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ACC NEWS

President's Page: The President's Mailbag

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One of the enjoyments of this presidency is the opportunity to communicate with a great many members of the American College of Cardiology (ACC) by telephone, mail and in person. Recurring themes from this correspondence indicate a commonality that would be of interest to other ACC members. The topics rarely concern educational aspects of College activities. Rather, they focus on a variety of practice dilemmas and problems. Misery loves company, so to speak. What follows is a potpourri of these topics with some personal reflections.

Electrocardiographic interpretation. Who should interpret the electrocardiogram (ECG) in a hospital setting? Traditionally, in university and community hospitals with educational or training programs the task is performed by cardiologists. But in the smaller community hospital it has been the prerogative of the internist or general/family practitioner who may have been on the hospital staff for many years. This responsibility is rewarded financially and often through enhanced professional stature.

As cardiologists who have completed training programs join these community hospital staffs, in some instances they find themselves welcomed into the ECG reading pool of physicians and enthusiastically accept this arrangement. On the other hand, some cardiologists suggest that to read and interpret the ECG is exclusively their province rather than a responsibility to be shared with others who previously performed this service. To complicate this situation, there are the new internists or family practitioners who join these staffs and feel that their training prepares them for this role. Who decides? And how is the decision made?

At present there are no credentialling guidelines. The decisions are made at the local level, sometimes with the help of a variety of written or oral local examinations. However, human nature being what it is, those noncardiologists now interpreting the ECGs will likely continue to do so until they retire or are proved unequal to the task by new staff members. In my view, cardiologists will eventually succeed to the responsibility of ECG interpretation by virtue of their training. New noncardiology staff physicians will be required to prove their competency. However, in an ideal situation the best qualified physicians should assume the role, qualification being a matter of competency resulting from training, experience and credibility.

As cardiovascular specialists continue to move into smaller communities, they are more likely to assume the role of ECG interpretation. An ACP/ACC/AHA Task Force is engaged in developing credentialling guidelines for ECG interpretations that should be available in 12 to 18 months. In addition, the College's Electrophysiology/Electrocardiography Committee is developing an ECG self-assessment examination that may assist in demonstrating competence. This examination will be available in about 18 months. In the meantime, hospital staff credentialling committees must decide who provides the most accurate ECG interpretations.

Coronary angioplasty guidelines. The Percutaneous Transluminal Coronary Angioplasty (PTCA) Practice Guidelines developed by ACC/AHA and published in the Journal in August 1988 were intended to provide a current consensus on the indications, contraindications and complexities of coronary angioplasty. I believe they have done so. Coronary angioplasty guidelines subsequently developed by ACP/ACC/AHA for credentialling were published in this Journal (1) and *Circulation* (2).

The number of procedures to maintain competency has encountered criticism. A minimum of 50 to 75 procedures per year per physician, depending on the total institution experience, is being challenged as too restrictive; many feel the guidelines may deprive community hospitals of the opportunity to provide this service to local patients. In larger hospitals with multiple cathing cardiologists, it is said the guidelines may prevent specialists from offering the service to their specific patients.

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It should be remembered that the number of procedures specified in the guidelines are simply estimates. There is no scientific literature on which to base these recommendations, only the judgment of those with experience. What may keep one physician competent may require twice that to keep another competent. In this setting volume is not meant to serve as a "surrogate" for quality. It must be determined by peer review (Joint Commission on Accreditation of Healthcare Organizations, for example) that a quality service is provided to patients by the staff physicians, no matter how many procedures they perform and, at the same time, that unnecessary procedures are not done merely to satisfy the numbers game.

