Pennsylvania
CHAPTER

Fall 2005

Heart of the Matter

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

President's Message *Steven M. Ettinger, MD, FACC*

I don't know about you, but I am exhausted!! It seems that everyday the list of things to do continues to grow more extensive and there appears to be no end in sight or "light at the end of the tunnel". From the start of the day [which typically begins before the sun rises] to getting home late at night, there is no time to stop and appreciate the moment. Days are filled with procedures and *meetings* [patients, families, faculty, medical house staff] and taking time to schedule more meetings. We are working at a frenetic pace and if you are like me, when there is a moment of respite instead of relaxing, you suddenly become concerned that you are forgetting about another *meeting*. To physicians **R&R** does not refer to rest and relaxation but rather to *rushing* and generating *RVUs*.

As the president for the chapter, I thought I would consider some **R&R** [retrospection and reflection] and dedicate my first article to the past eighteen months of service as your Vice-President. The members of the executive council and the members who serve tirelessly on the various chapter committees have been involved in multiple projects and have been working on several fronts all in an effort to achieve our chapter's goals…that of *advocacy, quality and education*. I would like to take this time and thank each and every member who dedicated their time to a mission and purpose that sought to elevate the level of cardiac and vascular care in our state.

On the advocacy front we have been working with insurance providers on issues relating to non-invasive imaging, billing, recertification, credentialing and the creation and implementation of practice guidelines. In the invasive area we have been working with the Department of Health in assuring quality of performance of catheter-based interventions in hospitals that do not offer on-site surgical backup.

On the quality front we are working with the ACC in an effort to develop standards as it relates to pay for performance issues that will affect the way in which we deliver health care in the future. There are ongoing discussions with other specialties within the Pennsylvania Medical Society as it relates to quality of health care and making certain that our concerns are recognized by other societies and organizations.

Steven M. Ettinger, MD, FACC

On the educational front our chapter has been involved in FIT programs, the national ACCF Diabetes Education Initiative (DEI) program, surveillance programs for patients diagnosed with congestive heart failure and the *Red Dress* program educating women about the risks of heart disease. Planning for the annual chapter meeting is proceeding on schedule and this year's program will be more extensive in content as the diversity of the membership in our chapter continues to grow.

The future challenges and direction of our chapter highlights the need for increased involvement from our membership. While there appears to be willingness of members to offer their time and expertise in dealing with the multiple clinical, educational and advocacy issues, we must recognize that as an organization with over 1,000 members we can always do better. We can always use another voice, another perspective and another volunteer. We can always use more **R&R** [resources and representatives]. I encourage everyone to become involved in the chapter and to participate in the activities and committees that are such a vital part of the PaACC. We also must recognize that not every problem has a quick fix or simple solution. Many issues require guidance and input at various levels of the College—local, state and

continued on page 2

Table of Contents

PREVIEW OF PAACC 2006 ANNUAL CHAPTER MEETING
PAGE 2

DISEASE MANAGEMENT UPDATE
PAGE 3

CARDIAC CARE ASSOCIATES UPDATE
PAGE 4

HGSA MEDICARE CARRIER ADVISORY COMMITTEE REPORT
PAGE 5

MEDICARE CARRIER ADVISORY COMMITTEE MEETING IN WASHINGTON
PAGE 7

HGSA NEWS

ENFORCEMENT OF MANDATORY ELECTRONIC CLAIM SUBMISSION
PAGE 8

LEGISLATIVE NEWS

HEALTH CARE LEGISLATION SLATED FOR THIS FALL
PAGE 9

PAYOR RELATIONS COMMITTEE REPORT
PAGE 10

MCARE ABATEMENT EXTENSION IS TWO-STEP PROCESS
PAGE 11

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President's Message

continued from page 1

national. The resources provided to us by the ACC are extensive and their staff has worked endlessly on our behalf—but we need more involvement working "at the ground level" by our members if we are to be successful.

As technology and services change we need more **R&R** [reevaluation and revisions] of how we educate our patients, how we educate insurance providers and perhaps most importantly how we educate ourselves. In developing a solution to a problem it is essential that we tap into the vast knowledge base and experience of our chapter members. Together, we will succeed and in the end, when all is said and done there will be plenty of time for what we, as physicians ultimately desire…**R&R** [respect and recognition]. Respect by our peers and recognition by society that we are providing exemplary cardiovascular care.

Preview of PaACC 2006 Annual Chapter Meeting

John U. Doherty, MD, FACC, Chairman, Planning Committee

The annual meeting of the Pennsylvania Chapter of the American College of Cardiology is scheduled for Friday, April 28th, 2006. We have secured the Wyndham Harrisburg-Hershey Hotel outside of Harrisburg for the event.

