



Heart of the Matter

President's Message *Daniel Edmundowicz, MD, FACC*

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Chapter Relevance and Member Involvement

While accepting the reins of the Chapter Presidency from Dr. Steven Ettinger this past March, it became clear that the momentum established by both Steven and Dr. Conrad Smith over the past 3 years is significant and has kept the PaACC Chapter and its members in a position of prominence, both at a state and national level. Initiatives such as the Pennsylvania Medical Society Imaging Task Force, payer credentialing processes oversight; the PCI demonstration project and the creation of the CTA/MRI consensus document brought with them increased Chapter exposure at many levels and provided opportunities for valuable member involvement. It now becomes crucial to both maintain this momentum and to sustain member involvement. The latter, of course, requires that the Chapter remains relevant to our professional activities. It is one thing to "fly the banner" of FACC after our names but another to give up our most precious commodity, time, for state chapter activities. There needs to be a tangible return on our investment.

In preparation for my responsibilities as President of Chapter for the next year and a half, I have immersed myself in ACC activities such as the 2006 Legislative Conference in Washington DC; the 2006 Medical Director's Institute in Lansdowne; the 2007 ACC Leadership Conference and the recent Board of Governors' meetings. I can assure you, as a professional organization, the ACC remains vibrant, focused and relevant. Dr. James Dove, President of ACC, and Dr. George Rodgers, Chairman of the Board of Governors, understand that the College is an important vehicle not only for advancing the art and science of cardiology, but also to be a voice and vehicle of change for the cardiologists and cardiac care associates "in the trenches." There is a clear understanding that continuing education, quality care for our patients, workforce issues and advocacy are topics of importance to all cardiologists and CCAs and

Daniel Edmundowicz, MD, FACC



are issues that are rooted in the *local* politics and payer milieu. Therein lies the relevancy of our Chapter; to remain the Grassroots voice of the ACC, mapping future trends in cardiology and healthcare by focusing the resources of the

national ACC on the local issues that affect our day to day practice.

Focusing the laser requires knowledge of the "hot button" issues in our state. I appreciate the time that almost 200 of you took to complete the recent chapter membership survey circulated by email from ACC national. While we continue to analyze the results of this survey, a majority of respondents are looking to the PaACC to stay actively engaged with state officials (i.e. Medicare/Medicaid, state legislators, regulatory offices) and third-party payers. I can assure you that the Chapter is poised to play an important and relevant role in advocacy efforts within Pennsylvania. The effectiveness of National ACC's political advocacy efforts was evident again this year by avoiding last minute cuts in Medicare and imaging reimbursements. It remains true, however, that "all politics is local" and state based advocacy efforts are crucial for changing the local landscape of cardiovascular issues. I have volunteered to act as the Pennsylvania representative to the ACC PAC and will be sure to draw National ACC resources to the state for legislative tracking and analysis of issues critical to us and, when needed, design appropriate lobbying and legislative strategies. Coupled with your own input on the issues that need attention, these ACC national resources will remain a powerful advocacy tool for us here at the state level. On the payer relations

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President's Message

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front, I am pleased to say that the PaACC chapter was asked to provide an expert in the field of CT angiography to present the current “state of the technology” and considerations for reimbursement to the Highmark Medical Advisory Committee. John Rumberger, MD, FACC, a pioneer of CT angiography and author of many of the original scientific studies demonstrating the usefulness of this technology, graciously accepted my invitation to present to the committee on behalf of the PaACC.

Providing our membership with quality educational opportunities for CME credit was another “hot button” survey issue and remains an important function of the Chapter. I’m very excited about this year’s new program and venue for the annual state chapter meeting being held at Nemaquin Woodlands Resort on October 12-14, 2007. This year’s Chapter Meeting Planning Committee, chaired by Dr. John Doherty and comprised of Drs. David Lasorda, Andy Waxler, Michael Rossi, David Scher and Victor Ferrari and Caroline Doherty, CRNP, have organized an excellent educational program and relaxing weekend. Please check the PaACC website (www.pcacc.org) for further details.

