CARDIOLOGY ADVOCACY ALLIANCE

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STATEMENT TO THE NATIONAL COMMITTEE ON VITAL HEALTH STATISTICS SUBCOMMITTEE ON STANDARDS

November 18, 2011

Dan Caldwell, Chairman

On behalf of the 5,000 cardiologists in private practice and within integrated organizations across the country that we represent, the Cardiology Advocacy Alliance (CAA) submits the following observations about agenda items for the National Committee on Vital Health Statistics (NCVHS) Subcommittee on Standards at the November meeting.

CAA's mission is to support the sustainability of the cardiovascular professional regardless of practice setting. CAA represents the common interests of the cardiovascular patient and professional on such issues and encourages its members to advocate for their patients and their practices. CAA member practices devote themselves to continuous quality improvement and use benchmarking data and other tools to ensure that they are offering the highest quality care to their patients. As such, the super majority of CAA members have electronic medical records and already have attained the meaningful use threshold for Phase I. Further, many CAA member practices belong to MedAxiom, Inc., a network that provides detailed feedback on how practices compare to their peers for more than 300 cardiology practices, representing over 5,500 cardiologists.

Claim Attachments

According to our many CAA members that participate in Medicare's Physician Quality Reporting Initiative, data reported by the Centers for Medicare & Medicaid Services on their quality indicators is incomplete and

inaccurate. These observations are consistent with the findings of the Government Accountability Office in their August 2011 report "Medicare Physician Feedback Program: CMS Faces Challenges with methodology and Distribution of Physician Reports." This is just one example for why the industry must move to a real-time clinical data transaction standard for sharing of quality indicators.

While CAA supports pay-for-performance standards that are based on clinical – not claims – data, there isn't an easy way to transmit this clinical data today. Instead, this type of granular information is dropped to paper and copies of medical record information then is sent through the mail for health plan review. Or, like with MedAxiom data, it is shared through a separate web portal and requires manual intervention to perform comparisons. Without a comprehensive final rule that addresses how medical record chart abstracts, that may even originate in an electronic medical record, can be transmitted privately and securely through a standardized electronic transaction, true clinical data sharing cannot be achieved. CAA recognizes that the Attachments Rule is only one part of the quality data interchange, however it plays a significant role and must consider how this type of data may be shared.

In addition, CAA supports specialty-specific appropriateness criteria such as those of the American College of Cardiology to address inappropriate imaging while ensuring that patients get the care they need. The Medicare Improvement for Patients and Providers Act of 2008 also requires that a study be conducted on the impact that appropriateness criteria have on imaging utilization. This data is stored separately in individual clearinghouses that today are organized by specialty. Thus, an ordering physician could report information to multiple clearinghouses that are unable to integrate data. A new concern for interoperability for appropriateness criteria and prior authorization clearinghouses looms as Medicare evaluates the use of these advanced imaging service coverage control tools. Yet, it remains unclear how this information could be shared with Medicare by the ordering physician to process a related health claim. For example, how would a physician tie their appropriateness criteria evaluation information to the evaluation and management service where the advanced image was ordered? Presumably, this information would be shared through a secondary transaction or by an attachment to the claim.

Lastly, in the private insurance world, radiology benefit management (RBM) companies are often used to facilitate the prior authorization of advanced imaging services. RBMs say their prior authorization decision pathways are based on quality indicators; however, they liberally interpret national guidelines in favor of not covering tests and refuse to share their decision-making guidelines with physicians. To date, the electronic dialog to facilitate prior authorization is not a standardized transaction or data set. Both the information submitted by ordering physicians for prior authorization and the response by the RBM must be standardized to enable better coordination of care and clarity on the health plan rationale for denial of coverage for medical appropriateness. The response must be granular enough to clearly identify what national guideline was used and why the order did not meet the criteria for coverage.

On a related note, the nomenclature used for all of these transactions must also be standardized. Today, quality metrics and prior authorization programs use incongruent medical terminology. CAA strongly recommends that NCVHS adopt the SNOMED medical nomenclature standard for all these future and updated transactions and standards so that health plans, venders and provides may compare data consistently.

Enrollment Forms

The CAA supports efforts to streamline and standardize all physician enrollment or credentialing processes and encourage movement to electronic transaction. As CAA members move into integrated practices, we also ask that the NCVHS Subcommittee consider how delegated credentialing, where the hospital completes this process on behalf of the physician, can be further standardized. Lastly, we ask the Subcommittee to also include hospital privileging in the scope of standardization as the process evaluates nearly identical information as a health plan credentialing review.

Claim Edits/Plan Payment Rules

Today, CAA members spend a great deal of time and expense on evaluating how claims were processed and why coverage was denied. This time could be better spent on direct patient care. CAA implores the

Subcommittee to evaluate how data and transaction standards can be strengthened to provide consistent responses across health plans that are predictable and transparent to the physician and their office staff.

An example of opportunity in this area is to provide health plans usage conventions of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC). Today, each health plan has very broad guidelines on when to use each CARC and RARC. CAA directs the Subcommittee to review and expand upon the work already achieved by the Minnesota Administrative Uniformity Committee for the standardization of CARC and RARC use by health plans.

Venders as Covered Entities

Today, cardiology practices are struggling with numerous implementation considerations such as the adoption and use of 5010 and ICD-10. CAA member practices rely on their venders to meet and exceed the standards within the deadlines established by Congress and NCVHS. However, these venders are not held accountable to the same level of compliance as CAA member practices. Instead, all compliance concerns are borne by the medical practice or health plan. Therefore, CAA strongly urges NCVHS to add clearinghouses and software venders to be within the scope of the covered entities that must comply with the health care data sets and transaction standard regulations. This change encourages the universal accountability and engagement of the entire health care community in the establishment, updating and sun-setting of these standards.

On behalf of CAA, I thank you very much for the opportunity to share our thoughts with you today. CAA realizes that NCVHS is called upon to accomplish an extremely difficult and complex task to address standards for health care transactions and data sets. Our members and staff are available as resources as you examine and address these critical issues.