgical treatments are paramount?
- What is the evidence for effectiveness of non-surgical treatments in prevention of weight gain for children and adults?
- What is the effectiveness and cost-effectiveness of treatments of obesity measured in $/QALY (quality adjusted life-years)?

Effectiveness of non-surgical treatments

The report includes a table comparing the effectiveness of weight loss medications and medications for which weight loss is a side effect. The weigh loss results are similar for each medication, all being low. Also compared are results of dietary, behavior and physical activity.

In studies of large groups, there is no evidence of long-term sustained weight loss in the non-surgical treatments of obesity, each yielding around 5 kg (≈11 lbs) of sustained weight loss. Within the groups, smaller subsets have better results; 20% of people will sustain greater than or equal to 10% weight less for more than a year. Further, Dr. Medak explained that, in the study of obesity, methods that keep patients from simply gaining more weight can be seen as a good result.

Dr. Saha interjected that small impacts on individuals can have large implications at a population level for highly prevalent diseases.

Dr. Sohl suggested that waist circumference might be a better indicator for obesity than BMI (Body Mass Index). Dr. Medak quickly agreed, sharing that very fit, very muscular individuals with high weight may have a high BMI but not be obese at all. Waist-to-hip ratio is the best indicator of abdominal obesity, but is currently not the standard measure.

Evidence for the effectiveness of a combination of non-surgical treatments

Successful patients utilize multiple modalities to achieve and maintain weight loss. Those who include exercise and behavior therapy add approximately 2 kg (≈4.5 lbs) each to weight loss.

Adverse effects associated with non-surgical treatments in patients

Gallstones, gout and hair loss are common adverse effects of medication.

Subgroups of patients in which the effectiveness of non-surgical treatments are paramount

The strongest evidence is for a positive impact with individuals with risk factors such as cardiac issues, diabetes and metabolic syndrome. Weight loss by any means improves metabolic control. A diabetes prevention study was perhaps the most promising, yielding an average weight loss of 7%, sustained for 3 years. The study was not intensive, urging moderate exercise and diet.

Effectiveness of non-surgical treatments in prevention of weight gain for children and adults

A multi-pronged approach of medication, diet, exercise and behavioral counseling/intervention (with contact more than once a month for three months), in concert with family support produces small but sustainable results.

Effectiveness and cost-effectiveness of treatments of obesity measured in $/QALY

The data on cost-effectiveness came from non-US studies; seem to suggest cost savings, especially in the prevention of diabetes.

There are many non-pharmacologic programs, such as supervised, medically supervised, semi-supervised and lay supervised programs, which produce similar outcomes. Very low calorie diets initially reduce more weight than low calorie diets;

however many people regain the weight. To sustain the loss, patients need maintenance and continued support.

This report comes to some conclusions but not clear recommendations; however, it is clear that the cost of doing nothing is too high.

Dr. Saha opened up the commissioner's discussion of this topic by stating that the interest in this subject is high; treating and preventing obesity moved to line #8 on the Prioritized List of Health Services during this year's biennial review. The commission has made its decisions regarding bariatric surgery and is now deciding the proper non-surgical treatments to include on this line.

Medication

It appears that while prescriptions are effective there are physical side effects and the weight comes back when medication is ceased. When used to treat obesity, as a chronic condition, therapy for the next 10 to 20 years will be expensive and may be found in the future to cause intractable harm.

Dr. Lisa Dodson commented that no single therapy works alone. Dr. Kevin Olson wondered, outside of creating a health care delivery system such as models that work in the treatment of diabetes, which is not the purview of the commission, how can we structure benefits to achieve weight loss goals? Busy doctors tend only to have time to write prescriptions.

Dr. Saha stated the larger impact may start with broader approaches to this issue, by educating children. Staying with the issue at hand, prescription studies extend at most to 4.5 years so their long term safety is not known. For the time being, until there is better longitudinal evidence (15 to 20 year studies), medications should not be covered.

Non-pharmacologic therapy

Intensive multi-modal therapy has been shown to be effective in weigh loss and management. The commission discussed allowing services from lay providers, though current guidelines require those receiving Medicaid dollars be licensed and hold current provider agreements with DMAP; Oregon Administrative Rules (OARs) could be re-written to allow reimbursement to lay providers. There are existing billing codes for health and behavior assessment and intervention as well as education and training which could be utilized.

Should OHP pay for weight-loss centers such as Weight Watchers or Jenny Craig? Dr. Chris Kirk shared that some private health plans reimburse members for successful completion. Quality and professionalism are variable within the lay provider realm; selecting one over the other might indicate that the state is endorsing a commercial provider.

