In response to advocacy by SCAI and others, the Centers for Medicare and Medicaid Services (CMS) has revised the 2010 fee schedule to increase Medicare payment rates for invasive and interventional cardiology by $36 million. Acting on SCAI’s recommendation, CMS has recategorized invasive and interventional cardiology procedures as subject to high malpractice risk. This news, published in the Federal Register on May 11, translates into reimbursement increases of 0.8 percent on a weighted average, compared to 2009, rather than the 4.6 percent decrease that was initially implemented. The change is retroactive for claims made since Jan. 1, 2010.

“This is welcome news, and it’s a testament to the value of advocacy,” said Larry S. Dean, M.D., FSCAI, who was installed as SCAI president just hours before the announcement from CMS. “This demonstrates that we should keep sending letters and emails to our elected officials and directly to CMS, even when decisions appear to be final.”

In fact, this is the third time in the 18-year history of the Medicare fee schedule that CMS has changed its methodology for calculating malpractice relative value units. Each time, the agency’s contractors assumed that all of the 90000 series CPT codes were low-malpractice-risk procedures, and each time SCAI has intervened successfully.

CMS also posted a variety of other technical corrections, some providing significant benefits for in-office nuclear cardiology procedures. Many of these revenue-neutral changes were offset by other slightly reduced fees across the Medicare fee schedule.

The CPT codes recategorized this month as high malpractice risk were 92973 through 92975; 92980 through 92998; 93501 through 93533; 93580 through 93581; 93600 through 93613; 93618 through 93641; and 93650 through 93652. Allowed charges for these procedures increased about 7 percent over previously announced 2010 fees; however, this is only a 2–3 percent increase over 2009 payment levels.

For a list of common interventional cardiology procedures for which reimbursement rates have changed, turn the page, or visit www.SCAI.org/Advocacy.aspx.

“We must thank our colleagues at the ACC and the AMA for supporting our efforts to persuade CMS to reconsider how invasive/interventional were being evaluated in terms of malpractice risk,” said SCAI Advocacy Committee Chair Joseph D. Babb, M.D., FSCAI. “Here’s an example of how the Houses of Cardiology and Medicine stood together and succeeded.”

On that note, SCAI is reminding members to stay tuned for guidance on how to help fight possible fee cuts based on the sustainable growth rate (SGR) and the continued four-year phase-in of practice expense changes.

“CMS did the right thing this time, but let’s not forget there’s a lot more work to be done to get the SGR fixed and to help CMS develop a better overall system for evaluating and reimbursing all health care providers who treat Medicare patients,” said Advocacy Committee Chair Mark Turco, M.D., FSCAI. “It is crucial for members to respond to surveys on practice expense and the work involved in procedures in order to obtain appropriate reimbursement levels.”

Visit www.SCAI.org often for updates, and watch your email for SCAI Alerts and Calls to Action.

Details on how these changes will be implemented are still uncertain; however, SCAI anticipates that Medicare carriers will auto-process all claims affected by CMS’s decision. Importantly, non-Medicare-contracted fee schedules that are based on Medicare rates may not be automatically updated, nor should members assume that underpaid claims by non-Medicare commercial carriers will be automatically reprocessed.

SCAI is advising members to contact all contracted non-Medicare carriers regarding corrections to the reimbursement rates for affected procedures. If you encounter problems getting these claims reprocessed, contact SCAI’s Director of Reimbursement and Regulatory Affairs Dawn Hopkins at dhopkins@scai.org or 202-741-9854.
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<th>2010 MALPRACTICE RVUs</th>
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<th>2010 MEDICARE ALLOWED CHARGES</th>
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*All procedures with > $10 million in allowed charges in 2005 and a few select codes of interest.

**Based on 2008 Medicare utilization.
Better Patient Selection Critical to Future of Renal Stenting

Renal artery stenting finds itself at a critical juncture these days. Despite technical success in about 98 percent of patients, clinical success rates continue to hover at about 70 percent. But just as emerging physiological tools promise to close that gap by improving patient selection, mounting data from flawed clinical studies could undermine the procedure’s future.

Some observers worry that health insurers could yank reimbursement for renal artery stenting based on misleading study findings, a move that would deprive patients of a critical therapeutic tool. To keep that from happening, they say, interventionalists need to demonstrate that renal stenting plus medical therapy is better than medical therapy alone for controlling refractory high blood pressure and other clinical symptoms.

The best way to do that is through more careful patient selection, says Christopher J. White, M.D., FSCAI, chairman of the Department of Cardiovascular Diseases at the Ochsner (continued on page 2)

SCAI Hosts Public Forum on Capitol Hill to Address Health Care Disparities

SCAI hosted a public education program on March 2, 2010, at the House of Representatives in Washington, D.C., to discuss the importance of innovation and examine ethnic, racial, and gender disparities in the current health care system. The event, co-sponsored by the Association of Black Cardiologists (ABC), Mended Hearts, and WomenHeart: The National Coalition for Women with Heart Disease, drew a diverse crowd of more than 100, including staff from the House of Representatives, physicians and other health care providers, patients, and members of the local community.

“With the help of our esteemed faculty and partner organizations, the program was a great success,” said SCAI Trustee and Program Director Mark Turco, M.D., FSCAI. “The timing and location of this well-attended, high-profile event highlighted its relevance to the ongoing health care debate.”

This latest in SCAI’s series of Know What Counts regional education programs included remarks from U.S. Senator Benjamin Cardin (D-MD); presentations and discussion by a panel of health care experts, including area cardiologists Allen J. Taylor, M.D., Ron Waksman, M.D., and Roquell Wyche, M.D.; and testimonials from patients who had suffered myocardial infarction and been treated with (continued on page 4)
“There’s no question that after renal stenting, patients get better. The question is, which patients? We need to educate. We need to make sure that the people who are already stenting learn how to do it better.”

— Christopher J. White, M.D., FSCAI

Clinic in New Orleans. “There’s no question that after renal stenting, patients get better. The question is, which patients?” he says. “We need to educate. We need to make sure that the people who are already stenting learn how to do it better.”

Many believe that poor patient selection is at the heart of why the ASTRAL trial found no benefit to renal artery stenting over medical therapy. Published in the November 12, 2009, issue of the *New England Journal of Medicine*, the study enrolled 806 patients with atherosclerotic renovascular disease, randomizing them to renal artery stenting plus medical therapy, or medical therapy alone. A substantial proportion of patients had renal artery stenoses of less than 70 percent, however, and there was no requirement to determine the hemodynamic significance of the lesions. In addition, the study’s primary endpoint was a change in renal function, a parameter that was unlikely to improve with renal stenting or deteriorate on medical therapy, given that most patients had only unilateral renal artery stenosis.

The ASTRAL trial follows on the heels of the STAR trial, which also found no benefit to renal artery stenting over medical therapy alone. But, as with ASTRAL, design flaws undercut STAR’s findings. The trial not only enrolled patients with moderate stenoses, it allowed the validity of its intention-to-treat analysis to be marred by cross-over in about 30 percent of patients, as had the DRASTIC trial nearly a decade earlier.

