ASNC to Offer Nuclear Cardiology for the Office-Based Practice

Physicians and technologists who practice in an office-based setting must deal with many clinical and business issues unique to that setting. Staying current on advances in nuclear cardiology, evaluating imaging procedures, understanding current private payer policies, and staying abreast of recent changes in coding and reimbursement are just a few of the areas of concern to these imaging professionals. This spring, the American Society of Nuclear Cardiology (ASNC) offers Nuclear Cardiology for the Office-Based Practice (April 15 – 17, Westin Philadelphia Hotel, Philadelphia, PA). The program provides an opportunity for professionals to focus on these concerns and others including:

- Advances in single-photon emission computed tomography (SPECT) and positron emission tomography (PET)
- Instrumentation of a gamma camera
- Advances in detectors to improve clinical performance
- Optimal methodologies for interpreting and reporting nuclear cardiology studies
- Methods for determining the strengths and weaknesses of imaging procedures and their incorporation into clinical practice
- The basic physiological approach to stress perfusion imaging, including the use of new pharmacologic stress agents.

The program faculty, led by program director Dennis Calnon, MD, FASNC, encompasses imaging professionals from throughout the United States who will provide a broad spectrum of insights and experiences.

Interested physicians and technologists can register online, by mail, via fax, or on site (as space permits). Physicians may claim a maximum of 17 AMA PRA Category 1 Credits™, and technologists may claim a maximum of 14.75 ASNC Continuing Education (ACE) credits, which are accepted by the Nuclear Medicine Technology Certification Board (NMTCB) and the American Registry of Radiologic Technologists (ARRT).

The registration fee includes access to an online syllabus (which participants may download to their laptops), meals, and refreshments. Participants who register by March 11, 2011, qualify for an early-bird discount. ASNC also offers on-site registration as space availability allows.

ASNC has reserved a block of rooms at the Westin Philadelphia Hotel at a rate of $189 a night for single/double occupancy. The room block is available until March 15, 2011, or until the block is full. Participants are encouraged to reserve their rooms early to ensure they receive the group rate. Located on Rittenhouse Square in downtown Philadelphia, the Westin is near many attractions including the Liberty Bell, Independence Hall, and the Constitution Center.

To register for this program and for complete details on the agenda, invited faculty, course materials, hotel accommodations, and more, visit http://www.asnc.org/office/.
Executive Director Search

ASNC is seeking a high-energy individual for the position of Chief Executive Officer at its Bethesda, Maryland location. The position requires innovative leadership, diplomacy, and public relations and communication skills. The new CEO will work in partnership with the volunteer leadership, maintain relationships with the radiopharmaceutical and camera industries, represent ASNC’s interests with related societies and national policymakers, and lead the Nuclear Cardiology Foundation. The successful candidate will possess an advanced degree in a related field and at least seven years’ experience managing staff and budgets and overseeing fundraising, advocacy, and strategic planning. Knowledge of current issues in national health care policy and health care reform, association experience or health care/medical organization experience is strongly preferred.

New CME Opportunity from the Journal of Nuclear Cardiology

Earn valuable continuing medical education credit while increasing your knowledge of the latest developments in the field of nuclear cardiology. Each issue of the Journal of Nuclear Cardiology now features an article designated for continuing education credit for physicians and technologists. To take advantage of this opportunity, visit www.asnc.org/journal and click on “Journal CME” to access eligible articles. Then complete a series of questions to earn AMA PRA Category 1 Credit™ or ACE credit.

MEETINGS AND PROGRAMS

Programs listed below are sponsored or co-sponsored by ASNC. For more information, visit www.asnc.org/event.cfm.