Workforce issues remain high on the priority list for many cardiology groups in our state. Before any relevant action plan can be put into place to ease the burden of cardiovascular specialist recruitment, it is important to understand the needs of our current practices. Instead of using predictive models that are fraught with incorrect assumptions, Dr. Jeffrey Williams, currently a fellow in training at the University of Pittsburgh and member of the National ACC Workforce Taskforce, and I will be asking the small, medium, large, and academic practices across the state for their recruitment goals over the next several years. This will help us clarify not only the training needs but also opportunities

for the state Chapter to provide tangible assistance in recruitment efforts. Please be sure to respond to the survey when you receive it.

Finally, advocating quality cardiovascular care for the citizens of Pennsylvania has been a longstanding goal of the Chapter and one that remains poignantly relevant. A state-based focus on ACC National’s quality initiatives will provide an opportunity for members to contribute ideas on “best-practices” within their own communities, thereby focusing a wealth of national resources on our local issues. As an example, The National ACC Door to Balloon (D2B) initiative, launched in November 2006, is a quality improvement campaign to save time and lives by reducing door to balloon times for STEMI patients. This “alliance for quality” now involves over 35 strategic partners, led by the ACC and including the AHA, NHLBI, and JCAHO among others. Currently there are over 900 hospitals in 48 states and other countries enrolled. In this issue of “Heart of the Matter,” Dr. Ettinger describes our own state’s efforts and an exciting meeting to be held locally as an opportunity for health care providers within our state to share their success stories and provide assistance to those just starting the initiatives in their communities. Mark your calendars now for Wednesday, October 17, 2007, at the Hershey Lodge and Convention Center.

We all are frequently asked to share our time, talents and treasure for various organizations and purposes. As the PaACC continues with momentum to affect change in our state, I hope that you continue to find the Chapter’s activities and purpose relevant to your day to day professional lives. It is my hope that you not only continue to find value in sharing your treasure in the form of dues, but that many may also find personal satisfaction by sharing your time and talents as well.

Highmark Medicare Services and National Carrier Advisory Committee (CAC) Meeting Reports

Donald C. Durbeck, MD, FACC, CAC Representative

It was my privilege to attend the February 8, 2007, meeting of the CAC Committee of Highmark Medicare Services. Dr. Bloschichak announced the new name for the organization, a new email address for himself, and the presence of two new physicians on their staff. Paula Bonino, MD, has become Contract Medical Director, and Mary Jeanne Krop, MD, MS, FACS, will be a Contract Medical Director for surgical services. Dr. Bloschichak's new email is Andrew.bloschichak@highmarkmedicareservices.com and his phone number is 717-302-4198. Dr. Bonino's phone is 717-544-1931 and Dr. Krop's is 717-544-1964.

Much discussion centered on the CERTS Program—Comprehensive Error Rate Testing Program. If your office receives a request for ad-

ditional documentation as a part of this program, please respond quickly and completely to their questions, most errors involve coding and documentation. Nationally, Cardiologists have a 5.1% error rate. The most frequently billed services in error in PA are: Office Visit, Established, Consultations, Nursing Home Visits, Office Visits—new, Hospital visits—initial, Emergency Room Visits and Hospital Visits—Subsequent. Further information is available at www.cms.hhs.gov/cert/ or www.highmarkmedicareservices.com.

The LCD of interest to the Cardiology Community was for Cardiac Ablation Procedures. This was developed as a result of consolidation of PA Part B, Pa Part A, and Delaware LCD's on this subject.

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Cardiac Care Associates Update

Lisa Maria Henry, CRNP, CCA State Liaison to the National Office

This is an exciting time for Cardiac Care Associates on both the national and state levels. The CCA role is rapidly expanding and opportunities exist that were not previously available to the CCA membership category. This update comes on the heels of ACC '07, where we had the opportunity once again to meet with the national CCA working group. This group is comprised of CCA state representatives from each chapter. This dynamic group collaboration benefits individual chapters, but also helps structure the framework from which CCAs continue to evolve.

