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Upcoming Annual Meetings Break New Ground Off US Mainland!



Third Annual Practicum Live from Canada!

As ASITN gears up for the Third Annual Practicum, scheduled for May 20–22 in Toronto, Ontario, Canada, the program committee is putting the finishing touches on what promises to be a full weekend featuring the most recent information on topics ranging from stroke to spinal abnormalities.

In the tradition of the first two Practicums, program chair Rob Tarr says this year's meeting will once again synthesize a variety of elements including didactic sessions, workshops and case presentation and discussion while introducing material that is current and relevant. "In the planning phase, we worked particularly hard to preserve the format of the first two meetings by offering attendees a good mix of sessions as well as hands-on training, while incorporating subject matter that is new and fresh."

Scheduled before the ASNR meeting this year, the Practicum will kick off on Friday afternoon, May 20, with didactic sessions related

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Second Annual Course & Workshops Heats Up in Hawaii!



From the balmy breezes of Florida to the beautiful beaches of Hawaii, the Second Annual Course & Workshops is already making a splash. Scheduled for August 1-6 in Oahu, the meeting will feature exciting new program elements as well as play host to an international audience.

Program chair Josh Hirsch, who led last year's highly successful Practicum in Seattle, says he is thrilled with the progress of the planning. "We are right on schedule and already can sense the excitement that surrounds our second annual stand-alone conference."

This year, program planners have incorporated significant new elements into the meeting including the opportunity for submission of scientific abstracts. With the overall goal of establishing the weeklong meeting as *the* annual scientific forum for ASITN, society leaders are enthusiastic about the opportunities afforded by this newest initiative. "In keeping with our long-term objectives," says Gary

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On March 17, 2005, the Center for Medicare and Medicaid (CMS) came out with their final decision on payment for Carotid Artery Angioplasty and Stenting (CAS). Since this is of great interest to our membership, I have devoted the presidential letter to describing and discussing this decision.

Although the Food and Drug Administration (FDA) has approved the use of the Guidant Acculink/Accunet CAS system in symptomatic patients who have $\geq 50\%$ and asymptomatic patients with $\geq 80\%$ narrowing of the carotid (using NASCET criteria), the CMS controls payment in the Medicare population (with those rules generally adopted by other insurers). The 3/17/05 decision by CMS is at <http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=157>.

Fundamentally, this describes the patients appropriate for treatment under CMS guidelines to be symptomatic, with a $\geq 70\%$ stenosis (as measured by Nascet criteria), who are at higher risk for Carotid Endarterectomy (CEA) due to specific medical or anatomical conditions. In addition, CMS will only pay for procedures performed at facilities which have met their minimum requirements.

This primer is provided to our members to assist you in approaching your facility to begin performing and getting paid by CMS for Carotid Angioplasty and Stenting (CAS).

CMS Facilities Requirements

The key requirements are summarized below:

1. High quality, DSA systems capable of subtraction, magnification, road mapping, and orthogonal angulations
2. Sufficient device inventory, staffing and infrastructure to support a CAS program
3. Intraprocedural physiologic monitoring and support staff
4. Emergency resuscitation equipment and personnel
5. Clearly delineated institutional program for granting carotid stent privileges

6. Oversight committee empowered to
 - a. Identify the minimum case volume for an operator to maintain privileges
 - b. Identify risk adjusted threshold for complications that the institution will allow before suspending privileges or instituting measures for remediation
7. For Physician privileging, the Oversight committee encouraged to apply published standards from national specialty societies recognized by ACGME
8. All CAS data must be collected at that facility, analyzed routinely to ensure patient safety, and made available to CMS on request. Interval data analysis will not be less than every 6 months

In order to become a qualified facility, the above must be in place and a written affidavit attesting to this fact needs to be submitted to CMS.

How does the practitioner start this process?

Numbers 1-4 are obvious, and the individual, with the facility commitment to stock the appropriate inventory, can easily provide appropriate documentation.

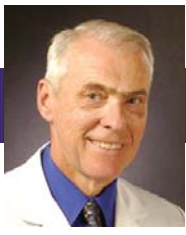
Number 5: This states that there must be a delineated process for granting privileges, and Number 7 recommends that those physicians meet the published standards.

Two approaches can be taken.

1. Take the Neurovascular Coalition Carotid Stenting Document to the Chief Medical Officer or Privileging committee and ask that it become the standard. This process may lead to resistance from other services, but assures that only those individuals with extensive cerebral angiography experience can perform CAS.
2. Give both the NVC and ACC documents as "acceptable pathways" for credentialing. This may be more acceptable to other services in the hospital, but opens the door to anyone to perform CAS.

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I have devoted this issue's letter to discussing the Center for Medicare and Medicaid's decision on payment for Carotid Artery Angioplasty and Stenting.



REFRESHER TRAINING OPPORTUNITY

By far the most important part of this issue is the news about the Practicum.

Rob Tarr and his committee have put together a superb program combining formal teaching with hands-on training. Impossible to beat if its two prior courses are any guide. It starts on Friday May 20, just before ASNR in Toronto. If you haven't yet registered, you still have time. Go to www.asitn.org for more information.

A WARNING SHOT ACROSS OUR BOW

In their best tradition of investigative reporting, the *Wall Street Journal* brought to light questionable — and probably illegal billing practices in some Radiology Scan Centers. Believe it or not, they gave the story more front-page space than they did when they broke the Enron scandal. (See www.wsj.com, to May 2005).

Is this important? Only if you are a Radiologist. Especially if you or your group has some ownership position in a center.

