



Heart of the Matter

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

President's Message *John U. Doherty, MD, FACC*

John U. Doherty, MD, FACC



The forces impacting cardiovascular practices are legion. Practices continue to be beset by changes in reimbursement, increases in regulatory initiatives, proscriptions against self-referral

coming from state legislatures and the ever-present specter of the Sustainable Growth Rate that continues to balloon on an annual basis. Based on a recent ACC survey of practices within Pennsylvania, this has resulted in several trends.

Statewide Practice Trends

The first major trend is the aligning of practices with hospital systems. This is a trend that began to accelerate last year and will probably do so to an even greater extent going forward. There are certainly many pitfalls associated with alignment with hospitals and the reader of this article is referred to our website (www.pcacc.org) to view the postings from our lecturers from the Annual Chapter Meeting in October. We presented a half-day symposium on practice survival and many of these trends are tracked in detail.

The second major trend in practices is for merger of practices for economy scale and market power. More than 40 percent of the practices in the state, however, have no plans to modify their practice activity in a significant way and are "staying the course."

Beltway Blues

All of you certainly remember the rule by the Centers for Medicare and Medicaid Services (CMS) that came out around this time last year that resulted in the draconian cuts to reimbursement,

especially in nuclear imaging. The CMS Rule for 2011 was released in early November. The implications for practices do not appear to be as drastic as last year and are still being analyzed.

The trend toward bundling of procedures continues. Specifically, bundled codes for diagnostic cardiac catheterization are implemented. These cuts at first flush appear to be modest. Lower extremity revascularization services received more significant payment cuts. CMS also finalized its decision to revise the "Medicare Economic Index," a formula adjustment that impacts all services paid under the physician fee schedule. This will diminish the negative impact on imaging for 2011.

However, it also moderates projected increases in services, such as office visits. The impact on individual practices depends on their mix of these services. The rule also finalizes the requirements for bonuses for the Physician Quality Reporting Initiative (PQRI) in electronic prescribing and sets the framework for the required 2012 e-Prescribing payment adjustments.

The Faster We Go, The Behinder We Get

The SGR Patch is scheduled to expire on Nov. 30. The Senate has voted to approve a one month patch until year's end. Sens. Baucus (D-MT) and Grassley (R-IA) have vowed to work on a one year patch before year's end. The House (which also needs to ratify the one month patch) re-convenes on Nov. 29. The timeline is tight and the prospect exists for a possible delay in Medicare payments in early December.

Health Care Reform

There are specific provisions of the Affordable Care Act that will impact practices going forward. The PQRI initiative is extended through 2014 with penalties in 2015 and 2016. The Independent

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Western Governor's Report

Rene' J. Alvarez, Jr., MD, FACC, FAHA

Rene' J. Alvarez, Jr., MD, FACC, FAHA



In the past 18 months, I've had a chance to examine and analyze some of the pivotal and vital issues pertaining to cardiology and health care in general. And all of this thinking, coupled with the cooler season, have

conjured up thoughts of alphabet soup.

As a child, I recall my mom serving my siblings and me hot alphabet soup that we all thoroughly enjoyed. We are in the midst of a political potpourri of letters of the alphabet in health care. By that I mean, ACO, PPO, DRG, EMR, EHR, H2H, CMS, SGR, ACA, PPO, along with an alphabet soup of members of health care, MD, NP, DNP, PA, RN...I could go on and on.

I have learned and developed an appreciation for the importance of this alphabet soup. These acronyms are important and vital for us to understand if we are going to influence our profession, have an impact on reform, and help shape our future as professional CV specialists influencing how we care for our patients. The two acronyms I want to focus on are ACOs and H2H.

The creation of Accountable Care Organizations (ACO) is a new initiative developed to contribute to restraining health care costs and improving health care outcomes. An ACO is a regional health care organization that includes a primary care provider aligned with specialty physicians and a hospital that would be held accountable for the cost and quality of care delivered to a specific population. The participants of an ACO ideally would meet goals of cost containment and improved health care outcomes resulting in financial rewards. However, if goals were not met, the participants would be subject to penalties.

The concept of ACOs has not been cemented and the specifics of its implementation are still being debated. Recent literature states that the main issues that need to be considered are:

- how the ACO will be assigned;
- whether provider participation will be voluntary or mandatory;
- how patients will enter an ACO;
- what the payment structure will be; and
- what the quality measures will be¹

There are approximately 900 million outpatient visits each year across the United States. More care is delivered on an outpatient basis than inpatient care. Cardiology practices and patients may be skeptical about the description of a previous change, namely HMOs. ACOs sound a lot like disguised HMOs and there is concern over restriction of physician choice, interruption of patient-physician relationship, and resulting lower quality care.

The alignment of physician practices and hospitals as partners may be concerning for some physician practices fearing hospital enforcement of policies or even employment. The ACC maintains that physicians, payers, and patients must all contribute and have input regarding the design and structure of changes in the delivery of health care that will affect physicians and patients.

It is only in this collaborative environment that the development and implementation of such changes will be successful. The ACC believes that participants of an ACO deserve rewards for restraining cost without denying necessary care, but that also members should not be penalized for costs for which they have no control.

New initiatives and cost-saving measures set by the Centers for Medicare and Medicaid Services (CMS) focus on preventable readmissions within 30 days after discharge in patients diagnosed with acute myocardial infarction, congestive heart failure, or pneumonia. The ACC has launched its new Hospital to Home (H2H) initiative, with the goal of reducing readmission rates for patients with cardiovascular disease.²

The aim is to make the transition from hospital to home a seamless progression for patients and their families with the resulting goal of H2H to reduce readmissions by 20 percent by 2012. The dominant goal of the initiative is to improve care for all patients with CVD. The three areas of focus with H2H are:

- post-discharge medication management;
- early follow-up; and
- symptom management.²

The H2H initiative provides educational tools, resources, strategies, and an online community to ensure its success. Thus far, there is great member leadership, supplemented by experts and partners such as the Institute for Healthcare Improvement (IHI). More than 800 facilities and more than 1,000

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Education Committee Report

Vincent M. Figueredo, MD, FACC, Education Committee Chair



Vincent M. Figueredo, MD, FACC

Our annual Chapter Meeting at Nemaocolin Woodland Resort was preceded on Friday by a well attended conference for Pennsylvania Fellows-In-Training (FIT). This year's topic was "Cardiac MRI and

CT: Basic Concepts, Clinical Usefulness and Cases." We also had another successful FIT Poster Session at the Chapter Meeting. The winning poster was entitled, "Reverse-Use Dependence of Antiarrhythmic Drugs: Role of Late Sodium Current" by Dr. Chinmay Patel of Lankenau Hospital (for more see FIT Report below).

FITs from the Philadelphia area got together Aug. 11 at a Philadelphia Phillies game with Dr. Alfred Bove, past president of the ACC. The event was put together by FIT Dr. Scott Lilly from the University of Pennsylvania. More FIT get-togethers

are in the works, including meeting with Dr. Harvey Waxman, Cardiology Chief at Presbyterian Medical Center, to discuss how he established his practice and features of competitive job applicants. We are hoping to get FIT events going in the Pittsburgh area in the near future.

Our annual PaACC Cardiology Care Associates (CCAs) Educational Conference was split this year into east and west meetings in Harrisburg and Pittsburgh. The meetings received excellent marks among 89 attendees. Next year's conferences are taking place in Valley Forge/King of Prussia on April 29 and Monroeville on May 13 (for more see CCA Report below).

This edition of Heart of the Matter debuts our expanded coverage of educational content for PaACC members, focusing on appropriate use criteria and current guidelines. Summaries from guidelines will now be included in the newsletter with web links to the complete reports.

We recently surveyed our FACC members to help us better understand their educational needs. We will be planning our future educational events to better serve you!

FIT Report

Anne Mani, MD, FIT Representative



Anne Mani, MD

The Pennsylvania ACC has been busy this year with FIT events! As part of the PaACC's commitment to support and educate Fellows-in-Training, a day-long educational conference on the clinical applications

of cardiac MRI and CT was held on Friday, October 15, prior to the annual PaACC Chapter Meeting at the Nemaocolin Woodlands Resort.

