



# NC Chapter of the American College of Cardiology

Fall Newsletter

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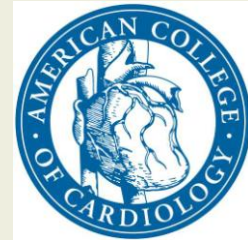
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## A Call to Political Action

*Linda Calhoun, MD, FACC  
Wilmington, NC*



I did not go to medical school to be a politician. Yet, where have you been that you have never encountered politics? In our nation, the specialties are under fire for giving advanced care, and a serious threat to our ability to provide care and survive as businesses marches to our door in just a few months. This is not just about healthcare reform, but something much more imminent and decisive in its effects.

## Stop the Cuts!

The ACC and our partners are prepared to wage an aggressive campaign to prevent implementation of these damaging policies. The ACC urges its members to contact their lawmakers and ask them to prevent these payment policies that will result in devastating cuts. You can reach your members using the ACC's toll-free grassroots hotline (800-210-7193) or by emailing your members of Congress by going to the CardioAdvocacy Network (CAN) website at [ACC.CAN](http://www.ACC.CAN).

[CMS Cuts Talking Points](#)

For 2010, CMS has proposed marked reductions in reimbursements in the field of cardiology, ranging from 11% to 40% for individual services performed by Cardiovascular specialists. Although an overall 11% reduction in overall reimbursements is proposed, there are proposed cuts for crucial, standard office based services up to 42%. These proposed reductions in the fee schedule are a result of flawed estimates of practice overhead and RVUs.

The current CMS fee schedule allows current cardiology practices to just break even, or even lose money, when caring for Medicare patients. The reality is that the proposed reimbursement schedule is even harsher than the existing fee schedule, and may push some older cardiologists considering retirement to go forth, and may encourage existing cardiology practices to "cap" their total number of Medicare patients to maintain their financial solubility as many of the primary care practices have already done. This would in effect cut patient access to Cardiologists. Given lack of financial incentives, it would probably further discourage young residents from considering a career that has traditionally been energy

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depleting and stressful due to the patient acuity. Let's face it, many acute myocardial infarctions occur in early morning hours. Due to a growing population of aging baby boomers, we are already facing a shortage of cardiologists with our existent pool.

So it is imperative that we take time from our hectic schedules to call, email, and meet with our congressmen to halt the proposed challenges. We must even involve our patients to heighten the awareness since the proposed changes will ultimately affect them as well and their access to care. It is rumored that one large Cardiology practice in the Midwest got 400 of their patients to send in letters to their Congressmen. The 2010 fee schedule will be approved November 1st, and will go into effect January 2010 unless met with forceful opposition. Go to [www.acc.org](http://www.acc.org), scroll down to the Advocacy section, and get involved!

## NC/ SC 16th Annual Joint Meeting

The NC/ SC Chapters of the ACC 16th Annual Joint Meeting was held at the Grove Park Inn in Asheville, September 11-13, 2009.

**NCCACC**  
**1500 Sunday Drive,**  
**Suite 102**  
**Raleigh, NC 27607**  
**919-861-5581**

The Annual Meeting had 150 attendees including physicians, Fellows in Training, Cardiac Care Associates, Nurses, PA's guests and children. Industry support was strong with 37 exhibiting companies participating with 80 representatives.



The Chapter held Fellows-in-Training Day on September 11 to get fellows involved in state issues and the Chapter early, as well as providing a learning opportunity to show what the Chapter can offer. The program consisted of an education session for fellows including sessions on Finding the Right Practice, a panel discussion on Choosing the Right Practice for You, Medical Contracting, Estate and Asset Protection Planning, and The Importance of Financial Planning.

This was also an opportunity to align Fellows with the American College of Cardiology as we believe this is our

best hope to speak with a unified voice as an advocate for our patients and the specialty.

Ten fellows and one resident attended FIT Day. All of the NC Medical Schools were represented and two fellows attended from Tennessee.



This is the first Fellows-in-Training Day held in North Carolina and other states/ chapters may use our FIT Day as a model in the future.

Our Chapter is the first to hold FIT Day in conjunction with the Annual Meeting and plans to hold the session again in 2011.

The meeting provided an update on important developing topics in the field of cardiovascular medicine. Lectures included presentations on myocardial infarction, approaches to patients with valvular heart disease, the COURAGE Trial, management of atrial fibrillation and diabetes management.