In summary, the commission would like to encourage obesity management by covering services for intensive counseling of nutrition and exercise, limited to health care professionals.

Ms. Celeste Symonette offered that DMAP is developing an RFP designed to mimic Washington's model, expanding the current disease management program by examining risk profile, which would include obesity. This would encompass group visits, self-management education and training.

Dr. Saha summarized that the commission should review and add the proper billing codes as well as write guidelines defining both intensive intervention and maintenance.

V. Legislative Update

Dr. Jeanene Smith reports that Senate Bill 329 (the Healthy Oregon Act) was signed into law by the Governor today. This bill sets up a planning process to build broad health care reform, largely based on the Bates/Westlund proposed legislation and the work of the Health Policy Commission (HPC). The HPC completed a report just before the session concluded that outlines the initial roadmap to broader health reform.

This legislation sets up the Oregon Health Fund Board and will be closely connected with OHPR; current commissions and committee personnel will also be staffing new subcommittees. A Benefits Subcommittee is forming that that will work with the HSC, utilizing the work this commission has been doing over the past years. A status report from this subcommittee is due in February, which will look at how the list might be applied to a commercial population. Work will begin once the Oregon Health Fund Board is staffed. The new board will propose a plan for a new health care system to the next legislative session.

Dr. Saha shared that he and Mr. Coffman have been involved with the Public Employees' Benefit Board (PEBB), discussing how PEBB might use the prioritized list as an option for state employee benefits. Dr. Smith, also a PEBB board member, said that PEBB has expressed interest in running a pilot program using this commission's work to offer benefits to state employees.

Dr. Saha asked for volunteers to continue exploring this possibility in defining an essential benefit package called for under SB 329. Mr. Bruce Abernethy, Dr. Lisa Dodson and Ms. Leda Garside volunteered. Dr. Kirk and Dr. Wally Shaffer will also be involved.

Dr. Smith thanked the commission for their work on the Benchmark report and reported the news that there is no budget for further studies.

Dr. Smith also reported that House Bill 2918 passed, which directs the Health Resources Commission (HRC) to study the evidence-based research on treatments for pervasive developmental disorders (PDD) and developmental delay. The bill ensures

that insurance companies cannot discriminate against those with PDD for other covered services. The HRC hope to complete their review of autism by early spring. This bill's passage does not affect the prioritized list.

The Healthy Kids bill has been referred to the citizens for a vote to amend the constitution to raise the cigarette tax to expand children's health care in Oregon. If it passes in November, the plan will be implemented by July, 2008. There is concern from the tobacco lobby; however the Governor is committed to covering kids.

VI. Director's Report

Mr. Coffman introduced Nathan Hierlmaier, a research analyst who has been working as Health Services Commission staff since January. Mr. Hierlmaier has been handling some of the technical aspects of the commission's work.

Recently, Mr. Coffman traveled to Madison, Wisconsin as part of a team with Dr. Alison Little and Mr. Mark Gibson from the Office of Evidence-Based policy, to meet with Wisconsin's Medicaid staff, who are seriously considering implementing an expansion program for childless adults using a prioritized list.

He noted that today's signing of Senate Bill 329 makes the HSC staff now DHS employees, as a part of the bill directs a migration of the OHPR office to DHS. This organizational change does not affect the function of the Health Services Commission.

HSC staff recently met with the OHP Contractors to discuss a realistic timing for changes related to new CPT codes. Codes will continue to be reviewed by the Commission in December and will be finalized at the January meeting. Though the official notice will be sent after that meeting, the proposed changes involving these codes will be posted on the HSC website for contractors to view before January 1st. Technical changes and corrections will be given every six months.

VII. Medical Director's Report

Dr. Ariel Smits reports that she is working on examining where the procedure codes fall on the list in a number of areas, which is extensive and may take some time. She is also involved in a series of DHS meetings discussing the delivery of mental health services. She and Mr. Coffman have been invited to participate in a program which is looking at the delivery of preventive services for children in the state, through CDRC, with DHS focusing on screening for children with the potential for developmental disabilities.

VIII. Report from Health Outcomes Subcommittee (HOSC)

Dr. Saha reported the subjects discussed and recommendations made at the morning's HOSC meeting.

Treatments for pseudotumor cerebri/benign intracranial hypertension: This means increased pressure inside the cranium mimicking a tumor in the brain. This condition had been prioritized to a low line on the list and not covered; the provider community asked to have it reviewed. This is a treatable condition with neurologists and ophthalmologists have a role in it. The subcommittee researched the condition and evidence, making it clear that the condition should be covered. A congenital form of the same condition appears on line 86.

