



North Carolina
CHAPTER

E-Newsletter | Issue 4

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The North Carolina Chapter of the American College of
Cardiology

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Find your State Legislators

To find North Carolina Legislators, you can visit ACC's website at <http://www.acc.org/advocacy/advocacy.htm>.

ACC Practice Opportunity Line

The NC Chapter of ACC is participating in an on-line job bank network. Applied Recruitment Technologies is an internet-based career recruitment and research resource. It allows candidates FREE access to upload resumes on the job bank and/or to review all available positions, receive alerts of positions that match criteria, respond to on-line positions, include a resume and cover letter, and indicate attendance at upcoming conferences and set up interviews. For more information visit our website at www.nccacc.org.

News

President's Message



Paul G. Colavita, MD, FACC
The Sanger Clinic,
Charlotte, NC

It has been a very busy and exciting year for the NC Chapter of the American College of Cardiology. As 2007 rushes toward its conclusion, I will take this opportunity to offer a year in review.

The year started with a survey of our members. It was felt by our members that advocacy and education should be our main focus.

Education, as it relates to clinical topics, quality and practice management, was felt to be important. Networking with colleagues was also felt to be an important function of the state chapter.

A Leadership Retreat was then held in Chapel Hill in April. The survey results were a major component of the retreat. The Chapter plans a half -day meeting with state legislators to discuss important issues. We would hope members from all regions of the state would attend. As no important issues were before the legislature in 2007, the meeting was deferred until issues directly related to cardiology needed to be addressed. The NC Medical Society was also contacted to better coordinate our advocacy agenda.

The Medicare physician payment strategy for 2008 is being discussed in Washington this week. If you have not already contacted your Senator or Representative, please do it soon. Ask your senators to (1) oppose any SGR proposal that would pay for a small update in 2008 with bigger cuts in 2009 and (2) instead urge them to work toward a package that would provide positive updates in 2008 and 2009, paid for in a way that does not make future cuts worse. Also, please call your Representative and urge him or her to sign a letter to Speaker Pelosi urging her to "take any cuts to medical imaging services off the table"

The council has also had some major changes in 2007. Darren Absher has replaced Debbie Wesley as the Cardiac Care Associate liaison on the council and John Piccini has been appointed the Fellow in Training on the council. Enhanced participation of all members of the cardiac care team will be a focus of the chapter in 2008.

The annual meeting held in Asheville this year was also a major success. Attendance continues to increase with participation from physicians, fellows, cardiac care associates and exhibitors. The faculty this year was world class with excellent lectures on both clinical and management issues.

The RACE (Reperfusion of Acute Myocardial Infarction in Carolina Emergency Departments) has been our major quality program. Recognition and appropriate management of myocardial infarction has improved across a 68 hospital state wide network. Many physicians have worked this to make this a success, but special thanks go to Drs Chris Granger and Jamie Jollis. RACE was presented at the American Heart Association meeting last month and received national recognition in the lay press.

The NC Chapter was recognized last year by the ACC with an award. This would not have been possible without the dedicated hard work of many. My thanks to all, who have helped. We expect this to be a yearly award.

Oscar Jenkins will replace me as President in March. The NC Chapter is in a position to be a leading Chapter within the entire ACC. To do this, we need to remain relevant to all the members. Please keep in touch and let us know how we can help.

Sincerely,
Paul G. Colavita, MD, FACC
President
NCCACC

Cardiac Care Associates - Important Part of ACC

The ACC's newest membership category, Cardiac Care Associates, is now accepting applications. Registered nurses, physician assistants, clinical nurse specialists, and nurse practitioners can download an ACC membership application. Questions? Call 800.253.4636, ext. 697.

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An Update on RACE Reperfusion of Acute Myocardial Infarction in Carolina Emergency Departments (RACE)



The RACE project is a collaborative effort to increase the rate and speed of coronary reperfusion through systemic changes in emergency care. The project is based upon the collaborative efforts of EMS personnel, physicians, nurses, administrators, and payers from five regions and 68 hospitals throughout North Carolina. The recommendations of this project are based upon established guidelines, published data, and the knowledge and experience of numerous individuals specializing acute myocardial infarction care. Key collaborators in this project include the

councilors of the NC Chapter, and in particular Drs. Colavita, Babb, Bohle, and Hathaway; Dr. James Jollis who is co-director of the project; Mayme Lou Roettig who is executive director; and cardiology and emergency care leaders from the five regions. Over the two years of the program, physicians collected information on 2,000 patients, measuring pre and post-intervention times for key processes: the time from when the patient arrives at the hospital door to either angioplasty or clot-busting therapy, and the time it takes for a patient at a feeder hospital to enter and leave the transferring hospital, and the time a patient enters a feeder hospital to treatment at a second, receiving hospital. Times improved substantially in all areas.

