



Heart *of the* Matter

A Publication of the Pennsylvania Chapter of the American College of Cardiology

President's Message *A.J. Conrad Smith,* *MD, FACC*

A great deal has happened since our last newsletter; we had another excellent chapter meeting in Harrisburg on April 5th, and we have made great strides in making the voice of PA cardiologists heard on two important issue **PCI without onsite surgical backup** and **Highmark re-credentialing for imaging services**. See page 10 for a summary of the events of the Chapter meeting. I will focus on the two issues of PCI and imaging.

As you may know the PA Department of Health (DOH) has granted waivers to a number of hospitals so that they can perform both emergent PCI for acute MIs and elective percutaneous coronary intervention (PCI). The PaACC has weighed in on these decisions on a number of occasions. When this process started the then president of the chapter went with a group of members and attempted to generate a dialogue with the DOH to make sure the specialist physician input would be considered. The PaACC was not included in this process.

To date 12 programs have been given waivers. Initially the rationale was the need for patient access – the programs were in geographically remote areas. But as the process evolved, fewer and fewer criteria were used to determine which programs were granted the waivers. Unlike other states monitoring these programs, there were no minimum volume criteria. This has culminated in the granting of a waiver to a hospital in eastern PA that has not done a single **diagnostic** catheterization, and two programs that have 10 tertiary care centers within the same county performing PCI with surgical backup.

We made additional overtures to the DOH at our 2004 Chapter meeting, where we invited their Deputy Secretary of Quality Assurance to participate in our meeting and discuss the topic. We, at that time, reiterated our interest in being involved in the process in an advisory capacity. The DOH at that time did not accept our offer. Our interest as a chapter has always been the

A.J. Conrad Smith, MD, FACC



maintenance of the highest possible quality for the cardiac patients in PA. As we learned of the qualifications of some of the programs that had been granted waivers we were very concerned that this quality was not being rigorously

pursued. Our concerns were heightened by two recent piece of data; 1) The David Wennberg article in JAMA (JAMA 2004;292:1961-8) and 2.) The Pennsylvania Legislative Budget and Finance Committee (LB&FC) report, *Quality Assurance for Specialized Clinical Services*, conducted pursuant to House Resolution 356 of 2003.

In the Wennberg article they looked at Medicare data on patients that received PCI at facilities with and without on site surgical back up. They found that among those having elective PCI the mortality was 38% greater at the programs without back up, and that the bulk of this excess mortality was in programs that did fewer than 50 Medicare PCIs/year.

As Medicare PCIs may only be a fraction of the number of PCIs performed at these facilities the true minimum cutoff may be 100 or 200 total interventions/year (for 50% and 25% Medicare populations respectively). Data from the LB&FC is in agreement with these findings.

The LB&FC was directed by House Resolution 356 in 2003 to “in consultation with health care experts and specialists, to study health care services requiring extraordinary expertise and resources such as cardiac catheterization, open heart surgery and organ transplants. The resolution also requires identification of standards for the safe and

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President's Message

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effective provision of such services...” We have worked closely with the LB&FC evaluation and interpretation of the data. The LB&FC released the findings of their intensive investigation in April (the report in its entirety is available at the following link <http://lbfc.legis.state.pa.us/>). Concerning data show that 2 of 3 hospitals providing PCI without on site surgery in 2003 performed, on average, only 4 interventions/month. This number is far below the minimum number of 200 that the ACC/AHA guidelines recommend for a facility performing PCI. Perhaps the most concerning finding was that one of the hospitals had underreported the number of deaths that had occurred at its facility. Given these and other equally concerning findings, the LB&FC has made a number of recommendations, including; 1.) the formulation by the DOH, in conjunction with the PaACC, of a cardiology oversight committee to evaluate these programs and make recommendations, and 2.) the institution of a moratorium on granting new waivers.

I think this is a critical development and an important step toward making sure that the cardiac patients are receiving the highest possible quality of care. Indeed, even prior to the release of this report, another set of overtures to the DOH were made and culminated in a meeting in January of this year where the DOH expressed interest in getting the PaACC involved in the process. We at PaACC will continue to work with the legislature and make ourselves available to the DOH. I would like to recognize and thank the following members of the PaACC PCI Task Force for their hard work and dedication to this process--Drs. Joe Cacchione, Paul Casale, Steven Ettinger, Howie Herrmann and Ancil Jones.

