Health Care Visions News
From The Cardiovascular Specialists

4TH QUARTER 2007

"MY HEART'S IN THE RIGHT PLACE"

MidMichigan Medical Center-Midland

Cyndi Havrilak

It is common knowledge among cardiovascular professionals that minutes matter when dealing with acute cardiac events. Research supports reducing the time to treatment for a heart patient greatly improves their chances of survival, while limiting the damage to the heart.

According to recent American Heart Association research, Michigan has one of the highest mortality rates in the nation for coronary heart disease. Only six of the 52 U.S. states and territories (including District of Columbia and Puerto Rico) studied had a higher rate of heart disease-related deaths than Michigan. In addition, the mortality rate in Clare, Roscommon, Gratiot and Gladwin counties is higher than the state average.

MidMichigan Medical Center-Midland felt the need to respond to this serious statistic since their healthcare system is a primary provider of healthcare services within these counties.

Dr. Robert Jones in one of the newly renovated operating suites designed for open heart surgery at MidMichigan Medical Center-Midland

Implementation of advanced cardiac services at their Midland hospital was necessary to improve patient access to life saving cardiac interventional and surgical services. It was a logical extension of services for MidMichigan Medical Center-Midland given that they were evaluated by Health Grades for excellence in patient care services. They are also considered to be a regional healthcare leader within their programs of Oncology, Women's Health, Interventional Peripheral Vascular and primary PCI.

Organizational support and visionary leadership was consistently provided throughout the year long implementation process by Mr. Rick Reynolds, President and CEO of MidMichigan Medical Center-Midland. He was a firm believer that MidMichigan Medical Center-Midland could and should provide these services. Co-chairing the implementation project at MidMichigan Medical Center-Midland was Ms. Jan Penney and Ms. Tricia Sommer. Together they conscientiously ensured that the implementation project was progressing smoothly, while minimizing delays. Many individuals throughout the organization and system devoted countless hours to the project, with a common goal—that these new cardiac services would deliver the same high quality standards.

MidMichigan Medical Center-Midland felt very fortunate to have had medical guidance provided throughout the process by the well known and respected cardiothoracic surgeon, Dr. Robert Jones and interventional cardiologist, Dr. William Felten. Both of these physicians are in the multidisciplinary physician practice of Michigan CardioVascular Institute (MCVI).

The program at MidMichigan Medical Center-Midland is a comprehensive cardiovascular program that has unique features

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Message From The President

Happy Fall

Barb Sallo

Writing this article for the October Newsletter made me realize we are in the "4th Quarter" of 2007. This gives me cause to reflect on where the year has gone.

During the last several months I have reviewed some interesting information that I wanted to share with you:

The 2005 National Hospital Discharge Survey is available from the U.S. department of Health and Human Services (CDC Advance Data). To no surprise, heart disease was the top diagnosis for patients hospitalized in 2005, representing 4.2 million hospital discharges. The average length of stay (LOS) was heart disease was 4.5 days.
The average length of stay for heart disease has begun to level off for all age groups over past few years, but the decline in average LOS since the 1970's is incredible. See the information for yourself at http://www.cdc.gov/nchs/.

The National Vital Statistics Reports from the CDC indicates the number of deaths in the United States rose in 2005 after a sharp decline a year earlier, a reversal from the 2004 reports. The age-adjusted rate for all deaths in 2005 fell to an all-time low of 799 per 100,000 population, down from 801 per 100,000 in 2004. U.S. life expectancy inched up to 77.9 years from the previous record, 77.8 years recorded in 2004. In comparison, life expectancy was 75.8 years in 1995 and 69.6 years in 1955. Heart disease is ranked number 1 and stroke is ranked number 3.

Healthy People 2010 is a publication available from the U.S. Department of Health and Human Services. Though the data may be dated, it remains a good way to review how far our community's health has come and what we still need to focus on. It is available at http:/www.health.gov./healthypeople/.

A ***Wall Street Journal*** article "Medicare Moves to Cut 'Self Referral' Practice" by David Armstrong, posted September 12, 2007 reported that Federal Medicare officials want to crack down on arrangements where doctors refer patients to businesses in which they have a financial stake. This is only at the proposal stage with Medicare but has already caused investor/developers to look closely at physician/hospital joint ventures.

U.S. Centers for Disease Control and Prevention published a study by Dr. Darwin Labarthe on the drop in deaths from heart disease. From 1980 to 2000 the death rate was nearly cut in half. It is felt this was largely due to advances in treatments and a reduction in cardiac risk factors. This news was tempered with caution as obesity and diabetes are increasing dramatically and cardiac complications as a result of those factors could offset the dramatic gains already made. Obesity is up by 10 percent and diabetes by 44 percent, which together caused approximately 60,000 additional coronary heart disease deaths.