- Median time from door to treatment for hospitals offering angioplasty fell from 85 to 74 minutes. (22 percent)
- Median time from door to infusion of clot-busting therapy fell from from 35 to 29 minutes. (17 per cent)
- Median time from door-in to door-out at transfer hospitals fell from 120 to 71 minutes. (41 per cent)
- Median time from arriving at a feeder hospital to beginning treatment at a receiving hospital fell from 149 minutes to 106 minutes. (29 per cent)

[View the AP story that also appeared in the Philadelphia Inquirer, NY Times and more than 400 other news outlets.](#)

[View the FOX News story.](#)

ACTION ALERT!

YOU Decide the Future of Medicare Physician Payment!

[Click Here to Take Action Now](#)

We are nearing the final stage of a battle on behalf of our patients and our profession. It has been a long, tough campaign and you have responded every step of the way. Now, with just a few weeks until the end of the legislative session, we need your help again.

The Senate is in the process of drafting its Medicare legislation. The House passed Medicare physician payment legislation (CHAMP Act) earlier this year. Our goal is to ensure that any legislation passed by the Senate stops planned cuts in Medicare physician payments, but does not include cuts to imaging that were approved in the House CHAMP Act.

We simply cannot afford to remain silent. **If Congress does not act before the end of the year, physicians will receive a 10 percent cut in Medicare payments effective Jan.1, 2008.** This is unacceptable. Our patients deserve better. [Click here](#) to take action now.
ACT NOW:

Contact your members of Congress by logging on to the CardioAdvocacy Network's website at www.acc.org/can. Contact your senators and representative and let them know that a 10 percent cut threatens patient access and quality care. You may also call your members of Congress by using the ACC's toll-free Grassroots Hotline at (800) 210-7193.

URGE YOUR COLLEAGUES TO JOIN THE FIGHT!

If you have questions, contact Molly Nichelson at (800) 253-4636 X 6470 / grassroots@acc.org.

BCBSNC Diagnostic Imaging Management Advisory Committee Interactions
Summary by Jamie Jollis, MD, FACC

With 15% growth per year, medical imaging has become the target of payers. At the Federal level, the congressionally supported Medicare Payment Advisory Committee (MEDPAC) has recommended an overall cut in reimbursement, and no reimbursement for nuclear imaging conducted in physicians' offices. While CMS has yet to adopt the latter recommendation, reimbursement for cardiac imaging will undergo significant reductions including an overall cut in physician reimbursement, elimination of separate Doppler echocardiography payment, large reductions in technical reimbursement for freestanding cardiac CT, and the reclassification of radiopharmaceuticals from "drugs" to "supplies" such that imaging agents will be bundled into Ambulatory Payment Classification reimbursement.

On the private insurance side, most large payers have implemented radiology benefits management (RBM) systems whereby outpatient cardiac imaging requires prior approval. Blue Cross and Blue Shield of North Carolina (BCBSNC) has contracted with American Imaging Management (AIM) to implement their Diagnostic Imaging Management Program (DIMP). On a quarterly basis, BCBSNC reviews the program with an advisory group composed of approximately 25 physicians, hospitals, professional societies, and imaging center representatives including three cardiologists. Highlights from the presentation in the October meeting led by Eugenie M. Komives, MD have been made available [link].

Since implementation of the RBM program, overall utilization of diagnostic imaging has dropped by approximately 15%. Insurance plans administered by BCBSNC that do not require pre-approval have not seen any decrease in utilization, suggesting that the program is not changing medical practice outside of specific insurance plan restrictions. Of the 153,000 requests since February 2007, 51% were made by telephone, 46% by an internet portal, and 3% by facsimile. Thirty seven percent of requests required additional review by nurses or physicians, a figure that has remained fairly constant throughout the first eight months of the program. A total of 3.9% of requests were directly impacted by the process, including 1.2% that were not approved, and 2.6% that were withdrawn.