On a different note, we have also been successful in advancing the dialogue that we opened with Highmark Blue Cross Blue Shield regarding their new privileging guidelines on imaging. Our Imaging Task Force met with them on April 20th, and as a result of this meeting Highmark has agreed to:

- Release a statement explaining that the privileging program implemented in Pennsylvania is representative of the current market and is not intended to disadvantage cardiovascular specialists from providing imaging services.

- Include ACC representatives in four Highmark committees responsible for evaluating coverage for imaging services, including MR and CT. The representatives will be selected by the PaACC.
- Remove language from the guidelines stating credentialed physicians certified in advanced cardiac life support (ACLS) or advanced radiology life support (ARLS) can perform stress testing.
- Evaluate the differences between accreditation criteria established by the Intersocietal Commission for the Accreditation of Nuclear Medicine Laboratories (ICANL) and the ACR.
- Allow sharing or part-time ownership of nuclear imaging equipment on a case by case appeals basis.

These are very important accomplishments, especially the development of PaACC input on advisory boards so that we as an organization comprised of greater than 90% of the cardiologists in the state, will have some say input into the modification of these guidelines. We look to our members to notify their district councilors, and/or the main PaACC office of any problems that you may be experiencing because of the new guidelines. We want to represent you as aggressively as possible, but we need to know your specific concerns and issues. Again I would like to thank the following members of the Imaging Task Force, Drs. Bob Biederman, Joe Cacchione, Steven Ettinger and Bill Follansbee, for their aggressive defense of our interest in imaging as cardiologists.

Vice-President's Report

Steven M. Ettinger, MD, FACC

Reality: *The quality or fact of being real; the quality of being true to life.*

Upon my return home from the national ACC meeting in Orlando, this was the first word that came to mind (no reference to the results of the recently released REALITY Trial). As I was greeted by my wife and daughter at the arrival gate at the newly renovated Harrisburg International Airport they inquired, "How was the meeting?" (A question I am certain that all who attended were asked within minutes of their arrival home). I am certain that *reality* would not be what the pharmaceutical and device industry hoped to hear was the word I thought best described my four-day visit to Orlando. I am certain that they would be much happier if I talked repeatedly about their drug or device or imaging equipment. I am certain that they did not hang their companies name on the side of my hotel, on the bottles of water I drank or on the bag I lugged around from morning till night simply for me to say, "*Reality*". In addition, I am certain that the planners of the scientific meeting would rather I mention the Presidential Plenary Session and Larry King or the Late-Breaking clinical trial results. However, try as I might I could not find a better word to define the ACC 54th Annual Scientific Session than *reality*. While this may seem trite and simplistic, I would like the opportunity to explain why I believe that on a scientific, educational and advocacy level *reality* is truly the definitive word that best describes this conference.

It all started as I sat at the Board of Governors meeting late Saturday afternoon. After several speakers discussed the direction and position that our national leadership was taking, I became immediately impressed by the incredible amount of work and effort that is being made on our behalf by the College to deal with issues relating to cardiac imaging. Being somewhat optimistic [and naïve] myself, I was hoping that we would have reached a consensus with our colleagues in Radiology by this time. As you may be aware, the chair of the American College of Radiology's board of chancellors was one of four imaging representatives to deliver testimony before the U.S. House Ways and Means Committee's

subcommittee on health. Radiologists are testifying before Congress in an effort to establish standards for allowing only qualified physicians to perform imaging studies. Subcommittee members are well aware of the possibility of a turf battle in disguise, questioning whether radiologists are trying to develop a monopoly in diagnostic imaging.

It is essential that we achieve an understanding about the best way to not only utilize this technology but to train all physicians - independent of specialty, who are interested in mastering this non-invasive technique. Unfortunately this altruistic vision may not become *reality*. Stringent guidelines are presently being created by the various imaging societies in an effort to define providers who may utilize this technology.

The *reality* of this scientific, educational and advocacy issue is that we all must get involved and have a voice in the formulation of these guidelines. This is a critical issue as it relates to our abilities to improve upon the care we offer our patients. In *reality*, we all must work together and not exclude any group or individuals who wish to utilize this imaging modality.

The *reality* of this issue is that government and health insurers are getting involved in the decision making process and our position and concerns need to be heard. It is critical that we not only support the recommendations and guidelines proposed by our society but follow through on a state and national level with their requests as it relates to contacting members of the legislature.

Another scientific, educational and advocacy issue arising from this meeting relates to the fact that standards of excellence and evidence based practices need to be achieved and maintained by all health care providers. The *reality* is that we cannot all be experts as it relates to the various techniques and studies utilized in the practice of cardiology today. While this statement may seem to be critical and contentious to some, it is supported by the fact that many of us have added additional training time for different subspecialties within the field of cardiology.