We expanded the committee membership this year representing members from throughout the state comprised of cardiologists that are university and community based. Clinical Care Associates (CCA) are represented as well. As many of you know, they were a strong presence at last year's meeting.

There was a desire for CME certification based on canvassing of last year's attendees. Therefore, CME credit will be available for the event.

In planning the program, we have tried to balance advocacy issues, clinical controversies, technological innovations and regulatory issues. For the first time, there will be a session on CCA practice models which hopefully going forward will become a staple for our meeting. The first topic discussed in this context will be billing issues specific to physician extenders.

Cardiac imaging has been a lightning rod issue both nationally and locally. This extended session will concentrate on reimbursement issues, credentialing and scientific content concentrating on cardiac Computed Tomography. Our advocacy session will address PCI without surgical back-up and include a medical liability update. Innovative techniques for valvular heart disease will be discussed—both surgical and catheterization laboratory based. There will be a session on advances in heart failure—both scientific and clinical.

In addition, we will be treated with a topic yet to be determined from ACC National. This year's format builds on last year's agenda which was generally seen to be quite successful.

We hope that you will make an effort to save the date and attend this meeting. For additional information, visit the chapter website at **www.pcacc.org.**

Planning Committee Members: Michael Ezekowitz, M.D., David Lasorda, M.D., Michael Rossi, M.D., Karandeep Singh, M.D., Andrew Waxler, M.D., Caroline Lloyd Doherty, MSN, CRNP

Disease Management Update

American College of Cardiology

Medicare Health Support Program: Pennsylvania Update

As you know, The Medicare Modernization Act of 2003 (MMA) authorized development and testing of Medicare Health Support Programs to improve the quality of care and quality of life for people living with chronic illnesses, specifically heart failure and/or diabetes. The Medicare Health Support Organizations (MHSOs) conducting the programs must meet clinical outcome, patient satisfaction, and savings targets. If MHS programs or program components prove to be effective, Section 721 provides for the Secretary of Health and Human Services to begin nationwide expansion of the MHS initiative in 2 to 3.5 years.

The MHS programs are designed to help participants understand and follow their physicians' care plans, communicate more effectively with their healthcare providers, and know when to seek medical care to reduce their health risks. This new type of customer support service is intended to help participants monitor their health, coordinate their medical care, and improve their self-care between physician office visits.

Based on analysis of the MHS design and scope and its potential ramifications, ACC participation is not only consistent with our mission, but will also advance our long term goals to "emphasize, synthesize, summarize, and disseminate cardiovascular science, knowledge, and best practices." The MHS programs will impact the health and healthcare for the majority of our patients in the very near future. ACC's active collaboration with selected MHSOs is critical to preserve our leadership position in the design, conduct, and delivery of cardiovascular health care.

Health Dialog's Medicare Health Support pilot was launched in western Pennsylvania on August 15, 2005. CMS identified approximately 20,000 beneficiaries in the region and invited them to participate in the voluntary three year program. Within 2 weeks, 5,000 beneficiaries were enrolled in the program. The goal is to enroll all 20,000 beneficiaries within the first six months. These 20,000 beneficiaries have been linked to 2,500 "primary" physicians through Medicare claims data. Health Dialog is sending individual patient registry forms to the identified physicians in order to confirm that they are the physician of record, that the patient is alive, and to report some clinical information. Physicians will be reimbursed for each completed registry they return to Health Dialog.

The PA Chapter and ACC participate in a biweekly workgroup conference call with Health Dialog, and representatives from the American College of Physicians (ACP) and the American Academy of Family Physicians (AAFP). ACC is represented on the calls by Janet Wright, MD, FACC (chair of the ACC Disease Management Oversight Task Force), Daniel Edmundowicz, MD, FACC, (UPMC), and Eileen Hagan, MSN, APRN, BC (ACC Associate Director, Payer Advocacy). Eileen serves as the link between Health Dialog and the PaACC. Chapter members who would like to learn more about the MHSP may contact her by e-mail at *ehagan@acc.org*. To learn more about the ACC position on disease management or Health Dialog, check out these links:

http://www.acc.org/pmr/pdfs/DMWhitePaper.pdf

http://www.healthdialog.com/NR/rdonlyres/70F1AB66-451D-46C3-80E1-CC8EC3FF6299/0/FinalNationalrelease.pdf

ACC Payer News

The new appropriateness review for SPECT MPI is now available on ACC's Website at: **http://www.acc.org/clinical/statements.htm**. It was published in the *Journal of the American College of Cardiology* (JACC) on October 18. The ACC is now focused on the implementation of appropriateness criteria and is working to foster collaboration among health plans, payers, and cardiologists to improve the efficiency and equity of cardiovascular imaging. The successful October Medical Director's Institute in Atlanta was an important first step in the process, generating good discussion on this important issue among a diverse group of players.