To get around anti-kickback laws and rulings, certain centers "lease" their facilities to other physicians. Those physicians then agree to send all patients to that center. The center charges a flat rate to the physician; the physician pays for the radiologic interpretation, then bills the insurance carrier the higher, going rate, usually making a few hundred dollars on the transaction.

Whether this practice is legal or not is beyond my capabilities to be certain. But two lawyers quoted in the article are waving red flags. "What part of this does *not* look like a kickback?" they ask. And, representatives of two centers say, "The practice is spreading like wildfire."

A little history: In the early '30s and '40s, the AMA came out firmly against a practice they termed "fee splitting." Dr. A had been referring to Dr. surgeon B not because he was the best for the patient, but because Dr. surgeon B returned a small percentage of his surgical fee to Dr. A. Not OK — the practice violated Medicine's golden rule. Through the years that anti kickback principle has been codified in laws both federal and throughout almost every state.

Who runs imaging centers today? Physicians — or business managers?

Scans are Medicare's fastest growing cost line item. Well, why not. They work. Can you think of practicing medicine without a scan? (It's a joke I know, but our neurologists, when consulted, get the scan — then see the patient.)

In all of this the inference is that physicians will overutilize the scanner because they will make a profit on each scan ordered. I cannot speak for everyone, and of course one can always find a dishonest professional, but I have yet to see any physician in the entire time I have practiced medicine order a test to make a profit. Physicians who refer to us have two primary motivations: first, to make a diagnosis, and second, sad to say, to protect themselves legally.

Note to Medicare: want to decrease scan usage? Address the plaintiff bar issue.

Back to reality, we must recognize that the front-page investigative article in a paper like the *Wall Street Journal* is a dire warning. Physician fees are a discrete and highly visible line item to any governmental organization wishing to control costs.

THE NEXT INTERVENTIONAL FRONTIER

The treatment of acute stroke — and perhaps more importantly, finding and treating the pre-stroke patient — is coming of age after a long gestation and difficult birth. The governmental agency that chooses who and how much to pay has, on 17 March, approved payment for carotid artery stenting, but only when done under certain conditions.

Our President has outlined the institutional and individual requirements and, though they seem somewhat onerous at first, are really quite straightforward.

Time is of the essence in this process: do you want to lead, or will you let the leadership position default to another service?

You can look on the Medicare web site for details, but Dr. Duckwiler has concisely summarized the needs and requirements, and getting the approval will take only a little timely work on our part.

See you in Toronto.

ASITN Elections Coming Soon!

Watch your mailboxes in late April for the nomination forms for the 2005-2006 Executive Committee. Final ballots will be mailed out in early June.

Positions that will be open for nomination are:

- Vice President (Automatically ascends to the position of President-Elect and President)
- Secretary
- Treasurer (2 year term)
- Nominating Committee Chair
- Member-at-Large

Remember, self-nomination is allowed and encouraged. So, if you have a desire to serve ASITN, please take a few minutes to participate in this important process.

Practice Building Corner

Firas Al-Ali, MD

People in the News

ASITN Member **Chris Dowd** and his colleagues at University of California, San Francisco appeared in the *San Francisco Chronicle* in an article about the use of the MERCI device on a 16-year-old girl who was 9 hours out by the time of treatment.

ASITN Member **Pierre Gobin** was featured in multiple media outlets, including CNN, *The New York Times*, and others, upon treating rocker Neil Young for a brain aneurysm.

If you have been featured in a local, national or worldwide publication, please let us know! Contact Marie Williams at 703-691-2272 or via e-mail at info@asitn.org.

Dear Colleagues,

I am writing to introduce a new committee, the Practice Building Committee. The ASITN Executive Committee asked that I serve as its first chair, and I am greatly honored.

The ASITN leadership and I think that practice building is extremely important for both our present as well as our future.

My first task as chair was to form a committee and I was pleased that the real problem was not finding qualified people, but rather choosing among the many qualified volunteers. Our Society is blessed with an abundance of extremely talented and innovative people who have found several ways to "skin a cat". Our inaugural Practice Building Committee includes:

Firas Al-Ali, MD – Chair
Adnan I. Qureshi, MD
Peter A. Rasmussen, MD
Harish N. Shownkeen, MD

As you can see, this is a truly multidisciplinary group, and includes a neurosurgeon, a neurologist and a neuroradiologist. Our goal is to promote a collaborative approach to building a business and identify relevant issues pertaining to our special field of medical practice both today and in the future. This is a very rapidly changing field, filled with challenges and opportunities, and we must be adaptable.

The most immediate goal of the Practice Building Committee is to give ASITN members the tools to build a large robust practice

through:

- Identifying opportunities for growth of practice using medical education. **Educational programs** can be created locally and within the existing ASITN meetings.
- Dissemination of information concerning positive techniques and tools used by other **physicians and practice techniques** which may help other members duplicate this success in their practice.
- Create a **network** of physicians throughout the country to participate in the growth of our specialty by collecting scientific data about our procedures and results. This would be accomplished in order to justify and validate our specialty and promote the benefits of the procedures that we have to offer. We must combine small series to make impressive large series of patients that document our outcomes and the gratifying results we can achieve with the amazing tools and procedures in the neurointerventionist's arsenal. It is imperative that we support our own registries and publish our results.

In essence, we believe that the neurointerventionist should become the "go-to" *stroke expert* who should be called any time there is a patient or clinician who has a question about hemorrhagic stroke, ischemic stroke, and most importantly — stroke prevention!

The Practice Building Committee is committed to helping our members grow their own business, and we are open to any ideas or suggestion. Please feel free to contact any of us.