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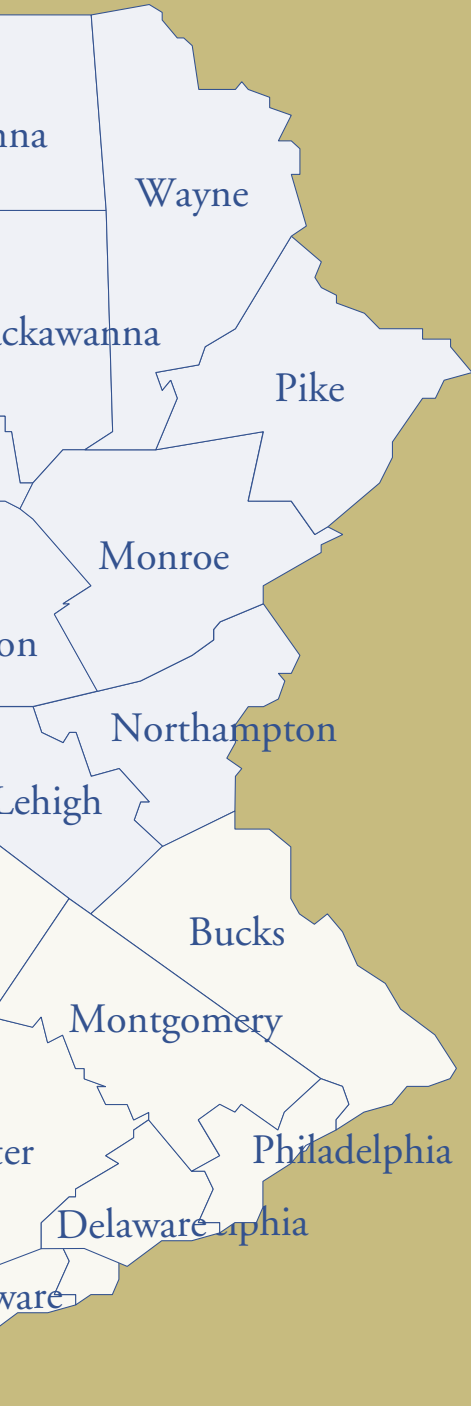
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Cardiac Care Associates Update

Michelle J. Nickolaus, MSN, CRNP

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We have exciting news from both the ACC and our PaACC Meeting. Presently there are 1,716 CCA members in the nation as of March 1st. At the ACC meeting in Orlando, the CCA State Network Liaisons met and we were updated with the latest progress. If you don't already know we have a membership toolkit for CCAs that contains information on CCA membership and benefits, frequently asked questions, application materials and contact information for the national office. This kit is being updated with the latest contact information for all State Liaisons; however in the meantime if you need one for your institution to encourage others to join, please contact me and I will get you one.

The CCA National Working Group on Continuing Nursing Education will be having their meeting with American Nurses Credentialing Center (ANCC) shortly at Heart House to obtain continuing nursing education accreditation through the ANCC for education programs. There are currently self-assessment programs (SAP) which are available on a variety of topics including Lipids, Heart Failure and Acute Coronary Syndrome. These come with CME credit and are priced with special discounts for CCA membership. Cardiosource Premium, which presently costs extra, is being discussed as a basic offering for all members.

Be on the look out as the ACC is in the process of developing a Bulletin Board for CCA members to discuss issues and concerns to their patients and careers. In addition, a Speakers Bureau is in development to assist members and local volunteers identify speakers that can present to audiences of cardiac care team members. Check out <http://www.acc.org/ccca/home/home.htm> regularly for updates.

Finally our Pennsylvania chapter is consistently GROWING! We now have 121 CCA members; 3% are Clinical Nurse Specialists, 16% are Physician Assistants, 40% are Registered Nurses and 41% are Nurse Practitioners. We have the second highest in numbers in the nation and I believe we are becoming a leader in the way of recognizing and integrating CCAs into our chapter.

In addition to the new bylaws being passed recently which incorporates the CCA membership

category, we decided recently at the Executive Council meeting in Orlando that we would like to have a CCA sit on the Educational Committees of both the East and the West. As well, we are preparing for elections of District CCA Liaisons who will be paired with each of the District Counselors in each region.

The District CCA position will be a 2-year term. Responsibilities will be to work with the District Counselor to organize a regional meeting at least once during the year. Our staff at PaACC will be able to provide the meeting manager support and secretarial support to assist in these endeavors.