Despite the shortcomings of ASTRAL and other trials, some worry that health insurers, particularly the Centers for Medicare and Medicaid Services (CMS), will take away the message that the benefits of renal artery stenting do not outweigh its risks. “It’s another nail in the coffin of renal artery interventions, based on poorly run, poorly designed studies,” says Michael R. Jaff, D.O., an associate professor of medicine at Harvard Medical School and medical director of the vascular center at Massachusetts General Hospital, both in Boston. “It’s terrible for patients. If CMS clamps down on reimbursement, it will make it much more difficult to provide the treatment they need.”

Reshaping the public perception of renal artery stenting will require that interventionalists become more successful in identifying which patients are most likely to experience clinical improvement after stenting. The first step is adherence to strict clinical criteria in selecting patients.

“In the past, if you saw a renal stenosis by angiography, you did stenting. That concept is no longer valid,” says Massoud A. Leesar, M.D., FSCAI, a professor of medicine and director of cardiac and vascular invasive services at the University of Cincinnati. “Selection criteria should be very rigorous.”

Typical clinical indications for renal artery stenting include–

- Refractory hypertension, resistant to optimal medical therapy;
- Sudden deterioration in blood pressure in someone who was previously well-controlled;
- Malignant hypertension;
- Renal failure;
- Azotemia after treatment with an angiotensin-converting-enzyme inhibitor or angiotensin receptor blocker; or
- Recurrent flash pulmonary edema without cardiac cause.

Once patients have met clinical criteria for renal artery stenting, the results of angiography will determine
the next step. Patients with a renal artery stenosis of 70 percent or more are candidates for stenting. Those with moderate lesions (50 to 70 percent stenosis) would benefit from further physiological testing to determine the hemodynamic significance of the lesion. Two promising techniques are fractional flow reserve (FFR) and hyperemic systolic gradient (HSG), both of which are performed using a pressure guidewire after papaverine injection has induced maximal hyperemia.

In a 2007 study published in *Catheterization and Cardiovascular Interventions*, Dr. White and his colleagues studied the predictive power of FFR in 17 patients with unilateral renal artery stenosis and refractory hypertension. They found that 86 percent of those with a renal fractional flow reserve of less than 0.80 showed an improvement in blood pressure at 90 days, as compared to 30 percent of those with a normal renal FFR.

In a separate study published in 2009 in the *Journal of the American College of Cardiology*, Dr. Leesar and his colleagues compared FFR and HSG in 62 patients with renal artery stenosis. They found that an HSG of 21 mm Hg had the highest sensitivity, specificity, and accuracy (82%, 84%, and 84%, respectively) for predicting an improvement in hypertension after stenting.

The next logical step in establishing the role of physiological testing in selecting patients for renal artery stenting would be a large clinical trial. Funding, however, has been hard to come by. The National Institutes of Health, for example, has indicated to Dr. Leesar that it plans to defer further funding decisions until after reviewing the results of the CORAL trial. This study is expected to report initial results in 2011.

Though CORAL is considered better designed than previous renal stenting trials, with a well-defined patient population and meaningful clinical endpoints, it is questionable whether it will provide definitive answers on the value of renal artery stenting. The trial has taken five years to recruit patients, and in the meantime, enrollment criteria have been loosened and some of the original technology has become outdated. Despite these problems, if CORAL, like its predecessors, shows no clinical advantage to renal artery stenting, it’s likely to further imperil support for the procedure.

For now, interventionalists should act on the information that is available and begin to use FFR or HSG on a routine basis to determine which patients with moderate renal artery stenosis should undergo stenting, Drs. White, Leesar, and Jaff agreed. Continuing to rely on angiographic findings alone will inevitably put some patients at unnecessary risk with little chance of clinical improvement.

“Angiography is old technology. We call it the gold standard but it’s not a gold standard,” Dr. Leesar said. “We need to adapt with new technology and new techniques to improve patients’ outcomes.”

Dr. Jaff went a step further. Given the scarcity of funding for a major clinical trial, he suggested that several centers collaborate in setting up a prospective clinical database to track outcomes in patients who have been selected for renal artery stenting using rigorous clinical criteria and physiological testing with FFR and HSG. This relatively low-budget approach might be the only way to collect the data needed to confirm the clinical effectiveness of renal artery stenting in carefully selected patients.
Health Care Disparities  (cont’d from pg 1)

percutaneous coronary interventions. Together, they discussed the challenges of providing affordable quality care to all when faced with considerable inequities.

Innovation and Quality Care

“In 1960, 30 to 40 percent of the people who had heart attacks died within days,” said Dr. Turco. “Today, because we’ve invested in innovation and technology, 94 percent of heart attack patients will survive. It’s a testament to innovation that, minutes after a heart attack, the arteries are opened and the patient feels well enough to want to go home. The issue we need to deal with in this country is that such innovation comes at a cost to the health care system. Physician specialists need to work closely with our legislative colleagues to find some common ground so we can continue to advance our field and health care in this country.”

Bruce Johnson, a journalist from WUSA News (Channel 9) in Washington, D.C., witnessed the benefits of technology first hand when he watched his own angioplasty. “It’s one thing to admit you’re a patient of cardiac disease, it’s another thing to accept it. My heart attack taught me it can happen to any of us.”

WomenHeart Champion Carrie Vincent learned from her experience that coronary artery disease strikes women, too. “I was having the best day ever. I had just gotten home after having my son when I experienced a tidal wave of bad energy. Something wasn’t right.” Emergency angioplasty saved her life. “I think I almost died,” she said. “Who has a heart attack at 31?”

Dr. Turco quoted Harvard economist David Cutler, Ph.D.: “Where we have spent a lot, we have received a lot in return,” and then added, “The cost of these life-saving treatments may be ten times more than they were 50 years ago, but if we look back to where we were in the 1960s, to where we are, with so many more

Society CME Program Attracts D.C. Area Health Care Professionals

SCAI welcomed more than 50 area health care providers to a continuing medical education program in Washington, D.C., on March 2, to examine innovation and disparities in health care. “It was an evening of thought-provoking and lively discussion,” said SCAI Trustee and Program Director Mark Turco, M.D., FSCAI.

The program, co-directed by Allen J. Taylor, M.D., Ron Waksman, M.D., and Marcos Pesquera, MPH, and cosponsored by ABC, Mended Hearts, and WomenHeart, featured an esteemed faculty of area cardiologists and health care experts as well as presentations by Kenneth M. Kent, M.D., FSCAI, NHLBI Clinical Medical Officer Nakela Cook, MPH, M.D., Andrew M. Farb, M.D., of the U.S. Food and Drug Administration, and WomenHeart Champion Marianne Lawrence.

