MINUTES
LINE ZERO TASK FORCE
Thursday, May 22, 2003

Members Attending: Daniel Mangum, DO, Chair; Andrew Glass, MD; Ellen Lowe; Donalda Dodson, RN, MPH (late).

Staff Attending: Darren Coffman; Carole Romm, RN; Laura Lanssens.

Others Attending: Tom Turek, MD and Marylou Hazelwood, RN, Office of Medical Assistance Programs (OMAP); Tina Kitchin, MD, DHS Seniors & People with Disabilities; Alison Little, MD; Kevin Olson, MD, NW Cancer Specialists; Lori Calkins, DNS, Crestview Convalescent; Mary Marquez, Metro West Ambulance Service; Diana Jones, Oregon Health Policy & Research (OHPR); Lisa Gilliam, Schering-Plough Pharmaceuticals.

I. Call to Order

Dr. Daniel Mangum called to order the first meeting of the Line Zero Task Force at 8:45 a.m. in Room 104 of the Meridian Park Hospital Community Health Education Center, 19300 SW 65th Avenue, Tualatin Oregon. Darren Coffman noted roll.

II. PET Scans

Dr. Kevin Olson, Chief Medical Officer for NW Cancer Specialists, gave testimony about PET scans and other imaging services. He first disclosed that his oncology group owns a PET scanning device and that he orders PET scans as part of his practice.

Dr. Olson said that PET scans are used primary for two purposes. The first is in the diagnosis of non-small cell lung cancer and lymphomas. It is also starting to be used in the diagnosis of breast cancer as well, but that is not the standard of practice yet. PET scans are also used in the staging of melanoma. PET scans can show fast growing cancers that do not have a significant enough volume to show up on a CAT scan. They have a sensitivity (proportion of people with disease who have a positive test result) of 85-90% and a specificity (proportion of people without disease who have a negative test result) of over 90%.

The other use of the PET scan is to follow a patient who has undergone treatment for a previous diagnosis of cancer to see if there is active disease remaining. Whereas Dr. Olson thought that the findings from a PET scan as part of the diagnostic/staging phase might cause him to change the recommended course of therapy in 3 out of 10 cases, he thought that it would be far less likely to make a difference in monitoring the patient with metastatic cancer.

In both instances Dr. Olson said that the PET scans can help avoid the use of aggressive treatment that wouldn't work as evidence of the additional disease found by the PET scan that the other imaging methodologies did not detect. He felt that the use of PET scans for diagnostic purposes rather than for follow-up provided the most "bang for the buck."

OMAP currently has a prior authorization (PA) on PET scans administered by OMPRO using Medicare guidelines.

III. Incontinence Supplies

Lori Calkins, Director of Nursing Services (DNS) for Crestview Convalescent gave testimony on the use of incontinence supplies. She has recently instituted changes in her facility whereby they have moved to a system of using a nighttime product that allows them to change a patient only once per night unless they are a heavy wetter. This has reduced the staff time needed for turning/changing and has improved sleep and behavior patterns.

She was surprised to find that the Oregon Health Plan pays for incontinence supplies and believes that soap, water, and a washcloth can also provide good care at far less expense.

Dr. Tina Kitchin clarified that these supplies were being used by OHP patients who are in adult foster care and in residential care facilities (RCFs), but the majority are at home. Possible ways to reduce costs would be to:

- Limit changing to every three hours and once per night (150/month)
- Limit the number of products covered (by brand and by type)
- Limit the number of providers of incontinence supplies (it was acknowledged that OMAP had already looked into a sole source contract without success)
- Establish guidelines that limit supplies according to a person's diagnosis
- Use cloth diapers instead of disposables if a laundry facility is on the premises
- Exclude coverage of panty liners

IV. Transportation Services

Mary Marquez, Business Office Manager for Metro West Ambulance Service, spoke on transportation services. She gave examples of the different levels of service that they provide:

- ALS2 – heart attacks (ALS = advanced life-support)
- ALS1 – cardiac monitoring & IV provided
- ALS non-emergency – paramedic on board, could develop into ALS1 or ALS2
- BLS – flu, headache, stubbed toe (BLS = basic life support)
- BLS non-emergency – stretcher transport, discharges, transport to hospital for tests.