The relatively large difference between the 3.9% of requests directly impacted by the review process and the 15% drop in imaging utilization suggests that other factors contribute to the drop in imaging procedures. Likely sources of the drop include discouragement of procedure requests that are likely to be declined, and the "hassle" factor of ordering diagnostic imaging, particularly for physicians and practices that lack the resources or volume to implement AIM requests.

The advisory group provides an excellent opportunity to review and comment on the program, and a number of issues have been discussed. One of the greatest concerns involves how to use medical resources in the most efficient manner while providing diagnostic imaging to those patients in need. Radiology Benefits Management systems represent fairly blunt instruments to reduce imaging and it is possible that some of the procedures that have been discouraged were medically necessary, potentially leading to earlier diagnosis and treatment of an illness before bad outcomes ensue, or simply obviating the need for specialist consultation. Details regarding rejected requests have been requested. Given the additional unfunded burden on medical practices and the significant cost to BCBSNC of implementing the RBM program, advisory group members and the organizations and institutions that they represent are very interested in more efficient methods to assure the best application of diagnostic imaging. A simple first step would be to allow physicians and practices that routinely adhere to best imaging practices to order tests without having to implement the AIM process. Termed "gold carding" or "Physician Recognition Program (PRP)" status, BCBSNC has indicated that they have been advised by American Imaging Management that a significant move of physicians out of the program will result in a predictable increase in utilization. Thus, in working with the providers of North Carolina, a limited PRP program has been developed according to 5 criteria (volume, guideline compliance, high tech imaging rate, not self referring, and fraud investigation) that would allow 62 of the 10,752 physicians ordering diagnostic imaging to avoid the AIM process. No cardiologist met these criteria.

A longer term approach would involve the systematic implementation of clinical practice guidelines to obviate the need for RBM review. Such an approach would have the

advantage of impacting utilization for all patients, not just those covered by plans participating in the AIM program, and could potentially lead to better application of medical imaging without jeopardizing patients treated in settings that lack the resources necessary to request diagnostic studies. In the past two years, the American College of Cardiology has published a number of clinical practice guidelines for diagnostic imaging to better inform such a system and encourage imaging utilization programs that focus on the patient.

The issue of implementing practice guidelines is somewhat confounded by the RBM system. Radiology Benefit Managers “pick and choose” practice guidelines to include in their review algorithms. The challenge with the RBM system is that the algorithms are often proprietary and not transparent, and there is also concern that RBMs may change their criteria in order to meet internal benchmarks for percent of requests reviewed. Thus, the opportunity for physicians, professional societies, and medical organizations to significantly decrease the 37% of requests that require nurse or physician review in the Diagnostic Imaging Management Program are currently limited.

Other concerns that have been discussed in the advisory group meetings include the significant financial risk that the program places on cardiology practices and imaging centers for patients who are referred for tests that are not approved, the quality of AIM physician review with anecdotes of “Russian endocrinologists” deciding on the best test for a patient with complex cardiac disease, and a concern that increased barriers to diagnostic imaging for primary care physicians will result in a shift of costs to consultation or coronary angiography, rather than a true reduction in expenses.

Cardiology is at the extraordinarily challenging crossroads of tremendous advances in imaging technology, and medical expenses are outstripping the resources of patients, employers, and taxpayers. Payers such as BCBSNC have moved to systems like the Diagnostic Imaging Management Program to address issues of rapidly mounting costs in the absence of better alternatives. For the sake of our patients, we must actively engage with payers and the public to design, inform, and support the best systems for beneficial and prudent use of cardiac imaging. Given changes at the federal and private payer level that are directly impacting our ability to practice the best medicine, there has never been a more important time to work together as a group to assure that the interests of major industries and leading politicians match those of our patients.

For more on the BCBSNC Diagnostic Imaging Management Program, visit www.nccacc.org.

Carrier Advisory Committee Update

The purpose of the Carrier Advisory Committee (CAC) is to provide:

- a formal mechanism for physicians in the state to be informed of and participate in the development of an LCD in an advisory capacity;
- a mechanism to discuss and improve administrative policies that are within carrier discretion; and
- a forum for information exchange between carriers and physicians.

The CAC serves in a strictly advisory capacity to the Carrier Medical Director, currently Dr. Boyd Honeycutt of Cigna Medicare. The CAC is composed primarily of physicians representing specified medical and surgical specialties and appointed by their specialty organizations. Other non-physician medical organizations are also represented, including Medical Review of NC, the Medicare Part A contractor, the NC Hospital Association, Medicaid, and others.