“The history of the current emphasis on heart disease and ways to treat it really began 50 years ago,” explained Dr. Kent. Over time it has evolved from treating patients with six months of bed rest to life-saving innovations and technologies such as using cell phones to activate cath labs. “The wider we can spread our knowledge about the progress of treating heart disease, the better,” said Dr. Kent. Marianne Lawrence was lucky enough to benefit from that innovation and technology. “I’m grateful for my five successful stents,” she said. Without them she might never have achieved her dream of climbing in the Himalayas.

But not everyone is as fortunate as Ms. Lawrence, emphasized Dr. Turco. Health care inequities prevent many from accessing the tools for prevention or the treatment they need—a problem NHLBI has studied for some time and is beginning to address more actively.

“The NHLBI is moving toward not just describing that disparities exist but where can we target areas to identify and intervene,” explained Dr. Cook. “If we start backwards at the patient’s health and work our way to areas of potential intervention, we see that they’re quite numbered.”

“I think everyone, including our expert panel, learned something that they can take back to their practices and anywhere else they care for patients,” said Dr. Turco, “even if it is only a better awareness of the challenges ahead as we work our way through the health care reform process.”
effective treatment options available, you can see that we have received a lot in return on our investment.”

Dr. Taylor pointed out advances in imaging as another example of the tremendous progress today’s patients benefit from. “It only takes 30 to 45 minutes of testing to fully diagnose your conditions. Whether you’re a patient, a payor, or legislator—one day you’ll be a patient and these are tools that all of us need to use daily for optimal cardiovascular diagnosis.”

Equal Access to Health and Health Care
The panel agreed that achieving optimal quality care also requires changes in how patients access the health care system. “If our goal in Congress is to expand insurance coverage, contain rising health care costs, and improve the overall quality of care, we can’t get there if we’re not attending to disparities by making equity a key goal of the legislation,” said Brian Smedley, Ph.D., Vice President and Director of the Health Policy Institute Joint Center for Political and Economic Studies.

Marcos Pesquera, MPH, Executive Director of the Center for Health Care Disparity and longtime bilingual health care provider, cited Institute of Medicine reports supporting Dr. Smedley’s message: “We are not providing the same care to everyone. Racial and ethnic minorities tend to receive a lower quality of health care than non-minorities, even when access-related factors, such as patient insurance, status, and income, are controlled,” he explained.

In his 30-year career as a Washington, DC, journalist, Mr. Johnson has seen this scenario play out time and time again, impacting health care in ways physicians may not consider. “Let’s say I live in a housing project where I’m at risk if I come home from work and want to walk for three miles,” said Mr. Johnson. “Which direction do you suppose I go—toward the drug dealers, the gunshots, or the highway?”

Dr. Smedley’s hometown provided yet another example. “There is not one grocery store within the city limits of Detroit. People are struggling to stay alive, and they can’t get healthy food. We have more and better resources in the healthiest communities, and we have the least and poorer quality resources in our most vulnerable communities.”

In many communities, trust is also in short supply, explained Mr. Pesquera. “Racial and ethnic minority patients are more likely than white patients to refuse treatment. We are having difficulty connecting and building trust. When I know that someone truly cares about me, I’m going to do what they ask,” he said. “We need to put our resources into building that trust so people will go home and do what they’re supposed to do.”

“Look Forward Now”
“Racial and ethnic health and health care inequities are deep and persistent, and they persist to the detriment of all of us,” asserted Dr. Smedley. “Thirty years from now, half the people in the U.S. will be people of color. If our health care systems are not prepared to meet that demographic challenge, we’re going to experience far greater problems in our health care systems than what we see today. We must look forward now.”

The same is true for prevention, he added. “Every $10 per person invested in prevention in the next five years would save us $16 billion on the backend,” said Dr. Smedley, echoing an earlier remark by Senator Cardin, who said, “By keeping the focus on wellness, we can save a lot of money and a lot of lives.”

“And, when patients do need treatment,” added Dr. Turco, “they need equal access to innovative quality care—in some cases, specialty care.” In our efforts to “reform” health care, he stressed, we have to ask ourselves questions not just about the cost of individual treatments and technologies, but “something very fundamental, namely: What is the cost of survival?”

SCAI Thanks ...
SCAI has undertaken the Know What Counts public education initiative with its own resources as well as support from Abbott Vascular and Medtronic CardioVascular. The Society gratefully acknowledges this support while taking sole responsibility for all content developed and disseminated through the effort.

Visit www.scai.org and www.seconds-count.org for video coverage from both events.

For more information about SCAI’s Know What Counts programs, contact Kathy Boyd David at kbdavid@scai.org.
More than two dozen regional and national cardiology societies from countries in Latin America, Asia, Africa, Europe, and the Middle East are cosponsoring SCAI’s Global Interventional Summit.

The Summit, the result of collaboration between SCAI and the Turkish Society of Cardiology, will be held Oct. 22–24, 2010, in Istanbul. Symbolized by the host city, which straddles Europe and Asia, the event’s goal is to improve patient care worldwide by bridging the gaps that often limit the dissemination of state-of-the-art knowledge in cardiovascular care.

“Instead of everybody coming to a SCAI meeting in the United States, we thought let’s bring a meeting to them,” explains SCAI Past President and GIS Program Chair Ziyad M. Hijazi, M.D., MPH, FSCAI, of Rush University Medical Center in Chicago. “We want to enhance collaboration between physicians in the U.S. and international physicians. We'll all share our knowledge and experiences with each other.”

Dr. Hijazi will co-chair the Summit with SCAI Past President Ted Feldman, M.D., FSCAI, of NorthShore University Health System in Chicago; Turkish Society of Cardiology President Oktay Ergene, M.D., FSCAI, of Izmir Ataturk Education and Research Hospital; and Levent Saltik, M.D., FSCAI, of Istanbul University Cerrahpaşa Medical School.

The Turkish Society of Cardiology will host the Summit, which will be held in conjunction with its own National Congress. In addition to allowing the two groups to share meeting infrastructure and save costs, says Dr. Hijazi, scheduling the two events at the same time and place will allow participants in the Turkish Society’s meeting to attend the Summit as well and further the goal of collaboration.

Even before the Summit begins, says Dr. Hijazi, it’s already achieving its goal of enhanced international collaboration. He points to the brand-new relationships SCAI has forged with some of the event’s cosponsors, such as the Gulf Heart Association and Saudi Arabia Cardiology Interventional Group as well as the societies from Eastern Europe.

An Exchange of Ideas

The three-day Global Interventional Summit will cover the latest advances in interventional therapies for coronary, peripheral, congenital, and structural heart disease. The program is divided into three tracks: sessions for adult cardiologists, sessions aimed at pediatric/congenital heart disease cardiologists, and sessions that will appeal to both groups.

The extensive program will feature lectures, case presentations, and collaborative question-and-answer sessions on both basic and cutting-edge topics.

“Most of the talks will be delivered by speakers from other countries,” says Dr. Hijazi. In addition, the event will feature live cases transmitted from hospitals in Istanbul, with host operators and guest operators from the various cardiology societies.