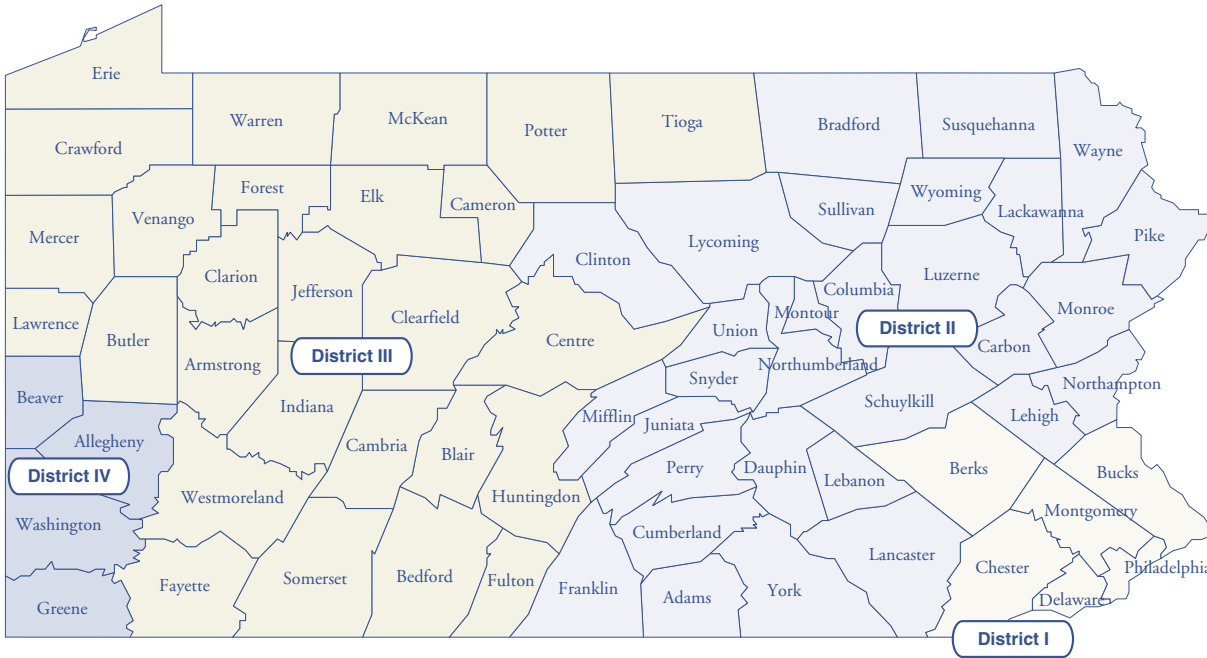
So now is the time to get involved! We are now accepting nominations by district. If you would like to nominate someone or yourself for any committee or the District Liaison position, please email me (mnickolaus@psu.edu) or Maria Elias (melias@pamedsoc.org) at the Chapter office. Nominations will be accepted through June 30. Each potential candidate will be required to submit a CV and brief bio. Elections will occur online by September. More information will follow.

We will be sending out a survey soon to find out what CCAs want/need out of ACC.

I extend the warmest invitation for your nominations and participation. We want to hear from you. This is our organization so for all of us; physician, nurse, physician assistant- it will only be as STRONG as we make it. I welcome all your questions and suggestions as we work together to make our Chapter even stronger than it already is.

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District Map ● Pennsylvania Chapter/ACC Districts



Districts by Postal Zip Codes

- District I 18900-19699
- District II 17000-18899
- District III 15400-16999
- District IV 15000-15399

Vice President's Report

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I would not profess to understand all of the intricacies of the latest bi-ventricular device. So perhaps I should not be implanting these devices even though I am able to access the coronary sinus. However, if I wanted to pursue this option, with proper training and oversight there should be no impediment to my desire to learn a new technique. The *reality* therefore, is that if we are to be the stewards of current and future technologies then we must be willing to regulate ourselves and to hold our practices to the highest standard possible. Clinical competency guidelines do just that. If we are to succeed as an organization, then we need to make certain that all physicians uphold our guidelines. Physicians who achieve these standards should be allowed to practice without impediment. In addition, physicians who are “short of the mark” must be provided with opportunities by which they can realize these established clinical competency goals.

Those who desire the opportunity to participate in diagnostic and therapeutic procedures in which they were not trained during formal fellowship must seek appropriate alternative training avenues. Here is where the state chapters and national ACC can help its membership. The issues that confront us relate to all fields of non-invasive [TTE, TEE, stress-echo, nuclear, MDCTA,

MRI] and invasive [coronary, peripheral, carotid, implantable devices] cardiology. The fact of the matter is that our CT surgical colleagues have been scored, graded and ranked on a state level for years. They have had to deal with competency issues in a public forum. This will soon be our *reality* and it is essential that we all understand and support the recommendations of ACC/AHA and SCAI clinical competency guideline statements. One can only envision how reimbursements might be linked to these guidelines in the very near future.