Speakers from across the state with expertise in both CT and MRI presented information on the physics of MRI/CT as well as the application of these technologies to diagnose cardiomyopathies and cardiac remodeling, valvular heart disease, coronary artery disease, pericardial disease and aortic disease.

Speakers for cardiac CT included Joan Lacomis, MD, from University of Pittsburgh; Marcus Chen, MD, from the NIH; and Ron Jacob, MD, from The Heart Group in Lancaster, Pa. Speakers for cardiac MRI included Julio Chirinos, MD, from the University of Pennsylvania; Matthew Martinez, MD, from the Lehigh Valley Heart Specialists in Allentown, Pa.; Robert Biederman, MD, from Allegheny General Hospital in Pittsburgh; and Erik Schelbert, MD, from University of Pittsburgh.

The presentations were informational and included a variety of actual cases in which cardiac CT and MRI helped in the diagnosis and management of patients. The conference was well-attended by fellows from across the state, and the day concluded with a welcome reception, where fellows had the opportunity to meet the presenters.

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Legislative Update

William Combs, MD, FACC



William Combs, MD, FACC

The essence of life is change, and change is upon us. The midterm election results are in, and what changes the new Congress will address in 2011 remain to be seen. Meanwhile, without rapid action from the lame duck

Congress to fix/extend the Sustainable Growth Rate (SGR) cuts, we will see major reductions in physician reimbursement and perhaps payment delays similar to what we experienced in the first six months of 2010.

The SGR fix passed earlier this year was extended by the Senate through Dec. 31. Legislators are still working on another extension past that.

Coincident with election day, the Centers for Medicare and Medicaid Services (CMS) has released information regarding the final 2011 Medicare Physician Fee Schedule Final Rule. The document is more than 2,000 pages long and sets the payment rates for all services paid to physicians for Medicare patients in 2011. Again, cardiologists will be affected by the bundling of codes, this time specifically for diagnostic cardiac catheterization and lower extremity revascularization procedures.

The exact rates have not yet been released, but the bundling of codes will likely result in reductions of total reimbursement for these services, and in the case of lower extremity revascularization are reported to be in the range of 29 percent.

What is the ACC doing about this? The ACC and other medical societies are working to introduce legislation into the lame duck Congress that would provide a 13-month SGR fix. This would fix physician payments at the current level through Dec. 31 of 2011, allowing the new Congress time to develop its own long-term solution to the physician payment problem.

In addition, Rep. Charlie Gonzalez of Texas plans to introduce a bill that would mitigate the effect of a physician payment cut of 15 percent or more for any service by having it phased in gradually over five years. You may recall that Rep. Gonzalez introduced similar legislation specific to the cardiology imaging cuts related to bundling of services that was not passed. Hopefully, the broader application of the new bill to all medical specialties will allow for a wider base of support and passage.

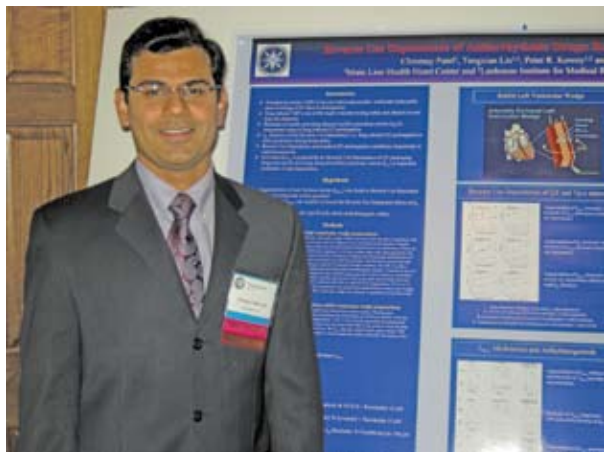
What can you do about this? Stay informed and stay involved. The PaACC has formed an FACC "point person" for each of the congressional districts in Pennsylvania, and we are in the process of forming a "grassroots" champion for each of the cardiology practices in Pennsylvania.

We need one champion to serve as point person in each of the larger cardiology practices in the state so that we can quickly disseminate information by e-mail and hopefully affect a rapid response to any action—political (state or federal), regulatory payer—or anything that requires our membership to become engaged. The only requirement is a valid e-mail that is regularly checked by the champion. Become a champion!

FIT Report

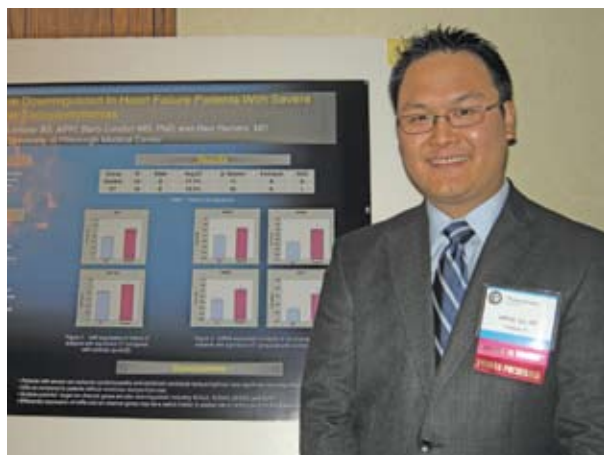
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The PaACC also sponsored an FIT poster contest during the annual meeting to spotlight the research activities of fellows from around the state. Participants in the poster contest received room and travel expense reimbursement for the conference.



Chinmay Patel, MD

The winners of this year's poster contest included Chinmay Patel, MD, from Lankenau Hospital, who won first place for his poster entitled, "Reverse-Use Dependence of Antiarrhythmic Drugs: Role of Late Sodium Current."



Jeffrey Liu, MD

Second place was awarded to Jeffrey Liu, MD, from the University of Pittsburgh, for his work entitled, "Myocardial MicroRNAs and Ion Channels are Downregulated in Heart Failure Patients with Severe Ventricular Tachyarrhythmias."



Scott Lilly, MD

Third place went to Scott Lilly, MD, from the University of Pennsylvania, for his research entitled, "Two-Dimensional versus M-Mode Tricuspid Annular Plane Systolic Excursion in the Assessment of Right Ventricular Function."

Monetary awards were given for first-, second- and third-place posters, and the first-place winner will present his poster at the ACC Heart House in January. Congratulations to all of the winners, and thanks to all the fellows who participated in this event!

In addition to promoting education and research for fellows in Pennsylvania, the PaACC has also sponsored social events for fellows from different programs to meet and network. Most recently, fellows were invited to attend a Phillies game in August. The event began with an informal talk by Dr. Alfred Bove, president of the ACC for the 2009-2010 term and Emeritus Professor of Medicine at Temple University in Philadelphia. Dr. Bove who discussed the development of his career as a cardiologist and what he sees in the future for cardiology.

Snacks were provided and fellows then attended the game. There was a great turnout, and fellows from most of the programs in the Philadelphia area were represented. We would like to thank Dr. Scott Lilly for making this event such a success! We would like to plan other social meetings for fellows in the western and central Pennsylvania areas. If you have any suggestions, please email your FIT Representatives—Anne Mani, MD, anne.mani@gmail.com or David Harris, MD, harrisd5@upmc.edu.

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Medicare/Medicaid Electronic Health Record Incentive Program: How Can Cardiology Practices Qualify?

Jeffrey L. Williams, MD, MS, FACC



Jeffrey L. Williams, MD, MS, FACC

Editor's Note: This is the first in a series of articles about EHR Incentive Programs. An article for hospital-employed physicians

will appear in a future edition of *Heart of the Matter*

The following information was adapted from the CMS EHR Incentive Program website: <http://www.cms.gov/EHRIncentivePrograms>. Dr. Jeffrey Williams, Director of Invasive Cardiac Electrophysiology Laboratory at Good Samaritan Hospital and Lebanon Cardiology Associates, Lebanon, Pa., will focus on Eligible Professionals not employed by hospitals as there are separate requirements for EHR Meaningful Use.

