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ASITN To Hold First Annual Practicum



Prac·ti·cum [prak-ti-kum] n. A course of study designed especially for the preparation of teachers and clinicians that involves the supervised practical application of previously studied theory.

ASITN is pleased and excited to announce our First Annual ASITN Practicum! This meeting will begin at the close of the ASNR annual meeting on Friday evening, May 2, and continue through Sunday noon, May 4. It will be located at the Marriott Wardman Park Hotel, the same place as the ASNR.

The Practicum is a combination of hands-on workshops and didactic sessions. The workshops will take place on Saturday morning and will cover such topics as vertebroplasty, carotid intervention, aneurysm intervention and stroke intervention, followed by an afternoon of problem-oriented, practical

didactic sessions. Sunday morning sessions will be devoted to practice-related issues: examples of different practice models and an open discussion of the complex issues facing us today. This session is intended to address some of the issues raised at our Joint Meeting with the Cerebrovascular Surgery Section in Phoenix this past February.

You should have received a hard copy of the registration brochure in the mail. If you have any questions, please feel free to contact ASITN at info@asitn.org or 703-691-2272. We look forward to seeing you in May!

American Stroke Association Includes Programming by ASITN

More than 2400 attendees enjoyed the February International Stroke Conference in Phoenix, AZ. The program offered more than 450 presentations focusing on current advances in the basic sciences of cerebral circulation and brain function, clinical stroke research and outcomes, rehabilitation science and surgery. There was a new Saturday afternoon session at the end of the Stroke Conference that was jointly sponsored by the

ASA, ASITN and JSCVS. This session, covering Vertebrobasilar Occlusive Disease and Imaging in Patient Selection for Acute Stroke Therapy, was very well attended and we look forward to more collaborations with the ASA.

New members of the 17-member ASA Program Committee were announced, including Pierre Gobin and Greg Sorensen. Tom Tomsick remains Co-Chair of the Hemorrhage Category.

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President's Message

Randy Higashida, MD

Cordis Neurovascular Presents ASITN with \$20,000 Grant

An exciting holiday gift was presented to ASITN in December by Cordis Neurovascular. Cordis has presented ASITN with a \$20,000 grant to be used to promote the results of ISAT and information on stroke to patients. We are very excited about this grant and will be reporting on our patient education campaign in a future issue of *The Embolus*. Our thanks go out to Cordis Neurovascular for their generosity.

Welcome to the 1st Quarter Issue of *The Embolus*! We hope that you continue to enjoy this quarterly member benefit.

ASITN is setting the stage for an exciting and successful 2003. We could not be more pleased that the First Annual ASITN Practicum will take place May 2-4, 2003. Colin Derdeyn and his Program Committee have put many hours into creating a program that is both informative and exciting! Make sure you have this meeting on your calendar.

ASITN remains committed to helping our membership thrive in what is an increasingly

competitive environment. We will be offering a practice building session on Sunday, May 4 during the Practicum and encourage you to attend. Also, all active members should have received the ASITN Practice Building guide last summer. This is a wealth of information that can and should be utilized to the fullest.

Thank you for your continued support of ASITN!

Randall T. Higashida
md

Practice Building Corner – Credentialing

Gary Duckwiler, MD

This is the first in a series of Practice Building articles that will appear this year in The Embolus. All of the articles will be consolidated in a special supplement at the end of the year. We hope you find this series helpful.

The importance of credentialing cannot be overstated. It forms the basis of specialties, training, hospital privileges, quality assurance policies and procedures, and ultimately an individual's or groups existence.

The range of credentialing processes go from informal practice parameters to well documented and enforced hospital policies. The particular arrangement for an individual will be highly dependent upon local polices, procedures and often on more political concerns. Modifications may be necessary at each institution.

As the specialty of Interventional Neuro-radiology or now more formally Endovascular Surgical Neuroradiology (as described by the ACGME), has many documents defining the training (position papers, editorials and ACGME Fellowship requirements) and expertise necessary for performance of Neurointer-

ventional procedures, these now form the basis and give the weight necessary to move forward with formal credentialing.

We encourage our members to review these materials, analyze their own local environment and proceed with this process.

We are a small society, and what we do is not always visible to the rest of the medical community. This process will not only inform the medical staff and hospital administration, but also solidify our members as clinicians and experts in this field.