Although the critical mass necessary to maintain proficiency remains to be determined, it was necessary to start somewhere. Coronary angioplasty technology is changing rapidly and the occasional operator may not have the expertise or competency to provide a high quality of service, especially if a complex problem is present. Would you prefer the procedure be done by a cardiologist who does 20 or 75 per year? More importantly, you would surely like to know his/her results. And being a physician, you are more likely to be interested in this information than an unsuspecting patient. I have had the personal experience and satisfaction of working in a high-volume angioplasty environment for many years and also experiencing the frustration and unease with developing technology and techniques as I myself became an occasional operator because of time constraints. I now leave angioplasty to my colleagues who are able to maintain their expertise, in part, because they perform many procedures. I am not yet persuaded that the final paragraph of the credentialling guidelines task force should, as yet, be amended in any way. "In the present climate of intense economic pressure, it should be clear that not every institution anxious to offer angioplasty as part of its health care program can be allowed to do so. Similarly, not every cardiologist desiring to perform angioplasty should perform the procedure" (1).

Another concern expressed is that the practice guidelines will come to be incorporated into third party payor schemes of payment. It seems likely to occur, although I am not aware that it is happening rapidly. I do believe that the cardiovascular community must be prepared to see that it happens properly. It has come to my attention that one third party payor is suggesting that diagnostic coronary angiography and therapeutic angioplasty would best be performed as a single procedure, obviously to save money. Currently the coronary angioplasty guideline strongly recommends against this practice except under specified conditions. We all understand that practice patterns change over time but change should not occur at the expense of appropriate patient care to accommodate someone's perception of cost saving.

Current procedural terminology (CPT). Misunderstanding of the interpretation and application of the CPT codes among physicians and Medicare carriers seems to be a common occurrence. For instance, local Medicare policy may consider Doppler color flow mapping to be an inherent part of the primary ultrasound study despite agreement between AMA and ACC committees that two distinct codes are required to describe these services. Variations in reimbursement for ECG, exercise treadmills, lipid profile testing, single vessel and additional vessel angioplasty and rehabilitation services have all been reported and probably represent only the tip of the iceberg in matters of this sort.

The College regularly submits new codes to the AMA for new technology or changes in practice patterns. For example, based on recommendations from the College and the Society of Thoracic Surgeons, the AMA has approved a new code for reoperation of Coronary Artery Bypass Grafts. In addition, recent approval by the ACC Board of Trustees of a position report on signal-averaged EKG may presage favorable action on a request submitted by ACC to AMA for codes describing this new technology. The ACC CPT Committee is developing a CPT manual for cardiovascular specialists that may reduce some areas of confusion. It should be available in March 1991.

Another concern expressed in relation to CPT coding is that implementation of carrier rules and regulations is often locally determined and not always consistent. Rules interpreted in one location may be interpreted differently in another and a carrier may have considerable latitude in determining the conditions under which CPT codes are reimbursed. It is entirely possible that the complexity of coding procedures has resulted in incorrect implementation in your area. In general, where there has been dispute, it may be helpful for local groups to approach the carrier collectively representing one specialty within the carrier's jurisdiction. Medicare carriers are often more reasonable if they are engaged in a constructive dialogue with specialty representatives in their local region.

Emerging interventional technology. Another discussion I have had with several members involves the lack of any good mechanism to identify cardiovascular physicians with specific interventional skills in the newer interventional technologies. Equally important is the need for a new therapeutic or diagnostic intervention to have proved clinical (and cost-effective) efficacy over established methods before widespread acceptance. Training and credentialling guidelines for cardiovascular specialists in these new fields are under preliminary discussion by several specialty societies including the College. Introduction of a new technology to a hospital armamentarium is often the occasion for a news release—a public-relations coup—especially if it occurs in an environment of competing hospitals. Laser angioplasty, atherectomy devices and stents are just a few examples of procedures that, for the most part, should remain in research protocols approved by hospital institutional review boards. I am aware of several hospital credentialling committees

that have prohibited the introduction of one or another of these mentioned procedures despite intense pressure by the interested physician and/or hospital administrators. But leadership of this sort requires character—and often a thick skin.

Comment. Mail and telephone calls to the President are an extremely important means of keeping the College leadership in tune with the "real world" of cardiovascular medicine and surgery. Keep them coming.

References

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