Why Strive for Meaningful Use?

The Centers for Medicare and Medicaid Services (CMS) is in a transformation to improve quality, safety and efficiency of care by providing incentives to utilize Electronic Health Records (EHRs).¹ The Medicare and Medicaid EHR incentive programs will provide incentive payments to eligible professionals and eligible hospitals as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. The programs begin in 2011 and are separate from the Physicians Quality Reporting Initiative (PQRI) and e-Prescribing programs.

A qualifying Eligible Professional (EP) can receive EHR incentive payments for up to five years with payments beginning

as early as 2011. In general, the maximum amount of total incentive payments that an EP can receive under the Medicare program is \$44,000.

Medicare EPs must participate by 2012 to receive the maximum payment. In general, the maximum amount of total incentive payments that an EP can receive under the Medicaid program is \$63,750. Medicaid EP must participate by 2016 to receive the maximum incentive payment. See **Table 1** for payment details for the Medicare incentive payments.

You cannot participate in both the Medicare and Medicaid EHR Incentive programs; you must choose one or the other. Most cardiology practices, given the demographic of those with heart disease, have a higher proportion of Medicare patients than Medicaid patients, thus most practices will opt for the Medicare EHR Incentive Program.

Getting Started with EHR Meaningful Use

Registration for the EHR Incentive Programs begins in January 2011 and payments for eligible professionals begin in the spring of 2011. The last year to initiate participation in the Medicare EHR Incentive Program is 2014. The official link to the Medicare and Medicaid EHR Incentive Program website is: <http://www.cms.gov/EHRIncentivePrograms/>.

Eligibility

A Medicare EP is a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor who is legally authorized to practice under state law. A qualifying EP is one who successfully demonstrates meaningful use for the EHR reporting period.

For the first year for which an EP applies for and receives an incentive payment, the

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Table 1. Payment Calculator for Eligible Professionals Demonstrating Meaningful Use¹

Calendar Year	First CY for which the EP Receives an Incentive Payment				
	2011	2012	2013	2014	2015 and subsequent years
2011	\$18,000	---	---	---	---
2012	\$12,000	\$18,000	---	---	---
2013	\$8,000	\$12,000	\$15,000	---	---
2014	\$4,000	\$8,000	\$12,000	\$12,000	---
2015	\$2,000	\$4,000	\$8,000	\$8,000	\$0
2016	---	\$2,000	\$4,000	\$4,000	\$0
TOTAL	\$44,000	\$44,000	\$39,000	\$24,000	\$0

Medicare/Medicaid Electronic Health Record Incentive Program

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EHR reporting period is 90 days for any continuous period beginning and ending within the year. For every year after the first payment year, the EHR reporting period is the entire year.

Eligible Providers who furnish substantially all their services in a “hospital

setting” are not eligible for incentive payments. A hospital-based EP performs substantially all of their services in an inpatient hospital setting or emergency room. Hospital-based EPs are now defined as EPs who furnish 90 percent or more of their allowed services in a hospital inpatient

setting, or hospital emergency department. In this situation, the hospital would then apply for EHR incentives through the Medicare Eligible Hospitals program.

A Medicaid EP is defined as a physician, nurse practitioner, certified nurse-midwife,

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Table 2. Eligible Professionals Must Complete the 15 Core Objectives²

1. Record patient demographics (sex, race, ethnicity, date of birth, preferred language, and in the case of hospitals, date and preliminary cause in the event of death)
2. For individual professionals, provide patients with clinical summaries for each office visit; for hospitals, provide an electronic copy of hospital discharge instructions on request
3. Record smoking status for patients 13 years of age or older
4. Record vital signs and chart changes (height, weight, blood pressure, body-mass index, growth charts for children)
5. On request, provide patients with an electronic copy of their health information (including diagnostic-test results, problem list, medication lists, medication allergies, and for hospitals, discharge summary and procedures)
6. Implement capability to electronically exchange key clinical information among providers and patient-authorized entities
7. Maintain up-to-date problem list of current and active diagnoses
8. Generate and transmit permissible prescriptions electronically (does not apply to hospitals)
9. Implement one clinical decision support rule and ability to track compliance with the rule
10. Maintain active medication allergy list
11. Computer provider order entry (CPOE) for medication orders
12. Implement systems to protect privacy and security of patient data in the EHR
13. Maintain active medication list
14. Implement drug–drug and drug–allergy interaction checks. Functionality is enabled for these checks for the entire reporting period
15. Report clinical quality measures to CMS or states

Table 3. Eligible Professionals Must Complete Five of 10 Requirements from the Menu Set²

1. Implement drug formulary checks
2. Provide summary of care record for patients referred or transitioned to another provider or setting
3. Incorporate clinical laboratory test results into EHRs as structured data
4. Submit electronic immunization data to immunization registries or immunization information systems
5. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach
6. Submit electronic syndromic surveillance data to public health agencies
7. Use EHR technology to identify patient-specific education resources and provide those to the patient as appropriate
8. Send reminders to patients (per patient preference) for preventive and follow-up care
9. Perform medication reconciliation between care settings
10. Provide patients with timely electronic access to their health information (including laboratory results, problem list, medication lists, medication allergies)

Table 4. Eligible Professionals Must Complete Six Clinical Quality Measures (CQM). This includes three core or alternate core measures and three of 38 from alternate set.³

Core Set CQM	Alternate Core Set CQM
HTN: Blood Pressure Measurement	Weight Assessment and Counseling for Children and Adolescents
Preventive Care and Screening Measure Pair: a) Tobacco Use Assessment, b) Tobacco Cessation Intervention	Preventive Care and Screening: Influenza Immunization for Patients 50 Years and Older
Adult Weight Screening and Assessment	Childhood Immunization Status

Medicare/Medicaid Electronic Health Record Incentive Program

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dentist or physician assistant who furnish services in a Federally Qualified Health Center or Rural Health Clinic that is led by a physician assistant. To qualify for an EHR incentive payment, a Medicaid EP must not be hospital-based and must meet one of the following criteria:

- Have a minimum 30 percent Medicaid patient volume;
- Have a minimum 20 percent Medicaid patient volume and is a pediatrician; or
- Practice predominantly in a Federally Qualified Health Center or Rural Health Center and have a minimum 30 percent patient volume attributable to needy individuals.

“Stages” of Meaningful Use

Meaningful Use Criteria will be developed in three stages over the next five years. **Stage 1** sets the baseline for electronic data capture and information sharing. The reporting period in the first year is 90 days and one year subsequently. **Stage 2** (est. 2013) and **Stage 3** (est. 2015) will continue

to expand on this baseline and be developed through future rule making.

The reporting may be yes/no or numerator/denominator attestation. Eighty percent of patients must have records in the Certified EHR Technology. A list of currently certified EHR platforms may be found at: <http://onc-chpl.force.com/ehrcert>.

Requirements of Stage 1 Meaningful Use

EPs must complete 15 core objectives (see **Table 2**), five objectives out of 10 from the menu set (see **Table 3**), and six total clinical quality measures (CQM). These six total clinical quality measures may consist of three core or alternate core (see **Table 4**) and three out of 38 from the Alternate Set (see **Table 5**).

Obviously, some of these Meaningful Use Objectives are not applicable to every EP's clinical practice; the ability to choose the CQMs that are applicable to each provider's practice will encourage adoption of EHR by the vast majority of clinical providers.

Summary:

The Medicaid/Medicare EHR Incentive Programs encompass the largest federal government resource allocation into expanding the use of Electronic Health Records. They are implemented in a stage-wise fashion and provide financial incentives each year of participation for up to five years. It is wise to work with your own particular EHR vendor to develop an implementation plan and start discussions sooner rather than later.

References:

1. “CMS Finalizes Requirements for the Medicare Electronic Health Records (EHR) Incentive Program,” CMS FactSheets, <http://www.cms.gov/apps/media/press/factsheet>, CMS Office of Public Affairs, Friday, July 16, 2010.
2. Blumenthal D and Tavenner M, “The ‘Meaningful Use’ Regulation for Electronic Health Records,” *NEJM*, V. 363, No. 6 (August 5, 2010), pp. 501-504.
3. The Official Web Site for the Medicare and Medicaid EHR Incentive Programs, <http://www.cms.gov/EHRIncentivePrograms/>.

