



# NC Chapter of the American College of Cardiology

Winter Newsletter

December 2009

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## WRITE A LETTER

(Better yet - have someone write one for you)!!!!!!

*By Oscar Jenkins, MD, FACC*  
*Chapter Governor*  
*Asheville Cardiology*

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If you are not aware that we are facing a pivotal time in our professional carriers then I will assume that you have been practicing in a true vacuum.

But, just to be certain that you understand the current crisis we face in terms of our ability to continue to provide quality cardiovascular care to Americans, let me review the current state of the union:

We have been handed new CMS cuts. Because CMS used the certainly flawed survey data from the new AMA PPIS (Physician Practice Information Survey) the specialty of Cardiology will be facing cuts ranging from 10 to greater than 40% over the next 4 years. The ACC feels strongly that these cuts will result in a devastating reduction in access and services to all of Cardiology but especially for office-based practice. A recent ACC survey suggests that 95% of members in private practice will be affected by cuts, with staff layoffs and service limitations being the leading impacts.

## Quick Links

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Where are the cuts? The three largest areas of impact in testing will be SPECT imaging, Coronary CT, and Cardiac MRI. SPECT will be hit the hardest with a 36% cut in 2010. Currently, CMS has exempted this cut from the phase-in. There is also a reduction in the malpractice RVUs for technical component of services (about another 1% reduction in payments). CMS has also finalized its proposal to change the agency's formula for calculating the per-procedure cost of medical equipment worth > \$1 million which also impacts cardiac MRI, CT and non-hospital cardiac catheterization services.

In E&M charges the biggest change is the elimination of payments for consultations provided in the office and hospital settings.

Currently, we are scheduled to have a reduction in Medicare Physician Payment due to the (flawed) SGR "fix". This is IN ADDITION to the payment reductions that result from proposed policy changes and is set at 21.5% as of January 1, 2010 for all physicians, which could be as high as 30% in Medicare payments to cardiology.

These changes are occurring at the same time that practices must beef up billing and coding services as well as IT and EMR changes to meet the new

PQRI requirements (new measures have just been added for CAD and CHF) and to be eligible for the e-prescribing bonus that is proposed.

### **WHAT DOES THIS MEAN?**

Data from the recent ACC survey clearly indicates that we are likely to see a mass migration from private practice to hospital based care with a shift from out-patient to in-patient services at more than double the cost to the system and higher co-pays for our patients.

### **WHAT CAN THE ACC DO?**

Rest assured that the [ACC](#) has been working literally around the clock. Your leadership at the Heart House and the Steering Committee of the BOG communicate nearly daily. We are working on legislative policies and securing co-sponsors. We have contracted with legal firms and are exploring options to protect practices from cuts. We are in constant communication with CMS and are demanding a phase-in of the SPECT nuclear cuts.

As we feel comfortable releasing details communications will be sent. As of now you will see the [ACC Advocate](#) out twice a week. This week - "Preserve Access to Cardiac Care Week" - during the "fly-in" there will be a media blitz. There will be ads daily on the hill, in Congress Daily and in the Hill newspapers. During the "fly-in" 2/3 of the BOT members will have Hill visits on Monday and Tuesday. In addition there will be other cardiologists traveling in to lobby - mostly that Wednesday.

### **WHAT CAN YOU DO?**

#### ***Write a check.***

You need the ACC now more than any other time in your career, and the ACC needs you. Join many of the cardiologists in North Carolina who have already written a check to the [ACC PAC](#). I would like to suggest an amount of \$1000 which would be well spent in helping the cause for our patients and our profession. If you can't send that amount, please send anything.

#### ***Write a letter.***

Several Hill offices have called us in the last few weeks to let us know how much they appreciate the messages they have already received from the cardiologists in their state. They specifically say that the letters being personal (and not form letters) and really discussing what will happen to their practices and patients if there is no change in the rule is really making an impact.

#### **ASK YOUR PATIENTS (especially seniors) to write a letter.**

We need letters and calls from seniors to their representatives! The Guarding Hearts website has some very good materials for patients to use. Steer them there. Check out the website [www.campaignforpatientaccess.org](http://www.campaignforpatientaccess.org) and refer your patients to this site so that they can also become educated about the potential consequences and engaged in the process.

[Sample letter from patient](#)

**OR YOU CAN JUST SIT BACK AND DO NOTHING** - but if you choose to do so - be prepared for the consequences. We need to be advocates for our patients so that they don't face the "double whammy" of a reduction in access to cardiovascular care at double the cost. For millions of heart patients in America the results could be severe - less access, higher fees, longer waits, impersonal care.

