Health Care Visions News
From The Cardiovascular Specialists
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Hospital Explores Peripheral Vascular Services Opportunities

Saint Michael's Hospital (SMH) in Stevens Point, Wisconsin contracted with Health Care Visions, Ltd. to conduct an assessment of their current cardiovascular services operations and explore peripheral vascular services opportunities. The hospital currently performs diagnostic peripheral vascular testing as well as various therapeutic vascular procedures in the cardiac catheterization lab and the operating room.

Health Care Visions believed that focused strategic planning for the peripheral vascular services would provide the platform for SMH to expand vascular services and become a market leader, recognized for the exceptional care that is being provided at this time.

The project involved interviewing twenty-six medical staff members and hospital/administrative representatives to assess the situation and identify issues for consideration. A formal SWOT analysis uncovered facts and perceptions of the current peripheral vascular services offered, the medical staff situation and the need for expanding clinical offerings.

The clinical assessment permitted the consultants to evaluate how patients are accessing care through the hospital's processes and what services are available. This part of the project analyzed procedures performed in the cath lab, noninvasive vascular lab, the operating room and in the outreach programs.

An important aspect was to work with Saint Michael's Hospital to determine the procedural opportunity. The initial efforts were focused on assessing the service area and developing a population based demand model. Prevalence was considered: Peripheral vascular disease (PVD) affects 12-20% of Americans age 65 and older, impacting 4.5 to 7.6 million adults. This is expected to grow significantly. Despite the dramatic numbers and the increased cardiovascular risk implication, only 25% of patients with PVD are undergoing treatment.

Health Care Visions was able to project the percent of SMH's population that is affected by PVD. A procedure analysis was conducted with Wisconsin state data. The actual hospital data was reviewed to determine the market opportunity for fourteen DRG's.

Once demand for peripheral vascular services at Saint Michael's Hospital was confirmed, the planning could begin. Health Care Visions did not hesitate to recommend that SMH formalize a vascular program with ***The Vascular Center*** as a geographic location for the centralization of services. Details on physician components, staffing, patient service offerings, patient management and referral processes were outlined.

Health Care Visions found that Saint Michael's Hospital has been providing quality services for patients with PVD, but can arrange the services into a formal program in an effort to grow market share. Monitoring program growth will permit the hospital to recognize the benefits to the health and well being of the community as well as the opportunity for good financial results.

Message From The President

Lets Talk AMI

Barb Sallo

Recent research projects that had their results published in March related to studied issues/care for acute myocardial infarction patients.

The first study authored by Jonathan S. Skinner, economics professor at Dartmouth College, was published in *Health Affairs*. Researchers examined records of nearly 3 million people 65 and older to find the areas in the United States that had the least amount of cost increase for treating heart attacks with the best outcomes. They discovered that those patients that incurred the most expense for treatment actually had poorer outcomes.

One reason for this occurrence, Skinner says, may be that physicians in lower-cost regions are more likely to send heart attack patients home with a prescription for a beta blocker and instructions to take aspirin daily—which is known to increase life span after AMI.

The second study authored by Jeffrey S. Berger, MD, a cardiology fellow at Duke, examined disparities of care after AMI. Women, members of minorities and the very elderly are less likely to receive the most effective care. The researchers determined this by surveying almost 400,000 AMI patients 65 and older.

The examination of Medicare and Medicaid statistics for AMI patients' transfers from hospitals that do not offer PCI or OHS showed significant differences for diverse patient groups. African Americans (69%) and Hispanics (53%) were less likely to be transferred as compared with Caucasians. Women were 84% as likely to be transferred for emergency care as men. Individuals 85 to 90 were only 25% as likely to be moved to another hospital as patients 65 to 69 years old.

An analysis of the care paths for AMI patients at your hospital should reveal how your results measure to these large national studies.

The other article that caught my attention was the publication of the Massachusetts Behavioral Risk Factor Surveillance System report on the dramatic increase of the obesity in the state. The participants (8,203 residents) were asked to provide information on their weight and height which was then converted into a Body Mass Index. Anyone with a BMI of 30 or higher is considered obese. To calculate BMI, go to www.cdc.gov/nccdphp/dnpa/bmi/calc-bmi.htm.

According to the report released on March 21, the ranks of the obese increased dramatically during the past decade and a half in Massachusetts, with nearly one in five adults now dangerously overweight. While obesity rates are increasing in Massachusetts, they remain lower than the national average.