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individual participants are enrolled in the H2H program.

As a heart failure specialist, this initiative is very important to me and I urge all of you to join the efforts and influence your hospitals to join in this vital collection of data and reform. There is no question in my mind that it will lead to better care of heart failure patients and better outcomes.

Like the challenges of implementation of the ACOs, the H2H initiative is not without its share of sobering issues. Recommendations for reducing readmissions are not clear. While the research is replete regarding prevention of readmissions, each institution and organization has its fair share of complications and challenges when tackling this issue.

There is a need for comprehensive and clear recommendations to aid in the implementation and success of this initiative. An interdisciplinary approach may work best as cardiology patients have complex and co-morbid disease states involving a network of professionals who care for them.

The ACOs and H2H are initiatives being developed with the goal of propelling the delivery of health care to a state of excellence. The goal of the PaACC is to continue to advance high quality cardiovascular care through education, research and advocacy to improve patient care outcomes. We will continue to keep the membership informed of the changes that impact us as a profession and intermittently will address these important acronyms.

There are other initiatives underway and in different stages of development. It is our duty as informed cardiologists to keep up with the changes occurring that will affect our practices, patients, and the way we deliver health care. So as the leaves fall off the trees and winter begins peeking its head through the cold, brisk air, enjoy some alphabet soup and keep in mind the acronyms that will play a critical role in cardiology in the near future.

References

1. Itchhaporia, D. Accountable care organizations and cardiology practice—a wave of the future? *Reviews in Cardiovascular Medicine*. 2010;11(2):100-101.
2. Brindis, R, Krumholz, H.H. President's page: national quality initiatives put ACC's mission into action. *J Am Coll Cardiol*. 2010;56(15):1260-2.

Table 5. Alternate Set of Clinical Quality Measures (CQM).³ EP must complete three of 38.

1. Diabetes: Hemoglobin A1c Poor Control
2. Diabetes: Low Density Lipoprotein (LDL) Management and Control
3. Diabetes: Blood Pressure Management
4. Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
5. Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)
6. Pneumonia Vaccination Status for Older Adults
7. Breast Cancer Screening
8. Colorectal Cancer Screening
9. Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD
10. Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
11. Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment
12. Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation
13. Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
14. Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
15. Asthma Pharmacologic Therapy
16. Asthma Assessment
17. Appropriate Testing for Children with Pharyngitis
18. Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer
19. Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients
20. Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
21. Smoking and Tobacco Use Cessation, Medical Assistance: a) Advising Smokers and Tobacco Users to Quit, b) Discussing Smoking and Tobacco Use Cessation Medications, c) Discussing Smoking and Tobacco Use Cessation Strategies
22. Diabetes: Eye Exam
23. Diabetes: Urine Screening
24. Diabetes: Foot Exam
25. Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol
26. Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation
27. Ischemic Vascular Disease (IVD): Blood Pressure Management
28. Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
29. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a) Initiation, b) Engagement
30. Prenatal Care: Screening for HIV
31. Prenatal Care: Anti-D Immune Globulin
32. Controlling High Blood Pressure
33. Cervical Cancer Screening
34. Chlamydia Screening for Women
35. Use of Appropriate Medications for Asthma
36. Low Back Pain: Use of Imaging Studies
37. Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control
38. Diabetes: Hemoglobin A1c Control (<8%)

ACC Practice Guideline Recommendations

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Recommendations for Surveillance of Thoracic Aortic Disease

The PaACC encourages members to take advantage of the ACC's many practice guidelines. As a new feature, Heart of the Matter will provide examples of these great resources. Below is information on recommendations for the Surveillance of Thoracic Aortic Disease on previously repaired patients. For more details on this set of guidelines, visit the PaACC website at www.pcacc.org:

continued on page 11

Figure 1



Recommendations for Surveillance of Thoracic Aortic Disease or Previously Repaired Patients

- I IIa IIb III**

 Computed tomographic imaging or magnetic resonance imaging of the thoracic aorta is reasonable after a Type A or B aortic dissection or after prophylactic repair of the aortic root/ascending aorta.
- I IIa IIb III**

 Computed tomographic imaging or magnetic resonance imaging of the aorta is reasonable at 1, 3, 6, and 12 months postdissection and, if stable, annually thereafter so that any threatening enlargement can be detected in a timely fashion.
- I IIa IIb III**

 When following patients with imaging, utilization of the same modality at the same institution is reasonable, so that similar images of matching anatomic segments can be compared side by side.

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Figure 2

Recommendations for Surveillance of Thoracic Aortic Disease or Previously Repaired Patients

- I IIa IIb III**

 If a thoracic aortic aneurysm is only moderate in size and remains relatively stable over time, magnetic resonance imaging instead of computed tomographic imaging is reasonable to minimize the patient's radiation exposure.
- I IIa IIb III**

 Surveillance imaging similar to classic aortic dissection is reasonable in patients with intramural hematoma.

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Figure 3

Suggested Follow-up of Aortic Pathologies after Repair or Treatment

Pathology	Interval	Study
Acute dissection	Before discharge, 1 mo, 6 mo, yearly	CT or MR, chest plus abdomen TTE
Chronic dissection	Before discharge, 1 y, 2 to 3 y	CT or MR, chest plus abdomen TTE
Aortic root repair	Before discharge, yearly	TTE
Aortic valve replacement (AVR) plus ascending	Before discharge, yearly	TTE
Aortic arch	Before discharge, 1 y, 2 to 3 y	CT or MR, chest plus abdomen
Thoracic aortic stent	Before discharge, 1 mo, 2 mo, 6 mo, yearly Or 30 days*	CXR, CT, chest plus abdomen
Acute IMH/PAU	Before discharge, 1 mo, 3 mo, 6 mo, yearly	CT or MR, chest plus abdomen

*US Food and Drug Administration stent graft studies usually required before discharge or at 30-day CT scan to detect endovascular leaks. If there is concern about a leak, a pre-discharge study is recommended; however, the risk of renal injury should be borne in mind. All patients should be receiving beta blockers after surgery or medically managed aortic dissection, if tolerated. Adapted from Erbel et al. Diagnosis and management of aortic dissection. Eur Heart J. 2001;22:1642-81.

Note: CT, computed tomographic imaging; CXR, chest X-ray; IMH, intramural hematoma; MR, magnetic resonance imaging; PAU, penetrating atherosclerotic ulcer; and TTE, transthoracic echocardiography.

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Table 17 in full-text version of TAD Guidelines.

Recommendations for Preoperative Evaluations

Below is information on recommendations for preoperative evaluations:

Figure 4

Recommendations for Preoperative Evaluation

I IIa IIb III
C ■ ■ ■ ■
In preparation for surgery, imaging studies adequate to establish the extent of disease and the potential limits of the planned procedure are recommended.

I IIa IIb III
C ■ ■ ■ ■
Patients with thoracic aortic disease requiring a surgical or catheter-based intervention who have symptoms or other findings of myocardial ischemia should undergo additional studies to determine the presence of significant coronary artery disease.

I IIa IIb III
C ■ ■ ■ ■
Patients with unstable coronary syndromes and significant coronary artery disease should undergo revascularization prior to or at the time of thoracic aortic surgery or endovascular intervention with percutaneous coronary intervention or concomitant coronary artery bypass graft surgery.

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Figure 5

Recommendations for Preoperative Evaluation

I IIa IIb III
■ C ■ ■ ■ ■
Additional testing is reasonable to quantitate the patient's comorbid states and develop a risk profile. These may include pulmonary function tests, cardiac catheterization, aortography, 24-hour Holter monitoring, noninvasive carotid artery screening, brain imaging, echocardiography, and neurocognitive testing.

I IIa IIb III
■ C ■ ■ ■ ■
For patients who are to undergo surgery for ascending or arch aortic disease, and who have clinically stable, but significant (flow limiting), coronary artery disease, it is reasonable to perform concomitant coronary artery bypass graft surgery.