Careful and meticulous documentation of one's own cases, outcomes, and financials is necessary in this process. Also, one cannot discount local knowledge. I have once heard that you never ask for a vote unless you know the count. The very foundation of our specialty is on the line, and the ASITN is committed to help in any way possible through this process. The ASITN website contains many of the materials necessary to proceed. This is not just "one more thing to be put off", but also an investment in our future.

No single approach is the right way, but inaction is definitely the wrong way.

HIPAA

A word to the wise: as we write this at the end of February, there is still no compliance deadline for the new Health Insurance Portability Accountability Act (HIPAA) Security Rule, but now is the time for each of us to get ready. In essence, this HIPAA set of rules, which will have the force of law, says that you have to take all reasonable steps to protect your patient's health information. No, we don't know what reasonable means yet, but now is the time to do your own internal security assessment for your own practice.

It appears that the chief problem will be providing computer security, as computers have come to be the basis of our data management. Restricting password access is probably the first step, and those passwords have to be secure. Who else has a back door to your computer? You don't know? Time now to find out. And, oh yes, remember all of those images you've shown at conferences with the patient name plainly visible? No more. Finally, it is time to set up a procedure for logging off your computer, requiring all your employees to log off, and, in the best of all possible worlds, have some person in the organization responsible for security, and especially responsible for terminating access rights to somebody who leaves the organization. A password-aging plan is a good idea too. The guidance is passwords to be changed every 35 days. I know that is an onerous task – personally, I have five separate passwords to change here at UCSD. There are knowledgeable people in our organization, and I will ask them to write a summary of this important set of rules for the next issue, because by that time we should have harder information.

PRACTICE GUIDELINES

Practice Guidelines are in the news again. We see in the February 3, 2003 *Wall Street Journal* that we are once more being criticized for lack of practice guidelines. It seems that a study done at Kaiser Permanente asked 135 physicians to evaluate the same patient who had a urinary tract infection. They recommended 82 different strategies. I don't think

we have that problem in our field, as we have published good guidelines (see the Website) but, in a rapidly evolving field such as ours, we need to keep the problem in mind. Probably where we fall down the most is in our outpatient care. Do you have an internal system that reminds you to contact the patient for a follow-up study, after for example an aneurysm coiling? It is easy to make a "bring up" plan today with the widespread availability of Palm and PDAs. If you express enough interest, we will put on a whole session on the use of Palm devices at one of the meetings.

HEALTH CARE COSTS AND THE FUTURE

More problems with money are on the horizon apparently. Laura Landro, a health-care-savvy reporter, who has written a book about her own personal management of her malignant lymphoid disease, predicts that the costs and politics of healthcare will dominate the next Senatorial and the next Presidential election. In a study conducted by the Kaiser Foundation and the Harvard School of Public Health, April-July 2002, healthcare costs and prescription drug costs are the greatest concerns of the general public. Medical errors, something we hear so much about in the news (see the 1999 Institute of Medicine report "To Err is Human" which said 44,000-98,000 Americans die each year from preventable medical errors) is an issue for only about 5% of people. We docs differ from the public, believing that 28% of our focus is on malpractice insurance costs and lawsuits, 27% on healthcare costs, and 22% on problems with healthcare plans. Like the general public, we ascribe only a 5% problem rate to medical errors. This has all to do with "healthcare headaches."

To put some numbers on the problem, national healthcare spending has grown last year 8.7%, which accounts for 14.1% of our gross domestic product. That's a lot of money.

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Spotlight on: Corporate Advisory Council

Since the Corporate Advisory Council was announced in the last newsletter, two more companies have joined. We are pleased to announce that **CORDIS NEUROVASCULAR** and **CONCENTRIC MEDICAL** have both become members of our Council. We hope to add many more companies in the coming months.

American Heart Association Abstract Submission Open

You're invited to submit abstracts for the American Heart Association's Scientific Sessions 2003. Scientific Sessions encompass four days of invited lectures and investigative reports. Simultaneous presentations represent all fields of cardiovascular and related disciplines.

Submit your abstract electronically to <http://www.scientificsessions.org/abstracts/index.jsp> by midnight May 30, 2003.

The AHA Scientific Sessions will be held from November 9-12, 2003 in Orlando, Florida.

Questions or comments can be directed to sessions@heart.org.

