Multispecialty Outpatient Cardiovascular Association

August Edition

HRS Position on Ablations in Ambulatory Surgical Centers

Background: ASC Covered Procedures List

Requests to add cardiac ablations to the ASC CPL were submitted to CMS by the Ambulatory Surgery Centers Association (ASCA). These codes were regrettably not accepted by CMS for 2023 and 2024. A request for 2025 has been submitted by ASCA and currently is under consideration. To establish that Medicare beneficiaries are protected, CMS welcomes additional evidence that a substantial number of these ablation procedures have been safely performed in the ASC setting on patients covered by other payers.

In July 2024, CMS will publish the Hospital Outpatient Prospective Payment System (OPPS) and ASC Payment System proposed rule that will clarify whether ablations have been proposed by CMS as an addition to the ASC CPL. At that time, HRS will submit comments to CMS for consideration. The final rule with the CMS decision about the ASC CPL for 2025 will be published in November 2024.

It is worth noting that rule-making changes typically take several years, and it is not uncommon for procedures to be submitted for inclusion in the ASC CPL multiple times before success is achieved, particularly for those procedures represented by codes that reside outside the CPT “surgery” range.

HRS/ACC Considerations and Findings

Members of a joint HRS/ACC Working Group are crafting a foundational document based upon patient considerations related to the safety of same day discharge (SDD) for ablations and including consideration for ablations performed in the ASC setting. This group has carefully reviewed published clinical data and engaged the Moran Company (a healthcare consulting group) to analyze historical Medicare fee-for-service claims data. https://www.hrsonline.org/guidance/advocacy-in-action/hrs-position-ablations-ambulatory-centers

FYI:

- GLP-1 Receptor Agonists May Lower Mortality in Immune-Mediated Inflammatory Diseases and T2D

Physicians Lament Over Reliance on Relative Value Units: Survey

Most physicians oppose the way standardized relative value units (RVUs) are used to determine performance and compensation, according to Medscape's 2024 Physicians and RVUs Report. About 6 in 10 survey respondents were unhappy with how RVUs affected them financially, while 7 in 10 said RVUs were poor measures of productivity.

The report analyzed 2024 survey data from 1005 practicing physicians who earn RVUs.

"I'm already mad that the medical field is controlled by health insurers and what they pay and authorize," said an anesthesiologist in New York. "Then [that approach] is transferred to medical offices and hospitals, where physicians are paid by RVUs."

Most physicians surveyed produced between 4000 and 8000 RVUs per year. Roughly one in six were high RVU generators, generating more than 10,000 annually.

In most cases, the metric influences earning potential — 42% of doctors surveyed said RVUs affect their salaries to some degree. One quarter said their salary was based entirely on RVUs. https://www.medscape.com/viewarticle/physicians-lament-over-reliance-relative-value-units-survey-2024a1000fe2

Mandrola's Five Big Trials to Look for at ESC 2024

Cardiology has mysteries. One of the biggest is how transcatheter edge-to-edge repair (TEER) of functional mitral regurgitation (MR) worked so well in the COAPT trial and failed in the MITRA-FR trial.

Some experts point to a difference in patients, but that argument relies heavily on precise measurements taken from echocardiograms, which, when it comes to grading regurgitant lesions, falls short of precise. Some point to the funding of the divergent trials as an interesting association: the positive one funded by industry; the negative one funded by government.

The RESHAPE-HF trial may act as tiebreaker. Investigators randomly assigned patients with functional MR and left ventricular dysfunction to TEER or medical therapy. The authors have published a baseline characteristics paper that included detailed comparison to patients in COAPT and MITRA-FR.

RESHAPE-HF patients match up well to those in the other trials in regard to age, comorbidities, use of cardiac resynchronization therapy, and left ventricular ejection fraction (LVEF). But RESHAPE-HF patients may have had less severe functional MR. For instance, the RESHAPE-HF patients had lower mean B-type natriuretic peptide values, slightly better kidney function, less severe MR, and a lower mean effective regurgitant orifice than patients in COAPT and MITRA-FR. https://www.medscape.com/viewarticle/mandrolas-five-big-trials-look-esc-2024-2024a1000fkt

Adaptive Brain Stimulation a 'Game Changer' for Parkinson's?

Personalized, adaptive deep brain stimulation (DBS) can enhance the control of motor symptoms of Parkinson's disease (PD) compared with standard DBS, new research suggests.
In a blinded randomized crossover pilot trial involving four patients, adaptive DBS reduced the time spent with motor symptoms by half and improved patients' quality of life compared with standard DBS.

"This is the future of deep brain stimulation for Parkinson's disease," study investigator Philip Starr, MD, PhD, professor of neurological surgery and co-director of the University of California San Francisco (UCSF) Movement Disorders and Neuromodulation Center, said in a statement.

"Adaptive DBS represents a major breakthrough in managing the symptom fluctuations in Parkinson's disease by tailoring stimulation in real time to patients' specific needs," Carina Oehrn, MD, PhD, research fellow in the Starr Lab at UCSF, told *Medscape Medical News*.

DBS is a standard therapy for advanced PD. Standard DBS provides continuous, fixed stimulation that is unresponsive to patient activities or variations in severity of symptoms during daily life. https://www.medscape.com/viewarticle/adaptive-brain-stimulation-game-changer-parkinsons-2024a1000f7y

The Most Misinterpreted Study in Medicine: Don't Be TRICCed

Ah, blood. That sweet nectar of life that quiets angina, abolishes dyspnea, prevents orthostatic syncope, and quells sinus tachycardia. As a cardiologist, I am an unabashed hemophile. But we liberal transfusionists are challenged on every request for consideration of transfusion. Whereas the polite may resort to whispered skepticism, vehement critics respond with scorn as if we'd asked them to burn aromatic herbs or fetch a bucket of leeches. And to what do we owe this pathological angst? The broad and persistent misinterpretation of the pesky TRICC trial. You know; the one that should have been published with a black-box warning stating, "Misinterpretation of this trial could result in significant harm."

Point 1: Our actively bleeding patient is *not* a TRICC patient. Published in 1999, the TRICC trial enrolled critical anemic patients older than 16 years who were stable after fluid resuscitation and were not actively bleeding. They had a hemoglobin level < 9 g/dL and were expected to stay in the intensive care unit (ICU) for more than 24 hours. They were randomly assigned to either a conservative trigger for transfusion of < 7 g/dL or a liberal threshold of < 10 g/dL. Mortality at 30 days was lower with the conservative approach — 18.7% vs 23.3% — but the difference was not statistically significant (P =.11). https://www.medscape.com/viewarticle/most-misinterpreted-study-medicine-dont-be-tricced-2024a1000f7k

Upcoming:

- Next Meeting: Wednesday, September 25th at 5:30pm via Zoom
- Have an interesting case you'd like to share with the group? Contact Sarah Cook to be the next M & M Speaker to the MOCA Group!