Few issues of particular importance to the Chapter were discussed in 2007. Medicare’s approach to selection of contractors for management of Part B benefits is in flux. The country has been divided into 15 regions. Competitive bidding for selection of a vendor to manage Part A and B services in each region is underway. NC along with Virginia, West Virginia and South Carolina constitute region 11. I am not aware that a contractor has been selected for our region yet.

In 2007, CMS assigned local carriers responsibility for pricing the codes utilized in non-facility settings for cardiac catheterization. This occurred due to the fact that CMS believed they did not have adequate data to evaluate the costs incurred in performing these procedures. Cigna Medicare elected not to change the fees previously assigned to these codes; however, for at least one lab, payment of the coronary angiography code has been denied in all cases. Please notify me of any billing issues associated with procedures performed in Independent Testing Facilities or Ambulatory Surgery Centers.

In the area of compliance, Medicare is concentrating on a number of areas of interest to Cardiologists. The first is expensive diagnostic testing. The manner in which these studies will be more extensively monitored is not clear. The second is the perennial favorite of E&M codes. Medicare is concerned that upcoding is occurring, particularly when excessive documentation is submitted for low intensity medical issues.

CERT is the CMS program that monitors the coding "error" rate. In the past, many errors were the result of Cigna's inability to obtain documentation from providers. Your cooperation with this program is requested. If Cigna solicits notes for a limited number of encounters, these can be provided without specific permission from the patients, as HIPPA permits transmission of protected medical information for this purpose, and without concern of significant financial penalty for inaccuracies in billing and coding. If a more extensive review of your practice's billing appears to be in progress, especially if directed by the "benefits integrity" group or the, program safeguard contractor (BI/PSC) professional advice should be sought.

I am available for any and all questions related to Medicare Part B and to Cigna Medicare.

Robert Rothbart, M.D., FACC
ACC Representative to the NCCACC
robmr@yahoo.com

ACC Membership Update

The ACC Board of Trustees approved a moderate increase in dues for 2008. This increase sustains membership benefits, continues leading-edge quality initiatives, and protects the viability of practice.

Fellows of the College will see an increase of a little more than 12% in annual dues, which have remained stable since the last dues increase three years ago. They'll also notice the following changes on their dues statements:

- **Health System Reform Assessment:** This \$50 assessment, required for U.S. members only, ensures our ability to play a leading role in health system reform, physician payment, access to care, imaging and health financing. The assessment will not be used to fund the PAC but for critical advocacy and quality initiatives.
- **Chapter Dues:** Strong chapters offer members ready resources. Chapter dues are optional, but please join me in encouraging your colleagues to pay this amount and get involved with the ACC at the local level.
- **Section Dues:** Members with specific professional interests may see section dues reflected on their statements.

Cardiac Care Associates' dues remain unchanged at \$100, although they may also pay chapter or section dues. Fellows in accredited training programs will continue to enjoy complimentary membership.

First-year members will pay half the price of full dues, and second-year members will join their more senior colleagues in paying the full cost of membership.

Should you or any of your associates have questions regarding 2008 dues, please don't hesitate to contact the ACC at (800) 253-4636, ext. 5603, or resource@acc.org.

Support your Chapter and remember to pay your Chapter dues

Chapter dues amounts are to be collected from Chapters this summer. Chapter dues (\$100) will be invoiced on the dues statement. Membership in local chapters provides access to chapter communications, meetings, and local projects. Chapters offer opportunities for leadership, career development and mentoring. The chapter also serves as the grassroots voice at the local and state level with regulators and legislators. We encourage you to stay involved at the local level and include chapter dues along with your member dues payment.

CMS Presents New Options for Medicare Hospital Payments

The Centers for Medicare and Medicaid Services (CMS) on December 3 sent Congress a series of options for changing Medicare hospital payment so that it is based on the quality of care a facility delivers. The report, mandated by the budget-savings law signed last year

by President Bush, would build on an ongoing program that pays hospitals more Medicare money if they report data on various performance measures designed to assess quality. The report calls for giving hospitals a "Total Performance Score" based on treatment outcomes as well as whether certain clinical treatment practices were followed. In addition, patient satisfaction ratings would be used to calculate the total score and determine payment. Facilities would be rewarded for both improvement and for meeting national thresholds of care. Congressional action would be needed before any changes could be made in how Medicare pays hospitals.

**Jack Lewin, CEO of ACC, Inside View: This is Amazing
ACC's Commitment to Invention**

[Click here to view the Presentation.](#)