Ms. Marquez said that non-emergent transportation can be provided by ambulance, wheelchair car, or comfort car/taxi, as well as through public transportation modes. There was some discussion that non-emergent transportation services may become capitated services under the FCHPs or that brokerages may be established around the state. The task force thought that transportation services may prove to be the most difficult to control and decided to wait until the changes being discussed played out before the issue was revisited.

V. Chair's Report

Dr. Dan Mangum thanked the task force members for joining him in this ongoing quest to find efficiencies within diagnostic and ancillary services. He would like to continue to bring experts to the meeting in the hopes of cultivating new ideas for creating savings.

VI. Description of Database

Darren Coffman explained that the data he had circulated by e-mail was in the previous weeks represented those services that could not be associated with specific line items on the Prioritized List, usually due to a lack of an ICD-9-CM diagnosis code. He also pointed out that the data was "raw" and does not include adjustments made by PricewaterhouseCoopers on aggregated data in developing per capita costs for OHP. These adjustments included such factors as trend rates, cost-to-charge ratios, and administrative costs. Therefore the information should not be seen as true figures, but can be used for evaluating relative magnitudes of differences between the costs of services in order to identify areas that the task force may want to focus their efforts.

Mr. Coffman suggested that the task force should look only at the utilization and cost data aggregated by CPT code. Only about half of the claims in the database included a revenue center code and even less (5-10%) listed an ICD-9-CM procedure code. He also found a significant number of codes included in the ICD-9-CM procedure code field to actually be CPT codes put in the wrong column. Mr. Coffman said that while the ICD-9-CM procedure codes were included in the database he acquired, ICD-9-CM diagnosis codes were not included, as the vast majority of the claims falling into "line zero" did not include such a code.

VII. Discussion of Other Categories for Possible Cost Savings

Other categories of service that generate discussion on areas for possible cost savings included:

- Emergency Department (ED) visits - commercial insurance plans are aware that there is abuse for these visits and the plans insist that the consumer pays a high payment for going to the ED. Mr. Coffman noted that while OHP Standard clients are charged a $50 copay for ED visits if not admitted, OHP Plus clients pay

nothing for ED visits and $3 for physician office visits. Mary Lou Hazelwood indicated that OMAP's disease management program has a 24-hour triage phone line that reports on avoided ED visits.

- Office visits – Dr. Tina Kitchin asked the task force to consider developing a guideline to limit the number of diagnostic visits. This limit could be done by diagnosis code over a set period of time, with an exception process.
- PT/OT/Speech Therapy – limits similar to commercial plans might also be appropriate. OMAP requires PA's for most PT using InterQual criteria.
- Other imaging services – Dr. Glass said that most commercial plans have PA's on MRI's, MRA's, and nuclear cardiology. CT scans of the chest without a prior x-ray could be researched. The guideline already in place for line 143 is being used by some plans to limit MRI's.

VIII. Medical Director's Perspective

Dr. Alison Little encouraged the task force to continue to look into these areas for potential savings. She said that she attempted to place a limit on diagnostic visits while the Medical Director for COIHS. While she was not successful in this venture, she did not want to deter the HSC from pursuing that effort.

IX. FCHP Perspective

Carole Romm noted that while she and Bruce Goldberg were at CareOregon they had created a list of ICD-9-CM diagnosis codes that they considered inappropriate reasons for ED visits. It was suggested that such visits could be reimbursed at the lower rate for a screening visit, thereby encouraging visits for such maladies as earaches and runny noses to be taken care of at more appropriate level of care. It was thought that this would perhaps lead to the development of more urgent care centers around the state.

X. Next Steps

Dr. Andy Glass said that National Imaging Associates manages imaging for HealthNet of Oregon and usually can achieve savings between 10-15%. He will contact them about doing a presentation at a future meeting. The task force agreed with Dr. Olson it that the diagnostic use of PET scans was more cost-effective and perhaps the HSC should consider not covering them for ongoing monitoring.

Darren Coffman will contact Raj Gala, the new DME policy person at OMAP, to see if the task force can get data on who are using incontinence supplies, how much are they using, what proportion of supplies used are disposable, and what the obstacles might be in limiting supplies according to diagnosis code.

Carole Romm will provide the task force with the list of 50 inappropriate diagnostic codes for ED visits for their review.