We have made great strides for our patients in the last decade. Deaths from heart disease are down 27% from 1995 to 2005 because as a profession we have CARED.

"We in America do not have government by the majority. We have government by the majority who participate". -Thomas Jefferson, 1787.

## Medicare 2010 Overview

*By Jeff Ozmon, MBA, CMPE  
VP of Clinic Operations  
Sanger Heart and Vascular Institute*

On October 30, the Centers for Medicare and Medicaid Services (CMS) released its final ruling regarding the 2010 Physician Fee Schedule. One of the major announcements in the Final Rule is the elimination of payment for consultation codes as of January 1, 2010. Physicians should not bill consultation codes to Medicare for dates of service past December 31. Instead, physicians will report either a new patient visit code (99201-99205) or established patient visit code (99211-99215) for outpatient services; or an initial hospital care visit (99221-99223) or subsequent hospital care visit (99231-99233) for inpatient services. Based on the proposal the RVU value for E&M codes will increase in relative value (see chart below).

Code	Proposed RVUs	2009 RVUs	Percent Change	2010 RVUs Under Current Rules	Percent Change
99213 - Level 3 visit with established patient	1.91	1.7	12%	1.72	11%
99214 - Level 4 visit with established patient	2.83	2.56	11%	2.57	10%
99232 - Level 2 subsequent hospital care	1.98	1.85	7%	1.87	6%

The other major change is the recommendation to reduce the Medicare conversion factor that is the fee paid per RVU to determine the reimbursement by CPT code. CMS estimates that, under the sustainable growth rate ("SGR") methodology in the Medicare statute, the conversion factor for 2010 will be reduced by 21.5% compared to 2009 unless Congress enacts overriding legislation. CMS also estimates reductions of 5% to 6.5% in the conversion factor for each of the several succeeding years under the

current law and administrative policies. This change is not acted upon by Congress would mean that the current conversion factor of \$36 would drop to \$29.

With the exception of evaluation and management services, nearly all services that cardiologists perform will see cuts ranging from 10% to more than 40% for individual services phased in over 4 years. It should be noted that the Physician Work RVU did not change significantly, rather most of the cut were in the Technical Component RVU's.

78452 SPECT Myocardial Perfusion Imaging	36%
93306 Transthoracic echo w spectral & color flow Doppler	10%
92980 Coronary Stent	4%
93000 EKG	5%
93880 Carotid Duplex Scan	5%

## FOCUS for 2010

*by Tom Johnson, MD*

*The Sanger Heart and Vascular Institute*

National attention is now focused on healthcare reform and two key components in the debate are quality and cost containment. Because of this, medical imaging will be a critical part of reform. The Government Accountability Office estimates that Medicare spending for medical imaging more than doubled from 2000 to 2006 increasing to 14 billion dollars. In addition, it is estimated that between 20% - 50% of all studies were either redundant or did not significantly improve patient care. It's no surprise that the President's healthcare plan includes implementation of a radiology benefit management (RBM) to help curb costs by promoting appropriate diagnostic imaging usage.

The ACC is striving to take the lead in this by promoting appropriate use of cardiovascular diagnostic imaging in a national campaign known as FOCUS (Formation of Optimal Cardiovascular imaging Utilization Strategies). The key goals are to reduce regional variation in imaging usage (both over and under usage) and reduce unnecessary imaging by 15% in 2010. Appropriate use criteria for cardiovascular imaging have been developed by clinical panels of experts from the ACCF and its partner organizations. These guidelines are used to determine the circumstances under which diagnostic imaging is appropriate and how often testing should be performed. Appropriate use criteria (AUC) for cardiac radionuclide imaging, stress echocardiography, transthoracic and transesophageal echocardiography, cardiac CT and cardiac MRI are available on the ACC website at [ACC.org](http://ACC.org) under the Quality and Science tab. Physician education is the first step in achieving these goals. Cardiologists should familiarize themselves with the appropriate use criteria for cardiovascular imaging.

Since it is very likely that this will become an integral part of the accreditation process for imaging laboratories, it will be important to be out in front on this issue. In 2011, there is a Medicare provision that limits reimbursement for diagnostic imaging to accredited labs only. Cardiovascular labs will need to develop processes to track appropriate utilization based on AUC. Implementation of this in Echocardiography is already underway with several studies in the literature describing methodology (1). Unfortunately there is no real roadmap regarding improvement in appropriate utilization in cardiovascular imaging.

