Congenital heart disease (CHD) is the most common birth defect, affecting about 40,000, or 1 percent, of American births annually. One of the most ambitious recent undertakings in treatment of CHD has been to harness data about critical procedures through both global and regional online registries. This is important work, experts say, because outcomes data in pediatric interventional cardiology are scarce compared to other fields.

“The unique challenge in CHD and interventional cardiology as compared to adult cardiology is that our patient population is quite diverse, with a wide range of ages from young infants, even fetuses, and adult patients,” said Lisa Bergersen, M.D., M.P.H., FSCAI, an interventional cardiologist at Children’s Hospital in Boston. “Not only are they of different ages, but they also have many different types of defects with different treatments, both surgically and in the interventional cath lab. This is particularly challenging when evaluating outcomes for CHD, because individual procedure types may be done infrequently at each individual institution.”

The variability and potential scarcity of data in rare cases of CHD result in dedicated registries that operate differently from adult cardiology registries. For instance, said Dr. Bergersen, a range of defects may be grouped together by shared expected risk, and information about these procedures—including adverse effects, radiation dose, and mortality rates—are studied for their respective outcomes in order to improve standards of care.

Thomas J. Forbes, M.D., FSCAI, director of the cardiac catheterization laboratory at Children’s Hospital of Michigan, has been at the forefront of CHD registry development since SCAI’s 2005 Scientific Sessions,

(continued on page 2)
where the idea of establishing a registry dominated discussions among pediatric interventionalists. Not long afterward, Dr. Forbes introduced the Congenital Cardiovascular Interventional Study Consortium (CCISC) registry, enabling “instantaneous access to data and people’s opinions worldwide on the server,” explained Dr. Forbes. The CCISC has grown from the initial 10 physicians involved to more than 240 physicians from 109 institutions around the world.

The first inquiries to the CCISC registry focused on acute, short-term, and intermediate outcomes comparing stent versus balloon angioplasty versus surgical treatment of native/recurrent coarctation of the aorta. Now, years later, the CCISC registry projects range from risk-stratifying patients undergoing cardiac catheterization procedures to answering specific questions on certain procedures performed in the cardiac catheterization lab. One recent study revealed a five-fold variation in radiation usage between participating cath labs, providing researchers with impetus to study the differences in practice use of fluoroscopy in the catheterization lab in order to standardize dosing for various procedures.

“With the help of SCAI, it has become a huge drive to reduce the administered dosage in the catheterization lab,” Dr. Forbes noted. “The information leading to these efforts would not be available without the CHD registries.”

Other registries include Dr. Bergersen’s Congenital Cardiac Catheterization Project on Outcomes (C3PO), which uses prospective CHD data across at least eight pediatric institutions as well as its Congenital Heart Disease Adjustment for Risk Method (CHARM); IMproving Pediatric and Adult Congenital Treatment (IMPACT), a National Cardiovascular Data Registry that includes SCAI representatives on its steering committee; and the Congenital Heart Disease Research Registry (CHDRR), which began collecting quality improvement data in 2008.

Whether the goal is reducing radiation doses, improving outcomes associated with coarctation stenting, comparing patent ductus arteriosus (PDA) stenting with surgical aortopulmonary shunts, or examining instances of coronary fistulae, the overall goal of the CHD registries is to build transparency into clinical practice. And the key, experts agree, is constant and long-term vigilance and dedication to quality improvement.

“Registries show us the reality of the situation. Without them we have no idea who is doing what and how well it is being done,” said Robert N. Vincent, M.D., FSCAI, professor of pediatrics and director of the cardiac cath lab at Children’s Healthcare of Atlanta.

Transparency not only improves quality of care but it helps physicians avoid high-risk clinical decisions and provides the solid statistical proof that is required to change clinical standards. Registry analyses allow institutions to see how they measure up to other centers and improve patient management by encouraging institution-wide quality checks based on the data available.

“I am a statistical heretic,” laughed David G. Nykanen, M.D., FSCAI, co-director of the Heart Center and chief of the interventional cath lab at Arnold Palmer Hospital for Children in Orlando, FL. “I tend to think that every data point is important. Every complication needs an analysis.”
Inherent Challenges

Setting up and maintaining a CHD registry comes with significant challenges. For starters, for the data to be useful, follow-up sessions with patients to get updated information about health outcomes are absolutely necessary, but hard to pin down. On average, only 35 percent of patients follow-up with their clinician regarding an ongoing study two years after the original procedure date. That is significantly short of the goal of 70 percent participation, said Dr. Forbes. CHD registry programs are designing efforts to encourage patients to return for their follow-ups, including personal touches like direct phone calls.