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Cardiac Care Associates Update

Michelle J. Nickolaus, MSN, CRNP
CCA State Liaison, Pennsylvania Chapter

Thus far it's been an exciting year. We have had elections and I am pleased to announce that we have four new District CCA Liaisons who will serve our chapter as your CCA representatives. They are:

District I: **Carrie Doherty, CRNP - Philadelphia**
District II: **Donna Petruccelli, CRNP - Allentown**
District III: **Sandra Thorpe, RN, BSN - Uniontown**
District IV: **Lisa Henry, CRNP - Pittsburgh**

All five CCA representatives including myself participated in the October Executive Council's teleconference. We all hope you rely on us to be your key contacts to share your opinions and desires about chapter membership. We have surveyed our CCA membership and while not everyone responded, we believe we did get a good sense of what is needed and wanted by the CCA membership. We found, as expected that we have a variety of folks practicing in both academic and private cardiology practices. A majority of respondents were nurse practitioners and physician assistants, yet there was fair representation from RNs and Clinical Nurse Specialists. Our total CCA membership consists currently of 145 members with the breakdown being 42.7% NP, 18.6% PA, 36.5% RN, and 2.0% CNS.

Our Pennsylvania CCAs work in all areas of cardiology including cardiac rehab, cath lab, lipid clinics, wellness and prevention programs, general cardiology clinics, heart stations with stress testing, EKG, tilt table testing, and pacemaker/ ICD clinics; intensive care units, telemetry units, intermediate care units, and anticoagulation clinics. Many are also employed as administrators, case managers and in research as study coordinators for clinical trials. There are those who see the general inpatient cardiology population doing hospital consults and rounds. There are also those who see the sub-specialty populations in CHF, Interventional cardiology, Adult Congenital Heart Disease, and Electrophysiology in both inpatient and outpatient settings.

Most respondents joined PaACC because they wanted clinical updates in order to stay abreast of the latest technologies and therapies in providing quality cardiovascular care. Most desired to network with other medical and nursing colleagues as a result of membership. A majority expressed that ACC membership provided opportunities to allow our physician colleagues to become more acquainted with the educational levels and high skill levels of knowledgeable, expert nurses including nurses holding Master's degrees. Many saw membership as a chance to improve understanding of the valuable role of the Nurse Practitioner. Still others joined for professional recognition, to be on forefront of research and obtain legal updates, have access to Cardiosource and as well as improve referrals to cardiac/ pulmonary rehabilitation wellness programs.

More than half joined to be involved in clinical improvement projects on a local level and to attend the annual Pennsylvania meeting for CME/CNE credits. Yet interestingly, about half of respondents specifically responded that they wanted CME credits and nearly ¼ of those that responded said they desired continuing nursing education credits. This seems to be an area where we will need some clarification from the CCAs as to if you want credits or if you just desire to attend educational sessions without formal credits. ***If you have an opinion on this please share with your District Liaison or me.***

In closing, we have at least 18 CCA who desire to be more involved in the chapter, and we want you to know we will be contacting you soon for committee involvement, so stay tuned. For those of you who have not volunteered but desire to be more active, please do email me at *mnickolaus@psu.edu* or your District Liaison. We welcome your suggestions and comments. We are truly excited to be moving the chapter ahead with CCA involvement and want you to know that our Chapter is on the cutting edge of integrating the CCA membership into full chapter involvement compared to other states. The opportunities here are boundless, so please do get involved!

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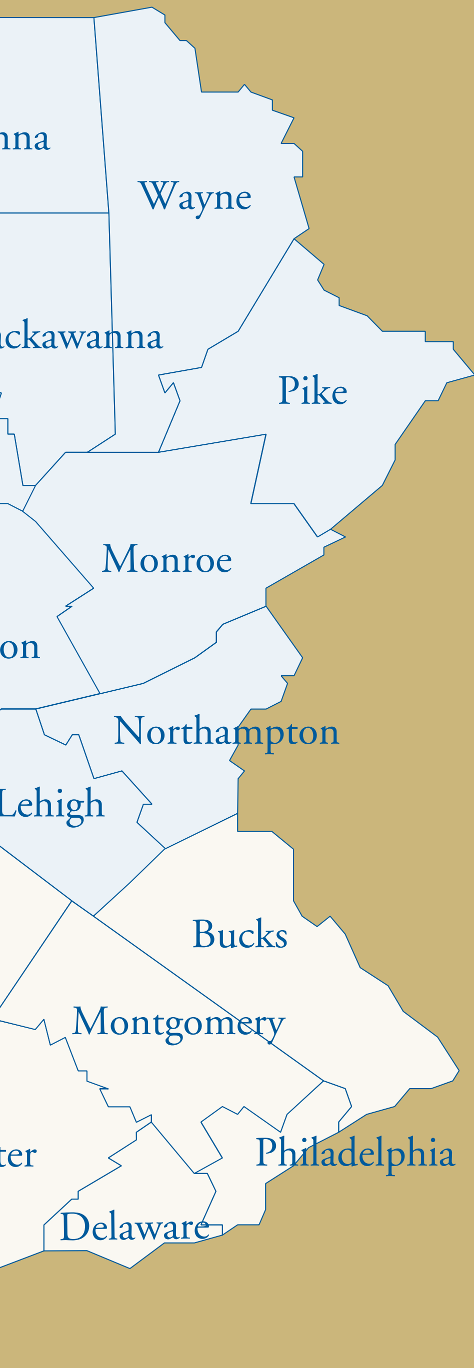