While the information that was presented at the recent American College of Cardiology meeting give us hope for advance technology and treatment options, the alarming growth in the obese and diabetic population (compounded by the aging "baby boomers") will place increasing demands on efficient and effective heart care.

Congratulations to Barb Sallo Recipient of the National Association of Women Business Owners-Pittsburgh 2006 "Make the Connection Award" for her volunteer work with PowerLink

Former Steeler Mike Wagner & Barb Sallo

Receiving Payment for Carotid Artery Stenting

Marsha Knapik

Carotid artery stenting (CAS), a catheter-based procedure performed in the cardiac catheterization laboratory, is gaining acceptance as a new treatment alternative to medical management or surgical intervention for patients with severe or symptomatic carotid artery disease. Refinements in CAS procedures over the last decade combining carotid angioplasty with the newer stent devices and cerebral embolic protection devices have demonstrated outcomes that are now comparable to carotid endarterectomy surgery. Based on the current data, CMS (Centers for Medicare and Medicaid Services) has approved reimbursement for CAS procedures only if the patient meets high risk criteria including:

- Arterial blockage of at least 70%
- Has had a stroke or displayed some other clear symptom of carotid disease
- Conditions which make surgery a high risk
- Significant comorbidities and /or anatomic risk factors

Based on the above criteria CAS is a reimbursable option for less than 10% of the patients who currently undergo carotid artery surgery (endarterectomy). Hospitals wishing to perform CAS must meet the above criteria and must apply and receive approval from CMS, in order to be reimbursed for these procedures.

Acceptable codes for carotid artery stenting include: DRG's:

- 533-Extracranial procedures, patients with significant CCs
- 534-Extracranial procedures, patients without significant CCs

ICD-9 Diagnosis Codes that support CAS:

- 433.10-Occlusion and stenosis of pre-cerebral arteries, carotid artery without mention of cerebral infarction
- 433.11- Occlusion and stenosis of pre-cerebral arteries, carotid artery with cerebral infarction
- 433.30- Occlusion and stenosis of pre-cerebral arteries, multiple and bilateral, without mention of cerebral infarction
- 433.31- Occlusion and stenosis of pre-cerebral arteries, multiple and bilateral, with cerebral infarction

ICD-9 Procedure Codes:

- 00.61-Extracranial PTA
- 00.63-Insertion of carotid stent

CPT Procedure Codes:

- 37215-Transcatheter placement of intravascular stent(s) with distal embolic protection
- 37216-Transcatheter placement of intravascular stent(s) without distal embolic protection

Other items to note in regards to CAS reimbursement:

- PTA alone is not always considered a recognized procedure for reimbursement and to assure receiving payment the facility should check with the local Medicare agency
- CAS is covered only as an inpatient procedure and reimbursement is provided via the DRG system
- For reimbursement under DRG 533 and 534 multiple codes must be supplied and in all stent cases ICD-9 codes 00.61 and 00.63 should be included to allow for the appropriate DRG selection. If both codes are not submitted, the procedure will be assigned to a medical DRG.

Revenue Cycle Improvement Tip

Role of a Clinical Documentation Specialist

Cyndi Havrilak

A clinical documentation specialist is a RN with special training in acute care coding that performs the following:

1. Reviews open record to enhance documentation and correct issues before discharge such as:
   - Physician documentation supports primary diagnosis
   - Physician documentation provides acceptable medical necessity for procedures such as echocardiograms, diagnostic and interventional catheterizations
   - Physician documentation includes co-morbidities
   - Physician documentation includes specific etiology of patient condition avoiding ambiguous documentation
   - Treatment is appropriate for primary diagnosis
   - Nursing and medical documentation supports regulatory requirements
2. Supports the hospital to obtain an accurate case mix index
3. Provides ongoing education to nursing and medical staff on correct documentation, reasons for compliance, and changes
4. Collaborates with HIM to facilitate efficient documentation for users
5. Facilitates completion of closed medical record to billing

Hospitals that have a clinical documentation process, have reported significant dollar savings that more than covered the operating expense of the additional personnel.

Health Care Visions
3283 Babcock Boulevard
Pittsburgh, PA 15237

Phone: (412) 364-3770
Fax: (412) 364-3161
E-mail: hcv@hcvconsult.com
www.hcvconsult.com
Consultants Specializing in Cardiovascular Programs