Another major challenge is cost. It typically costs $350,000 per year to maintain an effective registry. The funding can be either private, with exclusivity among a number of membership organizations, or public. Two essential pieces in getting registries up and running and keeping them sustainable are physician champions who promote institutional adoption and administrators who interact with patients, maintain web portals, and manage infrastructure.

Driving New Research and Clinical Trials

While the information derived from CHD registries is not backed by the rigor of clinical trials, CHD registries provide an excellent tool for assisting and implementing drug trials. For example, the CCISC registry is credited with reducing the time and costs of completing a recent AngioMax/Bivalirudin drug trial. The trial, which enrolled a cohort of infants and children undergoing cardiac catheterization procedures in the United States, was completed 15 months ahead of schedule at just over $1 million in savings.

“In this particular case, the CCISC was used to assist in making contacts with research coordinators at potential participating institutions, in addition to expediting institutional review board approval and contract negotiations,” said Dr. Forbes. Various CHD registries have also been approached for assistance in market surveillance once a device has been approved in the United States.

CHD registries are helping to revolutionize the field of CHD care, said Dr. Nykanen, but it takes ongoing commitment across the specialty. “Groups like SCAI are becoming more and more vocal about reporting data and being able to measure it,” he added. “If we can’t measure it, we can’t fix it. We really need to be involved and inclusive. We also need to be responsive and get the data in a timely manner—and if possible, in real-time.”

Much like when SCAI and leading interventional cardiologists working in the field of CHD convened in 2005 to discuss how registries should operate, resulting studies have become hot topics in regional and international cardiovascular meetings and, in turn, presentations at those meetings are promoting new and ground-breaking research programs and multi-center collaborations that keep interventional cardiology at the forefront of CHD care.

“Many of the collaborations that resulted in today’s CHD registries were initiated, advocated for, and/or expanded when congenital heart disease specialists convened at SCAI annual meetings and other member gatherings,” said SCAI Past President Ziyad M. Hijazi, M.D., M.P.H., FSCAI, who was instrumental in ensuring SCAI’s participation in the IMPACT registry. “We have made great progress in a short time, but there is much more work to do.”

To support the important work of CHD registries, SCAI encourages members to join its Congenital Heart Disease Council and to attend the SCAI 2014 Congenital Heart Disease Track. For more information, contact Joel Harder at jharder@SCAI.org. And to register for SCAI 2014, log on to www.SCAI.org/SCAI2014.
schedule that the Medicare agency has been listening to SCAI. Instead of limiting fees for in-office procedures to no more than the Medicare rates for similar procedures in hospital outpatient departments (HOPDs) or ambulatory surgical centers (ASCs), as the proposed rule suggested, CMS withdrew their plan for 2014.

SCAI and other groups fought the proposal to cap payments – earning the backing of the American Medical Association – by demonstrating that CMS was making comparisons that were neither fair nor complete. Had CMS proceeded as originally proposed, payments for some in-office peripheral procedures would have been cut by up to 40 percent, decreasing reimbursement to interventional cardiologists by more than $60 million.

SCAI expects CMS will continue to scrutinize the costs associated with these procedures, one of several reasons that physicians and coding staff must take steps to ensure they are accurately documenting the cost of providing these services. SCAI members and their teams can be instrumental in future advocacy on this issue. Interventional cardiologists at facilities that perform these procedures outside of hospitals are invited to contact Dawn Hopkins at dhopkins@SCAI.org.

Fees for Top Intervventional Cardiovascular Procedures Rise

The Final Rule shows a 1 percent overall increase in the relative value of the average cardiologist’s fees and a 1.1 percent increase for interventional cardiology procedures. The increase reflects that CMS has recognized that the cost of treating heart patients has changed.

Continued Efforts to Shift Reimbursement From Specialists to Primary Care

In the longer term, however, CMS will continue its efforts to shift funding away from specialty-based procedures and toward primary care, particularly as the agency develops new ways to identify procedures it considers to be overvalued. CMS has hired contractors to help with this effort, announcing plans for reviews of various specialty services.

“There is little doubt that we will have to work hard to defend the valuation of some interventional cardiology procedures over the next few years,” said Dr. Duffy. “Members will need to be responsive to surveys about the time and effort involved in the procedures they perform. Accurate reflections of the time, skill, and effort needed to perform the high-risk, high-reward procedures we perform on a regular basis must be clearly communicated through these surveys to ensure we are recognized for our work and appropriately compensated.”