XI. Adjournment

Dr. Mangum adjourned the meeting at 11:41 a.m. The next meeting is scheduled for Thursday, July 24, 2003, 11:30 am to 1:30 pm in Room 117B&C of the Meridian Park Hospital Community Health Education Center, 19300 SW 65th Avenue, Tualatin Oregon.

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Daniel Mangum, DO, Chair

MINUTES
LINE ZERO TASK FORCE
Thursday, July 24, 2003

Members Attending: Daniel Mangum, DO, Chair; Ellen Lowe; Donalda Dodson, RN, MPH; Dan Williams (late).

Members Absent: Bryan Sohl, MD.

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

Others Attending: Andrew Glass, MD, Health Services Commission (HSC); Tom Turek, MD and Chris Barber, Office of Medical Assistance Programs (OMAP); Megan Hornby, DHS Seniors & People with Disabilities.

I. Call to Order

Dr. Daniel Mangum called to order the meeting of the Line Zero Task Force at 11:45 a.m. in Room 117B&C of the Meridian Park Hospital Community Health Education Center, 19300 SW 65th Avenue, Tualatin Oregon. Darren Coffman noted roll.

II. Approval of Minutes

The minutes of the May 22, 2003 meeting were accepted as submitted with the exception of changing “primary” to “primarily” in the first sentence of the second paragraph on page 1 under Section II.

III. Chair's Report

Dr. Dan Mangum said he had nothing to report but asked the members how they thought things were progressing with the task force. Dr. Andy Glass said that he thought the May meeting was very informative and productive. Ellen Lowe noted that news was traveling fast that the task force is looking into incontinence supplies, which is an indication of how sensitive an issue this is.

IV. Emergency Department Visits

A list of diagnosis codes recognized by CareOregon as being inappropriate for Emergency Department (ED) visits was distributed (see Attachment 1). Carole Romm and Dr. Bruce Goldberg developed this list while still at CareOregon. ED visits with one of these ICD-9-CM codes and the principle reason for the visit were reimbursed at a lower “screening” rate. Dr. Mangum thought that consideration might be given to taking

enteritis and nosebleeds (784.7) off of the list, and possibly also acute gastritis and duodenitis (536.0-535.6).

It was thought to be contractually difficult to require plans to follow this method. Most plans are using their own system. Another negative aspect is that ERs and hospitals already think they are not getting paid enough. This could also potentially create another barrier to access if the client is unable to get into their primary care physician.

There was concern that some smaller hospitals might not be able to exist if hospital coverage is eliminated from the OHP Standard benefit package. There is also no additional funding in the safety net clinics in the budget that, along with urgent care clinics, would need to be expanded if there is no hospital benefit.

Staff were asked to see if they can get data on the utilization of the 50 ICD-9-CM codes on the list under fee-for-service (FFS), both in the ED vs. PCP setting. An inquiry should also be made as to how much cost savings CareOregon achieves with this system.

V. Imaging Services

Dr. Glass said that he has contacts with the National Imaging Association (NIA) through his work with HealthNet of Oregon. The can be accessed through the internet at www.radmd.com or www.nia.com. They have experience with both Medicaid and commercial plans in managing the utilization of imaging services. Dr. Turek thought that contracting with such a company would be worthwhile for OMAP to consider whether HSC recommends it or not. Dr. Glass was asked to invite a representative to speak to the task force at their next meeting.

The task force confirmed their intention to recommend limiting PET scans to diagnostic purposes only. Dr. Glass will draft language along with Dr. Kevin Olsen and Dr. Tom Dehn of NIA to present as a recommendation to the HSC. Lower cost measures will not be required first. Dr. Little will look at the language regarding Medicare's coverage of these services. Dr. Tom Turek noted that OMPRO reviews PET scans according to Medicare guidelines for OMAP FFS.

VI. Incontinence Supplies

Darren Coffman reported that he met with Raj Gala, who is the lead policy person for OMAP on durable medical equipment. He indicated that they are working with a very limited dataset on the utilization of incontinence supplies and could not provide anything more definitive than what the task force has already acquired. He hopes to have a more complete set of data to work with later in the year.