APRIL 2011
- April 2: Nuclear Cardiology for Fellows-in-Training
- April 15 – 17: Nuclear Cardiology for the Office-Based Practice

MAY 2011
- May 5 – 7: 33rd Annual Recent Advances in Clinical Nuclear Cardiology and Cardiac CT
- May 13 – 15: Nuclear Cardiology for the Technologist
- May 15 – 18: ICNC10-Nuclear Cardiology and CT

JULY 2011
- July 8 – 10: Nuclear Cardiology Board Exam Preparation Course

SEPTEMBER 2011
- September 8 – 11: ASNC2011: The 16th Annual Scientific Session of the American Society of Nuclear Cardiology

*This course is co-sponsored by ASNC.

FROM THE JOURNAL OF NUCLEAR CARDIOLOGY

From the January/February issue of the Journal of Nuclear Cardiology:

The January/February issue of the Journal of Nuclear Cardiology includes a study from Aljaroudi et al. evaluating whether the presence of reversible defects in stress images affect the phase-derived standard deviation and bandwidth (two commonly used dyssynchrony indices). Read about the authors’ findings in “Impact of Ischemia on Left Ventricular Dyssynchrony by Phase Analysis of Gated Single Photon Emission Computed Tomography Myocardial Perfusion Imaging” at www.asnc.org/journal.

EDUCATION

Fellows Program – Final Reminder

Cardiology, nuclear medicine, and radiology fellows and residents should note the approaching deadline for participating in the Nuclear Cardiology for Fellows-in-Training program, which covers the clinical and business aspects of nuclear cardiology practice. Supported by an educational grant from Astellas Pharma US, Inc., the program takes place April 2, 2011, at the New Orleans Marriott at the Convention Center, New Orleans, Louisiana. This free program provides participants with a better understanding of nuclear cardiology. It does not offer certification or continuing medical education (CME) credit.

Attendees can download the program syllabus to their laptops, print their own copy from the online version, or order a printed, spiral-bound copy from ASNC for a fee. Attendees who choose to purchase a printed syllabus will also have access to the online syllabus. For more details regarding course materials, the program agenda, and registration, visit http://www.asnc.org/fellows.

This program is not part of the official ACC Annual Scientific Session & Expo or the American College of Cardiology’s Innovation in Intervention: i2 Summit in Partnership with the Cardiovascular Research Foundation (CRF).

Nuclear Cardiology for the Technologist

The Nuclear Cardiology for the Technologist program (May 13-15, 2011, Hyatt Regency, Cambridge, Massachusetts) is designed for nuclear cardiology and nuclear medicine technologists practicing in private and hospital settings. Attendees will get a comprehensive overview of current standards in their field and discuss the future of nuclear cardiology and their role in it. This course qualifies for a maximum of 15.25 ASNC Continuing Education (ACE) credits. Early bird registration rates are available until April 8, 2011. ASNC members receive additional discounts on this course’s registration rates. Visit www.asnc.org/ncctechnologist for registration materials, hotel information, and a program agenda.

Visit www.asnc.org or call (301) 215-7575 for the latest registration and program information.

Please note that all program information as listed is subject to change. The American Society of Nuclear Cardiology is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. The American Society of Nuclear Cardiology is a recognized provider of continuing education credit for technologists. ASNC’s Continuing Education (ACE) credit is accepted by the MTFCE and ARRT.

ASNC NEWS BRIEFS

JNC SPOTLIGHT

The January/February issue of the JNC also features another important study on dyssynchrony in a article titled “Prevalence and Predictors of Mechanical Dyssynchrony as Defined by Phase Analysis in Patients with Left Ventricular Dysfunction Undergoing Gated Single Photon Emission Computed Tomography Myocardial Perfusion Imaging” by Borges-Neto et al. Learn even more about this important study with a free podcast interview with Dr. Borges-Neto at www.asncpodcast.org.
South Africa was the proud host of the 10th World Federation of Nuclear Medicine and Biology (WFNMB) Congress, which took place in Cape Town on September 18–23, 2010.

Following its objectives to support education, skills development, and scientific exchange in nuclear medicine, the 2010 Congress included 80 sessions and 83 guest speakers covering general nuclear medicine, PET/CT, cardiology, physics, radiopharmaceuticals, and new technology. Over 200 oral abstract presentations and 300 poster presentations were selected by renowned reviewers from more than 30 countries.