Recommended action:

1) Delete code 348.2 from line 701
2) Rename line 86 "Encephalocele, hydrocephalus, and benign intracranial hypertension"
3) Change treatment description for line 86 to "Medical and surgical treatment"
4) Add the following CPT codes to line 86: 31294, 62270, 67570, 92002, 92004, 92012, 92014, 92081, 92082, 92083 and 92250

Spinal surgery: There were some inconsistencies on the spinal surgery lines. As an example, some approaches were covered; others were not, though unintentional.

Recommended action:

Add and delete certain CPT codes relating to spinal surgery from certain lines as outlined in Attachment A.

Wound debridement/cesarean post-op debridement: A wound care provider shared that they were unable to bill for cesarean wound complications because it can't be coded with 998.83 (non-healing surgical wound) in the 6 week post-partum period.

Recommended action:

1) Add CPT codes 11040-11044 to lines 145 and 296
2) Add 674.1 and 674.3 to line 145
3) Remove 674.1 and 674.3 from line 54

Surgical treatment of pancreatitis: The surgical codes for placement of pancreatic drains for acute pancreatitis were inappropriately placed.

Recommended action:

1) Add 48000, 48001, 48020, 48120 to line 330
2) Change name of line 330 to "Medical and Surgical Treatment"
3) Delete 48000 from line 77, 48105 from line 326, 48000 from line 671
4) Add 48020 and 48120 to line 671
5) Add 48000 to line 257

Surgical treatment of secondary hyperparathyroidism: patients with kidney disease sometimes develop this condition. This condition exists only on the dialysis line. Moving the diagnosis code to the appropriate line allows the treatment to be covered.

Recommended action:

1) Add 588.81 to line 440
2) Delete 588.81 from line 247
3) Add 60500 to line 274
4) Delete 60512 from line 319

Capsule endoscopy: This is an expensive new technology whereby an encapsulated camera is swallowed, allowing the small intestine's image to be captured, an area that neither the upper and lower endoscopy can reach. Good evidence was found for use in diagnosis of obscure GI bleeding thought to be of GI origin and of Crohn's disease, when upper and lower endoscopy have not yielded a diagnosis. Given the lack of evidence in this tool's usefulness in diagnosing and screening of colon cancer and esophageal conditions, the members wish to add a guideline with its use.

Recommended action: Add 91110 to lines 194 [Ulcers, GI Hemorrhage; Surgical Treatment] and 293 [Regional Enteritis, Idiopathic Proctocolitis, Ulceration of Intestine; Medical And Surgical Treatment] with the following guideline:

1) Wireless capsule endoscopy is covered for diagnosis of
    a. Obscure GI bleeding suspected to be of small bowel origin with iron deficiency anemia or documented GI blood loss
    b. Suspected Crohn's disease with prior negative work up
2) Wireless capsule endoscopy is not covered for
    a. Colorectal cancer screening
    b. Confirmation of lesions of pathology normally within the reach of upper or lower endoscopes (lesions proximal to the ligament of Treitz or distal to the ileum)
3) Wireless capsule endoscopy is covered only when the following conditions have been met:
    a. Prior studies must have been performed and been non-diagnostic
    b. GI bleeding: Upper and lower endoscopy
    c. Suspected Crohn's disease: Upper and lower endoscopy, small bowel follow through
    d. Radiological evidence of lack of stricture
    e. Only covered once during any episode of illness
    f. FDA approved devices must be used
    g. Patency capsule should not be used prior to procedure

Add 91111 [Esophageal use of wireless capsule endoscopy] to never covered list.

Bariatric surgery guideline changes: Required completion of weight loss program and cessation of illicit drugs and nicotine were discussed. See Attachment B for revised guideline.

Comfort care wording changes: There was a misconception that the intent of the commission was to only provide comfort care if a patient was given less than a six month prognosis, which would fall under hospice care. The intent is that comfort care be provided to all patients given a terminal prognosis. Dr. Smits, Dr. Shaffer and Mr.

Coffman will work on a solution with all interested Medical Directors and plan to propose a solution at the August meeting.

Percutaneous vertebroplasty guideline: This procedure may be employed to accelerate healing of cracked vertebrae. Evidence shows that patients are significantly improved during the first 6 weeks, over those treated conservatively. After 6 weeks, there is no difference in outcomes.

Recommended action: Adopt the guideline, as follows.