I IIa IIb III
■ ■ ■ B ■ ■ ■ ■
For patients who are to undergo surgery or endovascular intervention for descending thoracic aortic disease, and who have clinically stable, but significant (flow limiting), coronary artery disease, the benefits of coronary revascularization are not well established.

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Chapter Awards 2010



John U. Doherty, MD, FACC and William P. Follansbee, MD, FACC, FACP, FASNC



William VanDecker, MD, FACC

PaACC President John U. Doherty, MD, FACC, left, poses with William P. Follansbee, MD, FACC, FACP, FASNC, after Dr. Follansbee was presented the Special Achievement Award at the Chapter Meeting in October. Dr. Follansbee and William VanDecker, MD, FACC, earned the award for their commitment to

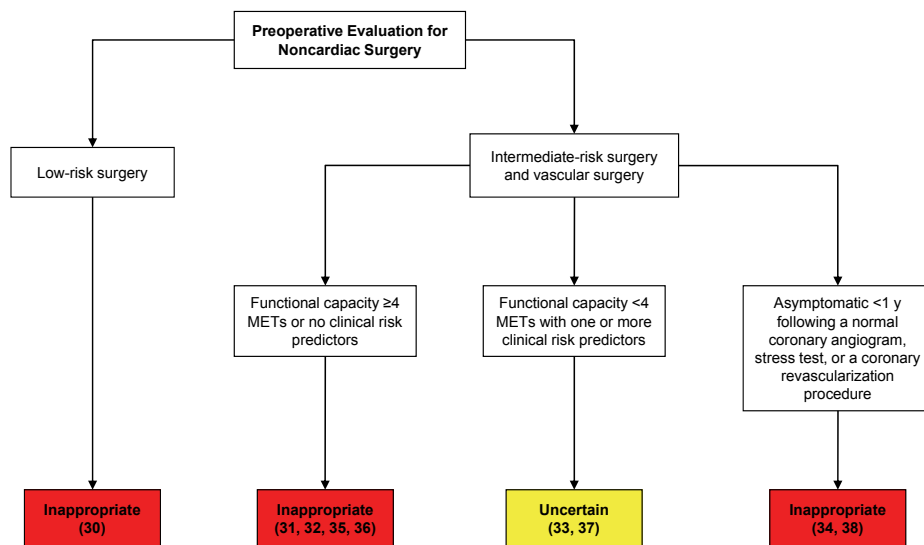
the issue of appropriate use of imaging technology and for representing the Chapter in issues related to self-referral and pre-certification. The Special Achievement Award goes to a Chapter member for his/her exceptional and outstanding support of a specific project, goal, and/or mission of the PaACC.

Appropriate Use Criteria: Cardiac Computed Tomography

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Figure 2

Risk Assessment Preoperative Evaluation of Noncardiac Surgery



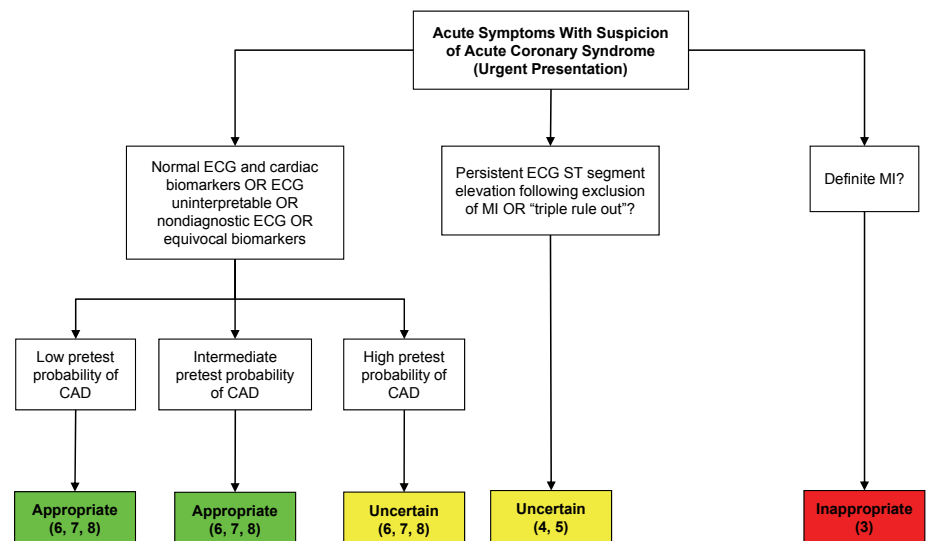
American College of Cardiology Foundation Appropriate Use Criteria Task Force, et al. J Am Coll Cardiol 2010;0:jacc.2010.07.005v1-15977



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Figure 3

Detection of CAD in Symptomatic Patients Without Known Heart Disease Symptomatic Acute Presentation



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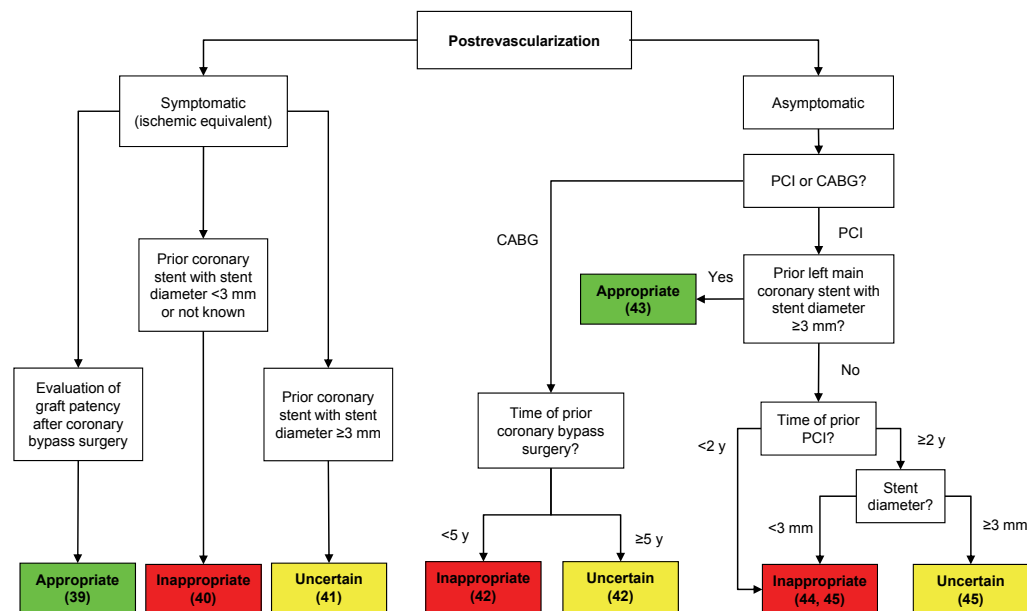
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The PaACC encourages members to take advantage of the ACC's many recommendations for practice management and appropriate use guidelines. As a new feature, Heart of the Matter will provide examples of these great resources. Below is information on the appropriate use criteria for Cardiac Computed Tomography. For more details on this set of guidelines, visit the PaACC website at www.pcacc.org:

continued on page 14

Figure 4

Risk Assessment Postrevascularization (PCI or CABG)