HGSA Medicare Carrier Advisory Committee Report

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

June 9, 2005

It was my privilege to attend the June 9, 2005, HGSA Carrier Advisory Committee (CAC) meeting as the PaACC's representative.

The subject of most interest to the Cardiology community was their local coverage determination document for "Treatment of Non-Coronary Vascular Stenosis". The portions of the document concerning Carotid Artery Stenting were the same as the national Medicare criteria. Basically, patients with symptomatic carotid artery Stenosis > 70% who are at high risk for endarterectomy may be treated with a FDA approved stent, an FDA approved embolic protection device, at a Medicare approved site.

Symptomatic patients who are at high risk but have a 50% to 70% Stenosis need to additionally be enrolled in an appropriate clinical trial.

Asymptomatic patients who are at high risk need to have a Stenosis of >80% to receive a carotid stent.

The document lists co morbid conditions and/or anatomic risk factors as well. They include CHF class III/IV, LVEF < 30%, unstable angina, recent AMI, contra lateral carotid occlusion, previous endarterectomy, prior radiation to the neck. The symptoms are those of a TIA without disabling stroke.

Several other issues of note were also discussed:

Medicare is striving for more and more accuracy in the claims they receive from us. An example given was a charge for EKG interpretation and report wherein the Cardiologist simply signed the computerized reading without additional comment. This is not an acceptable report for Medicare. You must also write at least "agree" and enter your signature.

Coding errors for office visits and hospital visits following a hospital consultation were also high on their list. Whatever level of care that is billed for must contain sufficient documentation to justify your charge. It appears that we will have to continue to be vigilant in these areas as well. (see article on Medicare Claim Coding for additional details).

In reviewing recent policies, Dr. Bloschichak indicated that the transtelephonic surveillance of AICDs has been approved with a change to allow for these studies to be done every 3 months instead of 4.

Professional component billing for 64 slice CT scans allows for Cardiologists to bill for the Cardiac part of the examinations and it allows Radiologists to bill for the non-cardiac portions. This change should circumvent some potential "turf battles".

Finally, Dr. Bloschichak indicated that, by January of 2008, Pennsylvania will be served by a single carrier for all of Medicare parts A and B. This same carrier will also be responsible for Delaware, New Jersey, Connecticut, and Washington, DC. Also, there is no mandate in the RFP's for a CAC in this new program. Might I be the last Pa ACC CAC representative?

Medicare Claim Coding—Documentation Requirements

The Comprehensive Error Rate Testing (CERT) Program was developed to monitor the accuracy of the Medicare Fee for Service Program. Reviews conducted by the CERT Review Contractor, AdvanceMed, have identified a need to provide education on the documentation requirements for electrocardiograms. The CERT errors identified were commonly due to the omission of documentation showing EKG interpretation and results. The purpose of this article is to reiterate these requirements and is intended for educational purposes only. Current Procedural Terminology (CPT) defines electrocardiogram (EKG/ECG) procedure codes as:

- **93000** Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report;
- **93005** tracing only, without interpretation and report; and
- **93010** interpretation and report only.[1]

Medical record documentation must support the medical necessity of the electrocardiogram service as well as the frequency for which the services are being performed. Documentation may also include history and physical, progress notes with presenting symptoms, laboratory/diagnostic test results, and active treatment protocol, as appropriate. Office/progress notes must contain the date of service and the physician's signature. A physician's order must be documented in the medical record requesting ECG performance.

Documentation of medical necessity must be available to the carrier upon request. When responding

continued on page 6

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Congratulations!

Congratulations to the new PaACC Secretary-Treasurer, Dr. Andrew R. Waxler, MD, FACC of Reading. The chapter membership elected him to his first two-year term in September.

HGSA Medicare Carrier Advisory Committee Report

continued from page 5

to the medical record request from HGSA or AdvanceMed, submit all the pertinent documentation necessary to substantiate the services billed.