Clinical pharmacists are the newest addition to the CCA category. As of April 1st, 2007, any member of the College may sponsor practicing clinical pharmacists (not those working in industry) for membership. Another development in progress is the CCA Core Curriculum. This program is being developed in response to the educational needs of the cardiovascular care community and is being designed to positively impact workforce issues in practice. It will be structured to meet the educational needs of early career CCAs as well as advanced practice CCAs and is consistent with the recently completed Scope and Standards of Cardiovascular Nursing. Some of the goals of this curriculum are shorter orientation periods, development of solid skill sets, facilitation of high performance practice teams, and increasing member growth. More information will be forthcoming as it develops.

It was an honor to help represent our Chapter in New Orleans. We're one of the largest and most active Chapters in terms of CCA involvement.

Five members from our chapter have accepted positions on national committees within ACC. While networking with other state representatives, it became clear that we're fortunate to have physician leadership that values and supports our contributions to the Chapter. CCA membership in the Pennsylvania Chapter continues to grow based on the excellent groundwork laid by my predecessor, Michelle Nickolaus, CRNP. We're up to 208 CCA members in Pennsylvania, including 11 new members this year so far. As most of you know, Tina Davis, CRNP has accepted the position of Eastern Statewide CCA Liaison effective March 1, 2007 through March 1, 2010. Tammy Outly, CRNP has also accepted the District IV Liaison position for a two-year term. In September, we'll be looking for interested candidates for CCA Liaisons in Districts I, II, and III, as the current terms expire.

We've formed a committee to revise the Operational Guidelines within the Chapter to better define these roles. CCAs are encouraged to join this or other committees within the state that may spark your interest or area of expertise. More information will be found on the revised website at www.pcacc.org/aboutus/aboutus5.html. Please visit the site and give us your feedback. Finally, Carrie Lloyd, CRNP, District I CCA Liaison, has been diligently working with the Chapter Meeting Planning Committee to make the annual meeting a valuable experience for CCA members. She's worked to incorporate breakout sessions pertinent to CCAs and I'm hoping to see and meet many of you there in October. Thanks to all of you for making our Chapter such a strong force within the cardiovascular care community.

Cardiac Computed Tomographic Angiography in Pennsylvania

The Pennsylvania Chapter of the American College of Cardiology and the national ACC have been working closely to present an organized approach in assisting Pennsylvania insurance plans and its Medicare carrier in developing clinical policies for Coronary Computed Tomographic Angiography (CCTA).

Initial efforts in 2006 focused on working with Pennsylvania's Medicare carrier when PaACC developed comments for Highmark Medicare Services draft local coverage determination (LCD) for Computed Tomographic Angiography of the Chest. PaACC was successful in amending the draft LCD to include more cardiac related indications for CTA services due to the work completed by the ACC, American College of Radiology (ACR), American Society of Nuclear Cardiology (ASNC), North American Society for Cardiac Imaging (NASCI), Society of Cardiac Angiography and Interventions (SCAI) and Society of Cardiovascular CT (SCCT) in 2005 when they developed the model LCD for Cardiac Computed Tomography and Computed Tomography Coronary Angiography. The PaACC attempted to suggest changes in Highmark's Medicare coverage that aligned with the model LCD. To review the current LCD for Pennsylvania, go to the Highmark Medicare Services website at <http://www.highmarkmedicare.com>

Throughout the past year and a half, PaACC and ACC have been working to address insurance plans' questions regarding the clinical validity of CCTA. PaACC has discussed with both Highmark and Independence Blue Cross the usefulness of CCTA in evaluating and treating patients with coronary artery disease. At the present time, Highmark does not have a coverage policy for CCTA; however with its current modality requirement in place for facilities to offer CT services, the barrier to entry is high. IBC has not developed a clinical policy at this time for CCTA services and because of a business model decision, they do not allow CT machines located in the physician office to be reimbursed. PaACC is actively addressing the issues of each payer. PaACC participates on Highmark's Imaging Council and is planning a meeting with them in June to present data on CCTA.