Help Wanted

Fulltime position for a Neurointerventional Radiologist to join solo Neurointerventionist within a large radiology hospital-based group in Orlando, FL. Full range of services provided including intra- and extra-cranial angioplasty/stenting, AVM remobilization, intervention for acute stroke, etc. For more details contact Frank R. Hellinger, M.D. c/o Susan Kemper via email: skemper@floridaradiology.com.

Making Headlines in the News – Our Job and YOURS!

ASITN Steps Up PR Efforts Locally, Regionally and Nationally

We need your “good news” patient stories — the case histories of people who have had neuro-interventional procedures and benefited.

Why?

The media is reporting on our field and want to know more. *People* magazine gave two pages to the MERCI system. CNN just reported on Neil Young's successful brain aneurysm repair, crediting “a minimally-invasive neuroradiology procedure,” and the *San Francisco Chronicle* reported on the successful treatment of a 16-year-old stroke patient. We even made prime time with the airing of the highly successful *ER* episode that featured the Merci device.

What do all of those placements have in common? They highlight the science of our advancing technology along with a poignant human-interest angle that puts a personal face on the multiple conditions you treat every day.

Indeed, we have made some great gains, but we could do much more. Without a doubt, you all are the “authors and producers” of the many stories which unfold in your treatment rooms week in and week out. With your knowledge and expertise and a patient who is enthusiastic about sharing his/her personal experience, ASITN can continue to work with media to

keep interventional neuroradiology and our practitioners in the news.

How can you help us? Start by simply considering whether any of the procedures you perform have the potential to attract media interest. Here are some basic guidelines to help you in assessing the “eligibility” of a potential story in the eyes of a journalist.

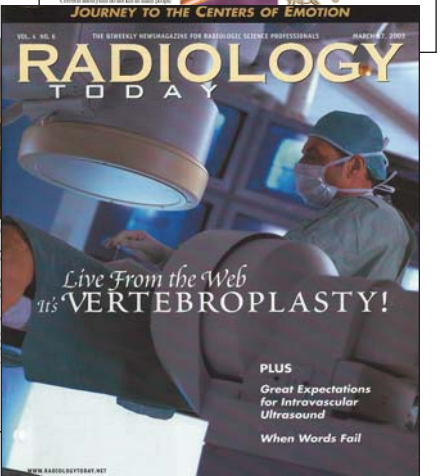
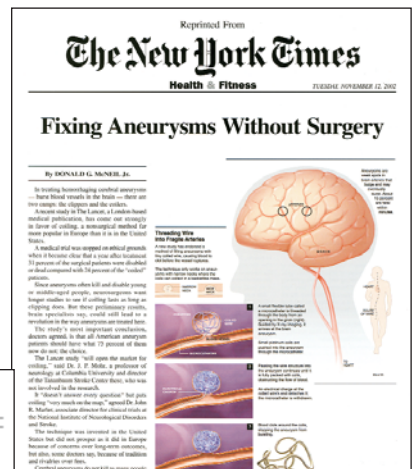
In general, a news story or news feature should be timely, relevant, and original, i.e. a new device, an application of a procedure to a different condition, a new clinical trial, etc. At the same time, however, if a procedure or technological advancement does not fit these criteria, it may still be a legitimate pitch if:

- it has not been covered locally (local media are always keen to report a national story with a local hospital angle);
- a celebrity or community notable has undergone the procedure;
- the procedure has been refined or improved upon in some way;
- the patient has an unusual stroke, aneurysm, etc. which, against odds, results in a good treatment outcome; or
- the human interest angle of the story has an unusual element, i.e. a colleague suffers a stroke and you are the one who treats him/her.

Do you have a story that meets any one of these criteria? Please send us a quick synopsis at info@asitn.org, and we'll call you to discuss the possibilities.

ASITN has gained momentum with the media this year and has the opportunity to approach reporters who are already interested in neurointerventions and gain additional coverage.

As ASITN embarks on this new initiative to elevate our public relations efforts nationally, regionally and locally, we are dependent on you and your individual medical experiences to make it happen. Ultimately, with your input, we can honor our field by promoting the medical advances for which you have been responsible. But more importantly, we can communicate vital information that can make a real difference in the lives and well-being of patients.



Chicago Tribune Magazine, February 12, 2009. Headline: THE TIME BOMB IN MY HEAD. Photo: DR. MARGARET OVERTON.

People magazine, February 12, 2009. Headline: Stroke of Genius. Photo: DR. MARGARET OVERTON.

San Francisco Chronicle, February 12, 2009. Headline: Teenager survives stroke. Photo: DR. MARGARET OVERTON.

Radiology Today, March 2009. Headline: JOURNEY TO THE CENTERS OF EMOTION. Photo: DR. MARGARET OVERTON.

ASITN Launches Newly Redesigned Website

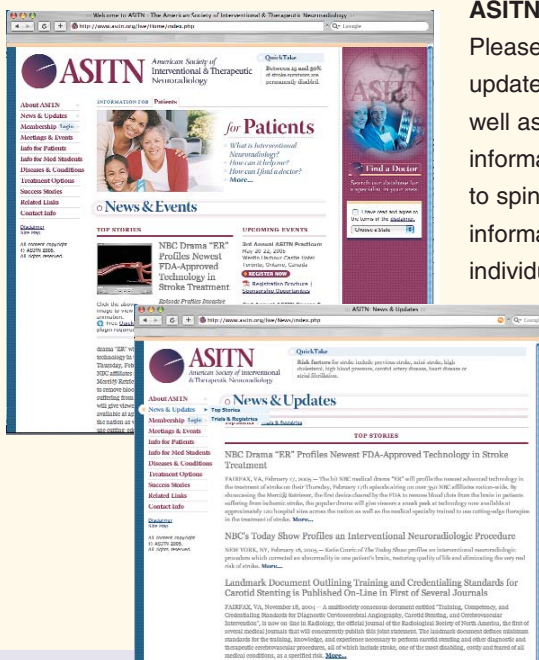
Rich Berger, MD

ASITN is pleased to announce that our website has undergone a major facelift!