Featured speakers were: L. Wiley Nifong, MD, Jamie Jollis, MD, Andrew Wang, MD, Paul Mounsey, MD, Hadley Wilson, MD, Jim Zidar, MD, Bruce Brodie, MD, Peter Zwerner, MD, Elizabeth Jackson, MD, Robert Applegate, MD, and Dan Bensimhon, MD.

The 17th Annual Meeting will be held **October 1-3, 2010** at the Wild Dunes Resort in Isle of Palms, SC. We look forward to seeing you then!

[www.wilddunes.com](http://www.wilddunes.com)

**The Last Leg of RACE-ER is Now!**



*Hadley Wilson, MD, FACC  
Charlotte, NC*

All cardiologists and emergency care providers in North Carolina should be aware that we are now in the final phase of the internationally known RACE-ER project for improved AMI care.

All of the integrated systems of pre-defined and expedient care of North Carolina's patients with acute myocardial infarction are now in place. The last quarter of 2009 is the critical data gathering period to see if improvement in the rate and timeliness of reperfusion in AMI can actually reduce mortality in a state suffering from nearly 4,000 heart attacks each year. Moreover, deaths in North Carolina from myocardial infarction are twice that of motor vehicle accidents.

## **Travel North Carolina**

North Carolina pop. 9,222,444 (2008) (10<sup>th</sup> largest state in the U.S.)



***The Safest Place in the Country to  
Have a Heart Attack!***

We have many people to thank for this project, but first must thank the leadership from Duke University Medical Center of Chris Granger, MD, James Jollis, MD and Mayme Lou Roettig, as well as State Coordinator, Lisa Monk. Their Herculean efforts may bring a great, long-lasting reward if we can show definitive improvement in the outcomes of our MI patients with such a comprehensive program involving over 1,000 health professionals across the state.

**The Crucial Phase of RACE-ER is 4th Quarter 2009!**



Please make every effort in your area to see that the RACE-ER protocol is being followed religiously and to thank those health professionals involved in the expedient transport and care of our AMI patients during this crucial phase.

Visit [www.race-er.org](http://www.race-er.org) for more information.

## **Obstructive Sleep Apnea**

*Dustin Letts, MD, FACC  
Gastonia, NC*

Typical chest pain is often not a diagnostic dilemma. A stress test combined with left and right heart catheterization will reveal the etiology in many patients. The combination of medical therapy and revascularization is usually sufficient to provide relief for these patients who then are able to experience an improved quality of life. Atypical chest pain may be more challenging.

When the ischemic workup is negative, patients are then referred for a number of other tests that are frequently nondiagnostic, and the patients remain symptomatic. This can be a frustrating situation for both the patient and the physician. In addition to coronary vasospasm and small vessel disease, one diagnosis that warrants consideration is obstructive sleep apnea (OSA), especially given the epidemic of obesity in most cardiology office waiting rooms.

OSA is a condition characterized by a reduction or cessation of breathing during sleep resulting in decreased oxygenation that interferes with the quality of sleep. During periods of apnea, patients often remain asleep, but the sleep cycle is interrupted. This results in poor quality sleep and chronic sleep deprivation. These patients subsequently are referred to a cardiologist for a variety of reasons including chest discomfort, dyspnea, fatigue, palpitations, difficult to control hypertension, and atrial fibrillation. Unless the physician considers OSA in the differential, treatment is inadequate. By some estimates, up to 50% of cardiac patients have OSA and only 10% of all patients with OSA are being treated.

Diagnosis of OSA requires a sleep study (polysomnogram), but is often suggested by an abnormal Epworth Sleepiness Scale questionnaire. Recent data suggests OSA is associated with both cardiac and vascular events. Patients with OSA are 2.3 times more likely to develop congestive heart failure, 2-4 times more likely to develop dysrhythmias including atrial fibrillation, and 1.5 times more likely to suffer a stroke. The repetitive episodes of intermittent hypoxia and reoxygenation have been

postulated as the trigger for vascular oxidative stress leading to an increased risk for cardiovascular events. Patients with OSA and nocturnal bradyarrhythmias should be treated for OSA prior to implantation of a pacemaker.

Unfortunately, it is still not known whether treatment of OSA results in a decreased vascular event rate. With the epidemic of obesity in North Carolina and the known strong association between obesity and OSA, this is a diagnosis worth considering in patients with chest pain of unknown origin, especially in the presence of the associated symptoms described above.