The PaACC and the ACC are opposed to the "five modality-rule" and have been in negotiations to modify such prerequisite. In support of this

requirement for in-office CT and MR services, insurance plans have argued that any physician group that is operating five or more modality imaging services is focused on the practice of imaging and therefore would be able to schedule the best imaging study for that particular patient and would be able to perform and interpret the study with enhanced skill. This requirement has also been advocated as a means to reduce over utilization of services that may occur in self-referral practices. The PaACC and the ACC are dedicated to ensuring that cardiovascular diagnostic imaging procedures are performed in an *appropriate* manner, on the *appropriate* patient, at the *appropriate* time. Together we can ensure the delivery of high quality cardiovascular care quality.

To ensure appropriate care, the ACC supports the development of cardiovascular specialists through specific training to achieve clinical competence in cardiac CT as outlined in the American College of Cardiology Foundation/ American Heart Association Clinical Competence Statement on Cardiac Imaging With Computed Tomography and Magnetic Resonance (*Journal of the American College of Cardiology, Vol. 26, No. 2, 2005*). The PaACC encourages all members who provide this service to be familiar with current ACC recommendations for Level I-III Clinical Competence particularly as it relates to the number of studies completed and the need for continuing education. Ongoing discussions with various payers in Pennsylvania have focused on modifying credentialing criteria to be consistent with the national ACC statement. Additional information relating to appropriateness criteria for cardiac CT and cardiac MR can be obtained by visiting our chapter's website (www.pcacc.org – click *imaging update*).

Finally the issue of over-reads for cardiac CT studies is being reviewed. While fellowships and various training programs have been developed that focus on reading the full window of the study, many cardiologists and radiologists have opted to develop a "reading protocol" that combines the expertise of both specialties in interpreting the entire image. The clinical expertise of the cardiologists involved in the imaging program will in part direct each group's decision as to how interpretations of the scan will be conducted.

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ACC - D2B GAP Program

Steven M. Ettinger, MD, FACC, Past-Governor, Eastern PA

In November 2006 at the American Heart Association (AHA) national meeting, the American College of Cardiology (ACC) announced a new Guidelines Applied in Practice (GAP) program- Door-to-Balloon (D2B) program designed to improve reperfusion strategies for patients presenting with acute coronary syndrome.

The goal of this quality initiative is to improve care in hospitals performing primary percutaneous catheter-based interventions by challenging these institutions to implement treatment pathways that achieved door-to-balloon times of 90 minutes or less. The ACC is working with over thirty partnering organizations who are serving essential supporting functions as *Collaborators, Sponsors and Visionary Supporters* in an effort to make this vision a reality. Recognizing the impact of this program, the American Heart Association, the National Heart Lung and Blood Institute, and the Society for Cardiovascular Angiography and Interventions have become partners in this national effort.

Practice guidelines created by the American College of Cardiology and the American Heart Association encourage those institutions treating STEMI patients with primary PCI to achieve reliable and reproducible reperfusion times. Realizing that this level of performance is an “organizational challenge” and can best be addressed by a multidisciplinary approach, the GAP-D2B program was created.

The D2B Alliance was developed to make “current extraordinary performances ordinary.” By providing programs with pathways that are evidence-based along with tools that have been shown to reduce D2B times to 90 minutes, the GAP-D2B program hopes to achieve a **door-to-balloon time of 90 minutes or less for at least 75% of non-transfer primary percutaneous coronary intervention patients with ST-segment elevation myocardial infarction in all participating hospitals performing primary PCI.**

Equally as important in reaching this benchmark, the D2B program provides a unique network throughout the U.S. that allows hospitals and health care personal to share their experiences and problem solving approaches.