Any cardiologist who takes care of patients with coronary, peripheral, congenital, or structural heart
disease should find this meeting of great relevance to their practice, says Dr. Hijazi. “The meeting will appeal to a broad spectrum of physicians, whether they’re interventional cardiologists, cardiac surgeons, echocardiographers, or even general internists who want to get the latest information on the technologies that are available for patients,” he explains, adding that the program will be a learning experience for the whole cardiac catheterization care team, including technologists, nurses, and interventional radiologists.

Of course, says Dr. Hijazi, participants will also want to leave some time to explore Istanbul. It wasn’t just Turkey’s prime location and lack of travel restrictions that convinced SCAI to hold the Summit there, says Dr. Hijazi. “Visitors who might have a hard time getting a visa to the U.S. should have no problems visiting Turkey, and Istanbul is a city rich with history. Everyone should experience it!”

For more information or to register for the Global Interventional Summit, visit www.SCAI.org.

Global Interventional Summit Sponsoring Societies*

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<td>Sweden: Swedish Working Group on Interventional Cardiology</td>
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<td>Tunisia: Working Group on Interventional Cardiology of the Tunisian Society of Cardiology and Cardiovascular Surgery</td>
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<td>Turkey: Working Group on Invasive Cardiology</td>
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<td>United Arab Emirates: Gulf Heart Association</td>
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<td>United Kingdom: British Cardiovascular Interventional Society (BCIS) and British Congenital Cardiac Association</td>
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<td>United States: SCAI</td>
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* As of May 2010.
New Charge, New Approach: SCAI’s Publications Committee Invites More Members to Influence Guidelines and Practice

When the Publications Committee redefined its focus early this year, it created many new and exciting opportunities for early-career and seasoned members to become directly involved in setting standards for the profession.

“A goal of SCAI’s Publications Committee is to enable our members to have more proactive roles in initiating and shaping the content of clinical and scientific documents that influence practice,” says Issam Moussa, M.D., FSCAI, the new chair of the Publications Committee and member of the NCDR CathPCI Registry Steering and Research and Publications Committees.

To facilitate member involvement in generating the Society’s official clinical and scientific documents, the committee has adopted a streamlined structure and process. Dr. Moussa explains: “What began as a mandate to operate more efficiently evolved into a formal, centralized process for prioritizing and generating SCAI’s scientific documents, eliminating redundant efforts, and involving a broader representation of the Society in the Publications Committee.”

The committee encourages members to promote optimal patient care by proposing research projects, writing the Society’s clinical documents, and participating in SCAI representative and peer review opportunities inside and outside of SCAI.

“As representatives of interventional cardiologists both in the U.S. and abroad, the development of these important documents must be a core role of the Society,” says Dr. Moussa.

Opening Channels of Communication

The reconstituted Publications Committee, led by Dr. Moussa and Co-chair Morton J. Kern, M.D., FSCAI, is composed of representatives from each of the other SCAI committees as well as the Editors-in-Chief of Catheterization and Cardiovascular Interventions and SCAI News & Highlights, and SCAI’s representatives on the National Cardiovascular Data Registry (NCDR) Committee. Members serve two-year terms that are staggered to ensure accountability and continuity, adds Dr. Moussa.

“With the new structure, the meetings are open only to committee members,” continues Dr. Moussa, “but the activities and production of the Publications Committee, including peer review and participation in writing groups, are open to the members of SCAI at large.”

Representatives from the other SCAI committees participate in the meetings to prevent duplication of efforts. “Every idea for writing a document will come to the Publications Committee first to avoid the overlap of ideas,” says Dr. Moussa. “The involvement of other committees also serves to improve communication and help the Society prioritize projects based on need.”

The new structure also facilitates collaboration with other organizations, including NCDR. “It is
very important to keep the lines of communication open between SCAI and the NCDR committees,” says Dr. Moussa. “Our hope is that by having a formal mechanism to periodically follow up and discuss the activities of each registry, we will involve more members in proposing research projects.”

SCAI is a full partner in the CathPCI, CARE, and IMPACT Registries.

Navigating the Process

The committee has also formalized its process for facilitating the development, peer review, approval, and publishing of new scientific statements, science advisories, guidelines, focused updates, appropriate use criteria, clinical alerts, and consensus statements, before their endorsement by SCAI.

First, the submitting SCAI member, either individually or with the help of the supporting SCAI committee, must complete and submit a request form for review by the Publications Committee on the first Monday of each month. “Ideas can come from an individual member or any SCAI committee,” says Dr. Moussa.

Then, the Publications Committee decides if there is an actual need that other entities, either within SCAI or externally, are not already addressing. If approved, the writing committee chairs for that document, who may or may not include the submitter, develop an outline and work with SCAI staff to write the document during the coming year.

“The new process has already started,” says Dr. Moussa, “but we need more involvement from members for peer review of documents and writing groups so we can always deliver what is asked of us.”

Three of the initiatives already underway are a consensus statement from the WIN Committee on radiation exposure to pregnant cardiologists and technologists, a consensus statement on transradial catheterization and PCI, and a consensus statement on PCI staging.

Offering Your Expertise

“This is a tremendous opportunity for members interested in becoming more involved in SCAI and shaping the future of interventional cardiology,” says Dr. Moussa. “We need qualified members to propose original ideas and write scientific statements and other documents to meet the current knowledge gaps in our field.”

The committee encourages early-career members to volunteer. “Peer review is an excellent initial introduction to the process of writing documents,” continues Dr. Moussa. “It is a first step to more involvement in future writing activities and an opportunity to influence the policy and practice of interventional cardiology.”

Important, members who have had no relationship with industry for 12 months and have a strong publications history have the highest chance of being selected to serve on a writing committee. If you are interested in peer review, joining a writing committee, or submitting a request to develop a clinical document, e-mail Joel C. Harder, Director of Clinical Guidelines & Quality Initiatives, at jharder@scai.org, to learn more.

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**Job seekers, benefit from:**
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- Access to qualified candidates: Email about job seekers matching your posted positions.
- The right price: Comprehensive and competitive pricing
- And much more!

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Healthcare Reform Law

**2009**
- Bars insurers from denying people coverage when they get sick.
- Bars insurers from denying coverage to children who have preexisting conditions.
- Bars insurers from imposing lifetime caps on coverage.
- Requires insurers to allow young people to stay on their parents’ policies until age 26.
- Requires health insurers to annually report medical loss ratios.
- Requires non-profit BCBSs have a medical loss ratio of 85% or higher or lose non-profit status.

- Medicare increase to PCPs in rural areas (2 years)
- Medicare cuts to inpatient psychiatric hospitals.
- Modifies the physician PE: GPCI
- Additional changes to the misvalued physician services.
- Provides Secretary with the authority to publicly report hospital acquired conditions.
- Provides Secretary with the authority to establish medical reimbursement data centers.
- Market basket update reductions go into effect for long-term care and rehabilitation facilities.
- Establishes the Patient-Centered Outcomes Research Institute.
- Establishes Commission to study aligning health care workforce resources with national needs.

