

Cardiac CT supporters celebrate Medicare decision to maintain status quo

Cardiac CT supporters are crediting a multisociety lobbying effort and solid scientific evidence for the Centers for Medicare and Medicaid Services decision Wednesday to not move forward with a national coverage policy for coronary CT angiography.

Enactment of a national coverage determination for coronary CTA would have set aside local policies that authorize payment for the procedure in all 50 states. Many local coverage determinations were based on a model developed and supported by the American College of Cardiology.

A national policy would also have strengthened resistance to granting payment among private insurers, especially Blue Cross/Blue Shield plans, according to several sources.

With its decision against a national coverage determination, CMS also set aside plans to demand additional evidence to justify reimbursement for coronary CTA. The proposed national policy, released in December 2007, would have limited reimbursement for coronary CTA to symptomatic patients with chronic angina at intermediate risk of coronary artery disease and symptomatic patients with unstable angina at low risk of short-term death or intermediate risk of CAD.

To qualify for payment, patients would have had to undergo the procedure at facilities participating in CMS-approved clinical trials. At the same time, Medicare payment would have been denied to most of the estimated 2000 U.S. facilities equipped with multislice scanners capable of performing coronary CTA until the end of the trials.

The proposed national coverage determination would not have affected Medicare payment for other cardiac CTA applications. For those procedures, policies enforced by the agency's local carriers would still have applied.

Still, the threat of a coverage-with-evidence-development requirement cast a pall over the medical imaging industry. Multislice CT equipment sales slowed, and plans for many new cardiac CT services were put on hold.

A CED would have been devastating for Medicare beneficiaries, according to Dr. Michael Poon, president of the Society of Cardiac Computed Tomography.

"Only a select few academic centers with the resources to conduct trials would have been able to do cardiac CT. Most rural hospitals equipped with 64-slice CT would not be able to do the tests," he said.

Radiologists and cardiologists were overjoyed with CMS's decision to maintain the status quo.

"They did the right thing," said Dr. Daniel Berman, president-elect of SCCT and chief of cardiac imaging and nuclear cardiology at Cedars-Sinai Medical Center in Los Angeles. "We are happy that CMS took into account all of the available evidence, and did such an unusual thing, which is to change their mind in the middle of a decision."

The favorable CMS decision demonstrated the value of a multisociety approach to lobbying Medicare about crucial policy questions, Poon said. His group joined with the American College of Cardiology, American

College of Radiology, American Society of Nuclear Cardiology, North American Society for Cardiac Imaging, and Society for Cardiovascular Angiography and Interventions in a joint effort in mid-2006, when CMS first proposed a possible national policy.

Data were assembled through the fall of 2007 and presented to CMS during a conference call in December. The argument presented at that time was not reflected in the proposed national policy CMS announced later that month, but the substance of several discussions between CMS and the coalition in January and February are reflected in the final decision, Poon said.

CMS was impressed that the nuclear cardiology association, whose members use perfusion SPECT to diagnose coronary artery disease, would adopt a position that runs against their vested professional interests, Poon said.

"The fact that we worked together was convincing," he said.

The coalition's emphasis on important clinical trials that CMS had not considered in the draft national coverage determination was also pivotal, Poon said. Through written comments and several meetings with CMS officials, the group stressed that 25 studies examining the efficacy of 64-slice CTA were not addressed in the CMS evaluation.

CMS was also informed about numerous studies that are pending publication, said Dr. Matthew Budoff, an assistant professor of medicine at Harbor-UCLA Medical Center.

"There are 20 to 30 manuscripts per month being published," he said. "It is very difficult to write national coverage policies when there is more science relevant to the decision appearing practically every day." The coalition's effort was also reflected in the written comments filed with CMS. The agency received 670 comments in the 30 days after publication of the proposed decision. Ten agreed and 649 disagreed with the proposal to apply a CED requirement. The other comments provided no clear direction for coverage. Seventy-nine elected members of the U.S. Senate and House of Representatives also sent letters asking CMS to reconsider its proposal, according to Dr. Bibb Allen, vice-chair of the ACR economics commission. CMS remains concerned that coronary CTA will add a new layer of medical imaging utilization and cost without reducing the use of existing nuclear cardiology, echocardiology, or coronary catheterization studies, said Dr. Pamela Woodward, president of NASCI.

"The message to physicians is that this test shouldn't be additive, especially for normal patients. It has a high negative predictive value. Patients who have a normal coronary CTA do not need additional imaging."

The ACR and ACC are both developing cardiac CT appropriateness criteria to address Medicare's fears, according to Allen.

"Our goal is not to make cardiac CT just another test but to have some ability to replace existing workups to save downstream costs and minimize risk to the patient by eliminating the need to perform catheter angiography in some cases," he said.