Please take some time to peruse the new and improved www.asitn.org. You will find a newly updated home page featuring a variety of links to information pages tailored to physicians as well as patients and the general public. Browsers will also find rotating "factoids" on patient information pages which impart pertinent information on conditions from stroke to aneurysms to spinal abnormalities. The Doctor Finder will remain a significant feature in the patient information section. Members will receive notice in May detailing the process to update their individual record on the Doctor Finder.

Currently under renovation is the "Members Only" section scheduled to be ready in May. Additionally, ASITN is soliciting your success stories for inclusion on the "Testimonials" page. If you would like to submit a story idea regarding a successful treatment outcome on one of your patients, please contact Marie Williams at info@asitn.org or 703-691-2272.

We hope that you enjoy this new and improved member benefit!



ASITN Symposium at American Stroke Association Meeting a Huge Success

Colin Derdeyn, MD

As many of you are aware, the 30th annual International Stroke Conference (ISC) of the American Stroke Association (ASA), was held February 2–4 in New Orleans, Louisiana, down the street from our 8th Annual Joint Meeting with the Joint Section on Cerebrovascular Surgery. Due to a scheduling problem, the meetings were held simultaneously, rather than consecutively as in the past. Our meeting was initially started as a satellite of the ISC and has grown over the years into a full meeting. As a consequence, many of our members no longer have the time or interest to attend the ISC as well as the Joint meeting. This is unfortunate, as the ISC meeting has become a major forum for the stroke neurology community. Over 3,600 professional registrants attended this meeting this year.

Given this scheduling situation, the leadership of the ASITN successfully lobbied the ASA to allow us to provide a full day of our programming at the ISC for the benefit of the ASA members, as well as free registration for Joint meeting registrants to attend the ISC for the afternoon. The aims of these efforts were

twofold: to better educate the ASA membership on endovascular issues and to re-acquaint our membership with the ISC. Greater involvement by ASITN members in the ASA will give us a louder voice in this important organization.

The day of joint programming on Thursday was a tremendous success by all accounts. All sessions were very well attended in a large capacity room. No official attendance was taken, but there were easily 1000 people in the room. We provided four symposia: acute stroke intervention, intracranial vascular disease, surgical versus endovascular aneurysm treatment, and stenting versus endarterectomy for carotid artery disease. These sessions were organized, moderated, and provided by ASITN and Joint Section members. In addition, over 300 of our registrants attended the ISC meeting that afternoon. Based on the attendance and reception of our symposia and the numbers of Joint Meeting attendees, the ISC has asked us to develop and organize a similar program for next year's meeting in Kissimmee, Florida. Please plan on attending the ISC next year.

Clinical Trials Update

Colin Derdeyn, MD

Since the last publication of *The Embolus*, two clinical trials of interest to practicing neurointerventionists have been published.

1. **Warfarin versus Aspirin for Intracranial Disease (WASID)**. Chimowitz, et al. *N Engl J Med*. 2005 Mar 31;352(13):1305-16. Warfarin was no better than aspirin in this randomized clinical trial for patients with angiographically-proven atherosclerotic intracranial disease. Aspirin was associated with a lower risk of death or hemorrhage. At 1.8 years of follow up, 21% of patients on aspirin had suffered a stroke or died. We finally have good natural history data for this difficult disease, laying the important foundation for clinical trials of intervention!
2. **NOVO-7 trial**: Recombinant activated factor VII for acute intracerebral hemorrhage. *N Engl J Med*. 2005 Feb 24;352(8):777-85. This was a randomized, dose escalation study. Patients treated with factor VIIa experienced significant reduction in ICH volume growth when compared to placebo; the largest reduction occurring in the highest dose group. Of the 103 patients who were treated with 160 ug/kg of factor VIIa, the mean percent change in ICH volume was 11%, compared to a 29% reduction in the placebo group ($p=0.015$). The 90-day outcome assessments also showed statistically significant improvements in the factor VIIa group in a similar, dose-dependent manner. A Phase 3 randomized clinical trial is being organized.

Presented abstracts and descriptions of ongoing trials can be viewed at the internet stroke center, an online searchable catalogue of ongoing and completed clinical trials <http://www.strokecenter.org/trials/index.htm>. This resource is maintained at Washington University with funding from the American Heart Association and the National Institutes of Neurological Disorders and Stroke.

Abstracts of interest presented at the 30th ISC in New Orleans include:

1. **TRUMBI**: The Transcranial Low-Frequency Ultrasound Mediated Thrombolysis in

Brain Ischemia. (TRUMBI) Study, a Phase II Clinical Trial. This is a pilot of intravascular ultrasound and tPA. It was halted for excess intracerebral bleeding among patients treated with both tpa and ultrasound. Of the 14 patients to receive the combination therapy, 13 (93%) experienced bleeds (5 of these were symptomatic); compared to 5 patients (41%) in the tpa-alone group ($p=.01$).