Vertebroplasty is included on line 112, Vertebral Fracture, under the following criteria:

1) Must be performed within the first 6 weeks after fracture
   a. Acute nature of fracture must be documented by MRI, X-ray or other modality
2) None of the following may be present:
   a. Coagulation disorder
   b. Underlying vertebral infection
   c. Severe cardiopulmonary disease
   d. Extensive vertebral destruction (>50% of height)
   e. Neurological symptoms related to spinal compression
   f. Lack of surgical back up for emergency decompression
3) Must document
   a. Pain is caused by non healing vertebral fracture
   b. Vertebral height is not more than 50% collapsed
   c. Procedure is not performed on a prophylactic basis
   d. Risks of open surgical approach are greater than risks of percutaneous approach

The following issues corrected condition/treatment pairings and housekeeping items:

Pinning of closed fracture: Add 20650 and 20670 to line 460

Thoracic vascular repair: Add 33320-33331, 33880-33891and 35211-35272 to line 114

PET scans for colon and testicular cancer:

1) Add line 191 and line 270 to Guideline Note 4 list of lines
2) Remove line 119 from Guideline Note 4 list of lines
3) Add 78811-78816 to line 191 and line 270
4) Add reference to Guideline Note 4 to titles of lines 191 and 270
5) Remove reference to Guideline Note 4 from line 119

V codes: ICD-9-CM codes are for various needs, immunization, personal history, family history, status codes. Dr. Smits reviewed V-codes in the range V01-V049 (see Attachment C)

The HOSC suggests all the changes are approved with the exception of the codes for a personal and family history of cancer, which are tabled until the August meeting. Also

tabled are codes V62.0 and V58.69, which have been used extensively and are seemingly costly.

Lymphedema is a condition where there is disruption of the flow of lymph through the lymphatic system in the legs or arms, typically due to surgery. This is currently on a non-funded line and the commission was asked to review this placement. Dr. David Pass from the Health Resources Commission spoke to the HOSC about this issue. He spoke about complex decompressive therapy (CDT), which is a combination of exercise, compressive massage and bandaging, and appears to be effective in reducing the amount of edema.

Dr. Smits and Dr. Pass will draft a guideline for review at the August meeting.

Recommendations from the May 3, 2007 HOSC meeting:

Unspecified Otitis Media: Delete from Chronic Otitis Media line 530: 382.9 (unspecified otitis media)

Cleft palate repair:: Add to line 110 (Cleft Palate With Airway Obstruction) and line 377 (Cleft Lip/Palate): 15732 Muscle flap pharyngoplasty

Croup: Add to croup line 16: 94640 - Inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes

Fluoride treatment: Add to line 298 (preventive dental services): 520.3 (mottled teeth).

Pelvic ring fracture: Add to line 474 (surgical repair of pelvic fracture): 805.6 (sacral fracture)

Chronic mesenteric ischemia: Add to line 293 to pair with 557.1 (chronic mesenteric ischemia): 35471 (percutaneous transluminal balloon angioplasty, renal or visceral artery) and 37205 (transcatheter placement of intravascular stent)

Routine pairings:

-721.42 (lumbar spondylosis with myelopathy) with 97530 (therapeutic activities, 15 min) and 97535 (self care/home management training) on line 324 (spinal deformities, clinically significant).

-883.2 (open wound of finger(s) with tendon involvement) and 881.20 (open wound of elbow, forearm, and wrist with tendon involvement) with 97110 (therapeutic procedure, 15 min) on line 375 (deep open wound).

-540.1 (acute appendicitis with peritoneal abscess) on line 12 (appendicitis) with 99231, 99232, 99233 (in hospital aftercare).

-146.0 (malignant neoplasm of oropharynx-tonsil) with 21557 (radical dissection of tumor) on line 234 (cancer of oral cavity).

-161.1 (malignant neoplasm of larynx-supraglottis) with 21555 (excision of tumor) and 60220 (total thyroid lobectomy) on line 234 (cancer of oral cavity)

-871.3 (open wound of eyeball) with 65101 (enucleation of eye) on line 396 (purulent endophthalmitits)

-Remove from line 234 (cancer of oral cavity): 20955, 20956, 20957 (bone graphs to low extremity areas)

Central pain syndrome: Add ICD-9 code 338.0 central pain syndrome to the stoke line 284

Ventricular Assist Device: Add VAD guideline #10 to Line 154. "Ventricular Assist Devices are only included on this line as a bridge to cardiac transplantation."