Finally, the scientific session served a very personal function. I was able to re-establish contact with a friend of mine who trained with me during my Fellowship at Penn State University –Hershey Medical Center. Even though we live relatively close to one another, the *reality* of practice and family minimized the time we share together. The 54th Scientific Session allowed us to “catch up” on life and recognize what our friendship was all about. In a very important way, the Scientific Session and the state chapter meeting serves as an opportunity to re-establish old friendships and to create new ones. And in *reality* isn't that what life is all about.

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John S. Wilson, MD
Pittsburgh

Disease Management Programs

American College of Cardiology

The Disease Management Association of America (DMAA) defines disease management as:

“A system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant.”

According to the American Medical Association more than 105 million people in the United States suffer from one or more chronic diseases and this will grow to 157 million by 2010. There are currently 4.9 million Americans with heart failure¹ and the number is expected to grow to an estimated 10 million in 2037². Similarly, hospitalization rates for heart failure related admissions are on the rise and it is likely that 50% of patients will be readmitted within six months of discharge.³ It is estimated that total costs associated with heart failure are reaching 21.4 billion⁴

Heart failure is the highest volume for hospital admissions for the Medicare program; it affects 14% of Medicare beneficiaries and accounts for 43% of Medicare expenditures.⁵

Widespread failings in chronic care management are a major national concern. The failings are from systemic problems rather than lack of effort or intent by physicians to deliver high quality of care. Medicare beneficiaries are disproportionately affected because they typically have multiple chronic health problems. Those with multiple chronic diseases are a costly subgroup of the Medicare population, representing 2/3 of all Medicare fee-for-service program payments.

Payers, both public and private are implementing disease management programs to address these issues. The use of disease management programs by payers and employers is increasing rapidly. While payers see disease management as mechanism to improve patient care, it also often is valued because of projected cost savings.

A primary function of disease management is to identify chronic conditions, such as, heart failure and diabetes, early prior to complex episodes and treat these patients in a more effective manner that will result in a slower progression of the disease.

Physicians, in many cases, are skeptical of disease management programs. This skepticism has been fueled by a number of forces including early confusion between disease management and pharmaceutical marketing, lack of a clear definition of what DM is really all about, plus the inherent concern over anything new. While physicians may show resistance to specific disease management programs that may be implemented by specific

payers, they do understand there is need to develop effective and efficient processes utilizing appropriate members of the cardiac care team to meet the needs of patient with chronic disease.

It is important to clearly define disease management so that past perceptions are dismissed. Disease management is a process of organizing care for specific high-cost and/or high volume conditions, with the intention of improving outcomes and, when possible, lowering overall costs.

Medicare Health Support Program

The Medicare Modernization Act (MMA) authorizes the development and testing of the Medicare Health Support Program (MHSP) to improve the quality of care for beneficiaries with multiple chronic illnesses. The intention of the Program is to assist participants in adhering to their physician's plan of care and obtain the necessary care to reduce health risks. This initiative represents one of multiple strategies that the Department of Health and Human Services (DHHS) is developing and testing to improve chronic care, accelerate the adoption of health information technology, reduce avoidable costs, and diminish health disparities among Medicare beneficiaries nationally.

This program is the first large-scale chronic care improvement initiative under the Medicare FFS program. Centers for Medicare and Medicaid Services (CMS) has selected, through a vigorous bidding process, nine organizations that will offer self-care guidance and support to chronically ill beneficiaries. Health Dialogs (HD) was selected to develop a program for western Pennsylvania. HD is a health coaching company. HD is interested in working with the chapter to develop an effective program.

The MSHP will be initiated in Central Florida, Tennessee, Chicago, Oklahoma, Mississippi, Georgia, Western Pennsylvania, Washington, D.C., Maryland, and New York City (Queens and Brooklyn). The total population in these areas represents at least 10 percent of the Medicare FFS beneficiaries. The primary focus will be programs for chronic heart failure (CHF) and/or diabetes, and COPD with significant co-morbidities. Program participants will be based on selection criteria that will identify at least 30,000 beneficiaries in each area. The participants will be split between intervention and control groups.