ASITN Represented at the NINDS Stroke Meeting

Tom Tomsick, MD

The NINDS Stroke Symposium "Improving the Chain of Recovery for Stroke in Your Community" was held at the Hyatt Regency Crystal City, Virginia, December 12 and 13. Leaders from the hospital, neurology, emergency medicine, nursing and public health communities and representatives of 70 professional societies (including the ASITN, ASNR, SIR, and ACR) and voluntary organizations analyzed current stroke care and discussed how to implement and improve systems to more efficiently identify, transport and treat acute stroke patients. The meeting was structured loosely on the consensus model – pre-designated task forces worked on revising "strawman" documents that had been drafted by the various task forces that are addressing six key barriers:

1. Public Recognition and Response to Stroke:

This session focused on the first link in the chain of recovery: public knowledge and motivation to act. Participants discussed campaigns that work, community outreach, stakeholders, and the need to reach special populations.

2. Choosing Your Level of Care:

This session focused on recognizing the tremendous variability in community settings and making the most of existing resources, focusing on the primary and comprehensive stroke center concept. Participants discussed assessing ability to provide basic requirements in the emergency departments, interdisciplinary teams, radiology and laboratory services, in-house stroke care, and visions for the future. These assessments will be used in stroke center designation.

3. Professional Education:

This session focused on ways to improve and expand targeted medical education for stroke care providers. Participants discussed targeting existing curriculae, professional development, and using new technologies.

4. Templates for Organizing Stroke Triage:

This session focused on what happens before the stroke patient gets to the hospital. Participants discussed EMS triage policies, stakeholders, hospitals and physician participation, successful models, and levels of service in both urban and rural areas.

5. Incentives for Stroke Treatment:

This session focused on a variety of means to provide incentives for health care providers and hospitals to deliver optimal stroke care. Participants discussed methods of overcoming monetary and medico-legal barriers in order to provide optimal treatment for patients.

6. Support Systems for Providers:

This session focused on developing and implementing mechanisms to support on-site physicians and health care providers in such areas as clinical diagnosis, radiological interpretation (including teleradiology), management decisions, and delivery systems. Radiologic interpretation was highlighted as one area emergency physicians find inadequate in many locales.

Clearly the emphasis of this symposium was on assessment of systems for pre-hospital, emergency department, and in-hospital stroke care. The emphasis was not on details, specifics, or modalities of treatment. The symposium leaders were careful to include all stroke in discussion (ICH, SAH, and ischemic stroke), and to emphasize all general facets of acute stroke management, not just hyperacute thrombolytic therapy. However, thrombolysis was acknowledged as the "elephant in the room", whose shadow can't be ignored in discussions of advanced acute stroke care, when 80% of strokes are ischemic.

Unfortunately, organized Radiology and INR was not included on any of the Task Forces authoring the documents. Section 2 above nicely incorporated INR into the original

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We Want You!



ASITN Committees are still looking for a few good men and women to swell their ranks! Listed below, please find committee descriptions. If you see anything that strikes your fancy, please contact Marie Williams at marie@asitn.org and she'll get you in touch with the Committee Chair.

Billing/Coding

The Billing/Coding Committee monitors and responds to coverage and payment challenges. It develops positions and advocates these positions on such relevant areas as Medicare coverage, facility and physician payment, and managed care reform. The committee authors model coverage policies on interventional neuroradiology procedures as a resource for local Medicare carriers. The committee fosters relations with the Centers for Medicare & Medicaid Services (CMS) and its local Medicare carriers. In addition, the committee provides educational resources to ASITN members including the *Interventional Neuroradiology Coding Users' Guide*, coding advice, and programs.

Communications

The Communications Committee serves as a resource to the Society. Committee members will be able to respond rapidly to requests for interviews from the media when comments are needed and may be called on to act as a spokesperson on specific issues. The committee will also focus on increasing the profile of interventional neuroradiology among other physicians and the lay public.

FDA

The FDA Committee shall develop and maintain a constructive relationship between the Society and the FDA and increase awareness of FDA programs within the Society's membership.

Research

The Research Committee shall promote quality research by informing the Society of new ideas for basic, applied/clinical, and health services research, identifying research priorities, serving as a source of research information, promoting the communication of research information amongst members of the Society, providing research training opportunities to members of the Society, and serving as the Society's liaison with other research organizations.