Coverage of Clinical Trials

The Final Rule also shows that CMS has modified its plan to centralize and restrict coverage of procedures performed as part of clinical trials. SCAI argued that non-inferiority trials offering patients more options and facilitating competition can hold down healthcare costs. In 2014, CMS will proceed with plans to centralize decision making, but it will not require all studies to be superiority trials.

“Keeping important research in the United States is crucial for the future of our healthcare system. It will yield more innovations, giving our patients access to more treatment options,” said Dr. Duffy.

Quality and Public Reporting Initiatives

The Final Rule also changed several of CMS’s quality reporting efforts that affect physician fees. For example, in the past, the Physician Quality Reporting System (PQRS) was applicable only to groups with more than 100 providers. Upon implementation of the Final Rule on Jan. 1, 2014, the PQRS program will enroll groups with as few as 10 providers.

Beginning in 2014, CMS will also expand its public reporting on individual physicians and groups of physicians, via the Physician Compare website, http://www.medicare.gov/physiciancompare. The website will include data on a wide range of issues, such as the proportion of patients with coronary artery disease who are not on recommended medications and on the portion of patients with poorly controlled hypertension.

“It’s important to keep in mind that all of the quality and reporting initiatives addressed in the Final Rule could be dramatically altered, depending on what happens with the SGR replacement proposals that Congress is currently considering,” said Dr. Duffy. “We will have to maintain our focus on these and be vocal on behalf of SCAI members and our patients. Some of the proposals are not in the best interests of patients.”

The Bottom Line

As mentioned, the net impact of the Final Rule on cardiologists is that average RVUs will rise about 1 percent and invasive/interventional procedures will rise about 1.1 percent. The President signed a three-month patch to the SGR with a 0.5 percent increase in the conversion factor, which brings the net increase for interventional cardiology procedures to 1.6 percent. See Table 1 for more details.

“SCAI will continue to be engaged in these and other issues, making sure that your voice and the voice of interventional cardiology are heard,” said Dr. Duffy.
“Please contact me at pld@nc.rr.com or join us on the Advocacy Committee as we continue to work to move our field forward.”

To stay current on these and other issues affecting the practice of invasive/interventional cardiology, visit www.SCAI.org/Advocacy.

### Table 1. National Medicare Fees for Common Invasive and Interventional Procedures

<table>
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<td>3%</td>
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<td></td>
<td>Coronary art/grft angio s&amp;i</td>
<td>$299</td>
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<td></td>
<td>Exercise w/hemodynamic meas</td>
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SCAI has just published “Care Coordination with Referring Physicians,” the newest addition to the Society’s highly regarded Quality Improvement Toolkit (SCAI-QIT). The Care Coordination tool is an informative slide deck addressing a range of topics concerning patient care before, during, and after cardiac interventions. Like all of the tools in SCAI-QIT, the Care Coordination resource is available for free download, and is aimed at fueling discussion and supporting efforts to improve the quality of care delivered to patients with cardiovascular disease.

“We hope the Care Coordination tool will serve as a useful starting point for interactive meetings and educational sessions hosted by SCAI’s more than 300 Quality Champions,” said the new tool’s first author, Henry Jennings, M.D., FSCAI, an interventional cardiologist at the Vanderbilt Heart and Vascular Institute and assistant professor of medicine at Vanderbilt University Medical Center in Nashville, TN. “The content is tailored for a wide range of referring providers, whether they are noninvasive cardiologists, internists, family physicians, or physician extenders, such as nurse practitioners and physician assistants.”

Care Coordination with Referring Physicians is available at www.SCAI.org/QIT, where each tool is denoted with an icon reminiscent of the tools in a builder’s toolbox.

Just as builders have essential tools that help them do their best work, SCAI-QIT is an expanding collection of tools that will help us provide the best care to our patients,” added Dr. Jennings. “The Care Coordination tool took over a year to build and it covers a lot of essential information.”

The new tool is divided into “chapters” that can be tackled one at a time or in various combinations, depending on the needs and interests of providers. Among the topics are –

- Appropriate use criteria (AUC),
- Patient management before and after cath lab referral,
- Dual antiplatelet therapy,
- Access site complications,
- Optimal medical therapy after PCI, and
- Diagnostic testing after PCI.

Team-Builder: Share, Share, Share

“This tool reflects the team-based nature of caring for patients with coronary artery disease,” said SCAI Quality Improvement Committee Chair Sunil V. Rao, M.D., FSCAI, associate professor of medicine at Duke University Medical Center and director of the cardiac catheterization laboratories at the Durham VA Medical Center in Durham, NC. “It’s important for all stakeholders to understand the issues facing patients who undergo diagnostic coronary angiography and coronary intervention. Patients often interact with several providers, many of whom are primary care providers, before they are referred for cardiac catheterization.”