An ECG with interpretation must have the full graphic tracings with formal written interpretation on file for review. The interpretation should appear on the designated sections of a page formatted ECG or written in the clinical records. At a minimum, interpretations should include appropriate comments on rhythm, rate, axis, acute or chronic changes, and a comparison with the most recent tracing (if available). Appropriate measurements must be mentioned if the purpose of repeated ECGs is to monitor the effects of a given parameter, e.g., the QT interval. ECGs that are electronically read must be over-read, corrected and signed.

For additional information, please refer to HGSA's Local Coverage Determination (LCD), M-45 for Electrocardiograms which can be found on our website at **www.hgsa.com/professionals/lcd-front.shtml.**

October 20, 2005

The October 20, 2005, CAC meeting started with a discussion of the new Medicare Drug Prescription Program. Individuals will be able to start signing up on November 15th, 2005, and can continue to sign up until May 15th, 2006. There will then be annual sign up periods from November 15th to December 31st each year. Additionally, when one plans to retire, presenting proof of cessation of your current health insurance will allow one to sign up for the Medicare drug plans for the 63 days following the date of cessation of ones current health insurance program.

Two web sites are available for use by your patients: **https://cms.hhs.gov** and **https://medicare.gov**. These web sites include a landscape of all the plans that are available in one's state, a comparison of the plans available in your area, the drugs that are covered by each plan, and comparable costs. Once you are signed up, you can change plans at any time. For those patients who do not wish to use the internet, they can call 1-800-MEDICARE and the person answering the phone will access the web site for them, review the choices with the recipient, and then mail them a hard copy of the coverage they chose.

The next topic discussed was the Medicare CERT Program—"Comprehensive Error Rate Testing." Each Medicare provider has been charged by Congress to reduce error rates in making claims to Medicare. Such errors include lack of documentation from the billing physician's office, insufficient documentation, incorrect codes, and was the service "reasonable and necessary". The Highmark officials asked that our offices promptly provide whatever documentation is asked for, rather than placing the request on the "to do" pile. They stressed that E&M charges should be accompanied by sufficient documentation in the medical record to justify the level charged. Medicare experiences under billing as well as over billing. Both constitute errors.

The next topic was the consolidation of Medicare into regions rather than by states. Our region will be Region #12 and it will include NJ, DE, MD, DC, and PA. Coverage will be the same for each state included. Currently 64 slice coronary arteriography is not covered in NJ but is in PA

Our practices are being asked to apply for a National Provider Number (NPI) that we can begin to use by May, 2007, and must use for Medicare claims by May, 2008. We need only one number per group, and applications can be obtained at **https://nppes.cms.hhs.gov**.

The only Local Coverage Determination of potential interest to the Cardiology community was an update of the LCD for Cardiac Output Monitoring by Thoracic Electrical Bioimpedance. You will be allowed to perform this assessment for differential diagnosis of dyspnea, monitoring home inotropic therapy, optimizing fluid management in CHF patients, monitoring cardiac transplant patients, and for adjusting A-V intervals. You can bill for one service daily and you must document that the measurement was useful in the patient's care. One can no longer use this test for the management of hypertension. Note was made that similar measurements are becoming available as a part of implanted pacer and AICD devices as well.

[1]Current Procedural Terminology – CPT 2005, Professional Edition, AMA Press, Chicago, p.361

Medicare Carrier Advisory Committee Meeting in Washington

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

The ACC Carrier Advisory Committee met in Washington, DC on September 19, 2005. Dr. Joseph Messer facilitated the meeting. The first subject discussed was the issue of Cardiac Computed Tomography Angiography. Dr. Michael K. Rosenberg, MD, Carrier Medical Director, Medicare Part B – Michigan led off the discussion. He indicated that Coronary CT is currently billed under and paid under CPT code 71275 (CTA, chest, without contrast followed by contrast and further sections, including image post-processing) as long as ischemic heart disease ICD-9 codes 410-414 are included. Medicare acknowledges that Coronary CTA is different from Chest CTA. Coronary CTA involves additional concerns such as field of view, anatomy covered, slice thickness, gating requirements, reconstruction algorithms, scanner requirements, and administration of beta blockers and monitoring.

The American College of Radiology has recommended that the NOC code 76497 (Unlisted Computed Tomography Procedure) be used. Currently you can use either code for coronary CCT. Radiologists currently bill for 71250 or 76275 for Chest CT and Medicare agrees that these are two different procedures and can be performed and billed for by different physicians. However, neither study can be used as a screening tool. This includes not being able to bill for coronary calcium score as well as normal chest CT's outside of the cardiac concerns.