Living in challenging times, WFNMB is especially proud to cover topics like: Benchmarking Quality, the Molybdenum Shortage Crisis, Poisoning Events, How to Deal with Terrorist Aggressions, and Ethics in Nuclear Medicine.

The American Society of Nuclear Cardiology was well represented with presentations by Joao Vitola on “Clinical relevance to measure unstable plaque,” and Richard Underwood on “Thallium-201, old tricks for an old dog.”

Best wishes to Dr. Enrique Estrada Lobato and his team as planning for the next WFNMB Congress in Mexico in 2014.

ASNC2011 Abstract Submission Period Opens February 1

Mark your calendars for the ASNC2011 abstract submission period, which opens February 1, 2011. ASNC will schedule accepted submission as posters during ASNC2011 (September 8 – 11, 2011, in Denver, CO) and also publish them in the Journal of Nuclear Cardiology. Physicians, technologists, and nurses may submit original research for considerations. Individuals who are currently in a residency or fellowship training program or who are younger than 35 may participate in ASNC’s Young Investigator Competition. Visit www.asnc.org/asnc2011 for submission requirements, research topics, and access to the online submission system.

Important Dates and Deadlines

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<tr>
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<tr>
<td>February 1, 2011</td>
<td>Abstract submission site opens</td>
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<tr>
<td>March 18, 2011</td>
<td>Abstract submission site closes</td>
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<tr>
<td>April 18, 2011</td>
<td>Notification to presenting authors of acceptance status</td>
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<tr>
<td>May 1, 2011</td>
<td>Late-breaking clinical trial abstract submission site opens</td>
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<tr>
<td>June 15, 2011</td>
<td>Late-breaking clinical trial abstract submission site closes</td>
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Legal Update: Clinical Integration and Value-Based Purchasing

In 1996, the Department of Justice and the Federal Trade Commission (FTC) published an opportunity for otherwise competing physicians to bargain together collectively with payers if they were not financially integrated, but clinically integrated. Since then, the FTC has published only four opinions addressing clinical integration – three of them positive and one negative. In settlement after settlement, when confronted with networks of physicians (and networks of physicians and hospitals) that bargained collectively over fees, the agency repeatedly said, “if you had been clinically integrated, you could have done this.”

From an antitrust regulator’s perspective, clinical integration is a process by which physicians use guidelines, protocols, or pathways, have an infrastructure that permits them to measure their performance, take action against those who do not measure up, and share data with payers. If otherwise competing physicians engage in such activities, they can bargain together for fees.

As far as the enforcers are concerned, the primary motivation to collaborate must be quality improvement. Any financial considerations for collective bargaining are ancillary. Health reform mandates included in the Affordable Care Act (ACA) only reinforce the role of clinical integration in helping physicians redesign clinical processes to create higher quality and better efficiencies.

What are these mandates?

On important provision for all Medicare physicians is the implementation in 2012 of a Medicare “value-based purchasing modifier.” To be coordinated with a hospital value-based purchasing program, the modifiers will initially target specified conditions which, for hospitals, must include acute myocardial infarction and congestive heart failure, among others. Since the hospital and physicians programs, although separate, are to be coordinated, it can be assumed physicians will be measured and paid differentially on the quality of their services associated with the treatment of these conditions. Beginning in 2015, efficiency measures will be added, assessing the overall costs incurred in providing services for the targeted conditions. By 2017, this program will be mandatory for all Medicare physicians.

In addition, the ACA calls for the development of outcome, quality, and efficiency measures with considerable transparency. Virtually all the data that is collected for measurement purposes will be posted on Medicare-sponsored Web sites, including the Physician Compare program. At the same time, hospitals will be penalized in their payment for hospital-acquired conditions and preventable re-admissions. This creates an incentive for hospitals and physicians to work together since they will be measured and reported on similar conditions.