FOCUS is hoping to develop tools for improvement with a collaborative effort to define best practices. It is my belief improvement will come from a combination of physician education, incorporation of appropriate use criteria into the ordering process and establishment of benchmark goals with performance feedback. Hopefully cardiologists will embrace the FOCUS campaign so we can shape our future rather than having it thrust upon us.

*1- Use of appropriateness criteria of transthoracic echocardiography in an academic medical center. J of American Society of Echocardiography. January 2009 Vol 22 :60-62.*

## BlueCross BlueShield of North Carolina Diagnostic Imaging Management Advisory Group

*By Jamie Jollis, MD, FACC  
NC Chapter Councilor, Triangle Region  
Duke University Medical Center*

Since February 2007, a number of BCBSNC administered health plans have required pre-authorization for outpatient cardiac imaging through American Imaging Management. Cardiac studies covered by the program include nuclear perfusion, cardiac computed tomography, and cardiac magnetic resonance imaging. They established the Diagnostic Imaging Management Advisory Group (DIMAG) to "work with the physician community to assure that there is no negative impact on the quality of patient care as a result of this initiative." This group meets on a biannual basis, with meetings in April and October 2009 that included two cardiologists and representatives from radiology, oncology, urology, internal medicine, family medicine, orthopedic surgery, pediatrics, and the North Carolina Medical Society. In the April meeting, the program manager presented a study of longitudinal claims data to examine whether patients were being shifted to substitute cardiac procedures not covered by pre-authorization. There was no increase in stress echocardiography utilization. Interestingly, heart catheterization procedures increased, but the financial impact on a per member per month basis was relatively small. Cardiology was listed as the primary ordering specialty for most stress echocardiograms (cardiology 66%, internal medicine 13%, , multispecialty 12%, family medicine 4%) and nuclear perfusion studies (cardiology 60%, radiology, 13%, multispecialty 13%, internal

medicine 7%, family medicine 2%).

The Advisory Group was also shown materials related to an American Imaging Management product being considered by BCBSNC called Optinet. This product is designed to provide patients with information about diagnostic imaging facilities including measures of quality, cost, and location. The quality measures include an assessment of equipment and other measures largely overlapping currently available national certification programs. In order to avoid duplicate, proprietary standards that may be confusing to patients and will likely increase administrative costs, we recommended that Blue Cross work with existing accreditation standards and agencies. For cardiac imaging, the predominant agency is the Intersocietal Accreditation Commission.

In the October meeting, BCBSNC presented a study of patients who were denied cardiac imaging procedures to assure there were no adverse outcomes. In collaboration with the ACC representative, insurance claims were examined covering denied cardiac studies for the period of one year, looking for any claims that may potentially represent adverse outcomes. Among all claims considered including hospitalizations and coronary revascularization, only one patient could be identified as being hospitalized following a denial. Data were not available to consider whether this hospitalization was related to underlying disease that would have occurred regardless of authorization, or whether the hospitalization could be attributed to a denied study.

Other items discussed during the meeting included an apparent increase in imaging procedures per patient per month among physicians and physician groups that have qualified for the Physician Diagnostic Imaging Recognition Program. BCBSNC exempts approximately 3% of physicians from pre-certification, selecting physicians and physician groups according to a number of criteria including volume, use of the web portal, high technology imaging rate, and guideline compliance. Physicians are invited on an annual basis to participate. The group considered possible explanations for the increase. BCBSNC also noted an increase in magnetic resonance imaging utilization for members covered by the AIM program. This increase largely involved MR for other regions of the body. In the case of cardiac MR, the AIM guidelines are fairly restrictive, often requiring equivocal results from echocardiography or nuclear imaging for evaluations of coronary artery disease, valvular heart disease, and congenital heart disease.

The American College of Cardiology has a long history of leadership in the proper application of imaging technologies as embodied in our research publications, clinical guidelines, appropriateness criteria, training, and board certification. While our preference would be to apply these guidelines and criteria without third party encumbrance or alterations, the Diagnostic Imaging Advisory Group provides a welcome platform for constructive engagement with Blue Cross and Blue Shield of North Carolina. As North Carolinian's struggle to a pay health care costs and insurance premiums, we will work together to ensure the best, most efficient use of health care dollars.

The Diagnostic Imaging Advisory Group alone does not provide a sufficient platform to identify all issues regarding the BCBSNC / American Imaging Management program. We make every effort to bring attention to opportunities for improvement including concerns about inappropriate or unavoidable denials for nuclear imaging, standards for cardiac MR that take into account patient safety and lower cost, and peer-to-peer reviews

concerning cardiac imaging to be conducted with cardiologists. We also urge colleagues to bring issues to our attention for review by DIMAG, and to use the BCBSNC appeals process when necessary.