Cochlear stimulator: Place CPT codes 69714 and 69715 on lines 299 and 499; delete from lines 300 and 501

Tunneled catheter: Move CPT codes 36589 and 36590 to ancillary services list from line 145

Chronic anemia codes: Add to line 170 and remove from line 171: 285.21 - Anemia in chronic kidney disease, 285.22 - Anemia in neoplastic disease, 285.29 - Anemia of other chronic disease

Skin graft for urinary anomalies: Remove CPT codes from line 99: 15576 - Formation of skin flap transferred to eyelid, nose, ears, lips, intraoral areas; 15630 - Delayed flap to those sites to eyelid, nose, ears, lips, intraoral areas; 15732 - Skin flap to head or neck; 15734 - Skin flap to upper extremity

Tendon repair/ foot wound: Add CPT code to line 375: 28208 - Repair of tendon of foot, extensor

Intrathecal pump codes: Add to lines 140 and 216: 62360 - Implantation of intrathecal pump; 62361 - Implantation of intrathecal pump, non reprogrammable pump;
Add to line 216: 62362 - Implantation of intrathecal pump, programmable pump
Add to line 216, 333, 574, and 578: 62367 - Electronic analysis of intrathecal pump; 62368 - Electronic analysis of intrathecal pump with reprogramming
Add to line 333: 95990 - Refilling and maintenance of intrathecal pump; 95991 - Refilling and maintenance of intrathecal pump administered by a physician

Mr. Coffman stated that all these changes will be included in the interim modifications for implementation October 1, 2007, with the exception of the bariatric surgery

guideline. That particular guideline will be incorporated to the new list effective January 1, 2008.

MOTION: To approve the recommendations of the HOSC: MOTION CARRIES: 7-0.

IX. Report from Mental Health Care & Chemical Dependency (MHCD) Subcommittee

The MHCD Subcommittee met February 21, 2007 and are scheduled to meet again in July. The subcommittee was to discuss services for autism and autism spectrum disorders. As it happened that topic was also being discussed in the legislature. As HB 2918 has passed, the subcommittee tabled their review until after the Health Resources Commission's report is released.

Dr. Dodson reported that the subcommittee answered the HOSC's concerns regarding CPT codes 96150-96155 (behavioral health assessment and intervention). These services are not aimed at the individual with psychiatric conditions that are new or unrelated (comorbid) to other physical health conditions, but rather those individuals with chronic health conditions for whom psychosocial treatments would be useful in the management of that illness in dealing with their adjustment issues. This would involve a complementary part of the overall care of the patient that could be provided by a behavioral care specialist in the primary care setting. These services would likely be from a Master's-level Qualified Mental Health Provider (QMHP) working in an integrated primary care setting and likely be the responsibility of the FCHPs. This includes psychologists, social workers and nurses. The services could involve psycho-education, support, and motivational services that could also be provided in a group setting.

Dr. Saha proposed that staff work with the subcommittee to review the chronic disease lines which these codes should be added to and report back with this list of proposed additions to the prioritized list.

X. Report from OHP Standard Benefit Design Workgroup

The last meeting of this group was held in February, 2007. From that meeting, it was suggested that HSC staff work with the OHP medical directors to examine how private health plans are handing the management of diagnostic and other "line zero" services.

Another workgroup was formed consisting of HSC staff, Dr. Shaffer and the DHS Actuarial Services Unit. The new group met yesterday and outlined some of the approaches they may want to take regarding line zero, including looking at some services that could be moved to lines on the prioritized list; suggesting some services where guidelines are appropriate, and the institution of prior authorization where

appropriate. The new group will continue to meet regularly, though the OHP Standard Benefit Design Workgroup is now defunct.

XI. Report from Actuarial Advisory Committee (AAC)

The AAC met on January 31, 2007. The report on the Benchmark Rate Study was subsequently released in February. Mr. Coffman presented the report's findings to the OHP contractors and had one legislative inquiry. There did seem to be interest in the report this year but is unaware of any difference it made in the legislator's deliberation.

As Dr. Smith reported earlier, there is no funds budgeted for this report in the new biennium.

XII. Other Business

No other business was offered at this time.

XIII. Public Comment

No public comment was offered at this time.