As a side note: Hospital admissions for patients with diabetes increased by 85% between 1993 and 2005 to 6.5 million, accounting for 17% of hospitalizations as reported by the Agency for Healthcare Research and Quality. Seniors were five times more likely than the average American to be hospitalized with diabetes. People who live in poor communities were 80% more likely to be hospitalized with diabetes than people in more affluent areas.

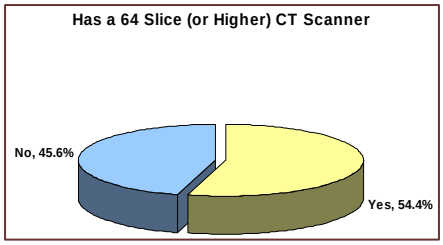
As a final note, we at Health Care Visions are happy to continue to provide informational audio conferences and pleased that so many people have participated. Please take the opportunity to send us your ideas for future topics.

We also have conducted surveys this year with excellent response rates. Those results have been shared with the participants and has provided a good way to keep abreast of what is happening in the cardiovascular field. If you have a question/issue/topic that you would like us to query—please give us a call.

Results Summary of Cardiac CT Scanning Survey

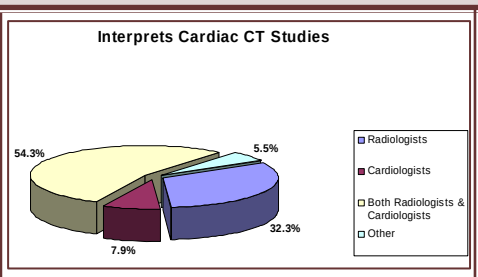
Marsha Knapik

Health Care Visions, Ltd. conducted a survey regarding hospital's acquisition and use of 64 Slice CT Scanning for cardiac diagnostic work. Two hundred and forty-one responses were received and detailed results are attached. The survey included hospitals with bed sizes from less than 100 (11.7%) to hospitals with greater than 300 beds (34.2%) with the majority of respondents from the south (37.2%) and Midwest (36.8%).



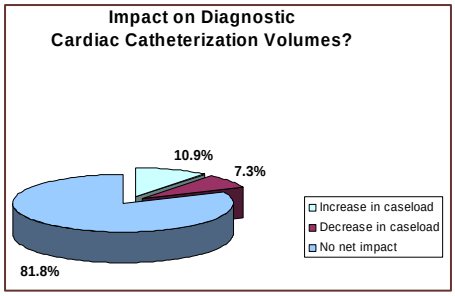
Of the hospitals surveyed, over half (54.4%) already have 64 slice (or higher) CT scanning capability with over 85% already performing CT angiography of the coronary arteries. One of the pressing issues for hospitals has been the competition between Radiologists and Cardiologists for the opportunity to interpret these studies.

HCV's survey indicated that most facilities have opened reading to both disciplines as 54.3% have both Radiologists and Cardiologists interpreting cardiac studies. Only 7.9% have



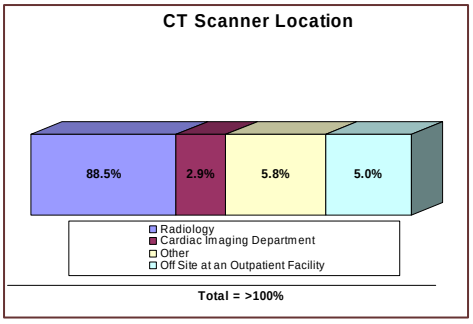
interpretations performed exclusively by Cardiologists while 32.3% have Radiologists exclusively performing interpretation.

Recent articles discussing use of cardiac CT angiography have debated its impact on cardiac catheterization and cardiac stress testing volumes and raise the issue that CT angiography could become just another "layer" of diagnostic testing. Results from HCV's survey seem to bear out this concern, at least at this early stage of cardiac CT angiography use.

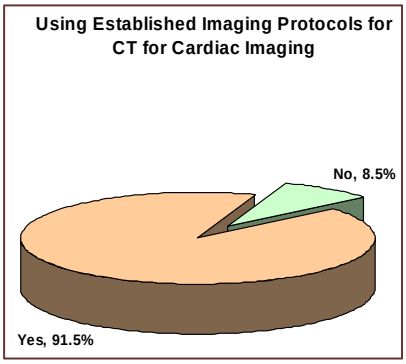


The survey indicated:

- No net impact on diagnostic cardiac catheterization volumes as reported by 81.8% of the respondents
- No net impact on cardiac stress testing volumes as reported by 82.6% of the respondents
- Cardiac CT angiography was used as an additional "layer" of diagnostic testing by nearly three quarters of the respondents
- Only 16.2% of respondents used cardiac CT angiography "in place of" other screening tools



Results concluded that most facilities are keeping CT scanning locations within the Radiology department (88.5%) and most staff CT cardiac imaging with Radiology/CT Technologists and an RN (66.7%).