[Contacts:

BCBS Member Health Partnership Operations: 800-672-7897 for a pre-service Provider Courtesy Review, or enter a Level 1 or Level 2 appeal:

<http://www.bcbsnc.com/content/providers/appeals/index.htm>

<http://www.bcbsnc.com/content/providers/appeals/LevelIProviderAppeals.htm>

<http://www.bcbsnc.com/content/providers/appeals/LevelIProviderAppeals.htm>  
American Imaging Management: 866-455-8414]

## Be Prepared for Changes in 2010

*Guest Editorial*

*By Linda Calhoun, MD, FACC*

*NC Chapter Councilor, Southeastern Region*

*Wilmington Cardiology*

We are in the midst of great changes. November 21st, the US Senate voted to open debate on the Healthcare Reform Bill. Details of the bill include establishment of a new government healthcare insurance program that would compete with private insurers. States could "opt out" of the proposed government insurance plan. The bill provides for creation of non-profit cooperatives that would provide coverage to members. The bill creates insurance market exchanges where individuals and small businesses can shop for insurance. Minimum benefits in four categories of insurance policies would be offered through the exchanges. Starting in 2010, insurers would be barred from dropping people from coverage and bans excluding people for pre-existing conditions beginning in 2014. It allows states to band together to form larger regional exchanges. The bill mandates that U.S. citizens and legal residents obtain health coverage beginning in 2013. It provides subsidies for people with incomes up to 400% of poverty level to help buy insurance. It limits deductibles and out of pocket expenses. These limits are put on a sliding scale based on incomes. The debate is expected to last three weeks.

November 19, the US House of Representatives passed H.R. 3961, the Medicare Physician Payment Reform Act of 2009. The legislation repeals the sustainable growth rate (SGR) formula used to calculate physician payments, which is based on flawed data. This may alleviate an estimated 21.2% across the board cut to Medicare providers in 2010, but still needs to go through the senate, where similar legislation failed to pass earlier this year.

Interestingly, with proposed Medicare cuts for 2010, cuts to imaging services will probably create a shift of care from private practice to hospital settings. The American Society of Echocardiography has been conducting a survey to

assess the impact of Fee Schedule changes on practice. 64% said that they would delay purchase of echo equipment, 56% would lay off sonographers or other staff, 53% would reduce staff salaries, 47% might reduce staff benefits, such as 401K programs or healthcare. 23% would refrain or limit accepting Medicare patients for such services, 19% are considering closing a satellite office, and 60% of these are located in rural areas.

A small bipartisan group of senators has cosponsored legislation that would pay a physician for work for a Medicare patient only if the patient's health status improves, the "Take Back Your Health Act of 2009" (S. 1640). "Comprehensive lifestyle programs" designed by physicians specifically for each patient in the program. The plans include nutritional therapy, exercise, medication management, care coordination, and tobacco cessation. Physicians would not be paid if a patient were re-hospitalized for a chronic illness accounted for in his or her plan. Multiple trials have shown that such programs can result in 50% reduction in medical costs, but is this just another form of capitated healthcare with substantial physician risk with wild card patients?

Last but certainly not least issue of concern is the CMS nationwide Medicare RAC audits. In an effort to collect on perceived overpayment to physicians, CMS is adopting recovery audits (or RAC audits). CMS has combined clinical pay-for-performance based purchasing initiatives with the strong arm of RAC audit collection agencies to insure both hospitals and physicians are doing their part to create a more nationalized, evidence-based healthcare structure. "If it's not documented, it's not done." CMS has hired independent medical collection agencies, to which they are paid 9%-12.5% contingency fees to guarantee substantial recollections (it is estimated that \$187.0 M was paid during the initial 3 year demonstration project). From 2005-2007, the Centers for Medicare and Medicaid Services conducted a demonstration project in Florida, New York, California (South Carolina, Massachusetts, and Arizona were added later). RAC audits recovered \$36.2 M in FY 2005, \$332.9 M in FY 2006, and \$610.9 M in 2009 from "overpayments" to physicians in demonstration states. During the demonstration period, the RAC auditors make an estimated 525,000 overpayment determinations, and providers filed over 118,000 appeals. Of those appeals, physicians won an estimated 40,000 cases or 34% of all RAC appeals cases settled in Florida, California, and New York.

In summary, many changes stand before us. Maximizing our practice efficiencies and our documentation are clear mandates. We still need to voice our concerns to the Senate. Private practice as we know it will never be the same.

## **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.](#)

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