The slide deck highlights ways to foster collaboration and shared understanding among healthcare providers from patient intake to after-care. For example, it offers a thorough discussion of the AUC in order to clear up misconceptions related to coronary revascularization, diagnostic cardiac catheterization, and other procedures. The slide deck also provides risk classifications related to patient referral; overviews of the use of certain diagnostic technologies; possible complications of interventional cardiovascular procedures; and the use of cath lab–related registries that currently collect PCI data. This information helps to streamline knowledge so that all parties are privy to the same essential data.

Use It Your Way: Customize, Customize, Customize

While developing the Care Coordination tool, SCAI’s Quality Improvement Committee considered the diversity of circumstances where the tool might be used, ranging from small-group discussions of specialists gathered around a conference table through presentations in lecture halls or even webinars accessed by groups of practitioners employed by a healthcare setting.

“We’re inviting interventional cardiologists to use this tool – portions of it or the whole slide deck – when they’re asked to give presentations
“Our primary goal was to focus on topics that referring physicians often ask about and to use a format that will allow individual presenters to customize the slide deck for any audience.”

Customize away, stressed Dr. Jennings. “We’ve pulled together as much information as we could without making it cumbersome, but each of us will use the portions that make sense for the audience we are working with on a specific day, addressing a specific issue.”

“Regardless of how or where you use the tool, the overall goal is to help interventional cardiologists facilitate conversations with their referral base to bring the most appropriate and best care to their patients,” explained Dr. Rao, who has piloted the tool to launch conversations with providers in his network. “I use the slide deck to stress that the appropriate use of procedures is truly a team effort that involves all of the providers who are participating in a patient’s cardiac care.”

It’s for You, Too: Refresh, Refresh, Refresh

While building successful teams is the primary goal of the Care Coordination tool, another aim is to help all health providers – interventional cardiologists included – to stay current on secondary prevention recommendations.

“We hope the Care Coordination tool will help SCAI members to shore up their own knowledge banks,” said Dr. Jennings. “Everyone is invited to use the slide deck to review the latest guidelines and procedural recommendations and get a refresher on the various ‘hot topics’ affecting our specialty.”

SCAI’s Quality Improvement Committee reviews all of the tools on a regular basis and will make periodic updates to the Care Coordination tool. To access “Care Coordination with Referring Physicians” as well as the other SCAI-QIT tools, go to www.SCAI.org/QIT. You can download the whole SCAI-QIT or individual tools. For more information about how to join SCAI’s growing cadre of Quality Champions and participate in the QI Listserv, go to http://www.scai.org/QITChampion.

Where will the new SCAI-Quality Improvement Toolkit Care Coordination slide deck come in handy for interventional cardiologists? Pretty much anywhere you’re asked to speak to members of the cardiovascular care team about hot topics, burning issues, and common questions related to the delivery of cardiovascular interventions. Here are a few places to get you started:

1. Divisional meetings, or anywhere care pathways are reviewed
2. Primary care clinics
3. Lunch & Learn sessions with primary care providers
4. Local & regional medical staff meetings
5. Grand Rounds with colleagues from related specialties: family practice, internal medicine, general cardiology
6. Cath Conference
7. Fellows Lectures
8. Up in the air! The Care Coordination tool provides a great refresher course for you, too, especially during quiet time, such as during air travel.

The SCAI-Quality Improvement Toolkit was developed with founding support from

Lilly

and support from

AstraZeneca

The Society gratefully acknowledges this support while taking sole responsibility for all content developed and disseminated through this effort.
SCAI’s HDRC Program Launches Clinical Trial Services

SCAI’s Health Disparities Research Consortium (HDRC) recently launched a set of clinical trial services aimed at improving the quality of life and health outcomes of women and minority patients.

Addressing the Life Cycle of the Clinical Trial

“We are currently looking to address two aspects of the clinical trial process through the HDRC clinical trial services,” said James Tcheng, M.D., FSCAI, an HDRC Advisory Panel member. “On the front end, we’re helping sponsors enroll and retain more women and minorities in their trials in order to enhance the ability to conduct more complete analyses and identify future areas for innovation.

“On the back end, we’re translating trial results into practical information that physicians can apply day-to-day. Many patients go untreated due to physician understanding of trial results at the population level. We’re advocating for more specific, patient-level analyses with the goal of increasing adoption of safe and effective treatments within undertreated populations.”

Partner-Based Services

HDRC trial services are based on its own research activities as well as strategic partnerships with organizations whose products and services demonstrate potential to improve trial practices. The goal is to identify best practices and encourage their adoption among trial sponsors and clinical researchers.