Over 90% of the facilities performing cardiac CT angiography are using established imaging protocols. Hospitals continue to choose to own the

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Results Summary of Cardiac CT Scanning Survey *(con't)*

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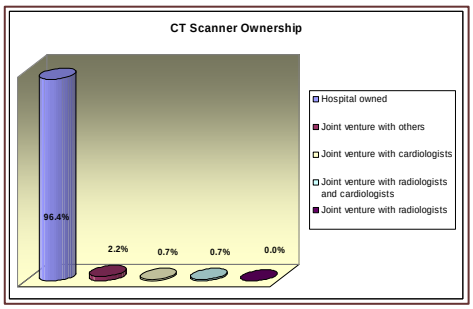
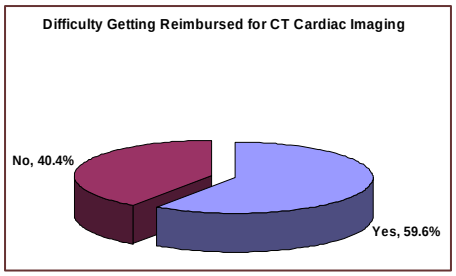
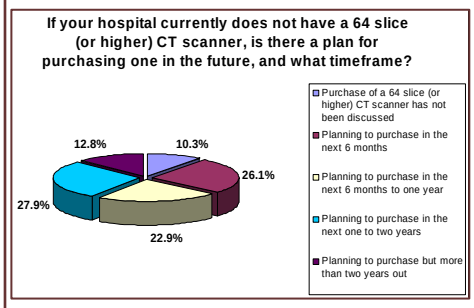


equipment (96.4%) as opposed to joint venturing with the physicians in some manner. Imaging is not available 24/7 at more than half of the facilities (55.6%) and of those were imaging is available 24/7 often interpretation was not. In essence, less than a quarter of the facilities (23.1%) were able to provide cardiac CT imaging **and** interpretation on a 24 hours a day, seven days a week basis.

More than half of the facilities performing cardiac CT angiography report having difficulty receiving reimbursement (59.6%) for the testing.



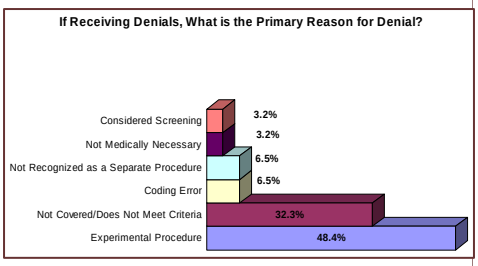
Most hospitals stated that several of their insurers consider it to still be investigational and not a covered service. Several of the surveyed facilities are in the very early days of offering cardiac CT imaging and have yet to determine if they will be successful in receiving reimbursement. Those facilities who are receiving some reimbursement are seeing it from both commercial payors as well as from CMS.



Of the respondents who do not currently have 64 slice (or higher) CT available, a total of 49% are planning to purchase a system within the next 12 months with an additional 27.9% planning a purchase within two years. Only about 10% of respondents have planned for this type of purchase. Of those planning to purchase a high level CT scanner over 80% said that cardiac work will definitely be included in the scanner's use.

Overall, the survey indicates:

- The majority of hospitals that were surveyed have 64 slice CT scanning and of those who don't the vast majority are planning to add this equipment in the next 1-2 years.
- The facilities that have 64 slice CT scanning are employing it for cardiac work (coronary CT angiography) and the majority are using it as an additional layer of testing as opposed to using it to replace other diagnostics.
- The overwhelming majority of facilities that plan to add a 64 slice CT scanner expect to perform cardiac work on that equipment



- Reimbursement remains a questionable area with mixed comments on the ability to receive reimbursement.
- The majority of facilities surveyed have Radiologists as well as Cardiologists involved in study interpretation.

Health Care Visions, Ltd. would like to extend our thanks to those who participated in the survey which allows us to give you a "snapshot" of how hospitals are using this technology in their cardiac programs.

DRGs Convert to MS-DRGs

Rose Czarnecki

The month of October can mean different things to different people. For example, the Supreme Court is back in session, the fall season is underway, the World Series and, of course this year, the implementation of the Medicare Severity DRGs, (MS DRGs).