- Provides access to high-risk pools uninsured with preexisting conditions.
- Creates a temporary reinsurance program for retirees.
- Provides a $250 rebate to Medicare Rx plan beneficiaries whose initial benefits run out.

- Tax on indoor tanning services begins (July 1)
- FDA authorized to approve “follow on” biologies.

**2010**
- Requires most plans to provide first dollar coverage for preventive services.
- Requires small insurers to spend 80% of premiums on medical services; large insurers 85%.
- Provides a 10% Medicare bonus payment for PCPs and general surgeons.
- New imaging standards; increases the PE for imaging services.
- Additional restrictions regarding MD self-referral.
- Establishes a GME policy allowing unused training slots to be re-distributed for purposes of increasing primary care.
- Medicare cuts to long-term hospitals.
- Medicare cuts to nursing homes and inpatient rehabilitation hospitals.
- Medicare cuts begin to ambulances, services, ASCs, diagnostic labs, and DME.

- Provides a two-year temporary credit for investments in new therapies to prevent, diagnose, and treat acute and chronic diseases.
- Americans begin paying premiums for federal long-term care insurance.
- Requires employers to disclose the value of the benefit provided by the employer for employee’s health insurance coverage on the employee’s W-2.
- Establishes a new Center for Medicare & Medicaid Innovation at CMS.
- Imposes an annual fee on manufacturers and importers of branded drugs.
- Raises the penalty for non-compliant health savings account withdrawals to 20%.
- Changes the definition of medical expenses for FSAs and health savings

**2011**
- Limit deductible companies
- Health insurers
- Health plans
- Establishes a post-acute care center.
- New requirement to report transactional group practices.
- Increases the tax on the unearned income of $250,000.
- Limits health benefits.
- Raises the cut off age of 65.
- Imposes a tax.
- Eliminates dual.

**2012**
- Encourage MDs to join together to “accountable care organizations” efficiencies and improve quality.
- Establishes a hospital value-based purchasing program for acute care facilities.
- Directs CMS to track hospital readmissions rates for certain conditions and associated payment penalties.
- Secretary submits proposal for a neutral value-based MD pay-for-performance program.
- Secretary establishes new Medicare website for Medicare beneficiaries.
- Medicare cuts to hospice.
- Medicare cuts to dialysis treatments.
- Medicare cuts to academic medical centers.
- Medicare cuts to graduate medical education.
- Medicare cuts to long-term care.
- Medicare cuts to physician assistants.
- Medicare cuts to teaching hospitals.
- Medicare cuts to other post-acute care.
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Law Timeline

- Establishes the Independent Payment Advisory Board.
- Reduces hospital DSH payments.
- Budget neutral value-based modifier for MD payment goes into effect.
- MD payments are decreased by 1.5% for not reporting to PQRI (2% for subsequent years).
- Medicare cuts to home health.
- Expands health insurance coverage to 32 million people.

- Institutes limitations on pre-existing conditions, rating rules.
- Imposes an annual fee on health insurance providers.
- Requires long-term care hospitals, inpatient rehab, PPS-exempt cancer hospitals and hospice providers to implement quality measure reporting.
- Health insurance exchanges, co-ops, and multi-State plan options are established.
- Provides subsidies for families earning up to 400% of the poverty level.
- Requires most employers to provide coverage or face penalties.
- Requires most people to obtain coverage or face penalties.
- Medicaid eligibility will increase to 133% of poverty level.
- Continues the second phase of the small business tax credit for qualified small employers.

- Excise tax on manufacturers and importers of certain medical devices.
- Reductions for expenses allocable to Medicare Part D subsidy.
- Medicare payroll tax and expands it to dividend, interest and other income for singles earning more than $200K and joint filers making more than $250,000 flexible savings accounts to $2500 current 7.5% floor for itemized medical expenses to 10% for those under the

2013 2014 2015 2018 2019
SCAI’s First Fellows Course in Asia Heralded as a Success

More than 230 physicians from India and surrounding countries convened Feb. 24–25, 2010, in New Delhi at the first “SCAI Fellows Course – Asia” for a rigorous two-day curriculum based on SCAI’s popular Fall Fellows program. The course connected internationally recognized faculty with both fellow-in-training and practicing physician attendees. This program, held in partnership with Escorts Heart Institute and Research Centre and led by Course Directors Ashok Seth, M.D., FSCAI, and Michael Cowley, M.D., FSCAI, marked the first time the SCAI Fall Fellows program has been conducted outside of the United States.

“This course fills a critical void in physician education,” said SCAI President Steven R. Bailey, M.D., FSCAI. “We are grateful to Dr. Seth for his vision and for his leadership in making the program a reality.”

“The SCAI Fall Fellows course has enjoyed enormous popularity in the United States, and offering the same curriculum to up-and-coming interventionalists in India and Asia Pacific ensures that SCAI can train as many physicians as possible. Not every physician can travel to the Fall Fellows course in Las Vegas, but when it is offered closer to home it opens this truly beneficial opportunity to many people,” said Dr. Seth, who is chairman and chief cardiologist at Escorts Heart Institute and Research Centre. “This is a unique opportunity for doctors planning to work as interventional cardiologists to learn from the best-of-the-best in the field.”

“SCAI Fellows Course – Asia” featured case-based content as well as core didactic education designed to enhance the participants’ knowledge of techniques and expected outcomes for a variety of interventional cardiac, carotid, and endovascular procedures. Attendees also participated in simulator workshops and enjoyed hands-on sessions that supplemented the curriculum.

“This course has a great personalized format,” said Dr. Cowley. “This is the largest medical simulation training program in India, and the physicians really appreciated the exposure to state-of-the-art technology in a small group setting.”

To honor the physicians who successfully completed the course, faculty and attendees were treated to a special ceremony during which participants received affiliate membership in SCAI, including access to benefits that will encourage continued education to supplement the course content.

“A real highlight for all physicians is SCAI membership,” said Dr. Seth. “SCAI provides strong benefits and opportunities for interventional cardiologists, and these new members are eager to grow and learn within the Society.”

“The success of the SCAI Fellows Course in India gives rise to numerous partnership opportunities around the world,” added Dr. Bailey. “This is an excellent model SCAI and other organizations can emulate to provide outstanding educational content to physicians interested in improving their interventional skills and outcomes. SCAI is fortunate to be a partner in offering such an important program.”

For more information about the SCAI Fellows Course – Asia, visit www.SCAI.org.
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BIGGER, Faster, EASIER-TO-USE & Still FREE!

Interventional Cardiologists Institute &
Interventional Fellows Institute

Comprehensive eLearning experiences

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ICI – Interventional Cardiologists Institute
www.InterventionalCardiologistsInstitute.com

IFI – Interventional Fellows Institute
www.InterventionalFellowsInstitute.com
SCAI Announces Winners of 2010–11 Interventional Cardiology Fellows-In-Training Grants

This spring, SCAI awarded Interventional Cardiology Fellows-in-Training grants to 46 Accreditation Council for Graduate Medical Education–accredited training programs. This marks the third year the Society has administered grants to support the training of fourth-year interventional cardiology fellows. Grants for four of this year’s award recipients are designated to support their structural, peripheral, or vascular training programs, allowing their fellows to further specialize.