Megan Hornby, RN, representing Seniors and People with Disabilities (SPD) for Dr. Tina Kitchin, is concerned with further limitations on incontinence supplies. The majority of these clients are not in nursing homes and caregivers can't be relied on to provide

the additional personal care necessary when regular changings are limited. She added that this could lead to isolation by the client and other medical issues, with costs ultimately being shifted from OMAP to SPD. She indicated that SPD could work with OMAP on identifying outliers.

Case managers and caregivers make the decisions now as to how many supplies are provided. DHS is currently working towards centralizing approvals for incontinence supplies to create consistency across the state. Dr. Glass doesn't see the usefulness of centralizing a currently dysfunctional system when companies exist that have algorithms already in place. Another option would be to carve out these services to the local managed care plans.

There was a desire to work towards developing comprehensive guidelines for disposible incontinence supplies with cost in mind. Best practices were thought to be available through the literature. Bladder training program data could be used to help determine the needed number of supplies. Ms. Hornby said that SPD could contact the Providence Elder Place, which cares for about 400 clients, as she felt they have very good utilization management system in place and their figures would be a good representation of appropriate amounts. OMAP will also be contacted for their figures on average monthly usage and what the range is. Ellen Lowe believes that a greater limitation to number of supplies allowed could affect a behavioral change.

VII. Other Categories for Possible Cost Savings

Non-emergency transportation was briefly discussed. During the work of a previous task force, coverage of these services were found to be required under our waiver as it pertains to the OHP Plus population. These services are currently centralized under DHS. A question was asked of whether the HSC could somehow support the brokerages and appropriate triage of ambulance services?

VIII. Next Steps

The next meeting was tentatively set for September 25, 2003 to be in conjunction with other HSC meetings on that date, with the time to be determined. The task force will continue to work on the various issues as previously discussed.

IX. Adjournment

Dr. Mangum adjourned the meeting at 1:30 p.m.

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Dan Mangum, DO, Chair

ATTACHMENT 1

CareOregon
Focused List Of Diagnoses To Review For ER Claims
Revised 06/21/2001

ICD-9	DIAGNOSIS
008.8	ENTERITIS NOS/ GASTOENTERITIS
052.9	VARICELLA WITHOUT MENTION OF COMPLICATION
057.9	VIRAL EXANTHEM, UNSPECIFIED
074.0	HERPANGINA
079.00	INFECTION, VIRAL NOS
112.0-112.3	CANDIDIASIS
112.82	CANDIDIASIS
112.84-112.9	CANDIDIASIS
132.0-132.9	PEDICULOSIS AND PHTHIRUS INFESTATION
133.0-133.9	ACARIASIS
307.81	TENSION HEADACHE
372.0-372.05	CONJUNCTIVITIS
372.8-372.9	DISORDERS OF CONJUNCTIVA
372.10-372.12	CHRONIC CONJUNCTIVITIS
380.10-380.12	OTITIS EXTERNA
380.4	IMPACTED CERUMEN
381.0-381.9	NONSUPPURATIVE OTITIS MEDIA AND EUSTACHIAN TUBE DISORDERS
382.0-382.9	SUPPERATIVE AND UNSPECIFIED OTITIS MEDIA
388.70	OTALGIA, UNSPECIFIED
461.0-461.0	SUNUSITIS, ACUTE
462	ACUTE PHARYNGITIS
463	ACUTE TONSILLITIS
464.0	ACUTE LARYNGITIS
465.0-465.9	ACUTE UPPER RESPIRATORY INFECTIONS OF MULTIPLE OR UNSPECIFIED SITES
466.0-466.19	ACUTE BRONCHITIS AND BRONCHIOLITIS
473.0-473.9	SINUSITIS, CHRONIC
477.0-477.9	ALLERGIC RHINITIS
487.1	INFLUENZA WITH OTHER RESPIRATORY MANIFESTATIONS
521.0-521.9	DISEASES OF HARD TISSUES OF TEETH
522.0-522.9	DISEASES OF PULP AND PERIAPICAL TISSUES
523.0-523.9	GINGIVAL AND PERIDONTAL DISEASES
524.0-524.9	DENTOFACIAL ANOMALIES, INCLUDING MALOCCLUSION
525.0-525.9	OTHER DISEASES AND CONDITIONS OF THE TEETH AND SUPPORTING STRUCTURES
526.9	UNSPECIFIED DISEASE OF THE JAWS