XVI. Adjournment

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

Spinal Fusion (Arthrodesis)

CPT Code	Description	Line 112	Line 140	Line 208	Line 231	Line 324	Line 460	Line 474	Line 546	Line 593
22532	Lateral extracavitary technique, thoracic	**X**	**X**	**X**	**X**	**X**		X		
22533	Lateral extracavitary technique, lumbar	**X**	**X**	**X**	**X**	**X**		X		
22534	Lateral extracavitary technique, thoracic or lumbar, each add'l segment	**X**	**X**	**X**	**X**	**X**		X		
22548	Anterior transoral approach, occiput-C2	X	X	X	X	X		**X**	X	
22554	Anterior approach, cervical	X	X	X	X	X		**X**	X	X
22556	Anterior approach, thoracic	X	X	X	X	X		**X**	X	X
22558	Anterior approach, lumbar	X	X	X	X	X		**X**	X	X
22585	Anterior approach, lumbar, each additional interspace	X	X	X	X	X		**X**	X	X
22590	Posterior approach, occiput-C2	X	**X**	**X**	**X**	X		**X**	**X**	X
22595	Posterior approach, C1-C2	X	**X**	**X**	**X**	X		**X**	**X**	X
22600	Posterior approach, cervical	X	**X**	X	**X**	X		**X**	**X**	X
22610	Posterior approach, thoracic	X	**X**	X	**X**	X	~~X~~	**X**	**X**	X
22612	Posterior approach, lumbar	X	**X**	X	**X**	X	~~X~~	**X**	**X**	X
22614	Posterior approach, lumbar, each additional vertebral segment	X	**X**	X	**X**	X	~~X~~	**X**	**X**	X
22630	Posterior interbody technique, lumbar	X	**X**	**X**	**X**	X		**X**	**X**	X
22632	Posterior interbody technique, lumbar, each additional interspace	X	**X**	**X**	**X**	X		**X**	**X**	X
22800	Posterior, for spinal deformity, up to 6 vertebral segments	**X**	**X**	**X**	**X**	X		**X**	**X**	X
22802	Posterior, for spinal deformity, 7 to 12 vertebral segments	X	**X**	**X**	**X**	X		**X**	**X**	X
22804	Posterior, for spinal deformity, 13 or more vertebral segments	**X**	**X**	**X**	**X**	X		**X**	**X**	X
22808	Anterior, for spinal deformity, 2-3 vertebral segments	**X**	X	**X**	**X**	X		**X**	**X**	X
22810	Anterior, for spinal deformity, 4-7 vertebral segments	**X**	**X**	**X**	**X**	X		**X**	**X**	X
22812	Anterior, for spinal deformity, 8 or more vertebral segments	**X**	**X**	**X**	**X**	X		**X**	**X**	X
22818	Kyphectomy, single or 2 segments	**X**	**X**	**X**	**X**	X		**X**	**X**	X
22819	Kyphectomy, 3 or more segments	**X**	**X**	**X**	**X**	X		**X**	**X**	X

~~X~~=REMOVE FROM LIST
X=LEAVE ON LIST
X=ADD TO LIST

Line 112: CERVICAL VERTEBRAL DISLOCATIONS/FXS, OPEN OR CLOSED; OTHER VERTEBRAL DISLOCATIONS/ FXS, OPEN; SPINAL CORD INJURIES WITH OR WITHOUT EVIDENCE OF VERTEBRAL INJURY
Line 140: DISORDERS OF SPINE WITH NEUROLOGIC IMPAIRMENT
Line 208: CHRONIC OSTEOMYELITIS
Line 231: CANCER OF BONES, WHERE TREATMENT WILL RESULT IN A GREATER THAN 5% 5-YEAR SURVIVAL
Line 324: SPINAL DEFORMITY, CLINICALLY SIGNIFICANT
Line 460: CLOSED FRACTURE OF EXTREMITIES
Line 474: CLOSED DISLOCATIONS/FXS OF NON-CERVICAL VERTEBRAL COLUMN W/O SPINAL CORD INJURY
Line 546: BENIGN NEOPLASM BONE AND ARTICULAR CARTILAGE INCLUDING OSTEOID OSTEOMAS; BENIGN NEOPLASM OF CONNECTIVE AND OTHER SOFT TISSUE
Line 593: SPINAL DEFORMITY, NOT CLINICALLY SIGNIFICANT

Spinal instrumentation

CPT	Description	Line 112	Line 131	Line 140	Line 145	Line 208	Line 214	Line 296	Line 324	Line 474
22840	Posterior non-segmental instrumentation	X		X		**X**	X		X	**X**
22841	Internal spinal fixation by wiring of spinous processes	X		**X**		**X**	X		X	X
22842	Posterior segmental instrumentation; 3-6 vertebral segments	X		**X**		X	X		X	X
22843	Posterior segmental instrumentation; 7-12 vertebral segments	X		**X**		X	X		X	X
22844	Posterior segmental instrumentation; 13 or more vertebral segments	X		**X**		X	X		X	X
22845	Anterior instrumentation; 2-3 vertebral segments	X		X		X	X		X	**X**
22846	Anterior instrumentation; 4-7 vertebral segments	X		**X**		X	X		X	**X**
22847	Anterior instrumentation; 8 or more vertebral segments	X		**X**		X	X		X	**X**
22848	Pelvic fixation other than sacrum	X		**X**		**X**			X	**X**
22849	Reinsertion of spinal fixation device	X	~~X~~	**X**	X		X	X	X	**X**
22850	Removal of posterior nonsegmental instrumentation	X	~~X~~	**X**	X		X	X	X	**X**
22851	Application of intervertebral biomechanical devices to vertebral defect or interspace	X	~~X~~	X		X	X		X	**X**
22852	Removal of posterior segmental instrumentation	X	~~X~~	**X**	X		X	X	X	**X**
22855	Removal of anterior instrumentation	X	~~X~~	X	X		X	X	X	**X**