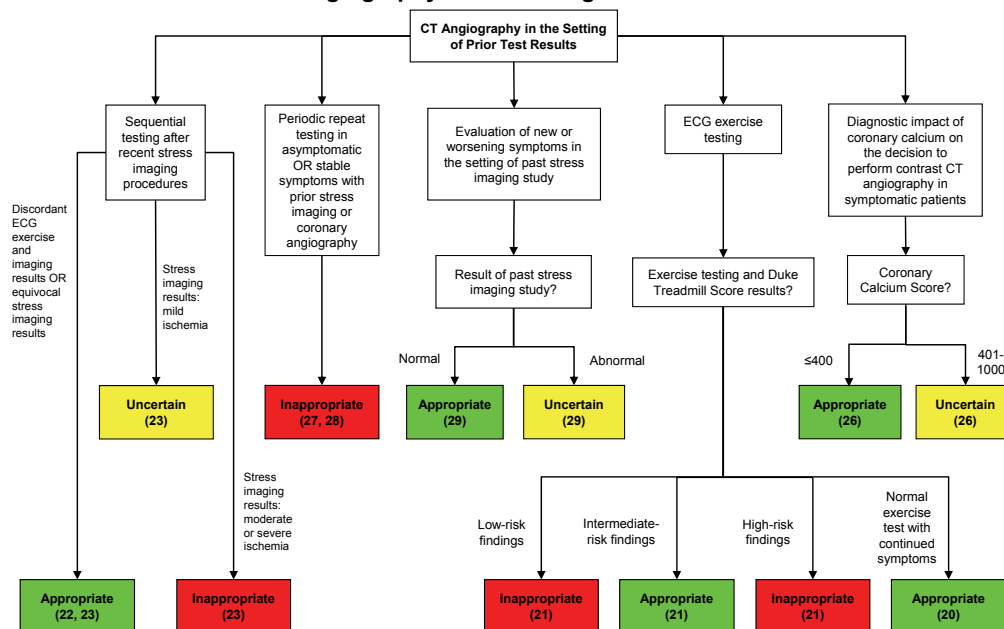
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Figure 5

Use of CT Angiography in the Setting of Prior Test Results



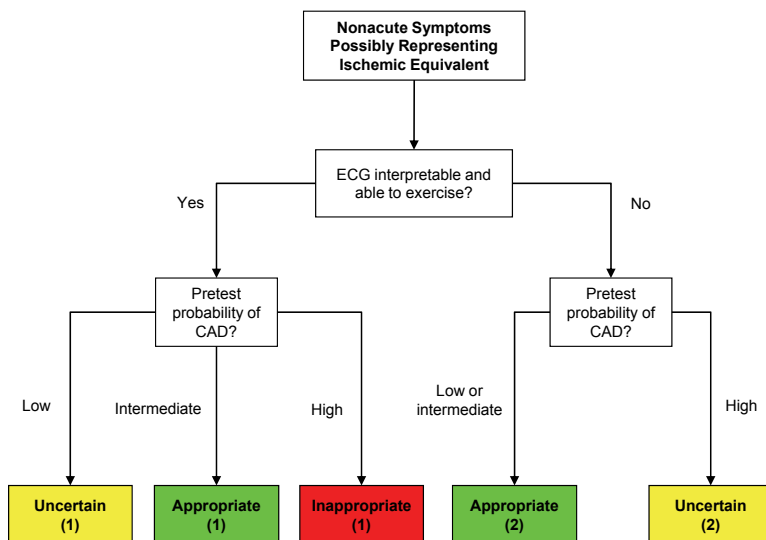
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Figure 6

**Detection of CAD in Symptomatic Patients Without Known Heart Disease Symptomatic--
 Nonacute Presentation**



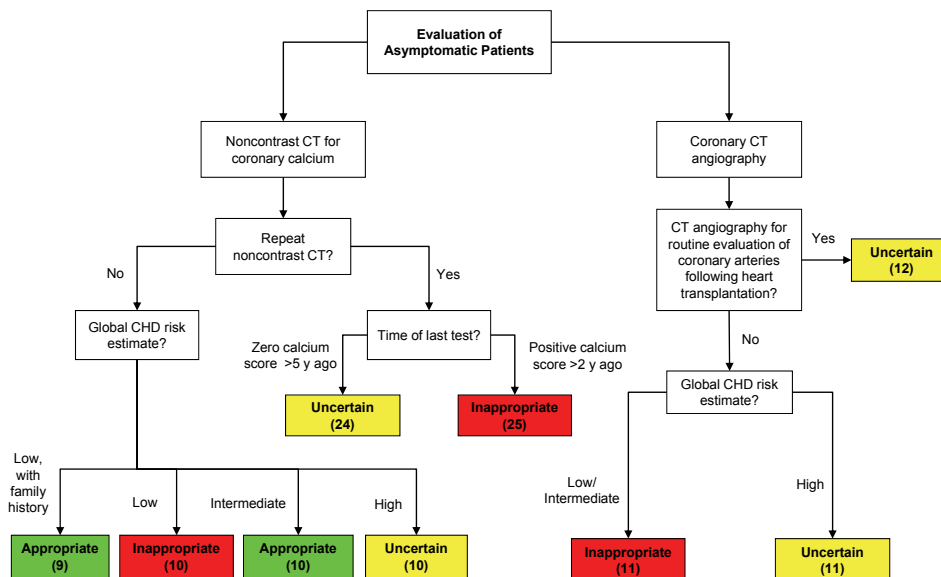
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Figure 7

Detection of CAD/Risk Assessment in Asymptomatic Individuals Without Known Coronary Artery Disease

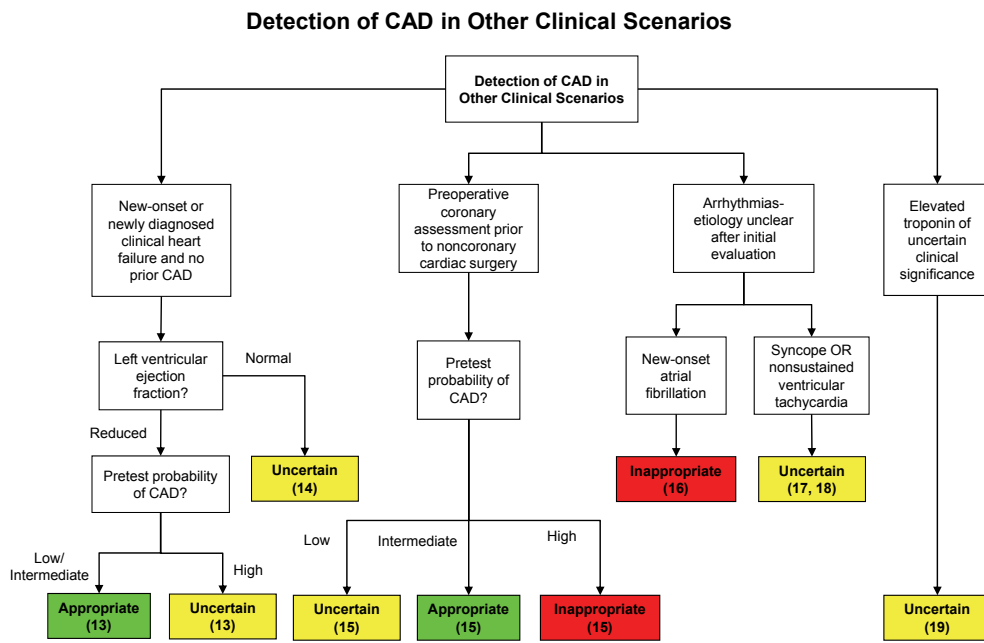


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Figure 8



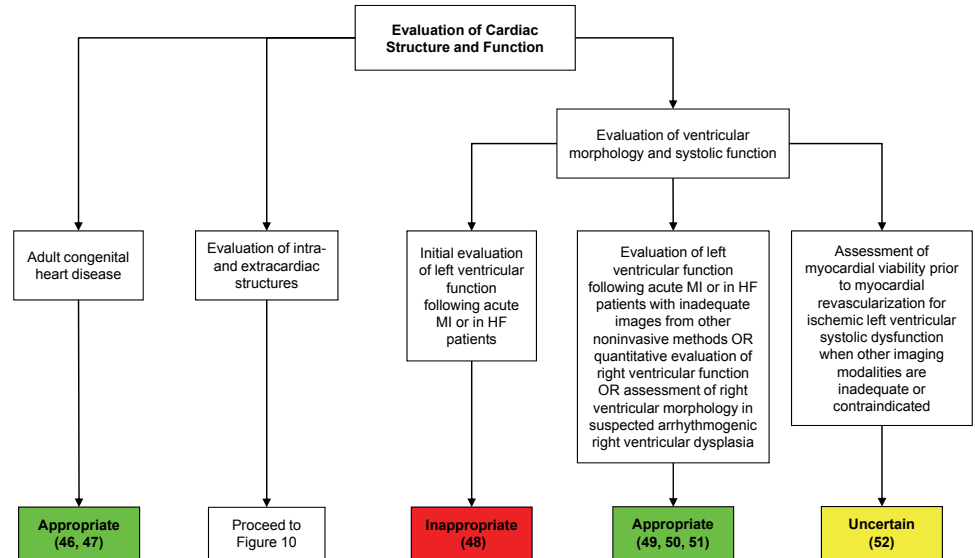
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Figure 9

