



## Accreditation, Appropriateness Criteria: Better Methods of Reducing Imaging Rates

**T**he use of radiology benefit management (RBM) companies by payers to decrease in-office imaging use is becoming increasingly prevalent. The practice by RBMs of “prior authorization” — where physician practices must clear imaging referrals with RBMs to secure coverage — is both an intrusion in the physician-patient relationship and a large administrative burden for physician practices.

Given the detrimental effects of RBMs on patients and practices, the ACC supports other methods of ensuring appropriate, high quality imaging, such as accreditation. Accreditation is a process that reviews three components of an imaging laboratory: the safety and accuracy of the imaging equipment; the training of the imaging technologists; and the training, certification, and/or experience of the supervising and/or interpreting physician(s). It allows imaging laboratories to be held to a high level of accountability for the patient care they provide and creates needed standardization across facilities.

Accreditation can also help reduce inappropriate imaging by serving as a barrier to entry for new imaging labs that otherwise would not meet standards set by accrediting bodies like the Intersocietal Accreditation Commission (IAC). The ACC believes accreditation is a valuable tool that can improve the quality of imaging services by providing an independent evaluation and validation of imaging facilities.

In addition to accreditation, the ACC supports the use of appropriate use criteria to restrain imaging growth. Physicians use appropriate use criteria to determine when and how often to do a given procedure. Appropriate use criteria may be used to assess patterns of care to understand and improve the rate

of clinically appropriate imaging tests — and understand and reduce the rate of clinically inappropriate tests. Their use can result in cost savings and a high quality of health care. Appropriate use criteria also support the current effort to increase transparency and cost effectiveness.

### Working with Payers

The ACC is working tirelessly with payers to revise their RBM policies. For example, the ACC, the ACC New York Chapter and the American Society of Echocardiography met with Aetna representatives on July 25 to discuss the insurer’s proposed requirement for prior approval for echocardiography. As a result of the meeting, Aetna decided to postpone the decision for six months while more research is conducted on usage rates. During the six-month period, the ACC will conduct research to determine the rates of imaging for repeat and duplicative echo tests. The College will continue to work with Aetna in the future to ensure that access to echo imaging is not compromised by payment policies.

### Working with Members

The ACC’s proactive response to the growth of CV imaging has been to work with members to limit inappropriate use by developing and promoting appropriate use criteria and supporting accreditation. The ACC believes that office-based CV imaging offers the opportunity for earlier, less invasive and more accurate diagnosis of disease and contributes to good decision making and better care. The College will continue these efforts long into the future.

## Vast Majority Says Health Care Reform Needed

**E**ighty-two percent of US residents believe that the health care system should be fundamentally changed or completely rebuilt, according to a survey released recently by The Commonwealth Fund. According to the survey, 80 percent of adults support efforts to improve the health system's performance with respect to access, quality and cost. The survey found substantial support for wider adoption of health information technology as a means of improving patient care. Nine of 10 adults wanted easy access to their own medical records and thought it was important that all their doctors have such access as well.

The survey also gauged respondent satisfaction with the current health system. Survey participants reported problems with access to health care, with nearly three out of four (73 percent) reporting a difficult time getting timely doctors' appointments, phone advice or after-hours care without having to go to the emergency room. In addition, the survey found that 47 percent of patients experienced poorly coordinated medical care in the past two years. The ACC strongly believes that health care reform is essential. To learn more about ACC's efforts to transform the health care system from the inside out, visit: [qualityfirst.acc.org](http://qualityfirst.acc.org).

### ACC Urges DOE to Allow Residency Loan Deferment

The ACC and other health organizations last month signed a comment letter to the US Department of Education Secretary Margaret Spellings in reference to a proposed rule that would amend the federal student loan program regulations in accordance with the College Cost Reduction and Access Act. On July 1, 2009, the new income-based repayment program (IBR) will become effective, replacing the "20/220 pathway." The IBR caps loan repayments of participating borrowers at 15 percent of their income that exceeds 150 percent of the borrower's family size. The IBR does not offer medical residents the option to postpone loan repayment during their initial years of residency. In the letter, the ACC and others urged Sec. Spellings to reinstate the 20/220 pathway, which allows medical residents to have the option of deferring loans during their residency without facing financial penalties, or put into place an equivalent funding mechanism. Helping medical students finance their education and assisting medical students, resident physicians and young physicians to better manage their high debt burden are top priorities for the ACC.

### CMS Releases IPPS Final Rule

The Centers for Medicare & Medicaid Services (CMS) recently released four final payment regulations that cover inpatient hospital care, inpatient rehabilitation facilities, hospice programs and skilled nursing facilities. Under the FY'09 inpatient prospective payment system (IPPS) final rule, CMS finalized three of nine proposed "never events" for which it will no longer reimburse, including: surgical site infections following certain elective procedures; poor control of blood sugar levels in certain circumstances; and deep vein thrombosis or pulmonary embolism after knee and hip replacement procedures.

The final IPPS rule updates payment policies and rates for hospitals paid under Medicare's diagnosis-related group payment system. It is expected to increase Medicare payments to acute care hospitals by close to \$4.75 billion. The final IPPS rule also expands the Reporting Hospital Quality Data for Annual Payment Update Program to include 13 new measures, increasing to 42 the total number of measures that must be reported in 2009 to receive full payment in 2010. The IPPS final rule is effective Oct. 1.

## NCD for Carotid Artery Stenting Released

**O**n July 31, CMS proposed to make no changes to the national coverage determination (NCD) for percutaneous transluminal angioplasty (PTA) of the carotid artery concurrent with carotid artery stenting (CAS). According to the agency, clinical studies and Technology Evaluation Center assessments do not clearly demonstrate that CAS should be used as an alternative to carotid endarterectomy (CEA). The agency stated the need for randomized clinical trials comparing CAS with other therapeutic options, including CEA. According to the decision, "As a result of the inadequate peer-reviewed, published evidence, CMS has determined that expanding coverage is not reasonable and necessary and is proposing to make no changes to the NCD." CMS closed the public comment period Aug. 31, and, after consideration, will issue a final decision memorandum. ACC joined the Society for Cardiovascular Angiography and Interventions, the Society for Vascular Medicine, and the Society for Vascular and Interventional Neurology to request that CMS reconsider its NCD to expand coverage.