2. **TARTS**: TPA Argatroban Stroke Study (TARTS). This was a phase I study of argatroban (iv) for patients with ischemic stroke. Recanalization at 2 hours was observed in 79% of patients, and in 92% of patients at 24 hours. Parenchymal hematoma occurred in one patient (6%), symptomatic ICH in two others (13%).
3. **CARESS**: Clopidogrel and Aspirin for Reduction of Emboli in Symptomatic Carotid Stenosis. TCD was used to measure microembolic signals (MES) in 100 patients with symptomatic carotid stenosis randomized to aspirin alone or aspirin and clopidogrel. 45.5% of patients on combination therapy had MES by TCD ($n=51$) compared to 73.5% in the aspirin alone group ($n=56$, $p=0.01$). The rate of MES at 24 hours was lower in the combination group (22.1%) than in the aspirin group (59.3%, $p=.001$); and the 7 day MES rate was also lower in the combination group (14.4%) than in the aspirin group (37.1%, $p=.01$).
4. **DEDAS**: Dose escalation study of desmoteplase in acute ischemic stroke. This was an MRI based, dose-escalation study of patients between 3 and 9 hours after stroke onset. Improved clinical outcome at 90 days was observed in 2 of 8 patients in the placebo group (25%), 4 of 14 patients in the low-dose desmoteplase group (28.6%), and in 9 of 15 patients in the high-dose desmoteplase group (60%). Reperfusion was seen on MRI in 3 of 8 patients in the placebo group (37.5%), 2 of 11 patients in the low-dose desmoteplase group (18.2%), and in 8 of 15 patients in the high-dose desmoteplase group (53.3%). There was one death in each of the desmoteplase groups, and there were no cases of symptomatic hemorrhage.

Help Us Find Your Colleagues!

ASITN has recently lost track of these members. Listed below are their names and the last location we had for them. They may have moved to new positions and institutions and forgot to forward us the information. If you know where they are, please let us know by e-mailing info@asitn.org so that we can reconnect. Thanks for your help.

Patricia M. Fernandez, MD
Beth Israel Medical Center
New York, NY

Bradley J. Glenn, MD
Radiological Associates of
Sacramento
Sacramento, CA

Robert S. Mals, MD
North Shore Medical Center
Salem, MA

David J. Shelley, MD
Diversified Radiology of
Colorado, P.C.
Denver, CO

Joon K. Song, MD
University of Texas
Houston, TX

William T.C. Yuh, MD, MSEE
University of Oklahoma
Health Sciences Center
Oklahoma City, OK

Third Annual Practicum Live From Canada! continued from page 1



to head and neck vascular anatomy, head and neck tumor embolization, and carotid stenting. On Saturday afternoon, attendees may participate in workshops of their choosing followed by multiple sessions on Sunday focused on aneurysm treatment and stroke intervention.

"The schedule is definitely ambitious," says Tarr. "Participants will find a great deal of pertinent and relevant information in every aspect of this year's meeting. It's going to be an exciting weekend."

Originated in 2003, the Practicum was designed to meet the multiple professional and educational needs of the practicing neurointerventionist. In two short years, the Practicum has made its mark. At the 2004 Practicum in Seattle, attendance increased by 25% over 2003 — and so did the accolades. Long-time ASITN member Rich Berger from Wichita, Kansas, says last year's Practicum was "the best meeting" he had ever attended.

In looking forward to May, Tarr anticipates similar enthusiasm. This year, he says, many new presenters have been added to the schedule, an initiative that introduces fresh faces and new perspectives. "I think that the success of the Practicum, to a large degree, is directly related to ASITN's vision to facilitate a forum which keeps pace with the evolving nature of our field. It is the perfect opportunity for practitioners from different backgrounds, both seasoned leaders and our newer colleagues, to come together and lend their own individual

perspectives to the most pressing issues that face us all, both in our field and in our own practices."

This year's meeting will take place at Toronto's Westin Harbour Castle, a 20-year recipient of the CAA/AAA Four Diamond Award. Featuring a scenic waterfront setting, the hotel is located near major attractions such as the Air Canada Centre, CN Tower, Financial and Theatre districts and the Eaton Centre.

Multiple friends and supporters of ASITN are once again lining up to sponsor the Third Annual Practicum.

The program committee extends a warm and welcome invitation to all of those interested in contributing their presence and expertise to what promises to be a valuable and worthwhile meeting opportunity. Don't miss it!

Participants may register for the Third Annual Practicum by submitting their registration form by mail, fax or on-line at www.asitn.org. The brochure may be downloaded from the ASITN website. Hotel reservations should be made directly with the Westin Harbour Castle Hotel by calling (416) 869-1600. Be sure to identify yourself as an ASITN attendee in order to receive the special room rate of \$219 CAD (approximately \$176 USD) single or double occupancy.



Second Annual Course & Workshops Heats Up in Hawaii!

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Duckwiler, President of ASITN, "we see the addition of abstracts as an important step in our larger strides to establish a worldwide scientific conference opportunity for the practicing neurointerventionist."

Towards that end, Hirsch says, the Second Annual Course & Workshops is already breaking new ground. In a strategic move to reach out to international audiences, ASITN chose the Hawaii location in large part due to its appeal to colleagues all over the world. "We felt Hawaii was a win-win for our second meeting as the location would mean an easier commute for our international friends as well as a great vacation get-away for the residents of the U.S." Survey results from ASITN members last fall confirmed the vision. More than 70% of respondents said they would happily make the trip to paradise.

Amidst the backdrop of the luxurious Turtle Bay Resort, conference attendees will enjoy a weeklong schedule of didactic sessions and workshops. In the spirit of the multi-national vision, the meeting will feature special lectures on "An International Perspective" hosted by leaders from Japan, Korea, and China. In addition to didactic sessions on state-of-the-art interventional techniques and an expanded presentation/discussion on complications and saves, this year's meeting will also offer a special roundtable session entitled "How I Do It", an in-depth discussion on the various techniques and tools for neurointerventional procedures.