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The Voluntary Chronic Care Improvement Program

Pilot in Pennsylvania

Medicare Health Support

The Pennsylvania Program

Health Dialog Services Corporation has been selected by the Department of Health and Human Services (HHS) to conduct a three-year pilot program in Pennsylvania that will help HHS evaluate various options for providing chronic care management services to fee-for-service (FFS) Medicare beneficiaries on a broad scale. The Voluntary Chronic Care Improvement Program pilot (CCIP) as authorized by the Medicare Modernization Act (MMA) of 2003, is going to be called “Medicare Health Support”.

Medicare Health Support is designed to improve the quality of chronic care, accelerate the adoption of health information technology, reduce avoidable costs, and diminish health disparities. In the course of the pilot, Health Dialog will provide care management services to at least 20,000 FFS Medicare beneficiaries that have been diagnosed with congestive heart failure or complex diabetes (or both).

More than 680,000 Medicare beneficiaries already have access to Health Dialog’s Collaborative CareSM services, which feature a unique whole-person approach to supporting individuals across their broad spectrum of healthcare needs.

The Approach

The legislation calls for a two-phased implementation approach focusing on targeted Medicare FFS beneficiaries.

- Phase I requires a three-year pilot project under which the Secretary of HHS shall enter into agreements with chronic care improvement organizations (CCIOs) using randomized control groups. If results of Phase I indicate improved clinical quality of care, improved beneficiary satisfaction, and achieved savings targets, CMS may expand the program nationwide.
- Phase II represents the Secretary’s ability to expand the implementation of programs (or components) to additional geographic areas not covered in Phase I. This phase could also result in national-level implementation.

Phase I Pilot will offer self-care guidance and support to chronically ill Medicare beneficiaries to help them manage their health, adhere to their physicians’ plans of care, and ensure that they seek and obtain the medical care and Medicare-covered benefits that they need. All participation in Medicare Health Support will be entirely voluntary on the part of beneficiaries.

The program will include collaboration with participants’ health care providers to enhance communication of relevant clinical information. The program is intended to help increase adherence to evidence-based care, reduce unnecessary hospital stays and emergency room visits, and help participants avoid costly and debilitating complications. Although each pilot program targets beneficiaries with selected chronic conditions, information and support will not be single-disease focused. Rather, the programs will be designed to assist participants in managing their health holistically, including all co-morbidities, relevant health care services, and pharmaceutical needs as well as unique individual needs and cognitive impairments.

Additional Information

For additional information about the CCIP, please visit the program’s website at <http://www.cms.hhs.gov/medicarereform/ccip/>

For additional information about Health Dialog, please visit <http://www.healthdialog.com>

For additional information about the PA program contact Cynthia Rosenberg at croseberg@healthdialog.com

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Additional Information

For additional information regarding cardiac perfusion/imaging related code editing logic, go to Aetna's provider Web site, then:

1. Log in or register to access to the "Physician Self Service" area
2. Look under "Claims"
3. Select "CPT/HCPCS Coding Tools"
4. Select "Code Editing Tool"

You can also call Aetna's Provider Service Center with any questions regarding the change:

Indemnity and PPO-based:
(888) 632-3862

HMO-based plans:
(800) 624-0756

Aetna Changes *Reimbursement* Policy for Cardiac Stress Testing

Provided by the Pennsylvania Medical Society

Removes claims system bundling logic for services on or after April 1

In March, Aetna announced that it would no longer use the current claims system bundling logic for cardiac stress testing CPT codes and related imaging agents when billed with cardiac perfusion/imaging codes. Effective for services performed on or after **April 1, 2005**, Aetna will reimburse **CPT codes 93015-93018** and related imaging agents (dipyridamole or adenosine) separately.

Aetna's decision to unbundle these code sets is a result of the State Society's educational efforts in seeking separate reimbursement for these services.

Note: The PaACC Chapter thanks the Pennsylvania Medical Society and our chapter members, Dr. Bindu Kansupada and Dr. Richard Schott for their efforts in bringing this to our attention and working with the Medical Society to see this through to a successful conclusion.

Disease Management Programs

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Upon review of the impact in each region, CMS will determine which program or specific segments of certain program will be rolled out nationally. CMS has full expectations of the MSHP becoming a national program. It is for this reason that the PA ACC must be involved in the initial implementation phase so that cardiovascular specialists can have a significant impact on the framework and operations of the program. This is an opportunity for the chapter to influence national Medicare policy.

The initiatives to be tested will have some characteristics in common with the private sector disease management programs but will be adapted to Medicare. Organizations will have the latitude to stratify targeted beneficiaries according to risk and need and to tailor interventions to the unique needs of the recipients, including self-care, care coordination, education, and use of in-home monitoring devices. Beneficiaries will not experience a change in access to providers or benefits. Additionally, the organizations involved shall assume some financial risk in the event of failure to meet agreed performance guarantees for clinical quality, beneficiary and provider satisfaction and savings targets.