Technology Assessment

The Technology Assessment Committee's charge is to advise the Society on device matters related to interventional neuroradiology. The Committee shall produce guidelines that ensure that devices used in the practice of interventional neuroradiology are applied safely and appropriately to patients. In addition, the Committee will ensure that patients have timely access to important new technological advances. The Committee also reviews documents produced by the Standards of Practice Committee.

We're Hungry for News...

About You!

One of the most valuable services that ASITN performs is to provide various forums to help members keep up with industry trends, swap stories, and share good news. To do that, ASITN has to hear from YOU!

How can you keep us informed? It's easy. Add us to your mailing list for all press releases, newsletters, and other publications. Call us or drop a note to let us know about new personnel, procedures, or studies. Send us copies of newspaper, magazine, or journal articles in which you are featured.

Send your materials to info@asitn.org, via fax at **703-691-1855**, or by mail at 10201 Lee Highway, Suite 500, Fairfax, VA 22030.

1 S T A N N U A L

ASITN Practicum

*You'll never get a second chance to attend the
First Annual ASITN Practicum*

May 2-4, 2003

Marriott Wardman Park Hotel • Washington, DC

Vertebroplasty Practice-Building Tip

Looking to expand your vertebroplasty referrals? The National Osteoporosis Foundation (NOF) web site, www.nof.org, has a listing of all the physicians who are members of its Professional Partners Network®. These physicians have a large component of osteoporosis patients in their practices and are listed geographically in the “doctor finder” feature on NOF’s web site. You can pull down a list of the osteoporosis doctors in your area and let them know you provide vertebroplasty.

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REIMBURSEMENTS, DENIALS, and HOW WE CAN HELP PATIENTS

Have you ever wondered what happens when your claim for payment is denied? Do you just let it slip on by? You know the hospital and your group then bills the patient, don’t you? We win and more importantly, the patient wins if we have a reasonable system to reverse denials.

Let’s face it, health provider organizations are programmed to say “NO,” and that our appealing brings headaches, time wasted, anger, frustration, and another “NO.”

Insurance companies, however, are not the invincible faceless bureaucracy we believe.

It appears that the best process is to have the patient initiate the appeal – with our help. Given that insurers are under intense pressures, both from the government and the press to present a “gentler and kinder” image, we can use this to our patient’s advantage. The public backlash against HMOs has led many of the states to pass laws setting up external review panels. Try the Internet for information on this because each state is a little different. Here is another study that will raise your hopes: A Kaiser Family Foundation Review, albeit only in four states – show that patients had a 52% chance of winning their first in-house appeal, and 44% of those remaining won on the second appeal. Of those remaining, 45% won when they went to the third level, the Independent State Review Board. Time and energy? Yes. Important precedent-setting for your own practice? Absolutely.

On the back of each insurance card, there is an 800 number to call for appeals. My advice, based upon a less than rigorous

scientific sampling, is to ignore it, and help the patient write a letter instead. Send it by Return Receipt mail. Document and keep copies of everything. Be reasonable, scientific when possible, and state in the last paragraph specifically what you want. Attach all appropriate medical records, bolded with fluorescent highlighter, and be certain to indicate that a “no” response will be followed by a higher appeal.

If you get a second denial, appeal again. I keep these letters generically on my computer desktop. Look at that second denial letter though, because it’s likely to focus on the key reason for the company’s refusing the coverage. If you can get a letter from another physician in

your division showing why the procedure was a medical necessity, you will be way ahead. Any literature that you can quote, even off the top of your head, will help.

If you get another denial, the letter will almost certainly state, “This is your last or final appeal.” Don’t believe it. Now is the time to go outside the company. And where to go depends upon the state you live in. Time now to hit the Internet, isn’t it?

If you had a denial for something fairly substantial – like a spinal cord angiogram – it is even worthwhile getting an attorney. In San Diego, we

have an attorney who specializes in these claims, and even though his rates are high, you will end up with more than if you had a Medi-Cal or Medicare discount.