SCAI received applications from more than 65 programs, making this year’s selection process the most competitive to date. “The FIT Committee found the overall caliber of the applications to be excellent, reflecting the dedicated work of interventional cardiology program directors around the nation. This speaks well to the educational offerings provided to trainees,” said Joseph D. Babb, M.D., FSCAI, who chairs the committee responsible for reviewing the applications and selecting the programs that will receive grants. Also serving on the committee are Barry Uretsky, M.D., FSCAI, Morton J. Kern, M.D., FSCAI, Michael Lim, M.D., FSCAI, and Karen Smith, M.D., FSCAI.

Most training programs are in need of funding to enable fellows to complete an additional year of training, to support fellows’ travel to educational meetings, and to provide resources for teaching the most relevant training methods, explained Dr. Babb.

“Our program is community-based and not supported through academic ties,” commented a training director whose program has received an SCAI FIT Grant in past years. “Because of the current overhaul of health care reform, support from the SCAI grant is more important than ever.”

In a recent survey of past grant recipients, one program director emphasized the value of the SCAI

The Society congratulates the following 2010–11 grant recipients:

Baystate Medical Education & Research Foundation, Inc.
Borgess Heart Institute, Borgess Medical Center
Brigham & Women’s Hospital
Brown University Program, Rhode Island Hospital
Case Western Reserve University
Cleveland Clinic Foundation
Columbia Presbyterian Medical Center
Duke University Hospital
Emory University Hospital
George Washington University Hospital
Georgetown University Hospital/Washington Hospital Center Program
Indiana University School of Medicine Program
Johns Hopkins University Program
Loyola University Medical Center
Massachusetts General Hospital
Mt. Sinai School of Medicine
New York Presbyterian Hospital (Cornell Campus) Program
Northwestern University Feinberg School of Medicine
Ochsner Clinic Foundation
Rush University Medical Center
Scripps Clinic
St. Louis University School of Medicine Program
St. Luke’s Mid America Heart Inst
Stanford University Medical Center
Tufts-New England Medical Center
UCLA Medical Center
University of California Davis
University of California (San Diego) Program
University of California (San Francisco)
University of Florida
University of Kansas
University of Kentucky at Lexington College of Medicine
University of Minnesota
University of North Carolina Hospitals
University of Pittsburgh Medical Center
Medical Education Program
University of Rochester
University of Texas Health Sciences Center at San Antonio
University of Toledo
University of Vermont Program
Vanderbilt University Medical Center
Virginia Commonwealth University Medical Center
Wake Forest University School of Medicine Program
Washington University School of Medicine
Westchester Medical Center
William Beaumont Hospital
Yale-New Haven Medical Center
FIT Grants for his program’s trainees: “Not receiving funds from SCAI could result in the loss of one or both of our interventional fellowship spots,” he said.

It was a sentiment echoed by many of the program directors who completed the survey. Were it not for grants like these, noted many, advanced interventional cardiology training would not be possible at many institutions, and the result would be a severe deficit of young interventionalists entering the field.

The SCAI FIT Grants are awarded to training programs, but their impact is on individual doctors who will comprise the next generation of interventional cardiologists and physician-scientists, noted Immad Sadiq, M.D., FSCAI, who is now the interventional cardiology program director at Brown University in Providence, RI. “As an interventional fellow, I had minimal opportunity to get vascular/endovascular training. I went ahead and did an extra year of vascular/endovascular fellowship, which was made possible by grants such as the FIT grant from SCAI. Now, thanks to the SCAI/FIT program, I have the opportunity to direct an advanced 12-month vascular/endovascular fellowship, contributing to the training of future interventional cardiologists.”

Applications for the SCAI/FIT Grant for 2011–12 will be accepted this fall. Contact Laura Brown at lbrown@scai.org for more information.

SCAI Past President to Serve on FDA Panel

SCAI Past President Gregory J. Dehmer, M.D., FSCAI, was recently appointed to the Circulatory System Devices Panel of the U.S. Food and Drug Administration’s (FDA) Medical Devices Advisory Committee.

He was nominated by the Society to serve on the advisory panel, which evaluates data on the safety and effectiveness of devices used in the circulatory system, data on devices that are being considered for approval by the FDA, and new data on devices that have been previously approved for use.

“We strive to provide impartial advice to FDA about the science behind these devices and whether the devices should be approved for use,” explains Dr. Dehmer, who is director of the Cardiology Division at Scott & White Clinic and a professor of medicine at Texas A&M School of Medicine, in Temple, TX.

When a device comes up for review, FDA selects from its pool of consultants individuals who have the needed expertise, are available, and lack financial conflicts of interest. The consultants then gather near FDA’s headquarters in Maryland for a day or two of meetings. At press time, Dr. Dehmer had not yet been called to evaluate a device.

A History of Participation

This isn’t the first time that Dr. Dehmer has been involved with the Circulatory System Devices Panel. In 2006, he helped develop testimony and delivered it to the panel during the time of heightened concern about thrombosis related to drug-eluting stents.

“That was a very challenging time in the history of stents,” remembers Dr. Dehmer, who joined many other experts in testifying before the FDA.

The experience helped spark Dr. Dehmer’s interest in a more extended relationship with the panel. “It was just the importance of the whole process and being able to evaluate the data fairly and objectively,” he says. “I view it as a real honor to have been selected to participate in this work.”

In addition to his work with the FDA panel, Dr. Dehmer also serves as a member of the Medicare Evidence Development and Coverage Advisory Committee. That committee provides independent guidance and expert advice on specific clinical topics to the U.S. Centers for Medicare and Medicaid Services.

Dr. Dehmer predicts that the FDA’s Circulatory System Devices Panel will have a busy agenda in the coming years. “There are some important devices that are coming along,” he says, citing as examples percutaneous heart valves and expanded indications for carotid artery stenting.

“There have been huge advances in many therapies,” says Dr. Dehmer. “It’s very important to have experts on panels who can critically evaluate new devices as they come along.”
Q: My hospital coder tells me that intravascular ultrasound (IVUS), intracardiac echocardiography (ICE), and fractional flow reserve (FFR) are considered bundled services and are not separately reportable? Why can’t I report and get paid for these additional services when I perform them?

A: While these services are considered bundled and not separately payable under the hospitals’ payment systems, they are separately reportable and payable under the Medicare Physician Fee Schedule and you should be reporting these services when performed.

The IVUS, ICE, and FFR CPT codes are:

+ 37250 Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel
+ 37251 Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; each additional vessel
+ 92978 Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention, including imaging supervision, interpretation and report; initial vessel
+ 93572 Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography, including pharmacologically induced stress, initial vessel
+ 93571 Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography, including pharmacologically induced stress, each additional vessel

While physicians have an obvious incentive to accurately report these services, which supports separate payment to the physician when clinical indication supports their performance, it is imperative that the hospital continues to report these services even though the payment to the hospital for these services is “packaged/bundled” into another procedure.