Evaluation of Cardiac Structure and Function



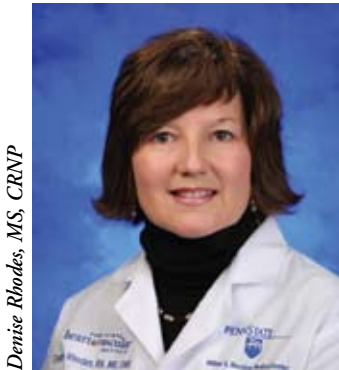
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PaACC Serves as Resource to Help CCA Members Deal with Change

Denise Rhodes, MS, CRNP



Denise Rhodes, MS, CRNP

I am writing this as temperatures and leaves are dropping, and this leads me to think how things are always “changing.” Just when

I seem to assimilate into my environment and routine, something changes. Change can have a positive and negative impact on our lives, regardless of where and when we experience it. Let’s take a look at where we have been over the past months and reflect on change...

We hope that all CCA members received your sample of CardioSmart cards to be given to patients. We offered these as patient teaching tools that direct your patient to a website sponsored by the ACC, www.cardiosmart.org.

This is an excellent site that provides evidence-based and accurate cardiovascular information written at a level that patients can understand and is easily accessible. We know that not all practices have embraced the use of the cards, but it is a good informational site and we hope you can incorporate the information into your practices.

Nearly 300 cardiovascular professionals from across the country attended the annual legislative three-day event in Washington, D.C., which culminated in face-to-face visits with members of Congress and/or their staff. This year’s conference focused primarily on health reform implementation, continuing to educate Congress about the impact of the 2010 Medicare Physician Fee Schedule cuts and payment reform opportunities.

The CCAs had a full afternoon session on the first day, which gave approximately 30 CCAs from across the nation solid information regarding advocacy and how to best serve the needs of our patients at this

conference. An additional training session highlighted how to focus on key points with regards to the current health care reform and how this would impact their visits to the Senators, Congressmen, and their staff.

Rep. Charlie Gonzalez, D-Texas, was honored by the ACC during the event. Rep. Gonzalez was responsible for introducing a House bill that would protect cardiology practices from drastic cuts in Medicare and Medicaid reimbursement levels in 2010. Look for information through the ACC with the progression of this legislation that directly affects our practices.

At the state level, we had a great weekend at the annual PaACC Chapter Meeting held at the Nemaocolin Woodlands Resort in western Pennsylvania from Oct. 15-17. We heard from cardiologists throughout Pennsylvania on how the health care reform was impacting practices and got a better understanding of how “*what is happening in Washington, D.C.*” affects “*what is happening in the state of Pennsylvania.*”

We held informal discussions on Saturday during the lunch hour with advanced practice clinicians and physicians who work side by side to provide quality patient care in a variety of settings. They talked about a variety of approaches to meet needs of the practice and their patient populations. We had two breakout sessions on Saturday just for the CCAs, which were well attended.

Thank you to Caroline Doherty, MSN, CRNP, from the University of Pennsylvania, who gave us an excellent session on cardiac testing with an emphasis on stress testing. Also, thank you to Kay Blum, PHD, CRNP, who traveled from the Maryland Chapter of the ACC to give us an update of the role of Cardiac Care Associates and their expanding involvement at the national level.

We hope that those who attended found the sessions to be helpful, and we were pleased with the dialogue that each speaker initiated.

Planning is underway for the 2011 CCA Conferences. Last year’s events provided a one-day agenda in both eastern and western Pennsylvania. This strategy was successful and will be again offered in 2011.

Save these dates:

- On the eastern half of Pennsylvania, April 29 at the Crowne Plaza in Valley Forge
- On the western half of Pennsylvania, May 13 at the Doubletree Hotel in Monroeville. Continuing education credits will be offered at both events.

We would like to remind everyone that participation in the ACC is extended to anyone who works in the area of cardiology, including clinical pharmacists, registered nurses, nurse practitioners, physician assistants or practice managers.

If your membership is due, please consider renewing your national and state ACC memberships now. If you know someone who is eligible for membership and has not taken advantage of this, encourage them to join the ACC.

Again, at the national level, the Cardiovascular Team Council continues to meet through teleconferencing within their specific work groups. You are invited to participate and offer insight to any of the following work groups:

- Advocacy Working Group
- CV Advanced Practice Nurses
- CV Registered Nurses
- Clinical Pharmacists
- Physician Assistants
- Publications and Website Working Group
- Research Working Group

Mark your calendars for the National meeting of *American College of Cardiology* to be held in New Orleans April 3-5. Special events are being planned for CCAs. If you have any concerns or have an interest in taking a more active role with the Chapter, do not hesitate to contact your liaisons, Denise Rhodes or Luann Richardson through the Chapter website, www.pcacc.org.

Medicare Carrier Advisory Committee Report

David Lee Scher, MD, FACC and Andrew Waxler, MD, FACC

Meeting of June 2010



David Lee Scher, MD, FACC

A couple of cardiology issues were discussed at the June CAC meeting. The first regarded Holter monitoring, cardiac event recording, and outpatient cardiac telemetry (Cardionet and other similar types). The issue was not to revamp any of the



Andrew Waxler, MD, FACC

reimbursement codes or indications, but to bring to light that outpatient telemetry was being billed by many (usually primary care physicians) as Holter monitoring done on a daily basis.

There is currently a one-time billing fee for outpatient telemetry. Medicare will be letting offending practitioners aware of this. The exponential growth of this abuse or mistake was what prompted the attention of the committee.

The second issue concerned nuclear stress testing. The proposed local carrier decision was admittedly modeled after a decision adopted in New York with admitted flaws. Our comments, made after the meeting by Dr. Waxler were as follows:

"In conjunction with verbal comments made by my colleague, Dr. David Scher, at the recent CAC meeting, I would like to follow up with a written summary. We found a few issues

which we would like to bring to your attention and ask you to reevaluate. The new LCD would no longer cover nuclear imaging studies for important indications like cardiomyopathy (425.0), dysrhythmias (427.81), and atherosclerosis (440.0). Obviously, certain diagnoses like cardiomyopathy and ventricular tachycardia (as well as the presence of extensive atherosclerosis elsewhere) should be indications to look for CAD/ischemia. Also, there is a stipulation that "new onset" CHF is an indication.

"What exactly does that mean? What if the patient had CHF 10 years ago and now has recurrent CHF? It is standard of care to look for ischemia/CAD in the setting of new/unexplained (and sometimes recurrent) CHF. There was a previous policy that stress nuc could be employed to evaluate 'asymptomatic patients at high risk for development or progression of CAD.' This has been removed/highly altered. We believe that the old policy should remain in place.

"Finally, there is mention (in 'other information' near the end of the LCD) that a MUGA scan done prior to ICD implantation must show the intent to implant an ICD. This is false reasoning as the MUGA scan is done to determine whether the patient even qualifies for an ICD.

"It is clear that the ACC appropriateness criteria are being used as a guide for some criteria regarding 'preoperative studies,' and perhaps it should be explicitly referenced (in addition to referencing the 2007 Perioperative guidelines.)"

The final LCD decision was made and our recommendations were not followed. The LCD proposal went through as is. Dr. Waxler is now going through a special objection process with Medicare, voicing our concerns again.

Meeting of October 2010

Four cardiovascular issues were addressed at this meeting. Firstly, there was a proposed LCD on limiting the frequency of BNP measurements to four per year per patient. This was objected to by Dr. Scher, stating that due to the current lack of communication of electronic information among offices, hospitals and outside laboratories, this will be impossible to comply with while clinically managing patients.