One final caution: Beware of bundling. If you do two procedures, expect that you will get a denial for both, often routinely. You have to make a moral decision about whether to do multiple procedures on the same patient. For example, if you do a physical examination and then a vertebroplasty here, you are likely not

A Kaiser Family Foundation Review... show that patients had a 52% chance of winning their first in-house appeal, and 44% of those remaining won on the second appeal. Of those remaining, 45% won when they went to the third level, the Independent State Review Board.

to get paid for the physical examination, as most carriers believe that you should be looking at the patient before you do that kind of an invasive procedure.

Isn't it time to give this problem serious thought? It's a shame to lose simply because of inertia.

In our hospital, we seem to make it a habit to hire parolees. The prison skin art (tattoos to you older readers) is often grotesque, usually graphic, and always extensive. One of our physicians tried to get our reception person at the CT scanner to wear up to the neck-buttoned long-sleeved shirts to hide the tattoos. He thought the tattoos were awful — intimidating to patients. I thought they were kind of interesting. Now this doc was a little guy, my size, and the receptionist in question weighed 270 pounds with less than a 3% body fat. The doc did not get too far with his request, (the interaction was amusing) and, quickly seeing the inadvisability of pressing the issue, retreated from his demand.

So how do you know about people? What if they don't have prison tattoos? How do you know whether somebody you hire, whether it is to manage your most sensitive office documents, or, even more importantly, to guard your kids, is reliable?

Background checks are, of course, a must. Try ussearch.com, tracetrust.com and mybackgroundcheck.com. Yes, there is a cost. Best money you can spend.

OPERATIONAL RISK MANAGEMENT

Two issues back, I promised you more information on risk managing in daily practice. Events have overtaken us, and if you will grant me a little patience, I will put together a whole article for the next issue.

In closing, we send the men and women who are fighting in distant lands our respect and our prayers.

document. However, there were a number of other areas where Radiology and INR input might have added substance to task force discussion, e.g., Radiologic interpretation as a perceived deficiency in acute stroke triage, and current availability of teleradiology as a community resource, among others. Inclusion of appropriate INR members to task forces would have added information on additional models of acute stroke care delivery, where an interventionist might be the champion for acute treatment delivery, as is the case in some locales. It must be acknowledged that the latter circumstance is the exception rather than the rule, and not to be misconstrued as the tail trying to wag the dog; even the interventionist needs the systems and infrastructure under discussion in place to be maximally effective.

During breakout and general sessions, ample time and opportunity was afforded for comments by Radiology organizations regarding the place diagnostic radiology, neuroradiology, and interventional neuroradiology do and must play in acute stroke care. Most of the deficiencies in the document regarding interventional neuroradiology did not warrant comment during general discussion, and were made as sidebar comments to chairs/authors/task force members during intermissions. This lack of Radiology input was acknowledged as a drawback by various section chairs during summary presentations on the second day.

I believe the final document will include substantial reference to INR's place in systems' resources, where appropriate. I foresee that final recommendations will include that Radiology departments assess and report their abilities to respond to guidelines for timely performance and interpretation of CT and MR imaging, as well as their position as resources for neurointerventional procedures. These assessments will ultimately be used (along with EMS, ED, neurology assessments) in designation of hospitals as primary or comprehensive stroke centers, as defined by criteria currently being drawn up by the Brain Attack Coalition.

Calendar of Events

American Society of
Neuroradiology
41st Annual Meeting
April 28-May 2, 2003
Marriott Wardman Park Hotel
Washington, DC
Contact: ASNR, 630-574-0220

1st Annual ASITN Practicum
May 2-4, 2003
Marriott Wardman Park Hotel
Washington, DC
Contact: ASITN, 703-691-2272

American College of Radiology
80th Annual Meeting and Chapter
Leadership Conference
May 10-15, 2003
Hilton Washington & Towers
Washington, DC
Contact: ACR, 1-800-227-5463

American Heart Association
Scientific Sessions 2003
November 9-12, 2003
Orlando, Florida
Contact: AHA, 1-800-242-8721

The Embolus

Editor in Chief:
Charles W. Kerber, MD
Managing Editor:
Marie Williams
Graphic Designer:
Barbara Erickson

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Send your articles, letters and comments to:

Charles W. Kerber, MD

The Embolus
10201 Lee Highway, Suite 500
Fairfax, VA 22030
703-691-2272
FAX 703-691-1855
www.asitn.org

American Society of
Interventional & Therapeutic
Neuroradiology
10201 Lee Highway
Suite 500
Fairfax, VA 22030