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Second Annual Course & Workshops Heats Up in Hawaii!

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Workshop opportunities on topics including stroke, aneurysms and spinal abnormalities will also be a highlight of this year's meeting. Tailored to meet the needs of practitioners from every experience level, the workshops remain a favorite feature for conference attendees according to survey results from last year's meeting. The Second Annual Course & Workshops will also feature one of last year's standout activities, the ASITN/ASNR/SIR officially "approved" carotid stenting training course. Including lectures and full "hands-on" labs, the course is designed to provide the interested practitioner with a comprehensive educational opportunity on one of the hottest topics in the neurointerventional field today.

Outside of the meeting, attendees and their families will have ample time to enjoy the beauty and recreational opportunities provided by the Turtle Bay Resort. Just one of the many available activities will be the ASITN Golf Tournament played on The Arnold Palmer Course, the site of an annual stop for the PGA Champions Tour.



When not in sessions, attendees can also enjoy interaction with multiple industry representatives.

"This conference is a compelling opportunity that truly offers something for everyone," Hirsch said. "Ultimately, it represents the best of every meeting in that it infuses the most relevant and current information on the science behind our field into sessions, roundtable discussions, case presentations and workshop opportunities in a way that gives the conference attendee a comprehensive learning experience."



All interested participants are encouraged to bring their families to this exciting vacation destination. Make it a once-in-a-lifetime summer get-away and join us in the tropical oasis of Hawaii!

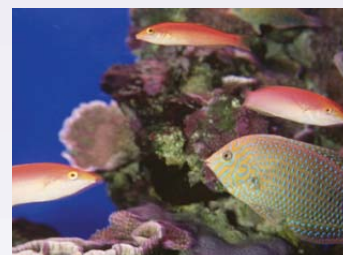
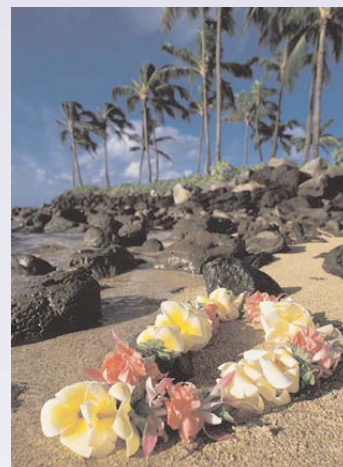
Participants may register on-line at www.asitn.org beginning in late May or by submitting the form that will be included in the registration brochure to be mailed out in May by fax or mail.

You can make your hotel reservations now on the Turtle Bay Resort website, www.turtlebayresort.com. Just click on the "Book Online" button, enter your arrival and departure dates, enter the ASITN code (19589), delete the word "leisure" from the "Company/Promotional Code" box and click "Begin Search".

Information on submission of scientific abstracts will be on-line at www.asitn.org in May. Don't miss this exciting opportunity.



Outside of the meeting, attendees and their families will have ample time to enjoy the beauty and recreational opportunities provided by the Turtle Bay Resort.



**Landmark INR
Clinical Practice
Document
Published in JVIR**

The *Practice Guideline for Interventional Clinical Practice* was published in the February issue of *JVIR*. These guidelines outline the mandatory infrastructure requirements necessary for a clinical practice and provide the benchmarks that define such a practice.

We encourage all members to share a copy of this document and discuss it with your diagnostic colleagues. The document will support your efforts to obtain clinical office space, privileges to treat patients, and the other infrastructure you need to be successful. Members frequently report that their diagnostic colleagues are their greatest barrier to developing a clinical practice.

The guidelines were developed and written collaboratively by the American Society of Interventional and Therapeutic Neuroradiology (ASITN), American College of Radiology (ACR), and the Society of Interventional Radiology (SIR). The ACR House of Delegates approved the document in 2004.

A special thanks goes out to Josh Hirsch and John Barr for their work on this initiative.

President's Message continued from page 2

Either way, this becomes the "delineated program for granting CAS privileges". This is, however, attached to a QA process delineated below.

Number 6: This depends upon the institutional character, which performs CAS, and how institutional QA operates. Several approaches are possible.

1. Create new committee of Vascular and/or Neurosurgery, Cardiology, Radiology, Neurology (or those who desire to be involved) in combined committee.
2. Use current hospital QA committee.
It would be preferred to include analysis of cases by an independent neurologist to assure that the appropriate cases are selected, and outcomes are well documented. This should be done routinely and cases entered into a database. This committee has to establish policies for cancellation of privileges or remediation. Having each group do their own QA is not acceptable.

Number 6a,b: For the minimum number of cases and the threshold for complications, we recommend

1. Use Sapphire results for complications. Although the Cordis Precise/Angioguard have tentative approval, the approved Acculink/Accunet Archer results have yet been formally published.
2. Minimum number 3/yr. While this number may be altered depending upon the individual applying, with the current CMS decision, there are expected to be relatively few symptomatic patients with $\geq 70\%$ stenosis seen in common practice.

Number 8: The QA committee should meet every 6 months to review all cases and have a process in place to assure that no cases are unaccounted for. Recommended auditing methods are billing records, procedural logs, and device implant logs.

Below are the supporting documents necessary to implement the above. With this submitted to the hospital credentialing committee, an affidavit can be submitted by the hospital to:

Director, Coverage and Analysis Group
7500 Security Boulevard, Mailstop C1-09-06
Baltimore, MD 21244.