### **Recovery Audit Contractor**

*Robert Rothbart, MD, FACC  
Greensboro, NC*

CMS (Centers for Medicare and Medicaid Services), formerly HCFA (Healthcare Financing Administration), loves AAAA (All And Any Acronyms). Their latest creation with the potential to seriously impact medical providers is the RAC (Recovery Audit Contractor). These corporate entities review Medicare bills for accuracy. When errors are identified, refunds to the Trust Fund are requested, or less commonly, in the event of an underpayment additional funds are transferred to the provider. RACs are paid on a contingency fee basis, receiving a percentage of the improper payments they identify.

Initiated as a demonstration project in New York, California and Florida under the Medicare Modernization Act of 2003, and subsequently expanded to South Carolina, Arizona and Massachusetts in 2007, RACs will be operational in all states before the end of 2010 as mandated by the Tax Relief and Health Care Act of 2006. Connolly Consulting Associates, Inc. of Wilton, Connecticut, the principal contractor for North Carolina, plans for audits to start later this year. Connolly initially gained experience in South Carolina and Florida during the demonstration program. Viant Payment Systems, Inc. will serve as a subcontractor to Connolly.

RACs are highly motivated to seek and detect errors since their compensation is based upon the erroneous payments they identify. With a commission rate between 9% and 12.5%, they received \$185 million over the 3-year term of the demonstration project. After identifying only \$36.2 million in FY 2005, RAC audits recovered \$332.9 million in

FY 2006 and a staggering \$610.9 million in FY 2007 for a 3-year total of nearly \$1.03 billion. Approximately 96% were overpayments that were subsequently returned by providers, while the remaining 4 percent were underpayments for which payment was submitted to providers. Most overpayments (91%) were collected from inpatient facilities. Refunds from physicians amounted to only 2.5% of the total with the major areas of concern being injectible medications and in-office testing. Evaluation and management codes were not examined during the demonstration program, a policy that reportedly will be continued except when such services are not reasonable and necessary or violate global surgery payment rules. Any services delivered under programs other than traditional Medicare fee for service, e.g. Medicare Advantage plans, will not be reviewable by the RACs.

Providers questioned 14% of the RAC judgments but were successful in only 4.6% of these appeals. CMS estimates billions of dollars in overpayments for patient services will be identified and recovered annually once the review mechanism is functioning in all states.

Initially, RACs will be permitted to review billings submitted on or after October 1, 2007. In the future, the contractors can only examine claims filed within the prior 3 years. The number of patient records that can be requested from physicians is limited, ranging from 10 - 50 in any 45 - day period, depending upon group size. Extrapolation is permitted if a pattern of improper billing is established. Thus, if review of a sample of your records indicates that criteria for medical necessity for cardiac catheterization were not met for 10% of those procedures, the return of 10% or so of all of your billings for cath codes over the prior 3 years can be requested

The NC Chapter is very interested in monitoring the RAC. Please call if any records or recoveries are requested of you under this program.

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### **Practice Administrator Membership**

The Practice Administrator membership category of the ACC was established to address the business aspects of practice management. This is an initiative set forth by Dr. Dove to address concerns unique to non-physician members of the cardiac care team involved in managing

practices. The membership category is supported by the Board of Governors and approved by the Board of Trustees.

Practice Administrators are important to ACC Physician Members as they are non-clinical cardiovascular care management team members who administer workplace and healthcare practice success for the majority of ACC members in private practice settings. Practice administrators impact the efficiency and success of cardiology practices. They are the link between the private practice cardiovascular care management team and the ACC.

Goals of the member category are:

- To engage all participants of the cardiovascular care team in ACC initiatives.
- To provide Practice Administrators with key advocacy, clinical, and other practice-related news that affects how doctors practice medicine.
- To provide Practice Administrators with a forum to discuss issues and solutions with other colleagues.

Benefits of Practice Administrator Membership are:

- Cardiovascular medicine's news and developments through online Cardiosource- the premier clinical resource in the field, the online version of Journal of the American College of Cardiology, Cardiology magazine, and a dedicated practice management website.
- Cardiology Careers online in partnership with HealthCareers, the one-stop solution for a practice's job recruitment needs.
- Practice guidelines and quality standards for cardiovascular medicine.
- Professional meetings, including the ACC practice management programs; and the Advanced Cardiology Leadership Workshop in partnership with MedAxiom.
- Workforce information on physician supply and demand, and team-based care.
- Advocacy and reimbursement news directly affecting cardiology practices.
- Leadership opportunities to bring practice administrator perspectives to ACC initiatives.

New initiatives in the developing stages include:

- Practice Administrator online member-only community with discussion board, document library, and message board
- Practice Administrator Advisory Committee
- Practice Administrator Town Hall Meetings
- Practice Administrator Online Community

[Click here to join online.](#)