For example, HDRC is now working with Omniscience Mobile, a mobile solutions company based in the Washington, DC, area, to leverage mobile technologies that are particularly well suited to communicating with minority and ethnic patient populations.

“Research companies such as Pew have identified significantly higher mobile phone usage among certain ethnic and minority groups,” explained Jeff Lee, CEO of Omniscience Mobile. “We are excited to partner with HDRC to respond to those trends and offer a smarter way of reaching patients who have historically been difficult to engage in the clinical trial process.”

HDRC is working with other organizations with the similar goal of seeking out high-potential services, testing them, and, if they are effective, distributing them.

“We’re trying to be innovative in our approach to disparities research. There are still gaps in awareness, access, and outcomes that we believe can be addressed at the clinical trial level through creative partnering,” said Roxana Mehran, M.D., FSCAI, HDRC medical director. “The goal here is not to compete, but to complement the great work of other organizations.”

Driving Innovation

HDRC is also poised to launch a study that would measure the impact of peer-to-peer education in advancing awareness, knowledge, and willingness of women to participate in clinical trials. Working with the Mayo Clinic and WomenHeart: The National Coalition of Women with Heart Disease, HDRC will design and implement educational activities through WomenHeart’s national support networks. The goal is to validate peer-to-peer education as an effective, scalable method of reaching subgroups with clinical trial information.

“Our goal is to fill a void that exists between academia and industry, considering health disparities in clinical research as an opportunity for innovation and change,” said Dr. Tcheng. “This is only the beginning of where we think we can go.”

To learn more about the Health Disparities Research Consortium, visit www.disparitiesresearch.org or email Rebecca Ortega at rortega@disparitiesresearch.org. To learn more about Omniscience Mobile, visit www.omnisciencemobile.com.
Mastering a new job is a tall order in any line of work. Cardiologists who take on the role of cath lab director may find it especially challenging, says SCAI President-Elect Charles Chambers, M.D., FSCAI. “The responsibilities of a cath lab director are a bit like that of the president. There isn’t a good job description.” Similarly, cath lab managers confront a bevy of administrative issues, juggle rapidly evolving technology, and address conflicts among an array of stakeholders.

While most cath lab leaders bring a wealth of clinical experiences to their positions, there has been no defined career path or training program. Most learn on the job.

Introducing Boot Camp: SCAI’s Leadership Training Ground

This year at SCAI 2014, cath lab leaders – as well as those who aspire to the role – can attend a unique educational experience designed specifically to address the challenges and goals they may face. SCAI’s Cath Lab Leadership Boot Camp is an essential two-morning symposium offered to all attendees as part of the registration fee.

Both positions – cath lab director and manager – include a broad range of responsibilities for quality, education, and “other duties as assigned,” says Dr. Chambers. Continuous quality improvement across all activities comprises a major portion of cath lab leadership, typically including credentialing, committee assignments, outcomes, and benchmarking. Together the director and manager handle the team’s ongoing education, including morbidity and mortality and cath lab conferences, current topics, and new challenges.

The final set of responsibilities falls into what Dr. Chambers terms other duties as assigned, and ranges from budget to discipline to new equipment purchases and even marketing.

“The program is a natural extension of SCAI’s two primary missions: quality and education,” says Dr. Chambers. “The chairs of the Society’s Education and Quality Improvement Committees set the vision for ongoing training.”

Gear Up: Dedicated Sessions for Cath Lab Directors & Managers

“We’re going to present a broad range of timely topics in two sessions,” promises Dr. Chambers. Day 1 presentations will address the roles of the medical director and manager and also delve into common challenges, conflict resolution, and technology evaluation and integration. The second session will focus on issues physician directors may face, exploring administrative challenges, with an emphasis on quality and reporting, team building, budgeting, and building a research program.

Beyond Boot Camp

What happens after you graduate from Boot Camp? There is no current cath lab directors group. SCAI is going to fill that void, says Dr. Chambers. SCAI’s longer-term goal is to establish a meaningful group by providing online educational programs and a listserv, where Boot Camp attendees can continue learning together, sharing information, and discussing the challenges of cath lab leadership.

To learn more or register for Boot Camp, visit www.SCAI.org.
“Every element of SCAI 2014 is being planned to help us – interventional cardiologists and our teams – put our entire attention on improving our profession and enhancing the care we deliver to our patients,” says SCAI 2014 Program Director Morton J. Kern, M.D., FSCAI. “I concentrate on the action words in our goals: enhancing those procedures we’re performing today, enlightening one another, and sparking excitement about what’s coming.”