Dr. Messer then updated the committee on the development process for the upcoming ACC Model LCD document for Cardiac CTA. A draft is not yet available. Dr. Diane Wallis, MD of the ACC then outlined new CPT codes which are being developed for Cardiac CTA including morphology only, calcium score only, coronary circulation, EP type special evaluations such as left atrial morphology, and functional evaluations such as EF, wall motion analysis, etc. These codes will apparently be available sometime in 2006. A major consideration is that we use only the CT procedures that we need for each case. The doses of radiation can be quite significant.

Sandra Foote, Sc.M. and Eileen Hagan then presented results of 3 pilot studies involving care management activities for several cardiac diagnoses. I believe we are all familiar with the Core Measures for the care of AMI and CHF patients. More criteria for more disease processes are being developed. They will be looking for the quality of care we are providing, and will be looking for improved outcomes, less readmissions, and the like. They are talking about increases in Medicare payments to those of us who do follow our own guidelines. If anyone wishes to see how his/her hospital is doing, simply sign on the **www.hospitalcompare.gov** and you will see how easily patients, colleagues, and third party carriers can access this information. Several private health care providers are also participating with these programs; Aetna being one example. The ACC is actively participating in the development of these processes.

Dr. William Rogers, MD, FACEP then discussed what to expect in the future from Medicare. He stated that medical care currently takes up one forth of the average family's income. The growth in health care costs cannot be sustained. Drug coverage by Medicare was discussed. Patients can access the necessary information either on the web—**www.medicare.gov**—or by calling 1-800-MEDICARE. Dr. Rogers recommends that you give your patients these two means of access, and limit the time you, yourself, spend educating patients to the amount of time you wish to take. It is NOT the physician's job to educate patients on Medicare Drug Coverage.

From an administrative point of view, Medicare is streamlining their organization by combining parts A and B, and there will be only 15 CMS contractors for the USA rather than the 50 or so we have now. Pennsylvania CMS will be combined with 4 other nearby states; one contractor will serve all 5 states; and CAC functions have not been outlined in the new regulations. CAC may not be continued under the new system.

The meeting finished with mentioning Appropriateness Criteria. Such criteria for SPECT MPI will be published in the October 2005 issue of JACC. Stay tuned for more!

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HGSA News

Enforcement of Mandatory Electronic Claim Submission

The Administrative Simplification Compliance Act (ASCA) requires that you submit your claims electronically unless you meet the exception(s) listed in Section 1862(a).

Beginning with the July through September 2005 quarter, and continuing with each quarter thereafter, we will analyze reports displaying the number of paper claims that all providers submit each quarter. At the end of each quarter, providers with a high paper volume will be contacted and asked to provide information that establishes an exception.

If you:

- Do not respond to this initial "Request for Documentation" letter within 45 days of receipt, we will notify you by mail that we will deny and not pay any paper claims that you submit beginning 90 days after the date of the initial request letter.
- Respond to this initial "Request for Documentation" letter within 45 days of receipt and your response does not establish eligibility to submit paper claims, we will notify you by mail of your ineligibility to submit paper claims. This Medicare decision is not subject to appeal.
- Respond to this initial "Request for Documentation" letter within 45 days of receipt and your response establishes eligibility to submit paper claims, we will notify you by mail that you meet one or more exception criteria to the requirements, which permits you to submit paper claims. If you are permitted to submit paper claims, we will not review your eligibility to submit paper claims again for at least two years.

For more details about the exceptions, please refer to the CMS Medlearns Matters article at: **http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3440.pdf**

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CME Credit: AMA will award up to 25 hours of PRA Category 1 credit for earning an advanced degree. Contact AMA for more details.

On-site Seminars: 5 (Reading or Harrisburg)

For information: Contact Karen Schroder, Alvernia College, at (610) 796-8410 or karen.schroder@alvernia.edu, or visit www.alvernia.edu/graduate/onlineMBA.htm

Legislative News

Health Care Legislation Slated for This Fall

This information is provided courtesy of the Pennsylvania Medical Society

The General Assembly returned to Harrisburg in late September with a demanding session schedule that will take them deep into December.

Among the top health care issues expected to move forward this fall are:

- Property tax reform—House Bills 116-120 would repeal residential and commercial school property taxes and replace them with a more broadly applied sales tax at a lower 5 percent rate. The Society is working to preserve this exemption for health care services.
- End-of-life-care—Senate Bill 628, legislation dealing with end-of-life issues, is currently in the Senate Appropriations Committee. The Society is working with the Rendell administration to address mutual issues of concern that led the governor to veto an identical bill last legislative session.
- Fair contracting—House Bill 503, sponsored by Rep. Tom Gannon (R-Delaware) and introduced at the request of the State Society, promotes health insurers to treat physicians fairly in contractual dealings with them.
- Medicaid—In an effort to alleviate the annual fiscal crisis in the Medicaid program, the Society is pursuing an alternative to the existing system that would improve the entire program. A meeting of physician specialty and other provider organizations was also held to seek support for a major reconstruction of Medical Assistance.