While time saving reperfusion strategies have been in place for several years, studies suggest that only 40% of hospitals have been able to perform primary PCI in 90 minutes or less on a consistent basis. Given the previously successful clinical initiatives including the ACC-AMI and CHF-GAP projects, the D2B program utilizes a standardized toolkit and systematic processes of care to assist programs in reducing door-to-reperfusion times.

Currently, there are forty-one participating hospitals in Pennsylvania enrolled in this quality initiative and whether your hospital is well established in minimizing delays

in reperfusion times or wants to implement strategies and pathways that can significantly reduce D2B times...the PaACC encourages you to join. Nationally over 900 hospitals that perform primary PCI have enrolled in this initiative. For more information please contact the Pennsylvania Chapter of the American College of Cardiology or visit the D2B Alliance on the web at www.d2balliance.com

Given the number of successful primary PCI pro-

grams in our state, and the excitement within the medical community that this program has created, the PaACC in collaboration with the Blue Plans based in Pittsburgh and Philadelphia will be holding a D2B Conference Wednesday, October 17, 2007 in Hershey, Pennsylvania. This full day educational meeting will feature best practice models currently being implemented by paramedics, Emergency Medicine physicians and cardiologists throughout our state. All health-care related workers are invited to attend and we encourage all hospitals and health-care workers to submit abstracts for presentation at this meeting. The keynote speaker for the conference is scheduled to be Dr. Harlan Krumholz, chair of the ACC-D2B program. For additional information and details regarding this meeting contact our PaACC Chapter Executive Maria Elias at 888-633-5784 x1475 or melias@pamedsoc.org. Additional information can also be found on our website at www.pcacc.org.

Remember, together we can truly make a difference.

“...the GAP-D2B program hopes to achieve a door-to-balloon time of 90 minutes or less for at least 75 % of non-transfer primary percutaneous coronary intervention patients with ST-segment elevation myocardial infarction in all participating hospitals performing primary PCI.”

Highmark Medicare Services

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The philosophical issue of the existing indications for this only in patients who have not responded to antiarrhythmic therapy was thoroughly discussed. For SVT, ablation is felt to be the primary therapy of choice by our EP community and hopefully the LCD will be modified to reflect that view. Otherwise there appeared to be little disagreement with the LCD as it stands. A note of irony is that the original indication, 33253, the MAZE procedure is no longer covered. Modified MAZE procedures continue to be covered. Endoscopic MAZE is also covered, as well as the various intracardiac approaches. I thank Dr. Scher for his input on this LCD.

A number of LCD issues in regards to physical Therapy, Occupational Therapy, and Rehabilitation services were also discussed. I learned that Cardiac Rehab and Pulmonary Rehab are covered by a national LCD that our Cardiac Rehab personnel feel is badly in need of revision with current coverage existing only under an "incident-to" clause which allows each Medicare contractor to "interpret" what this means in their localities.

They urge that you contact Arlen Specter at www.specter.senate.gov (fax: 202-228-1229) and Robert Casey at www.casey.senate.gov (fax: 202-228-0604) asking for their support of bills S329 and HR 552 which address these issues in a favorable manner. Your Cardiac Rehab programs will be very grateful for your support. There appears to be no local CAC way to approach this issue.

The next CAC meeting will be held on June 14th, 2007. More to come!

National CAC Meeting

It was my privilege to attend the National CAC Committee meeting held during the ACC sessions held in New Orleans on March 26th, 2007. A number of subjects of interest to the membership of the PaACC were presented.