SCAI 2014 Program Director
Morton J. Kern, M.D., FSCAI

ENHANCE
The first priority of the SCAI 2014 Program Committee is to make sure every SCAI 2014 attendee leaves the meeting prepared to deliver even better care. “For many attendees, that’s focusing on complications. There is simply no better meeting for learning about complications – how to prevent them and how to handle them if they arise, and inevitably, they do,” Dr. Kern said.

The meeting’s size is ideal for case-based education on complications, for early, mid, and late career interventionalists and for cath lab nurses and technicians. “Our faculty will be dissecting the unique as well as the common complications,” added Dr. Kern.

SCAI 2014 will also feature dedicated sessions aimed at topics last year’s attendees reported they want more of – more on transradial interventions, chronic total occlusions, and TAVR. Explained Dr. Kern: “By participating in these sessions, our members will go home more excited than ever about transradial access; with deeper knowledge of complex PCI, especially CTO; and they’ll know how to start a TAVR program.”
The attendees say it best, year after year: The single most valuable aspect of the SCAI annual meeting is its intimate, collegial “feel” and more specifically the opportunities for collaboration and conversation that come with bringing together interventional cardiologists and their teams.

“We’re ramping up the team experience at SCAI 2014,” said Dr. Kern. “Smaller rooms, even more interaction time built into every session, and use of technologies like Twitter to help everyone get the most out of the meeting.”

Attendees will also see the concept of “Heart Team education” in action at SCAI 2014. Many of the sessions will feature the Heart Team ♥ symbol, indicating specially designed sessions aimed at engaging everyone who works in, or supports, the cath lab. “Now more than ever, we all need to learn from one another. I’m looking forward to seeing our nurse and technician colleagues on the podium and in the audience, providing their insights on how we can keep improving quality on behalf of our patients,” said Dr. Kern.

Teams-learning-together will be evident throughout all of SCAI 2014, with the TAVR How-To session setting the example. Teams are invited to attend as a group, immersing themselves as a unit in interactions about indications, technique, and the information the whole team must understand to successfully offer this procedure at their facilities.

Military Medicine: Focus on Interventional Cardiology. Enhanced education for our men and women in uniform.

Not just 4 interventionists: #SCAI2014 welcomes the entire cath lab team. Look for the ♥ for Heart Team programming.

The State of the Society
Welcome Address by SCAI President
Ted A. Bass, M.D., FSCAI

All new, and complimentary! Cath Lab Leadership Boot Camp, debuting at #SCAI2014 – see page 9
Maximizing Social Media: Four Steps for Physicians

Have you ever Googled yourself? By doing so you’ll find you already have an online presence, so why not play a part in developing a professional identity for yourself online? Interventional cardiologists report it can be difficult to find time to “do social media,” but by following the steps below, you can begin to manage your own online presence, impact patients’ lives beyond an office visit, and extend the reach of your practice.

1. **WATCH AND LISTEN.** Begin by doing a search on Twitter using key words (cardiologist, interventional cardiology) to find peers and organizations to follow. By creating these connections, you will begin to expand your online network exponentially. “Listen” by watching what others are tweeting, posting, and linking to give you a sense of what works, what doesn’t, and what you need to know before tweeting for yourself.

2. **MIND YOUR W’S AND H’S.** Before dipping your toe in the social media waters, know what you wish to accomplish; otherwise your goals could be diluted and you may feel overwhelmed.
   - **Why?** Why are you going to engage in social media…for ideas, research, collaboration?
   - **Who?** Who is your audience? Staff, new patients, existing patients, colleagues?
   - **Where?** Which social media platforms make the most sense for you? Twitter? LinkedIn?
   - **When?** Dedicate an allotted amount of time – at the same time – each day to devote to social media use. Guard this time and make it a habit.
   - **What?** Which outcomes will you measure for successful social media use?
   - **How?** Are you going to push out information, retweet, or have an actual dialogue? An example: “I am going to share evidence-based interventional cardiology messages and create a place of learning and respectful dialogue to current and new patients in my demographic area.”

3. **KEEP IT PROFESSIONAL.** Follow the advice from Mayo Clinic’s Dr. Farris Timimi: Don’t lie, don’t pry, don’t cheat, can’t delete, don’t steal, don’t reveal (embargo, patient information, etc.).