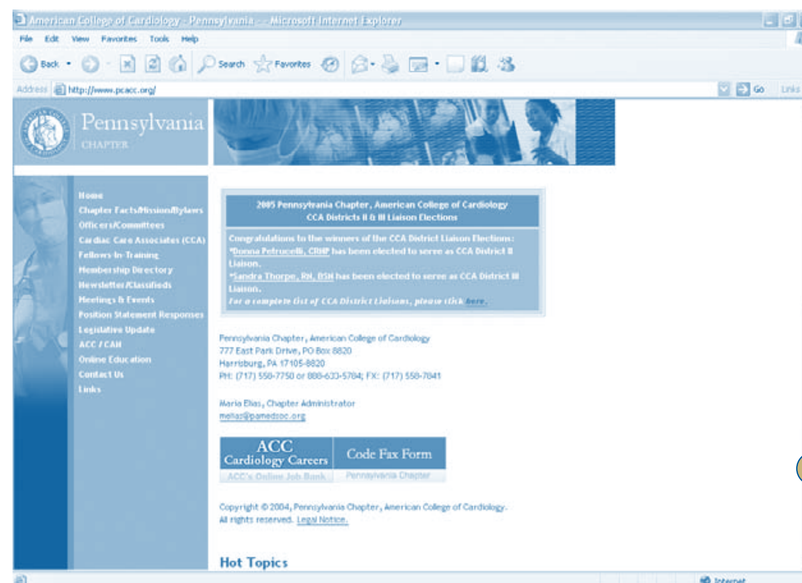
Take action to prevent Medicare physician payment cuts.

Contact members of US Congress to support SR1081, HR 2356 and HR 3617.

Better than Ever

The PaACC Website www.pcacc.org

It's the web address you should be visiting for the latest information on imaging issues, PCI without back-up updates, chapter election news, meeting and event information, who's who in the chapter and how to contact your Governor, District Councilor or CCA Liaison and much more.



PaACC Governor Elections

Attention voting members of the PA Chapter

National ACC will soon be distributing information regarding the upcoming election for our next two chapter governors. The elections will again be on line and you will need your six digit ACC member number in order to vote. If you need assistance locating your number, call the chapter office at (888) 633-5784, ext. 1477.

Newsletter Topics

If you, as a member of the chapter, have an article that idea for an article that you would like to submit to Heart of the Matter, please contact the PaACC office.

Articles subject to review and approval by PaACC Executive Council.

Payor Relations Committee Report

Bindu Kansupada, MD, FACC, MBA

IBC (Independence Blue Cross)

Payor Relations Committee members Ancil Jones, MD; Bindu Kansupada, MD; ASNC Board of Director William Van Decker, MD; and ACC Representative Suma Thomas, MD, were actively involved with Steven Brown, MD of IBC during the development of the AIM web site – RQI pre-certification program. The recommendations made by ACC and ASNC were well received by IBC.

PaACC would like to receive notification of all rejections from members or any delay in obtaining pre-certification from IBC/AIM-web site. Any questions relating to the AIM web site can be forwarded to Jennifer Nichols, Provider Representative for AIM at (732) 620-6487 or by calling (800) 554-0580.

AETNA

Based on additional information provided to the PaACC Payor Relations Committee, Aetna will allow separate reimbursement for:

93015 - Stress Test
78478 - Wall Motion
78480 - Ejection Fraction
A9500 - Cardiolite Injection
A9502 - Myoview
J1245 - Persantine
EFFECTIVE JUNE 15, 2005.

PaACC members are encouraged to inform members of the Payor Relations Committee if they are not paid by Aetna for these procedures.

Note:

- Cigna does not reimburse physicians who perform nuclear stress testing in their office.
- Oxford Health Plan does not reimburse physicians for nuclear stress testing if the physicians do not hold a valid nuclear cardiology certificate [CBNC].

For physicians performing nuclear studies—Please refer to the recently published ACCF/ASNC Appropriateness Criteria for SPECT/MRI, Approved September 2005 (pdf file) see site: **http://www.asnc.org/resources/accf_asnc_appropriateness_criteria_1005.pdf**

Median scores of 1-3 will very likely result in

Imaging Resolutions at Pennsylvania Medical Society House of Delegates Meeting

Four resolutions related to imaging were put forward during the PA Medical Society's 2005 House of Delegates Meeting in October. Of those resolutions, 05-303, was adopted as amended in lieu of resolutions 301, 308, & 312.