Facility's name and complete address;
Facility's Medicare provider number;
Point-of-contact for questions with telephone number;
Mechanism of data collection of CAS procedures; and,
Signature of a senior facility administrative official.

Obviously, this is an editorial comment and individuals must utilize their own best judgment and knowledge of their practice situation when implementing any new process of credentialing and certification. It is my hope that this primer is helpful in formulating your own plan of action to perform CAS.

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Importance and Methodology of the RUC Survey Process

Andrew Ku, MD

Interventional neuroradiology/endovascular neurosurgery is a rapidly evolving field compared to more traditional specialties. Due to this rapid evolution, our group has seen and will see more new procedure codes in the next 5 years. We have already seen approval of codes for vertebroplasty, balloon test occlusion of CNS vessels, and angioplasty and stenting of the extracranial cerebral vessels. Upcoming codes include angioplasty and stenting of the intracranial vessels. The determination of reimbursement for these procedures depends on the AMA/Specialty Society RVS Update Committee (RUC).

The RUC makes recommendations to the Centers for Medicare and Medicaid Services (CMS), which then sets the reimbursement for Medicare covered procedures. Most insurance carriers then pattern their reimbursement based on the precedence set by Medicare. Physician reimbursement is currently based on the RBRVS: resource-based relative value scale. The major components of the RBRVS as they pertain to the physician include:

- RVS
- Conversion Factor
- Geographic Adjustments
- Balance Billing

Based on prior precedence, the relative value of a procedure for our specialty is based on the Work Component (55% of relative value), the Practice Expense (42% of relative value), and Professional Liability Insurance (PLI) (3% of relative value). Based on reality, there probably should be a change in the component

valuation since these numbers seem far from current reality, especially the PLI component. The other major fudge factor which affects our level of reimbursement is the Conversion Factor. There has been a gradual push by the government to reduce or eliminate the Geographic Adjustments which has been traditionally based on urban resource utilization costs being higher than rural areas. The Conversion Factor, Geographic Adjustments, and Balance Billing are components of our reimbursement over which we as physicians have very little control. The only area where we as physicians have some significant input to determining the degree of our reimbursement is through our input into the determination of physician RVU and practice expense RVU.

The Medicare Payment Schedule is based on the following 6 Components:

- Physician Work RVU
- Physician Work GPCI (Geographic Practice Cost Index)
- Practice expense RVU
- Practice expense GPCI
- PLI RVU
- PLI GPCI
- Total RVU = (work RVU x work GPCI) + (practice expense RVU x practice expense GPCI) + (malpractice RVU x malpractice GPCI)

Your best shot at making sure you get paid for the work you do is in the initial RUC practice survey. The RUC is where the determination of the Physician Work RVU is made. This is one of the few places where you have direct physician input into the reimbursement process. Your survey opinion for the amount of physi-

cian work involved in a procedure will provide the numbers in determining actual reimbursement. That is why it is vital for every physician surveyed to complete their survey.

- The Survey Numbers are Usually Small in Our Subspecialty. i.e. 200 or Less
- That Means Every Evaluation Counts a lot!
- **If You UNDERVALUE Your Procedure You Will Get UNDERPAID!**

For example, on the recent survey document for CPT 362XX Temporary Carotid Balloon Occlusion Test, only 80 practitioners were surveyed. We are the experts. Not every neuroradiologist or surgeon knows how to do one. Most are highly allergic to them. This now is primarily performed by Interventional Neuroradiologists and Endovascular Neurosurgeons. Only 30 practitioners responded. We have to do better! There was one person on the recent Carotid Stent Survey who put down a SERVICE-Time of Zero (sad to say but true)! They must really be slick. It takes a minimum of a second to deploy a stent in my hands, and in reality much longer, since I would do a lot of damage if I were to drop a stent that quickly.

During the RUC process, it's you against the rest of the world. What you say will be downplayed and trivialized — you have to have the facts to back it up when you want credit for the work you do. Don't underestimate the intensity of your procedure. If they could do it, they would, but they can't.

Strategic Importance of Concurrent AMA Membership for Members of the ASITN

Andrew Ku, MD

Lest We Forget

We received the following letter at the ASITN office:

My name is Keren Baruch. I am thirteen years old. When I was five years old, my ten-year-old brother, Jonathan, died of a brain aneurysm. I have many sad memories of that tragic day as well as many wonderful memories of Jonathan. As his younger sister, Jonathan always watched over me and I believe that he still is. For my bat mitzvah and in memory of Jonathan, I am making a donation to ASITN to do my part to support your work to find a cure for brain aneurysms. I hope that no other family will have to experience the loss that my family and I have.

The AMA is an influential organization and is recognized by the state and federal government, insurance companies, hospitals, and other medical organizations as a source of accepted medical opinion, standards, and policies. The AMA organization structure is based on a House of Delegates, with representation by the various state medical societies and by recognized medical specialties. The key words for members of the ASITN are "recognized medical specialties". That means that various specialty organizations have a voting member and alternates in the AMA House. This is where the horse-trading and policy making occurs in the AMA.

We currently do not have representation in the AMA. Organizations such as the AANS, ASNR, AAN and many other groups do have representation. Unless you are at the table, when medical policy is made and opinions are given for public consumption, such as advice

to the CMS, it is very difficult to influence government and corporate policies. Our society is well positioned to request to have a member in this organization. We have an ACGME-accredited fellowship. We are an organization dedicated to the promotion, advancement and education of our specialty. We are recognized as leaders in the field of endovascular neurosurgery/interventional neuroradiology and minimally invasive therapies. In order to be eligible to request a position and representation at the AMA, at least 50% of our members must also be members of the AMA. This is another expense, but the potential benefits to you as a member, and to the ASITN, should not be underestimated.