~~X~~=REMOVE FROM LIST
X=LEAVE ON LIST
X=ADD TO LIST

Line 112: CERVICAL VERTEBRAL DISLOCATIONS/ FRACTURES; OTHER VERTEBRAL DISLOCATIONS/ FRACTURES, OPEN; SPINAL CORD INJURIES
Line 131: OPEN FRACTURE OF EXTREMITIES
Line 140: DISORDERS OF SPINE WITH NEUROLOGIC IMPAIRMENT
Line 145: COMPLICATIONS OF A PROCEDURE ALWAYS REQUIRING TREATMENT
Line 208: CHRONIC OSTEOMYELITIS
Line 214: INTRASPINAL AND INTRACRANIAL ABSCESS
Line 296: COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
Line 324: SPINAL DEFORMITY, CLINICALLY SIGNIFICANT
Line 474: CLOSED DISLOCATIONS/FRACTURES OF NON-CERVICAL VERTEBRAL COLUMN W/O SPINAL CORD INJURY

HSC Approved Patient Eligibility Criteria for Bariatric Surgery Approved on 6/28/07

Bariatric surgery for obesity is included on Line 33, TYPE II DIABETES, under the following criteria:

1. Age ≥ 18
2. BMI ≥ 35 with co-morbid type II diabetes
3. Participate in the following four evaluations and meet criteria as described.

A. Psychosocial evaluation: (Conducted by a licensed mental health professional)

- **i. Evaluation to assess compliance with post-operative requirements.**
- **ii. No current abuse of or dependence on alcohol. Must remain free of abuse of or dependence on alcohol during a six-month observation period immediately preceding surgery. No current use of nicotine or illicit drugs and must remain abstinent from their use during the six-month observation period. Testing will be conducted within one month of the surgery to confirm abstinence from nicotine and illicit drugs.**
- **iii. No mental or behavioral disorder that may interfere with postoperative outcomes[1].**
- **iv. Patient with previous psychiatric illness must be stable for at least 6 months.**

B. Medical evaluation: (Conducted by OHP primary care provider)

- **i. Pre-operative physical condition and mortality risk assessed with patient found to be an appropriate candidate.**
- **ii. Maximize medical control of diabetes, hypertension, or other co-morbid conditions.**
- **iii. Female patient not currently pregnant with no plans for pregnancy for at least 2 years post-surgery. Contraception methods reviewed with patient agreement to use effective contraception through 2nd year post-surgery.**

C. Surgical evaluation: (Conducted by a licensed bariatric surgeon associated with program[2])

- **i. Patient found to be an appropriate candidate for surgery at initial evaluation and throughout a six-month observation period while continuously enrolled on OHP.**
- **ii. Received counseling by a credentialed expert on the team regarding the risks and benefits of the procedure[3] and understands the many potential complications of the surgery (including death) and the realistic expectations of post-surgical outcomes.**
- **iii. If the patient is found to no longer be an appropriate candidate for surgery for any reason listed in these criteria during the six-month observation period, a new six-month observation period will be required to precede surgery once surgical candidacy has been re-established.**

D. Dietician evaluation: (Conducted by licensed dietician)

- **i. Evaluation of adequacy of prior dietary efforts to lose weight. *If no or inadequate prior dietary effort to lose weight, must undergo 6 month medically supervised weight reduction program.***
- **ii. Counseling in dietary lifestyle changes**

4. Participate in additional evaluations: ~~*(Conducted after completion of medically supervised weight reduction program)*~~

- **i. Post-surgical attention to lifestyle, an exercise program and dietary changes and understands the need for post-surgical follow-up with all applicable professionals (e.g. nutritionist, psychologist/psychiatrist, exercise physiologist or physical therapist, support group participation, regularly scheduled physician follow-up visits).**

[1] Many patients (>50%) have depression as a co-morbid diagnosis that, if treated, would not preclude their participation in the bariatric surgery program.
[2] All surgical services including evaluation are to be performed at a center of excellence for bariatric surgery as recognized by Medicare.
[3] Only Roux-en-Y gastric bypass and laparoscopic adjustable gastric banding are approved for inclusion.