528.0	STOMATITIS
535.0-535.6	GASTRITIS AND DUODENITIS
564.0	CONSTIPATION
595.0	ACUTE CYSTITIS
595.2	OTHER CHRONIC CYSTITIS
599.0	URINARY TRACT INFECTION, SITE NOT SPECIFIED
616.10	VAGINITIS NOS
623.8	OTHER SPECIFIED NONINFLAMMATORY DISORDERS OF VAGINA
625.8	OTHER SPECIFIED SYMPTOMS ASSOCIATED WITH FEMALE GENITAL ORGANS
625.9	UNSPECIFIED SYMPTOM ASSOCIATED WITH FEMALE GENITAL ORGANS
626.8	DISORDER, MENSTRUAL NEC
691.0-691.8	ATOPIC DERMATITIS AND RELATED CONDITIONS
719.40-719.49	PAIN IN JOINTS
723.1	CERVICALGIA
724.2	LUMBAGO
724.3	SCIATICA
724.5	BACKACHE, NOS
729.0-729.2	OTHER DISORDERS OF SOFT TISSUES
780.6	FEVER
780.79	MALAISE AND FATIGUE NEC
780.9	SYMPTOMS, GENERAL NEC
782.1	RASH, OTHER NOSPECIFIC SKIN ERUPTION
784.0	HEADACHE
784.1	PAIN, THROAT
784.7	EPSTAXIS
786.2	COUGH
787.0-787.0	SYMPTMS INVOLVING DIGESTIVE SYSTEM
873.63	BROKEN TOOTH W/O COMPLICATION
V65.5	PERSON W/FEARED COMPLAINT
V67.59	FOLLOW-UP EXAM NEC
V68.1	ISSUE REPEAT PRESCRIPTION
V68.81	REFERRAL OF PATIENT WITHOUT EXAM
V71.8	OBSERVATION, SUSPECT CONDITION NEC

MINUTES
LINE ZERO TASK FORCE
November 20, 2003

Members Present: Daniel Mangum, DO, Chair; Andrew Glass MD.

Members Absent: Ellen Lowe; Donalda Dodson, RN, MPH; Dan Williams.

Staff Present: Darren Coffman; Alison Little, MD; Carol Anderson.

Staff Absent: Laura Lanssens.

Also Attending: Tom Turek, MD and Mary Lou Hazelwood, RN, Office of Medical Assistance Programs (OMAP); Thomas Dehn, MD, FACR, National Imaging Associates, Inc.

I. Call to Order

Dr. Dan Mangum, Chair, called the Line Zero Task Force to order at 8:00 am in Room W112 of the Clackamas Community College, Wilsonville Training Center, 29353 Town Center Loop East, Wilsonville, OR. Darren Coffman noted attendance.

II. Approval of Minutes

The Line Zero Task Force minutes from July 24, 2003 were approved as written.

III. Presentation by Thomas Dehn, MD, Chief Medical Officer, National Imaging Associates, Inc (NIA)

Dr. Dehn presented information about his company, beginning by expressing his admiration for the Oregon process (the series of PowerPoint slides he presented are included as Attachment A). He pointed out that radiology services typically account for 10 to 15% of medical expenditures, and his program is one way of trying to control these costs. They are currently in the process of negotiating with Regence and Providence to implement their program, and if this comes to fruition, it would be very efficient to work with OMAP as well. He also reported his awareness that one of their competitors had been in the state a few years ago (HealthHelp) and had alienated many providers. This resulted in some negative opinions regarding radiology benefits management in general.

He then explained that it is possible to construct a table using CPT and ICD-9 codes to determine appropriateness of a procedure. In general, 72% are appropriate based on

coding. In response to a question by Dr. Mangum, he explained that on audit, the coding is consistent with the clinical picture, because those who do sloppy coding are balanced out by those who up-code to increase their revenue. There is very little evidence-based medicine in radiology. There is a problem with demand management. It is unknown how much should be inappropriate. It is clear that if 100% of tests are appropriate, there is probably under-utilization, but it is not known what the right amount is. His program can shift the mean of the utilization curve, and can identify truly high utilizers. Shifting the curve is where cost control occurs. He stated that physicians are making $1000 buying decisions without any accountability. Even strictly using prior consultation and not denying any services, as his company does for United Health Care, succeeds in achieving 80% of the cost savings that they would with the full prior authorization program. His estimate is that 85% is probably the ideal percentage for appropriateness of services.