745 new severity-adjusted DRGs were developed to replace the current 538 DRGs. The existing DRGs were consolidated into 335 base DRGs. Of these, 106 were split into two sub groups and 152 were split into three subgroups. These subgroups were determined based on the presence of complications or comorbidies (CCs) or major CCs (MCCs). 77 DRGs were classified with no complication or comorbidity (non-CCs). The MS-DRGs are assigned based on the presence or absence of specific ICD-9CM diagnosis codes indicating the MCCs (highest level of severity), CCs (lowest level of severity) or non-CCs.

The MS-DRGs are intended to provide for a substantial improvement in the recognition of severity of illness and resource consumption, compensating healthcare organizations based on the severity of a patient's condition. Medicare believes that payment to institutions will be better aligned to their cost of care thus eliminating any incentives for them to selectively treat patients within the lowest cost severity levels.

The table on the following pages demonstrates how the old MCD 5 DRGs were split into the new MS-DRGs. *(Continued on page 6)*

"My Heart's in the Right Place" *(con't)*

(Continued from page 1)

differentiating their heart program from others in the region such as:

<u>One Stop Post Op™</u> - patient care delivery model that allows the patient to remain in the same critical care room immediately from the operating room until discharge. The model is being utilized throughout the nation with impressive patient and staff satisfaction.

<u>Excellence in Patient Care</u>- MidMichigan Medical Center-Midland has received multiple distinguished patient care service awards from Health Grades confirming their strong foundation for patient care quality.

MidMichigan Medical Center-Midland's Cardiovascular Services include:

- Diagnostic cardiac catheterization
- Emergent and elective Percutaneous Coronary Interventions
- Diagnostic peripheral catheterizations
- Electrophysiology testing

Open heart surgery:

- Traditional surgery
- Minimally invasive
- Valve surgery

MidMichigan Medical Center-Midland brought a team of highly skilled providers to their community. They are positioned to deliver the same high standards of patient services, improving access and the time to treatment along with the convenience and comfort of being closer to home.

MidMichigan Medical Center's heart is in the right place!

DRGs Convert to MS-DRGs *(con't)*

Old DRG	Old DRG Description	New DRG	New DRG Description
103	Heart Transplant or Implant of Heart Assist System	001	Heart transplant or implant of heart assist system w/MCC
		002	Heart transplant or implant of heart assist system w/o MCC
104	Valve w/CC	216	Cardiac valve & other major cardiothoracic procedure w/cardiac cath; w/MCC
		217	Cardiac valve & other major cardiothoracic procedure w/cardiac cath; w/CC
		218	Cardiac valve & other major cardiothoracic procedure w/cardiac cath; w/o CC/MCC
105	Valve w/o CC	219	Cardiac valve & other major cardiothoracic procedure w/o cardiac cath; w/MCC
		220	Cardiac valve & other major cardiothoracic procedure w/o cardiac cath; w/CC
		221	Cardiac valve & other major cardiothoracic procedure w/o cardiac cath; w/o CC/ MCC
106	CABG w/PTCA	231	Coronary bypass w/PTCA w/MCC
		232	Coronary bypass w/PTCA w/o MCC
108	Other Cardio Procedures	228	Other cardiothoracic procedures w/MCC
		229	Other cardiothoracic procedures w/CC
		230	Other cardiothoracic procedures w/o CC/MCC
110	Major CV Procedure w/CC	237	Major cardiovascular procedures w/MCC or thoracic aortic aneurysm repair (Procedure code 3973--Endovascular implantation of graft in thoracic aorta—is always assigned to MS-DRG 237 regardless of severity level)
111	Major CV Procedure w/o CC	238	Major cardiovascular procedures w/o MCC
117	Cardiac Pacemaker Revision, except device replacement	260	Cardiac pacemaker revision except device replacement w/MCC
		261	Cardiac pacemaker revision except device replacement w/CC
		262	Cardiac pacemaker revision except device replacement w/o CC/MCC
118	Pacemaker Replacement	258	Cardiac pacemaker device replacement w/MCC
		259	Cardiac pacemaker device replacement w/o MCC
120	Other Circ. System OR Proc	264	Other circulatory system O.R. procedures
121	Circ Disorders w/AMI w/Major Complications	280	Acute myocardial infarction, discharged alive w/MCC
122	Circ Disorders w/AMI w/o Major Complications	281	Acute myocardial infarction, discharged alive w/CC
		282	Acute myocardial infarction, discharged alive w/o CC/MCC
123	Circ Disorders w/AMI, expired	283	Acute myocardial infarction, expired w/MCC
		284	Acute myocardial infarction, expired w/CC
		285	Acute myocardial infarction, expired w/o CC/MCC
124	Circ Disorders except AMI w/Cath and Complex Diagnosis	286	Circulatory disorders except AMI, w/cardiac cath w/MCC
125	Circ Disorders except AMI w/Cath and w/o Complex Diagnosis	287	Circulatory disorders except AMI, w/cardiac cath w/o MCC
127	Heart Failure and Shock	291	Heart failure & shock w/MCC
		292	Heart failure & shock w/CC
		293	Heart failure & shock w/o CC/MCC
130	PV Disorders w/CC	299	Peripheral vascular disorders w/MCC