V Code Review
V01-V49

Question: Which V codes should appear on the list and which line(s) should they appear on?

Question source: HOSC, HSC staff, medical directors

Process:

1) List reviewed and V codes currently on list and their current location(s) determined
2) DHS consulted, status of each V code in DHS system determined
3) Samaritan Health System coders met with HSC staff; suggestions given for V code inclusion and placement
4) Proposal for inclusion/non inclusion of codes started by Medical Director

Recommendations:

1) Immunizations (V01-V06):
    a. Add
        i. V04.5, rabies vaccination, to lines 141 and 181 (preventive services)
            1. Recommended by Oregon Veterinary Association for certain animal bites
        ii. V05.4, varicella vaccination, to lines 141 and 181 (preventive services)
            1. On CDC recommended vaccine schedule
    b. Remove
        i. V06.9, vaccination with unspecified combined vaccine, from lines 141 and 181 (preventive services)
            1. Nonspecific
    c. Add to never covered list
        i. Travel vaccinations
            1. V03.0, V03.1, V04.4, V06.0, V06.2 (cholera, typhoid-paratyphoid, yellow fever, alone or with other)
        ii. Contact with smallpox (V01.3)
            1. Want notification if smallpox suspected
        iii. Non-specific vaccination codes: V01.9, V05.9, V06.8
        iv. Vaccinations not on current CDC vaccine schedule
            1. V03.3, V03.4, V04.1, V04.7, V05.2 (plague, tularemia, smallpox, common cold, leishmaniasis)

2) Miscellaneous 1 (V07-V08)
    a. Add
        i. V07.2, prophylactic immunotherapy including Rhogam, to pregnancy line 54 (maternity care)

b. Remove
    i. V07.4 (Need for prophylactic postmenopausal hormone replacement therapy) from line 181 (preventive care)
        1. USPSTF Guideline from 2005 recommends against prophylactic use of HRT for prevention of any condition in post-menopausal women; risks outweigh benefits
c. Add to never covered list
    i. Non specific immunotherapy codes (V07.39, V07.8, V07.9)

3) Personal history (V09-V15)
    a. Add
        i. V15.88 (history of falls) to line 181 (preventive services)
            1. Fall prevention is recommended screening and intervention in the over 65 population per screening table in List
    b. Add to never covered list
        i. V10-V15.7 (personal history of disease)
            1. Secondary use only per Samaritan
            2. Should put code for disease screening (i.e. colon cancer screening) first, and personal history (i.e. history of colon cancer) as secondary code
    c. Note: V09, V13.61, V14, and V15 codes other than V15.88 are secondary only codes per CMS

4) Family history (V16-V19)
    a. Add
        i. V18.9 (family history of genetic disease) to diagnostic line
    b. Remove
        i. All codes V16-V19 currently on list
            1. Currently on lines 141 and 181 (preventive services)
            2. Secondary only codes per Samaritan
            3. Should put code for disease screening (i.e. colon cancer screening) first, and family history (i.e. family history of colon cancer) as secondary code
    c. Add to never covered list
        i. V18.51, V18.59 (Family history of colon polyps, other digestive disorders)

5) Maternal/child (V20-39)
    a. Add
        i. V23.2 (pregnancy with history of abortion) to line 54 (maternity care)
            1. Thoroughness
        ii. V26.3 (genetic testing codes) to diagnostic list
        iii. V29 codes (“rule out” infant codes) to diagnostic list
    b. Add to never covered list
        i. V26.0-V26.2 (infertility codes)
        ii. V26.8, V26.9, V39 (nonspecific codes)
    c. Note: V21, V22.2, V26.5, V27 are secondary only codes per CMS

6) Behavioral/special senses (V40-V41)
    a. Add V40-V41 to never covered list
        i. Samaritan: not used
        ii. DHS: not allowable as primary code

7) Status (V42-V49)
    a. Remove
        i. Secondary codes per CMS
            1. V42.0 from lines 108, 109, 435
            2. V43.1 from line 406
            3. V43.3 from lines 147, 195, 310, 316
    b. Add to never covered list
        i. V43.22, V45-V49
        ii. Samaritan: these codes are secondary
    c. Note: V42, V43 (except V43.22), V44, V45 (except V45.7), V46.0, V46.2, V46.8 are secondary codes only per CMS

Note: all secondary only codes should be added to never covered list