The Centers for Medicare and Medicaid Services (CMS) has been trending toward the bundling/packaging of services for all Medicare payment
systems. New “bundled” diagnostic cardiac catheterization CPT codes will be announced in 2011.

In 2008, CMS elected to bundle IVUS, ICE, and FFR under the HOPPS (Hospital Outpatient Prospective Payment System) APC (Ambulatory Payment Classification) payment system, despite the advisement of the CMS expert APC Panel and comments submitted by SCAI opposing the bundling of these services at that time. It is imperative that hospitals continue to report all services and the associated costs for “bundled”/“packaged” services despite not receiving separate payment.

The directive from CMS regarding the continued reporting of these services can be found in the 2008 HOPPS final rule, Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2008 Payment Rates at http://www.cms.hhs.gov/quarterlyproviderupdates/downloads/cms1392fc.pdf.

An excerpt from the 2008 Final Rule (pages 66634-66635 of the Medicare Program: Changes to the Hospital Outpatient Prospective Payment System and CY 2008 Payment Rates) provides clear instruction that hospitals should continue to report these services despite no longer receiving direct, separate payment for them:

“The reporting of packaged services will not result in more multiple procedure claims because the packaged service, which has a status indicator of “N” for data purposes, unless it is changed to be separately paid, will not by itself cause a claim to be viewed as a multiple major procedure claim. Moreover, if packaged services and their charges are not reported, the payment for the services into which their cost is packaged may be understated. Therefore, it is important that hospitals report all services furnished and the associated charges.”

Thus, not reporting these bundled services and associated costs can and will have a dramatic negative impact on future payment rates. ■

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**ASPIRATION THROMBECTOMY DURING PRIMARY PCI**

*Is A Large Multicenter Trial Possible?*

Use of aspiration thrombectomy during primary PCI has grown after the publication of the TAPAS trial. We are in the planning phase of a large multicenter randomized trial to examine this question, powered for clinical outcomes. To help us determine the feasibility of such a trial in the post TAPAS era, please click on the following survey link:

http://www.surveymonkey.com/s/thrombectomy

The brief survey should take less than 5 minutes to complete and thank you for your help.

Sanjit Jolly MD, MSc, FRCP(C)
Interventional Cardiologist,
McMaster University,
Hamilton, Canada
On Behalf of TOTAL trial steering committee

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SCAI’s Redesigned Web Sites Feature New Content, Enhanced Navigation

Streamlined navigation, new content, and better customer service: Those are just a few of the improvements revealed when the Society recently relaunched new versions of its main Web site (www.scai.org) and its patient information site, Seconds-Count (www.seconds-count.org).

“As with all technology, every few years you have to take a look at things and ask yourself how you can do things better,” says Bonnie Weiner, M.D., MSEC, MBA, FSCAI, eSCAI Committee chair and a past president of the Society. “Plus, the Society has grown significantly, and there was a need to reflect the breadth of SCAI activities and member interests.”

The Society’s new site is sleeker and easier to navigate. “You don’t end up having to scroll down the pages anymore,” says Dr. Weiner. “And it’s easier to find the places that you want to go.”

Whether users are SCAI members, fellows-in-training, other health care providers, journalists, or patients, they’ll now find the information they need with just one click in the “SCAI Network” box on the homepage. “The goal is for the site to be the go-to place for information about interventional cardiology,” says Dr. Weiner.

The Society’s other sites — Seconds-Count.org and the SCAI e-Learning Library — are now more clearly integrated into the main site.

Additions to SCAI.org include dedicated landing pages for the following interest areas:

• International Efforts, to recognize the Society’s burgeoning partnerships and ventures outside of the United States;
• Fellows and Early-Career Interventionalists, including a new Job Bank and career-advancement tools; and
• Guidelines and Publications, highlighting the latest studies appearing in Catheterization and Cardiovascular Interventions as well as guidelines of relevance to members.

In recognition of SCAI’s growing international connections, there’s also a new “International” navigational tab. Designed to grow and support international connections, this new section allows users in the United States and abroad see what’s happening in interventional cardiology around the world.

Behind the scenes, the new site also helps SCAI provide enhanced customer service. It’s now easier for staff to track members’ online education activities, manage dues, and handle other services for members.

The plan is to eventually personalize the home page. “Just like Amazon.com knows what you’ve been shopping for and presents you with things you’re interested in, we’ll be able to present to individual users the things they’re most interested in,” says Dr. Weiner, citing advocacy and congenital heart disease as two examples. “It will be a much more personal experience.”

A New Look for Seconds-Count.org

SCAI’s patient education site, Seconds-Count.org, has also been redesigned.

“Our goal all along has been to give patients and families a first-class Web site for credible information they can use to guide discussions with their health care providers,” says Editor-in-Chief J. Jeffrey Marshall, M.D., FSCAI.

In keeping with that goal, the site now focuses exclusively on patients and their families, with information for health care professionals moved to SCAI’s main site. Plus, SCAI is rewriting all of the content on Seconds-Count.org with patients and families in mind.

In addition to streamlining the site’s navigation, SCAI has also added a great deal of new content. A whole new section, for example, focuses on women and heart disease. There are new animations, videos, and many new patient stories. And there’s new information about cardiac rehabilitation, thanks to a new collaboration with the American Association of Cardiovascular and Pulmonary Rehabilitation. “Other societies have expertise in areas that we’re not experts in,” Dr. Marshall explains.

The site will keep evolving, says Dr. Marshall. “I hope all of our members will take a minute to check out the new site, and I encourage them to point their patients to the site. We want our patients to be informed and educated about their medical condition and their treatment options,” he says. “Seconds-Count.org is an excellent resource to help them get there.”
SCAI-Sponsored Programs

**Global Interventional Summit, in Collaboration with the Turkish Society of Cardiology**
- **Date:** Oct. 22–24, 2010
- **Location:** Istanbul, Turkey
- **Directors:** Ziyad M. Hijazi, M.D., MPH, FSCAI, Ted Feldman, M.D., FSCAI, Oktay Ergene, M.D., FSCAI, FESC, and L. Saltik, M.D., FSCAI
- For more info: [www.scai.org/GIS](http://www.scai.org/GIS)

**SCAI 2011**
- **Date:** May 4–7, 2011
- **Location:** Baltimore, MD
- **Directors:** James B. Hermiller, M.D., FSCAI, Christopher J. White, M.D., FSCAI, Frank F. Ing, M.D., FSCAI, and Daniel S. Levi, M.D., FSCAI
- For more info: [www.scai.org](http://www.scai.org)

Jointly Sponsored with SCAI

**PICS & AICS 2010 - Pediatric & Adult Interventional Cardiac Symposium**
- **Date:** July 18–21, 2010
- **Sponsor:** The PICS Foundation in Collaboration and Rush Center For Congenital & Structural Heart Disease
- **Location:** Chicago, IL
- **Directors:** Ziyad M. Hijazi, M.D., MPH, FSCAI, William E. Hellenbrand, M.D., FSCAI, John P. Cheatham, M.D., and Carlos Pedra, M.D.
- For more info: [www.picsymposium.com](http://www.picsymposium.com)

**Global Endovascular Complications Seminar**
- **Date:** Aug. 22–25, 2010
- **Sponsor:** Strategic Medical Seminars LLC
- **Location:** Jackson Hole, WY
- **Director:** L. Nelson Hopkins, M.D.