RESOLUTION 05-303
(Referred to Reference Committee C)

Subject: Physician Phone Appeals for Denied Procedures
Introduced by: John A. Straka, MD, on behalf of the Allegheny County Medical Society
Author: John A. Straka, MD

Whereas, Insurers are trying to decrease their payouts by having fewer diagnostic studies performed; and

Whereas, When a physician requests a CT scan, MRI, Pet Scan, or other study, the physician is already required to specify the indication for the study; and

Whereas, In our litigious society, there is increasing pressure to obtain diagnostic tests; and

Whereas, The insurer's requirement that the ordering physician call and speak personally to a reviewer for approval of a diagnostic study can be perceived to be a possible roadblock or impediment; and

Whereas, Phone calls to attempt to obtain approvals take away time physicians could be using to take care of sick patients which is the best utilization of physicians' time; therefore be it

Resolved, That the Pennsylvania Medical Society ~~encourage~~ require insurers to accept the reason provided for a ~~CT, MRI, Pet Scan or other~~ diagnostic study ~~is necessary~~ as written on the request constitutes medical necessity and further that the Society oppose pre-authorization of medically relevant tests; and be it further

Resolved That the Pennsylvania Medical Society study and seek legal definition of physicians' and third party payers' legal responsibility, that the Medical Society create a means to assess the negative impact such pre-authorization policies have in areas of patient satisfaction, diagnosis delay, and increased emergency department usage, and that the results of these efforts be reported to physicians and third party payers as soon as available.

~~Resolved, That if an insurer requires a physician's time in an appeal of a denial of a CT, MRI, Pet Scan or other study, the Pennsylvania Medical Society call on insurers to provide a fair financial reimbursement for the time involved advocating for the patient(s).~~

Fiscal Note: No significant fiscal impact.

Mcare Abatement Extension Is Two-Step Process

This information is provided courtesy of the Pennsylvania Medical Society

Extending the Mcare abatement program is an annual two-step process.

To get another year's partial relief from medical liability insurance costs, physicians must begin the process now by contacting their legislators to urge:

- Passage of an amendment to the Public Welfare Code before the end of the calendar year (step one)
- Re-appropriation of cigarette tax revenues in the 2006-2007 state budget (step two)

Step one begins again this fall; step two must be repeated next year during the legislative budget process.

While the Society was successful in getting the legislature to fund 2005 Mcare abatement as part of the recently approved state budget, the battle for 2006 Mcare abatement looms in the fall legislative session.

The legislature probably won't turn to matters such as Mcare abatement until mid-October when they return for several weeks of session. **They must act before the end of December 2005**, because many physicians' 2006 Mcare assessments are due on January 1.

The Society has reminded legislators of the importance of extending abatement into 2006 and beyond. While the Society continues its work this fall to build support among legislators, your legislator need to hear from you soon about the urgent need for 2006 Mcare abatement.

ACC Education & Quality

The American College of Cardiology Foundation (ACCF) is preparing to undertake it's second in a series of appropriateness reviews. The ACCF, in collaboration with the Society for Cardiovascular Computed Tomography (SCCT) and the Society for Cardiovascular Magnetic Resonance (SCMR), is initiating an appropriateness review of Cardiac Computed Tomography (CCT) and Cardiac Magnetic Resonance Imaging (CMR).

ACC Atlanta *2006*

It's just around the corner

Mark your calendar now to attend

the Sunday, March 12, 2006 All-Chapter Reception

Location to be determined

Pennsylvania
CHAPTER

777 East Park Drive
PO Box 8820
Harrisburg, PA 17105-8820

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HARRISBURG PA
PERMIT NO. 922

Pennsylvania
CHAPTER

Save the Date

Friday, April 28, 2006
Wyndham Harrisburg-Hershey

Who Should Attend

Cardiologists
Fellows-in-Training
Cardiac Care Associates
Practice Administrators

2006 Annual Chapter Meeting*

Don't miss this opportunity for networking and quality CME on relevant topics.

8:00 – 8:30 am	**CCA Practice Models: Billing Appropriately with Physician Extenders**
8:30 – 10:30 am	**Controversies in Clinical Practice: Cardiac Imaging-Reimbursement, Credentialing, and Turf**
10:30 – 10:45 am	Break
10:45 – 11:45 am	**Advocacy Issues including PCI & Medical Liability Updates**
11:45 – 12:15 pm	Annual Business Meeting
12:15 – 1:00 pm	Luncheon with ACC speaker
1:00 – 2:30 pm	**Innovative Techniques for Valvular Heart Disease: Surgical and Cath Lab Based**
2:30 – 2:45 pm	Break
2:45 – 3:30 pm	**Advances in Heart Failure**
3:30 – 3:45 p.m.	**HGSA: Comprehensive Error Rate Testing**
3:45 – 4:00 pm	**Disease Management**
4:00 pm	Adjourn

*Final topics and agenda are subject to change.