4. **DEVELOP A CONTENT SHARING PLAN.** Follow the 70-20-10 percentage rule for content development.
   - **70 percent** can be written from someone else and be content you link to or retweet. Set up RSS feeds to deliver content of interest to you, and then file that content in electronic folders by topic area. You can use it later to develop blog posts, tweets, Facebook updates, and so on. This content can also be a source to ask probing questions via your Twitter account. For example, with the recent cholesterol guidelines, you could tweet, “Confused about new #cholesterol guidelines? Review this Twitter chat.”
   - **20 percent** can be original content you create, and can be used as an opportunity to fill gaps based on conversations you have with patients, or to answer questions patients often ask you. For example, you could tweet, “Got the flu? Know its impact on #heart health” and link to a SecondsCount.org post that provides further information on the topic.
   - **10 percent** can be for fun – birthdays, at the office photos, a comment about your golf game. By showing a bit of your personal side, you’ll engage visitors and help build your profile.

Whether you’re already on social media or are just setting up your accounts, be sure to follow SCAI. The Society’s Twitter handles include @SCAI, @SCAInews, and @SecondsCountOrg.
FEBRUARY 2014

– STRUCTURAL HEART INTERVENTION AND IMAGING 2014: A PRACTICAL APPROACH
Date: Feb. 6–7, 2014
Location: La Jolla, CA
Co-chairs: Matthew J. Price, M.D., FSCAI, and David S. Rubenson, M.D.
For more info: www.scripps.org/conferenceservices

– SCAI PERIPHERAL AND ENDOVASCULAR TRACK AT INDIA LIVE 2014
Date: Feb. 28–March 2, 2014
Location: New Delhi, India
Co-chairs: Herbert D. Aronow, M.D., FSCAI, Robert M. Bersin, M.D., FSCAI, Tyrone J. Collins, M.D., FSCAI, and D. Chris Metzger, M.D., FSCAI
For more info: www.indialive-cardiointervention.com

APRIL 2014

– SOUTHWEST VALVE SUMMIT II – ON THE RIVER
Date: April 11–13, 2014
Location: Austin, TX
Co-chairs: Stephen H. Little, M.D., FASE, FACC, FRCPC
Director: www.houstonmethodist.org/southwestvalvesummit

– EMORY PRACTICAL INTERVENTION COURSE
Date: April 24–26, 2014
Location: Atlanta, GA
Co-chairs: John Douglas, M.D., FSCAI
For more info: http://med.emory.edu/cme

MAY 2014

– SCAI 2014 SCIENTIFIC SESSIONS
Date: May 28–31, 2014
Location: Las Vegas, NV
Director: Morton Kern, M.D., FSCAI, Michael Jaff, D.O., FSCAI, Roxana Mehran, M.D., FSCAI, Matthew J. Gillespie, M.D., FSCAI, and Doff McElhinney, M.D., FSCAI
For more info: www.SCAI.org/SCAI2014

Promoting healthy hearts, one family at a time.
Send your patients to SecondsCount.org for the latest information on cardiovascular health, from symptoms and treatment to prevention and recovery.
New, SCAI-Secured Interventional Cardiology Codes Went Into Effect Jan. 1, 2014

During the 2014 CPT cycle, SCAI succeeded in securing new CPT codes for four interventional cardiology procedures, each of which will enable members to accurately report and be reimbursed for their services.

SCAI pursued a new code for **PDA closure** after CMS demanded revision to the existing catch-all cardiovascular percutaneous embolization/occlusion code (37204 – to be eliminated in 2014). SCAI crafted a proposal seeking the creation of a new code specific to reporting PDA closure procedures. Previously, most carriers had directed use of the non-specific embolization/occlusion code. However, coding instructions regarding separately reportable related components were fairly inconsistent across the nation, resulting in inconsistent payment rates. Additionally, prompted by requests from SCAI members, the Society also sought a new code to report **alcohol septal ablation** procedures.

New and revised codes are granted by the AMA CPT Editorial Panel with value recommendations for Category I codes developed through the AMA RUC (RBRVS Update Committee) process. Arthur C. Lee, M.D., FSCAI, serves as SCAI’s advisor to the AMA CPT Editorial Panel Advisory Committee, and Clifford J. Kavinsky, M.D., Ph.D., FSCAI, is SCAI’s advisor to the RUC Advisory Committee. SCAI also works with leading clinical experts in the development of coding proposals. Srihari S. Naidu, M.D., FSCAI, lent his expertise to help drive the new alcohol septal ablation code through both the CPT and RUC processes.