Real barriers exist for physicians and impact their ability to provide care management to patients with chronic disease. The current fee-for-service reimbursement structure is not appropriate for the care chronically ill patients require. The workload of the average physician is increasing and chronically ill patients require more time while patient loads are increasing. The need for improved systems of care and enhanced communication between specialties and primary care providers is critical. ACC and its members can begin to break down these barriers through the experience of the MSHP.

The ACC and its chapters have determined the need to be an active leader role in shaping the long-term health care environment while continuously educating members, patients, and payers regarding the importance and value of cardiovascular specialty care. The ACC's involvement in related activities is important since cardiovascular specialties are key stakeholders in the disease management process. It is important for the ACC to ensure that tools and processes being developed are done in conjunction with the ACC guidelines and that such tools are developed and are relevant to physicians and not considered barriers.

¹ AHA 2002 Heart and Stroke Statistical update, 2001

² Croft JB et al American Journal of Geriatric Society 1997

³ Aghababian, RV Rev Cardiovascular Medicine 2203: 3 suppl 4 s3-s9

⁴

⁵ Foote SM Population Disease mgt Under FFS Medicare, Health Affairs (wed exclusive 7/30/03)

Medicare Carrier Advisory Committee Report

Donald C. Durbeck, MD, FACC, PaACC CAC Representative

It was my privilege to participate in the February, 10, 2005, Highmark Blue Shield HGSAdministrators meeting, otherwise known as the CAC. A number of issues were relevant to the field of Cardiology.

Dr. Blosschichak began the meeting by discussing the Medicare Modernization Act, which begins next January and involves, chiefly, the new drug benefit provisions. He commented that throughout the remainder of this year they will be trying to make Medicare recipients aware of these benefits, but their studies are showing that at least 30% will turn to their physicians for advice. He asks that we also gain knowledge about this program so that we can help answer our patient's questions.

An independent contractor continues to review our Medicare part B claims for both paid claims error rates and for provider compliance errors. Our state had the 8th lowest number of paid claims errors as compared with the other 49, but there were errors in 9.7% of payments. Our provider compliance error rate, chiefly E & M codes was 23.8%. This means that the independent contractor found errors in 23.8% of our claims! Most were E & M codes; specifically insufficient documentation for subsequent hospital visits and in patient consultations and incorrect coding for established office visits and subsequent hospital visits. Most of these are one level changes. Please document what you do! Dr. Blosschichak is quite willing to address our society on these issues.

Another "addition" to Medicare coverage is a "Welcome to Medicare" physical exam. This is a level 3 payment and can be done in conjunction with other care issues during the same visit. A -25 modifier will allow billing for both aspects of the visit. The physical exam must include an EKG and the program also includes screening lipid determinations every 5 years. However, one aspect not publicized is that the yearly deductible of \$110 is not waived. Assuming the first service a new Medicare recipient might get is this "Welcome" exam, the \$110 deductible might be considered more of a rude awakening.

Getting on to the Cardiology issues, non-invasive Cerebrovascular Arterial Issues revisions were presented first. These include extracranial

testing such as duplex exams, and transcranial Doppler as well. The indications, codes, etc are on their website and appear to be reasonable.

The next issue was Surveillance of Implantable Cardioverter Defibrillators. Metronics has developed the software to interrogate their devices over the Internet. Dr. Scher and I stressed that the same reimbursement should be given as the current interrogation without reprogramming, because the Internet approach involves all of the same technical and professional components as the current face-to-face approach. Additionally the same methodology should be applied to pacemakers as well. These recommendations appeared to be well received.

The third issue of interest is that of 64 (or more) slice CT angiography of the heart. This proposal does NOT include calcium screening or calcium scoring. The draft proposal indicated that this approach could be utilized for patients who are "Not a candidate for cardiac catheterization" as well as symptomatic patients with known disease when the results may guide the decision for repeat invasive intervention – e.g. post stent, post CABG, etc. CT angiography can also be utilized for the study of congenital anomalies, Dissections, PE's, etc, but the 64 slice technology is not necessary for these studies and the radiation dose necessary for the 64 slice studies is also not desirable for extracoronary work.