**Cardiology Fiesta**
- **Date:** Sept. 8–10, 2010
- **Sponsor:** University of Texas Health Sciences Center at San Antonio
- **Location:** San Antonio, TX
- **Directors:** Steven R. Bailey, M.D., FSCAI, John M. Erikson, M.D., and William Wu, M.D.
- For more info: [www.cardiologyfiesta.com](http://www.cardiologyfiesta.com)

**International Society of Advanced Level Medical Imaging Physician Specialists Cardiovascular Medical Simulation Enhancement Training and Certification Conference (ISMIPS)**
- **Date:** June 2–5, 2010
- **Sponsor:** International Society of Advanced Level Medical Imaging Physician Specialists
- **Location:** New Orleans, LA
- **Directors:** Jack Chen, M.D., Charles Williams, BS, RPA, RCIS, RT R, CV CI, Manuel Viamonte, Jr., M.D., and Neil E. Holtz, BS, RCIS, EMT-P
- For more info: [www.ismipsi.com](http://www.ismipsi.com)

**13th Annual Live Symposium of Complex Coronary and Vascular Cases**
- **Date:** June 17–20, 2010
- **Sponsor:** Mount Sinai School of Medicine
- **Location:** New York, NY
- **Director:** Samin K. Sharma, M.D., FSCAI
- For more info: [www.cccSYMposium.org](http://www.cccSYMposium.org)

**Essentials of Transradial Angiography and Intervention**
- **Date:** July 15–16, 2010
- **Sponsor:** Duke University
- **Location:** Durham, NC
- **Directors:** Sunil Rao, M.D., FSCAI, and Mitchel Krucoff, M.D.
- For more info: [http://www.dcri.duke.edu/research/meetings/transradial](http://www.dcri.duke.edu/research/meetings/transradial)

**TIPS & TRICKS IN COMPLEX INTERVENTIONAL CARDIOVASCULAR CASES**
- **Date:** July 30–31, 2010
- **Sponsor:** Conference Management Solutions
- **Location:** San Francisco, CA
- **Directors:** Issam Moussa, M.D., FSCAI, Joseph De Gregorio, M.D., FSCAI, Antonio Colombo, M.D., FSCAI, Bernhard Reimers, M.D., FSCAI, and Jonathan Tobis, M.D., FSCAI
- For more info: [www.cict2010.org](http://www.cict2010.org)

**International Symposium on the Hybrid Approach to Congenital Heart Disease (ISHAC)**
- **Date:** Aug. 31–Sep. 2, 2010
- **Sponsor:** Nationwide Children’s Hospital
- **Location:** Columbus, OH
- **Directors:** Mark Galantowicz, M.D., FSCAI, and John P. Cheatham, M.D., FSCAI
- For more info: [http://www.nationwidechildrens.org/ishac-home](http://www.nationwidechildrens.org/ishac-home)

**2010 Heart Valve Summit**
- **Date:** Oct. 7–9, 2010
- **Sponsor:** American Association for Thoracic Surgery
- **Location:** Chicago, IL
- **Directors:** David H. Adams, M.D., Steven F. Bolling, M.D., Robert Bonow, M.D., and Howard Herrmann, M.D., FSCAI
- For more info: [http://www.aats.org/CME/Heart-Valve-Summit.html](http://www.aats.org/CME/Heart-Valve-Summit.html)

For more information or to register for any of these programs, contact Laura Brown at lbrown@scai.org or 800-992-7224, or visit [www.scai.org](http://www.scai.org)
1. TELL US YOUR NAME AND CONTACT INFORMATION. (PLEASE PRINT)

Name (Last, First, MI): ___________________________ Gender: □ Male □ Female

Email: ___________________________________________ Degree: □ MD □ PhD □ DO □ MBBS □ Other

Address (This is where your journal will be mailed—check one): □ Business □ Home

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City: ___________________________ State: ______ Zip: _______ Country: ______________

Phone: (_____)______________ Mobile: (_____)________ Fax: (_____)________

2. CHOOSE THE MEMBERSHIP TYPE THAT IS RIGHT FOR YOU.

**US AND CANADA APPLICANTS (CHECK ONE)**

- Intervventional Affiliate (online journal only): ... FREE
  - Currently in an interventional training program
  - Start Date: __________ End Date: __________

- Fellow (FSCAI): ......................... $475
  - Board certified in interventional cardiology, or
  - 5 years in practice & 1,000+ procedures
  - 375+ for pediatric
  - Two sponsorship letters required

- Member: .................................. $475
  - Significant percent of time performing catheterization/interventions but not eligible for/desiring fellowship

- Advancement to Fellowship: .................. $100
  - (current member only):
  - A CV is required for Fellowship.

**INTERNATIONAL APPLICANTS (CHECK ONE)**

- International Fellow (FSCAI): .................. $335
  - 5 years in practice & 1,000+ procedures (375+ for pediatric)
  - Two sponsorship letters required

- International Associate (online journal only): .... $100
  - Current member of a non-U.S. interventional society
  - List Society: ........................................

*Sponsorship letters required as follows: 1st letter from an SCAI fellow, 2nd letter from other sponsor (e.g., colleague, cath lab director)

3. PROVIDE US WITH YOUR PAYMENT INFORMATION.

Payment Method: Check # ___________ □ Mastercard □ Am. Exp. □ Visa □ Amount $ ___________

Credit Card #: ___________________________ CCV #: ___________ Exp. Date ___________

Billing Address

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I hereby consent to the release by any hospital, educational institution, governmental agency, physician, professional society, or other person possessing or requiring the same, whether or not listed above, of any and all information in any way pertaining to my personal character, training, experience, or professional competence.

I hereby release from any liability any and all individuals and organizations or their authorized representatives who provide this information in good faith and without malice subject to this consent.

I hereby release from all liability. The Society for Cardiovascular Angiography and Interventions and any and all individuals for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications. I hereby certify that all information recorded on this application and any attached documents is accurate and supports my qualifications for membership in The Society for Cardiovascular Angiography and Interventions for which I now apply. I hereby agree that The Society for Cardiovascular Angiography and Interventions may verify any of the above data. If approved for membership, I agree to conform to the Constitution and Bylaws of the Society (available upon request).

_________________________ ___________________________
X Date

SCAI staff will follow up with you for missing documentation.

THREE EASY WAYS TO SUBMIT!

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