The CMS 2007 Physician Quality Reporting Initiative (PQRI) was first on the agenda. All health care providers to Medicare patients are invited to participate in this 6 month program, including physical therapists, Dentists, Chiropractors, etc. The quality measures are updated weekly on their web site www.cms.hhs.gov/PQRI. New CPT Category II codes are available for most cardiology quality measures, and a temporary G-Code can be used for anything currently not covered. We are being expected to submit these quality indicator codes at the same time that we submit our standard CMS

codes. The new forms are available at www.cms.hhs.gov/cmsforms. Each practitioner can choose 3 or more quality measures to report on a one time basis (for now). Compliance with 80+% of cases will earn you a bonus payment of 1.5% of total allowable charges billed during that 6 month period. Statutory requirements are being developed for these measures starting in 2008. Comments that were made included "This is a change from pay for volume to pay for quality and efficiency." "This is something that physicians should try." "Try to learn; try to earn." You need your National Provider Identifier (NPI) for this.

Recovery Audit Contractors (RACs) are being put in place in all states to identify overpayments and underpayments by Medicare. In 18 months they have "recovered" 54.1 million dollars in overpayments, and have paid back 2.9 million in underpayments. No one at the meeting could recall receiving the latter. Our state is not on the radar screen for these (RAC's) as Highmark continues to actively monitor these through their CERTS program.

Appropriateness Criteria are being developed for SPECT MPI in conjunction with the American Society of Nuclear Cardiology. Input is being requested.

The ACC actively participates in Coding and Reimbursement issues including codes for P4P, Cardiac MRI, Cardiac Remote Monitoring, as well as in the development of new CPT codes—Optival was mentioned. Getting a code for a procedure, etc. does not necessarily mean that you will be paid for that code as well. Local coverage determinations play a role in coverage decisions, and they may use new codes for tracking utilization of new technologies.

Databases were discussed at length. The ACC, as you know, began their cath and interventional data base in 1998. A mandatory ICD registry was put in place in 2005. The Carotid Stent Registry (CARE) started in 2006, and in 2007 the NIRMI and CRUSADE databases are being merged into the ACTION registry. On the drawing boards are an ICD longitudinal registry, a long term PCI registry, an imaging registry, and a congenital registry. There is growing interest in making the ACC databases compatible with the STS database, so that data entry and retrieval would be expedited. Finally, electronic medical records in all hospitals as well as all physician offices is a CMS goal that will allow Pay for Performance in both settings.

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Pennsylvania Annual Chapter Meeting

October 12-14, 2007 • Nemaquin Woodlands Resort & Spa

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

The time is rapidly approaching for our Annual Chapter Meeting taking place the weekend of October 12th to October 14th, 2007. This will be held at the Nemaquin Woodlands Resort and Spa in Farmington, Pennsylvania. This is the first time that we have extended our Chapter Meeting to two half days to allow a mix of family-friendly recreational activities along with our scientific sessions.

Advocacy has always been a primary goal of our Chapter Meeting and this meeting is no exception. We have attempted to stay abreast of trends in reimbursement by presenting a session on appropriateness criteria and its utilization by payers. Likewise, Pay for Performance (P4P) has already begun, as many of you know, with the PQRI Medicare initiative. The

ability to garner Medicare bonuses will depend upon developing an appropriate mechanism for reporting data.

We are also pleased to have Kathleen Flood from ACC National to update us on the general topic of reimbursement challenges and solutions for cardiovascular specialists.

This will be underscored by a presentation highlighting successful advocacy initiatives in other Chapters.

There will be a clinical update on coronary interventions and the importance of Door-to-Balloon time. In addition, there will be a state-of-the-art update of atrial fibrillation highlighting patient selection for pharmacotherapy or ablative therapy.

There will be a clinical controversies session of LDL goals in various patient subsets. There will also be a summary session on the procedure for achieving laboratory certification for non-invasive studies.

We have planned a session highlighting scientific advances as well as reimbursement challenges in cardiac CT. There will be break-out sessions for Cardiac Care Associates (CCA) and a session for our Fellows in Training (FIT) about the importance of employment contracts.

We on the Committee feel that we have put together a stimulating two-day meeting at a picturesque location. Please pay special attention to early mailings since rooms will be limited and we expect the meeting to be very popular. Additional information will soon be available on the website.