A number of issues were explored. The chief role envisioned for this technology is in the patients who appear in our ER who "rule out" for ACS and yet may have disease. These would appear to be ideal candidates, although there may be imaging problems in those with prior surgery, intervention, or heavily calcified vessels. The recommendation was made that we add this technology to our list of tests, including plain old stress tests, stress echo, stress nuclear, MRA, etc. and that we chose the most appropriate test for each patient. This might be called the "Willie Sutton" approach – "go where the money is". Performing more than one non-invasive test per individual patient encounter might require documentation as to justification. Cardiologists certainly should be involved in the pretesting strategy and not leave such decisions up to our primary care associates.

Another issue, which is ever present, is who will read the study. Medicare is receptive to

providing a professional feel for interpretation of the cardiac portion and a separate fee for interpretation of the non-cardiac portions. The radiologists will be in the role of generalist – in charge of the "whole" image, and we in the role of specialist – in charge of the cardiac portion. This might be groundbreaking! It also might work for other interests such as virtual colonoscopy.

Dr. Blosschichak closed the meeting by asking that we all respond to their proposals on their web site, www.hgsa.com.



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HGSAdministrators,
the Medicare Part B carrier for the state of Pennsylvania, encourages you to join their E-mail groups (listservs). As a member of an HGSA listserv, you'll receive important information on time sensitive Medicare changes. It's a valuable tool for keeping abreast of Medicare information. Subscribe today, <http://www.hgsa.com/maillinglist.shtml>.

**Chapter
Recognition
Award**

Quality... Education... Advocacy.



Dr. Paul Casale received the Chapter Recognition Award for his continued support and dedication to the Pennsylvania Chapter.

On April 5th, the PaACC Annual Chapter Meeting was held at the Harrisburg Hilton and Towers. In what was the largest turnout in years, cardiovascular specialists were treated to informative and provocative lectures by Michelle Ashby, CRNP, Dr. William R. Davidson, Jr., Dr. John W. Hirshfeld, Jr., Dr. Robert Larsen, Dr. Gerald V. Naccarelli, Dr. Andy Nassef Jr., Michelle J. Nickolaus, CRNP, and Dr. Guy N. Piegari. The guest speaker, Dr. Pamela S. Douglas, President of the ACC, highlighted the session with a lecture on Women and Heart Disease. Dr. Douglas provided critical insight into concerns relating to the shortage of women entering the field of cardiovascular medicine. Dr. Douglas also emphasized the need to support the national ACC Political Action Committee, which serves to improve the position of health care providers as it relates to federal regulators and policy writers.



Drs. Cacchione, Smith and VanDecker provided the Imaging Update



Drs. Guy Piegari and Robert Larson spoke on Carotid/Peripheral Interventions including Vascular Surgery

The success of this year's chapter meeting was a direct result of the efforts and attention to detail by the planning committee. The members included Caroline Doherty, CRNP, Dr. John Doherty, Dr. David Lasorda, Dr. Michael Rossi, Dr. Karandeep Singh, and Dr. Andrew Waxler. Their work and dedication to the chapter resulted in an outstanding program that was informative and provided opportunity to discuss the future directions of cardiology.

Finally, it is extremely important given the current political environment and the rapid growth and development of newer technologies and treatment strategies, that the members of the Executive Council of the PaACC are made aware of your concerns. By listening, the Chapter can take the appropriate actions to fulfill its mission as your advocate. The executive council encourages all of its members to get involved. We look forward to seeing you at the annual Chapter Meeting in 2006.



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Liability Award Legislation Introduced

Provided by Pennsylvania Medical Society

Just a few months into the state legislative session, several medical liability-related bills have been introduced, specifically addressing the issue of caps on non-economic damage awards.

In the Senate

SB 50 permits a constitutional amendment to allow caps on non-economic damage awards; re-introduced by Senator Jake Corman (R-Centre).

In the House

HB 132 and HB 167 would specifically cap non-economic damage awards in only medical liability cases.

HB 423 is not specific to medical cases, but would provide a “cap” for general liability awards.

2005 Mcare *Assessment Abatement* Application Process

The Health Care Provider Retention Program is providing eligible health care providers financial relief in the form of an abatement of the Mcare assessment for policy year 2005.

To get started, you will first need to complete the electronic online application found at their website:
www.mcare.state.pa.us

All documents must be received by February 15, 2006.

National Award Honors Outstanding Mentors in Medicine, Nursing and Science

The Joy McCann Foundation recently named Dwight Davis, MD, FACC, one of four 2005 McCann Scholars. Dr. Davis is a chapter member from the Pennsylvania State University College of Medicine, Hershey, Pennsylvania. He was recognized as a distinguished cardiologist who has played a leading role in medical education for almost 25 years. Congratulations, Dr. Davis.