His company is fully URAC and NCQA certified and was awarded the URAC HIPAA privacy accreditation. They currently do business with Gateway, which is the Medicaid program in Pennsylvania, as well as Amerigroup, which is also a Medicaid program. They cover approximately 12 million lives, of which about 500,000 are Medicaid. He reported that the population in Oregon is similar to that of Colorado, with a basically healthy population who does not utilize a lot of services. The current commercial trend in Oregon for radiology services is 26 to 30%. It should be closer to 6 to 8%. In Oregon, cardiologists use echocardiography more than nuclear cardiology. The reverse is true on the East Coast. Dr. Mangum asked how much of the trend was due to the practice of defensive medicine. Dr. Dehn responded that those costs should be included in the 6-8% trend that they strive for.

One aspect of his program may involve evaluation and limitation of the panel of radiologists providing service. In Oregon, he feels the quality is good, however, some radiologists insist on performing unnecessary tests, such as a CT of the pelvis every time one of the abdomen is done. He recommends a program of graduated payment, so that for multiple exams, only a percentage is paid for additional testing after the initial one.

Other than the above, the primary complaint that will be heard is from primary care offices, who have to place the call for prior authorization. To minimize this inconvenience, their call center has service guarantees built into the contract. Prior authorization is only required for outpatient exams, and does not apply to the ER or inpatient exams. Dr. Mangum asked whether or not it could be applied to the ER. Dr. Dehn responded that theoretically it is possible, and that profiling can also accomplish similar results. He clarified that the studies that require prior authorization are CT, MRI, nuclear cardiology and PET. Also, a denial never occurs unless there has been a physician-to-physician discussion first. This significantly limits the number of appeals, but a secondary appeal process is also available. He then described the profiles of the various specialties, which showed that the obstetricians and urologists have the highest level of consistency, while primary care and ER physicians have the lowest, with cardiologists being close behind (primarily because of all the codes added on to the

primary exam). He recommends case rates for nuclear cardiology. There was discussion about whether or not such negotiations were allowed. Dr. Turek confirmed this would not be outside the rules of OMAP. Another area to focus on is duplicate payment, where the same exam is performed twice, simply because there is a lack of communication between physicians.

He next discussed the network, and steering patients to preferred providers. There was again discussion about whether or not this was feasible or legal. Sometimes limitation of the network can be done based on quality (for example, if a radiologist is not on site, this can result in the need for repeat studies with contrast at a later time that could be avoided if the radiologist had been present at the first exam).

Next he described the call center, which takes about 200,000 calls per month. An algorithm is used which approves about 65% of the cases in the first 2 minutes by a clerk. An authorization number is then provided on the website so that both the referring physician and the radiology center have access to it. If the request fails the algorithm, it then goes to a nurse, who approves about 20% more cases. There is an iterative process of looking at what is always approved to update the algorithm. About 20% of requests get reviewed by physicians. It is likely that a pod of physicians will be hired in Oregon. They are ideally radiologists, but if unavailable, they will be internists, orthopedists and neurologists. Company physicians are available at any time to speak with the requesting physician between the hours of 8:00 am and 5:00 pm.

The algorithm they use was built by NIA and is called Case Logic. In one analysis, they found that 20% of the lumbar MRIs ordered had no corresponding E&M code, suggesting that they were ordered after only a phone consultation. Also, 18% of the studies done had been suggested by the radiologist in a written report. He then reviewed utilization of the commercial population in Oregon, and showed that on average, there is about one exam per person per year. This rate is not significantly different for managed care versus PPOs in Oregon, though it is in California. In general, there are 3 times as many exams in the Medicare population, and half as many in the Medicaid population. One exam to be alert for is ultrasound, as used equipment is inexpensive, and many primary care physicians are performing and interpreting the exams. This can be controlled by requiring the use of an ultrasound technician, or requiring that the physician be accredited by the Institute of Ultrasound in Medicine or the American College of Radiology.