Although nuclear cardiology is not explicitly named in the ACA, imaging services will be implicated as they are incorporated into treatment for the targeted conditions. While Medicare is headed in this direction, commercial payers are also increasingly profiling, measuring, and treating differentially physicians who deliver better value.

To succeed in an era of measurement of clinical performance and efficiency, all physicians should be (1) analyzing where there is waste in their clinical processes, (2) taking steps to enhance the physician-patient relationship, and (3) developing techniques to adhere to an explicitly identified evidence-base for the delivery of services.

Whether physicians are in nuclear-only practices, in cardiology or multi-specialty groups, or even employed by a hospital or in a hospital affiliated group, to be successful they will need to clinically integrate with their colleagues within and outside their practice settings. Using clinical practice guidelines, measuring individual performance, analyzing where changes can be made, and re-measuring performance will be fundamental. Physicians changing their clinical behavior, together – not just cutting expenses – is crucial.

Alice G. Gosfield, Esq., is an expert in health law and health care regulations. She has been cited as one of the Top Twenty-five Health Lawyers in the country and has served as a committee member for the Institute of Medicine and a consultant to AHRQ, the GAO, and the Robert Wood Johnson Foundation, among others. She will serve as a regular contributor to the ASNC newsletter in 2011.
Health Policy Update

Enrollment Open for Federal Electronic Health Records Incentive Program

The Medicare and Medicaid Electronic Health Record (EHR) program began in January 2011. The program provides incentive payments to eligible professionals, hospitals, and critical access hospitals as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology as defined in the program. Under the EHR incentive programs, eligible professionals can receive as much as $44,000 over a five-year period through Medicare. For Medicaid, eligible professionals can receive as much as $86,750 over six years. Under both Medicare and Medicaid, eligible hospitals may receive millions of dollars for implementing and meaningfully using certified EHR technology. State agencies will phase in incentive programs for Medicaid providers starting in January. By May, Medicare EHR incentive payments should begin. For registration details, eligibility, and other requirements, visit the Centers for Medicare & Medicaid Services (CMS) Web site at http://www.cms.gov/ehrincentiveprograms/.

Affordable Care Act Disclosure

Effective January 1, 2011, the Affordable Care Act (ACA) requires office-based physicians to inform Medicare patients about alternate providers of select imaging services (PET, CT, and MRI) any time they are referred for one of these services. This provision requires practices to disclose a list of five alternate suppliers within 25 miles of the referring physician’s office. The disclosure provision is only required when a Medicare patient is referred for a PET, CT, or MRI study, which falls under the in-office ancillary services exception to the prohibition against physician self-referral as described in Section 1877 of the Social Security Act. This provision does not apply to hospital facilities providing outpatient services.

ASNC has summarized this disclosure requirement and has created a template to help members comply with the law. Visit www.asnc.org/content_10708.cfm for the complete disclosure guide and a copy of the disclosure template.

CMS Revisions Result in Modified Reimbursement Rates for 2011

The Centers for Medicare and Medicaid Services’ (CMS) final 2011 Medicare Physician Fee Schedule (MPFS) includes proposals and policies affecting all physicians paid through the Medicare system. As part of the 2011 MPFS, CMS implemented a policy that would revise the Medicare Economic Index formula used to calculate practice expense for services. Due to this change, as well as the passage of legislation to freeze the cuts to the sustainable growth rate, CMS reconfigured the 2011 MPFS conversion factor used to calculate payment rates under the MPFS to ensure budget neutrality. As a result, nuclear cardiology professionals will still benefit from increases to the practice expense values, and in most cases reimbursement rates are expected to be higher for myocardial perfusion codes than the previous 2010 rates. Technical rates for PET (positron emission tomography) will be reduced, however, because of reductions in payment rates under the MPFS to ensure budget neutrality. As a result, nuclear cardiology professionals will still benefit from increases to the practice expense values, and in most cases reimbursement rates are expected to be higher for myocardial perfusion codes than the previous 2010 rates. Technical rates for PET (positron emission tomography) will be reduced, however, because of reductions in payment rates in hospital payments. See below for a table comparing 2010 and 2011 reimbursement rates for nuclear cardiology and PET services, and visit the Health Policy section of the ASNC Web site to see ASNC’s summary of the rule and a more detailed payment chart that includes CT and stress testing services.