DRGs Convert to MS-DRGs *(con't)*

Old DRG	Old DRG Description	New DRG	New DRG Description
131	PV Disorders w/o CC	300	Peripheral vascular disorders w/CC
		301	Peripheral vascular disorders w/o CC/MCC
132	Atherosclerosis w/CC	302	Atherosclerosis w/MCC
133	Atherosclerosis w/o CC	303	Atherosclerosis w/o MCC
143	Chest Pain	313	Chest pain
144	Other Circ System Diagnosis w/CC	314	Other circulatory system diagnoses w/MCC
145	Other Circ System Diagnosis w/o CC	315	Other circulatory system diagnoses w/CC
479	Other Vascular Proc w/o CC	252	Other vascular procedures w/MCC
515	Cardiac Defibrillator Implant without Cardiac Cath	226	Cardiac defibrillator implant w/o cardiac cath w/MCC
		227	Cardiac defibrillator implant w/o cardiac cath w/o MCC
518	PCI without Stent or AMI	250	Perc. cardiovascular proc w/o coronary artery stent or AMI w/MCC
		251	Perc. cardiovascular proc w/o coronary artery stent or AMI w/o MCC
525	Other Heart Assist System Implant	215	Other Heart Assist System Implant
535	Cardiac Defib Implant w/Cardiac Cath w/AMI, HF or Shock	222	Cardiac defib implant w/cardiac cath; w/AMI/HF/shock; w/MCC
		223	Cardiac defib implant w/cardiac cath; w/AMI/HF/shock; w/o MCC
536	Cardiac Defib Implant w/Cardiac Cath w/o AMI, HF or Shock	224	Cardiac defib implant w/cardiac cath; w/o AMI/HF/shock; w/MCC
		225	Cardiac defib implant w/cardiac cath; w/o AMI/HF/shock; w/o MCC
547	Coronary Bypass w/Cardiac Cath w/major CV Dx	233	Coronary bypass w/cardiac cath; w/MCC
548	Coronary Bypass w/Cardiac Cath w/o major CV Dx	234	Coronary bypass w/cardiac cath; w/o MCC
549	Coronary Bypass w/o Cardiac Cath w/major CV Dx	235	Coronary bypass w/o cardiac cath; w/MCC
550	Coronary Bypass w/o Cardiac Cath w/o major CV Dx	236	Coronary bypass w/o cardiac cath; w/o MCC
551	Perm. Cardiac PM Impl. w/major CV Dx or AICD Lead or Generator	242	Permanent cardiac pacemaker implant w/MCC
552	Other Perm. Cardiac Pacemaker Implant w/o major CV Dx	243	Permanent cardiac pacemaker implant w/CC
		244	Permanent cardiac pacemaker implant w/o CC/MCC
553	Other Vascular Procedures w/CC w/major CV Dx	253	Other vascular procedures w/CC
554	Other Vascular Procedures w/CC w/o major CV Dx	254	Other vascular procedures w/o CC/MCC
555	Percutaneous CV Procedures w/major CV Dx	248	Perc. cardiovascular proc w/non-drug-eluting stent w/MCC or 4+ ves/ stents (Combination procedures (0066 and 3606) with 0043 or 0048 is always assigned to MS-DRG 248 regardless of severity level)
556	Perc. CV Procedures w/ Non-Drug Eluting Stent w/o major CV Dx	249	Perc. cardiovascular proc w/non-drug-eluting stent w/o MCC
557	Perc. CV Procedures w/ Drug Eluting Stent w/major CV Dx	246	Perc. cardiovascular procedure w/drug-eluting stent; w/MCC or 4+ vessels/stents (Combination procedures (0066 and 3607) with 0043 or 0048 is always assigned to MS-DRG 246 regardless of severity level)
558	Perc. CV Procedures w/ Drug Eluting Stent w/o major CV Dx	247	Perc. cardiovascular procedure w/drug-eluting stent; w/o MCC