Next, he showed the Task Force utilization tables broken down by patient demographics. It was agreed that our population may be somewhat higher utilizers because of the higher proportion of disabled members compared to a commercial population. He presented the standards for physician profiling, as outlined by the American Academy of Family Practice and embraced by his company. They should include an opportunity to change behavior, or presentation of the profiling will be useless. As an example, he presented spiral CTs of the chest as a screen for lung cancer, and showed how he identified the physicians ordering these exams, which are not covered.

The cost of this program is around $.30 PMPM for a commercial plan. This is modified by call center performance and achievement of projected savings. It would likely be less for a Medicaid plan (~$.20 PMPM).

Dr. Glass asked about the quality of the physician reviewer panel. Dr. Dehn explained that they currently employ about 40 physicians, and every afternoon, they hold a "denial meeting", which provides them an opportunity for peer review and assures inter-rater reliability. Dr. Turek stated that for OMAP to move forward, they would need an estimate of the amount of money that could be saved. There would also need to be an RFP. Then, the legislature would need to give their approval. Discussion occurred regarding whether or not such a program would be blocked by political lobbying. It was felt that it would not be, as the constituency affected is relatively small (primary care physicians and radiologists). It was also discussed whether or not some modification would need to be made to the algorithms to accommodate the Prioritized List.

IV. Imaging Services

A. Medicare Coverage of PET scans

Dr. Mangum had suggested that PET scans be limited to use for diagnosis. Dr. Little referenced the Medicare criteria in the packet, noting that in Medicare, PET is used primarily for staging. Dr. Turek pointed out that PET currently requires prior authorization by OMPRO, who uses Medicare criteria. Ultimately it was decided to not specifically limit PET use, but to have this monitored by an imaging service similar to the one presented today.

V. Incontinence Supplies

Dr. Kitchen began the discussion, and reported that the utilization information that she got from the Providence ElderPlace program was not helpful. She then surveyed the contracted health plans regarding their incontinence supply statistics and policies. Policies vary widely between plans. She reported that the current limit is 360 per month, which is 12 per day. Most plans average 150 to 180 per month. She felt that a limit of 200 per month with an easy exception process would be reasonable. In addition, she suggested possibly limiting auto shipping, in which a set amount of supplies are shipped each month, regardless of need. It is administratively simple, but tends to promote over utilization (supplies used by someone else, or not used). It was agreed that the goal is to decrease inappropriate use only, but not to limit supplies to those who truly need them. Discussion also occurred regarding sole sourcing. It was agreed that there was political opposition to this concept, but that the Commission could recommend this strategy to achieve economies of scale. A competitive bidding process was suggested by Dr. Glass, and Dr. Kitchen replied that there were some in the legislature who were opposed to this, on the grounds that it will limit access, especially in rural areas, and that it impacts some rural providers' business. Dr. Turek reported that when OMAP

decreased the allowable reimbursement for these items during the last legislative session, they were told to reverse it by the legislature. The following was ultimately recommended to OMAP:

- that the number of incontinence supplies allowed per month be decreased to 210 (6 per day and one at night), with an exception process
- that a single source or limited group of suppliers be selected by competitive bidding, with a requirement that they be able to serve the entire state
- that the autoshipping procedure be examined and limited

There was additional discussion about the email from Jack Sanders regarding the type of products used. Specifically, that bladder control pads are used inappropriately instead of doublers, and that there is disagreement over the necessity for pull ups, but no further recommendations were made.

VI. Emergency Department Visits

A. OMAP Study in Progress

Mr. Coffman reported that he had spoken with Judy Mohr-Peterson at OMAP. The Task Force had asked previously what kind of change in utilization CareOregon had seen after implementation of a program in which certain diagnoses, identified by ICD-9-CM codes, are paid at a lower, triage rate instead of at the usual ER charge. She responded that she could not answer that specific question, but that CareOregon continues to have the highest number of emergency department visits per member of any plan in the state. They are in the midst of a study on this topic that should be completed next month, hence Mr. Coffman asked her to present the results of that study to the Task Force at the next meeting.

VII. Adjournment

Dr. Mangum adjourned the Line Zero Task Force meeting at 10:00 am. The location, date, and time of the next meeting are yet to be determined.

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Daniel Mangum, DO, Chair