In addition, there is clinical utility in repeating BNP measurements from a prognosis standpoint pre-discharge from the hospital. The proposal was defeated and will not be brought again.

The LCDs on peripheral vascular MRA was approved. This LCD made no changes from the prior LCD and was raised for renewal purposes.

The LCD on cardiac rehabilitation was also discussed. It was recommended by Dr. Scher that post-hospital discharge rehabilitation for congestive heart failure be added to the current indications. It was met favorably.

The LCD on aquapheresis for management of fluid overload in cardiac diseases was defeated. It was rejected on the basis that there were no clinical utility peer reviewed studies presented to the committee by the proposer. At the PaACC Executive Council meeting, Dr. Rene Alvarez cited studies that showed benefit. These will be presented by Dr. Waxler to Medicare during the public review period.

It was also decided at the PaACC Executive Council meeting to have all proposals sent to expert ACC physicians involved in the subspecialty to which the LCD proposal pertains, for comments well in advance of the CAC meeting. These proposals will then be transmitted to the representatives.

President's Message

continued from page 1

Payment Advisory Board that is appointed by the administration is especially problematic.

This 15-member board is tasked with developing and presenting proposals to the President and Congress starting in 2014. This could result in Medicare reimbursement cuts that would not need to be approved by members of Congress. The ACC finds the Independent Payment Advisory Boards to be especially troublesome.

There will be Physician Assessment Programs. The Physician Feedback Program, which starting in 2012 will provide reports to physicians comparing resource use to that of other physicians or groups of physicians caring for patients with similar conditions. Physicians Compare is a website that will have information on physicians enrolled in Medicare. Physician performance that provides comparative information and quality indicator will be made available.

Tort reform projects appear to be mainly symbolic and without any "teeth." The ACC supports meaningful tort reform as a way to reel in medical costs.

The Imaging Equipment Use Rate increases the utilization rate assumption from the current 50 percent to 75 percent in calculating reimbursements for medical imaging services on high cost equipment. This will result in lower payments for cardiac CT and MR in 2012.

By 2012, Health and Human Services will establish Accountable Care Organizations that will allow groups of providers to enter into risk sharing contracts for specific diagnoses through the Medicare Program. This is the beginning of a departure from traditional Fee for Service reimbursement. How quickly these programs will get underway is uncertain.

The ACC supports the opportunity to participate in such projects and strongly believes that participation by physicians in small independent practices should be facilitated. Physician Owned Hospitals that do not have a Provider Agreement prior to Dec. 31 are prohibited.

The so-called Sunshine Provisions require that, beginning in 2012, pharmaceutical companies and

pharmaceutical distributors will need to report to the government the names of practitioners to whom they provide samples and, by 2012, manufacturers of pharmaceutical devices of biological supplies will be required to disclose information regarding payments made to health care professionals, including consulting fees, honoraria, research funds, and grant support for continued medical education.

In addition to the national initiatives, which represent a challenge to maintenance of current practice, there are local initiatives as well. Over the past six months, the PaACC has been involved in a dialogue with Highmark Blue Cross and Blue Shield of Pittsburgh. The conversation surrounds the precertification process for nuclear imaging and the proposal of test substitution of stress echocardiography for nuclear studies. Again, visit the PaACC website (www.pcacc.org) for more on this issue.

At this point in time, the PaACC, ACC National, American Society of Nuclear Cardiology and the Pennsylvania Medical Society have strongly opposed the implementation of these initiatives. There will certainly be much to follow over the next year in this regard. It has put the issue of Radiology Benefit Managers (intermediaries between insurance companies and clinicians) front and center. Radiology Benefit Managers are designed for the most part to limit utilization of expensive technology by implementing a precertification process. The PaACC believes that an "honest broker" process that involves the right test at the right time for patients is much preferred. To this end, ACC National is in the process of developing the Focus tool that will allow point-of-service test ordering of all cardiac studies based on Appropriate Use Criteria and Evidence Based Medicine. There have been legislative challenges as well over the past year. A bill introduced in the state legislature could potentially have limited in-office testing depending on the fate of the Stark Laws. Past PaACC Governor, Dr. William Follansbee, and Dr. William VanDecker, have done the "heavy lifting" in this initiative.

What's a Cardiologist To Do?

All these issues are certainly overwhelming and could occupy us full time just thinking about them, let alone doing anything about them. We feel that advocacy is one of the most important activities of the PaACC during this difficult time. To this end, Dr. William Combs has put together a program of point persons for state and federal legislatures and has also put together a Practice Champion Program that will allow communication within practices and mobilization of individuals as these crises arise.

Specifically, the legislative initiative came up very suddenly and required action almost immediately and it convinced us that we need to have a group of individuals who understand the issues and are committed to act to advocate for their practices.

Are We Having Fun Yet?

It is certainly easy to lose track of the reasons we went into medicine in the first place when beset by all these issues. What I have been impressed with in speaking to cardiologists throughout the state is that people still genuinely enjoy the practice of medicine and enjoy the positive interaction that comes from a favorable patient encounter.

The PaACC is committed to serving as a resource to all its members, whether it be tools for more effective practice management, maintaining a network of graduating fellows for jobs, or helping educate your patients with the newly minted CardioSource cards for patients. We are entering a "brave new world" that will be more highly regulated, include revamped reimbursement models and require us to do quality reporting.

I would like to encourage members of the Pennsylvania Chapter to let us know what their needs are from an educational perspective, a practice management perspective and with regard to practice advocacy. I would definitely recommend that you go on our website (www.pcacc.org) and browse through the resources that were placed there from our practice survival symposium. Hopefully, you will find them useful.

Pennsylvania ACC Chapter Begins ‘Twinning’ Program with Italian Federation of Cardiology

Paul N. Casale, MD, FACC

The Pennsylvania Chapter of the ACC and the Italian Federation of Cardiology have initiated a collaborative relationship, also known as the “Twinning Program,” with the objective of building relationships between cardiovascular professionals in Pennsylvania and Italy. Opportunities for participation in educational activities are being identified by each organization, including mini-fellowships, preceptorships and joint symposium at various local and national meetings.

To kick off the Twinning Program, the Pennsylvania Chapter Executive Council invited a representative from the Italian Federation of Cardiology to lecture at the Pennsylvania Chapter Meeting this year, which was held at Nemacon. Dr. Leonardo De Luca spoke on “The Italian System of CCUs and the STEMI system in Italy,” and also highlighted the results of the 20-year history of the landmark GISSI clinical trials (GISSI 1, GISSI 2, GISSI 3, GISSI Prevention) that have involved more than 60,000 patients with myocardial infarction.

Dr. De Luca graduated from the University of Bari Medical School and



Dr. Leonardo De Luca, left, poses with Dr. Paul Casale, former PaACC Governor, at the Pennsylvania Chapter Meeting in October.

received a PhD in cardio-respiratory pathophysiology from Sapienza University of Rome. He is currently a Senior Assistant in the Division of Cardiology at the European Hospital-Aurelia Hospital in Rome and is an interventional cardiologist.

We look forward to further educational exchanges in 2011 and are tentatively planning a joint symposium with the Italian Federation of Cardiology at ACC 2011 in New Orleans. If you are attending ACC 2011, be sure to join us for this important event.



Dr. Leonardo De Luca, a cardiologist from Italy, speaks at the Pennsylvania Chapter Meeting in Nemacon Woodlands Resort.

Treasurer's Update

Michael Rossi, MD, FACC

I am pleased to report that the PaACC remains financially strong. We continue to grow our membership, particularly amongst our FIT and CCA colleagues. Approximately 80-85 percent of eligible ACC members are dues paying members of our Chapter, along with nearly 300 CCA and 250 FIT colleagues.

In addition, we are also welcoming practice administrators to join our Chapter. Despite these challenging economic times, our balance sheet has remained stable, and we are addressing opportunities at managing expenses while providing value to our members.



Michael Rossi, MD, FACC



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