Nuclear Cardiology for the Office-Based Practice

EARLY BIRD REGISTRATION DEADLINE MARCH 11, 2011!

April 15 – 17, 2011
Philadelphia, PA, The Westin Philadelphia Hotel

Program Chair:
Dennis Calnon, MD, FASNC

All physicians and technologists practicing nuclear cardiology in the office-based setting are encouraged to attend this program.

Visit www.asnc.org/office or call 301-215-7575 for the latest registration and program information.

The Role of Radionuclide Myocardial Perfusion Imaging for Asymptomatic Individuals

Radionuclide myocardial perfusion imaging (RMPI) has served as a clinical mainstay in managing patients with known or suspected coronary artery disease (CAD) for more than two decades. RMPI delineates the extent, severity, and location of perfusion abnormalities and may suggest the need for additional therapies. Robust medical evidence supports RMPI use for the diagnostic evaluation and risk assessment of asymptomatic patients with known or suspected ischemic heart disease. However, a similar body of evidence is not available for asymptomatic individuals.

ASNC is pleased to announce the publication of a new information statement that outlines asymptomatic patient subsets in which RMPI may be appropriate. In addition, the statement discourages the use of RMPI in several groups of asymptomatic patients. Clinical risk assessment is key with regard to applying RMPI to evaluate asymptomatic individuals, although the exact method of risk determination remains unclear. Many settings warrant a tiered approach to clinical evaluation, with risk determination and possibly other testing such as calcium scoring. Certain subgroups of asymptomatic patients warrant special attention and consideration. Patients with a family history of premature CAD risk equivalents may benefit from RMPI testing, but there is little supportive data to sustain a recommendation. Current data for RMPI use in diabetes appears to discourage its use in asymptomatic patients. However, it may be reasonable to consider RMPI for high-risk diabetics, including older individuals and those with an abnormal electrocardiogram or an elevated calcium score.

Data, albeit inconclusive, suggest using RMPI in asymptomatic patients with chronic kidney disease. Currently, RMPI for HIV patients or those with autoimmune diseases is not recommended. For patients undergoing pre-operative evaluation, physicians should order RMPI based primarily on the risk of the surgical procedure and the presence of at least one risk factor and, in the absence of symptoms, not repeat the procedure within two years of a prior study.

For patients with known disease, inferential data support RMPI, but no strong recommendation may be offered. After an acute coronary syndrome, testing has been shown to allow for optimization of therapy and may play an important role in management. However, there is no value in performing RMPI in asymptomatic patients within two years of percutaneous coronary intervention or within five years of coronary artery bypass graft. The optimal use of RMPI in asymptomatic individuals requires further research. Future trials must closely examine the potential impact of therapeutic intervention on patient outcomes, as well as cost-effectiveness. For more information and to read the entire statement on which this abstract is based, visit www.asnc.org/ imageuploads/Asymptomatic.pdf.

Quality Assurance

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GE Healthcare

At GE, we believe what’s needed, right now, is a new mindset: that health is everything.

We call it 

healthymagination

Just as we delivered innovation in environmental technology with ecomagination, healthymagination will change the way we approach healthcare, with over 100 innovations all focused on addressing three critical needs: lowering costs, touching more people, and improving quality.

By keeping people well, we all do well.

Reduce Costs
By 2015, our goal is to reduce by 15% the costs of many procedures and processes with GE technologies and services.

Increase Access
By 2015, our goal is to increase by 15% people’s access to services and technologies essential for health, reaching 100 million people every year.

Improve Quality
By 2015, our goal is to improve quality and efficiency by 15% for customers by simplifying and refining healthcare procedures and standards of care.