Both procedures met the criteria to support creation of Category I codes, which support a fairly consistent national valuation. In developing recommendations as to placement for these new codes within CPT, it became apparent that a new subheading within CPT was needed. The request was granted, affording a new “home” of their own for interventional cardiology structural repair codes

**New CPT Subheading**

“Repair of Structural Heart Defect”

**PDA Closure**

**93582 Percutaneous transcatheater closure of patent ductus arteriosus**

- 93582 includes congenital right and left heart catheterization, catheter placement in the aorta, and aortic arch angiography, when performed.
- Do not report 93582 in conjunction with 36013, 36014, 36200, 75600, 75605, 93451-93461, 93530, 93531, 93532, 93533, 93567.
- For other cardiac angiographic procedures performed at the time of transcatheter PDA closure, see 93563, 93564, 93565, 93566, 93568 as appropriate.
- For left heart catheterization by transseptal puncture through intact septum or by transapical puncture performed at the time of transcatheter PDA closure, use 93462.
- For repair of patent ductus arteriosus by ligation, see 33820, 33822, 33824.
- For intracardiac echocardiographic services performed at the time of transcatheter PDA closure, use 93662. Other echocardiographic services provided by a separate physician are reported using the appropriate echocardiography service codes, 93315, 93316, 93317.

2014 Cardiology Coding Webinar Available Online

In early December, hundreds of healthcare providers from across the United States, including billing staff, attended the SCAI/ACC webinar reviewing all of the major cardiology coding changes for 2014. Webinar faculty Robert Piana, M.D., FACC, Arthur Lee, M.D., FSCAI, and Srihari S. Naidu, M.D., FSCAI, shared their insights and expertise from presenting CPT proposals to the AMA CPT Editorial Panel. Their efforts resulted in securing the new interventional cardiology codes that went into effect in 2014. The program has been archived and is available at www.SCAI.org/2014CodingWebinar.
Alcohol Septal Ablation

93583 Percutaneous transcatheater septal reduction therapy (eg, alcohol septal ablation) including temporary pacemaker insertion when performed

- 93583 includes insertion of temporary pacemaker, when performed, and left heart catheterization.
- Do not report 93583 in conjunction with 33210, 93452, 93453, 93458, 93459, 93460, 93461, 93531, 93532, 93533, 93565, 93567, 93568.
- 93583 includes left anterior descending coronary angiography for the purpose of roadmapping to guide the intervention. Do not report 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93563 for coronary angiography performed during alcohol septal ablation for the purpose of roadmapping, guidance of the intervention, vessel measurement, and completion angiography.
- Diagnostic cardiac catheterization procedures may be separately reportable when no prior catheter-based diagnostic study of the treatment zone is available, the prior diagnostic study is inadequate, or the patient’s condition with respect to the clinical indication has changed since the prior study or during the intervention. Use the appropriate codes from 93451, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93530, 93563, 93564, 93566, 93567, 93568.
- Do not report 93583 in conjunction with 33210, 33211.
- Do not report 93463 for the injection of alcohol for this procedure.
- For intracardiac echocardiographic services performed at the time of alcohol septal ablation, use 93662.
- Other echocardiographic services provided by a separate physician are reported using the appropriate echocardiography services codes, 93312, 93313, 93314, 93315, 93316, 93317.
- For surgical ventriculomyotomy [-myectomy] for idiopathic hypertrophic subaortic stenosis, use 33416.

New Category III Interventional Cardiology Codes

SCAI also drove requests to create Category III codes for the new percutaneous renal denervation and transcatheter mitral valve repair (TMVR) procedures. Category III codes are used to describe emerging technologies. While Category I codes are typically nationally valued, Category III code values are determined at the local level by local carrier medical directors (CMDs). Category III codes are also released electronically by the AMA on a biannual basis. A listing of all active Category III codes can be found on the AMA website http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance cpt/about-cpt/category-iii-codes. page. For assistance in identifying potential crosswalks to existing nationally valued procedures to be used in developing a value recommendation for Category III codes to guide your local CMDs in pricing these services, email Dawn Hopkins at dhopkins@SCAI.org.

Renal Denervation

0338T Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; unilateral

- Do not report 0338T, 0339T in conjunction with 36251, 36252, 36253, 36254.


Transcatheter Mitral Valve Repair (TMVR)

The TMVR codes do not appear in the print version of CPT, but they were published online by the AMA and are effective Jan. 1, 2014.

0343T Transcatheter mitral valve repair percutaneous approach including transseptal puncture when performed; initial prosthesis

- Use 0343T in conjunction with 0344T.


Please note: SCAI is committed to making every reasonable effort to provide accurate information regarding the use of CPT®, and the rules and regulations set forth by CMS for the Medicare program. However, this information is subject to change by CMS and does not dictate coverage and reimbursement policy as determined by local Medicare contractors or any other payor. SCAI assumes no liability, legal, financial, or otherwise, for physicians or other entities who utilize this information in a manner inconsistent with the policies of any payors or Medicare carriers with which the physician or other entity has a contractual obligation. CPT codes and their descriptors are copyright 2013 by the American Medical Association.
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