Information on how to join the AMA may be obtained by calling 1-800-262-3211. The Executive Committee strongly encourages each of you to join the AMA for the benefit of ASITN.

Neurovascular Coalition Holds Formation Meeting

The Neurovascular Coalition (NVC), conceived under the leadership of ASITN, held its first meeting in February in New Orleans. Member organizations of the NVC represented at the meeting include: the American Society of Interventional and Therapeutic Neuroradiology, the American Academy of Neurology, the American Association of Neurological Surgeons, the American Society of Neuroradiology, the Congress of Neurological Surgeons, the Cerebrovascular Section of the American Association of Neurological Surgeons/ Congress of Neurological Surgeons, and the Society of Interventional Radiology.

On the heels of its first successful project, the completion and publication of the multi-society document entitled "Training, Competency, and Credentialing Standards for Diagnostic Cervicocerebral Angiography, Carotid Stenting, and Cerebrovascular Intervention" in such journals as *Radiology*, *Neurology*, and the *American Journal of Neuroradiology*, the NVC turned its attention toward the organizational details involved in establishing the NVC as a multi-functional working group. To this end, Buddy Connors was named Chairman of the NVC and Tony Furlan assumed the role of Vice Chairman. The group's immediate goal is to solidify a mission statement and determine other structural details relevant to a multi-society effort. ASITN will provide administrative support for the Neurovascular Coalition.

Medicare Expands Coverage of Carotid Artery Stenting for Patients at High Risk for Surgery

The Centers for Medicare & Medicaid Services (CMS) announced on March 17 that it is expanding coverage of Percutaneous Transluminal Angioplasty (PTA) of the carotid artery concurrent with stent placement to patients who are at high risk for carotid surgery — also known as carotid endarterectomy or CEA. The coverage expansion reflects the latest evidence on the effective use of stenting, and includes support for development of better evidence in additional uses.

“CMS is committed to providing broader access to appropriate and innovative care to our beneficiaries in the management of their carotid artery disease,” said CMS Administrator Mark B. McClellan, MD, PhD. “We are working with health professionals and product developers to reduce the occurrence of stroke in our population, and getting the maximum health improvements possible by soliciting and responding to public comments on the most effective way to provide improved coverage.”

The national coverage determination (NCD) issued in March expands Medicare coverage for carotid artery stenting to high risk patients with symptomatic narrowing of carotid artery of 70 percent or more.

Medicare also will cover patients who meet the FDA labeled criteria for carotid stents (who are at high risk for CEA and have symptomatic carotid artery stenosis between 50 percent and 70 percent and asymptomatic high risk patients with carotid artery stenosis of 80 percent or more) in Category B IDE clinical trials, as a routine cost under the clinical trials policy, or in post approval studies.

Under previous policy, CMS only covered carotid artery stenting in clinical trials being conducted prior to Food and Drug Administration (FDA) approval (so-called Category B Investigational Device Exemption [IDE] clinical trial) and more recently in FDA required post approval studies.

CMS and Guidant Corporation are working with the FDA to expand the scope of post approval studies and increase the number of participating facilities and study enrollees. Guidant Corporation is currently the only company with an FDA approved carotid stent and an ongoing post approval study.

To help ensure optimal patient outcomes and to evaluate and monitor provider and facility performance, Medicare is limiting use of carotid stenting to facilities and providers who have been determined to be competent in performing the evaluation, procedure, and necessary follow-up care.

Competency will be based on published clinical guidelines that outline physician training and facility support requirements for carotid artery stenting. Facilities must also meet CMS' minimum standards in performing carotid artery stenting.

These standards outlined in the coverage determination include physician training criteria, facility support requirements and data collection to evaluate outcomes during a required reevaluation. Facilities can provide a written affidavit to CMS attesting that the facility has met these standards.

Each year about 700,000 people experience a new or recurrent stroke. More than 70 percent of stroke victims are over 65 years of age and eligible for Medicare.

“The evidence on carotid artery stenting demonstrates its effectiveness in improving net health outcomes for certain patients,” said CMS chief medical officer Sean Tunis, MD, MSc. “By requiring hospitals to certify their competency, CMS can help ensure patient safety and quality care for those undergoing this procedure.”

ASITN is composing information packets on carotid stenting and relevant CMS information that will be mailed out to all members.

Welcome New ASITN Members!

The following new members were approved in the 4th Quarter of 2004. Please help us extend a warm welcome to them!

Senior Members

Baljit Deol
Johns Hopkins Medical
Institutions
Baltimore, MD

David Fiorella
Cleveland Clinic
Cleveland, OH

Reza Malek
Minimally Invasive Surgical
Solutions
San Jose, CA

Franklin Marden
University of Illinois at Chicago
Chicago, IL

Bahram Varjavand
Radiological Associates of
Sacramento
Sacramento, CA



Member Profile

Richard M. Berger, MD

“You have to have a way to blow off steam.”

That is the philosophy behind the kind of things Rich Berger does in his spare time to keep himself fresh and alive.

These are words he’s lived by most of his life. From motorcycles, his favorite passion, to dreams of flying, Rich has managed to find adventure at every road stop along the way. The ride has led him down some unexpected paths, but the surprises around every bend were worth it.

Rich did not start out with dreams of becoming a doctor. His first thought was that he would become a math major in college, but then he realized there were no “math” jobs. So then he turned to another childhood interest — chemistry. With a BS in

Chemical Engineering from Cornell University in hand, he left his native Connecticut for the wide-open spaces of the Texas oil fields. “I was a wanna-be-cowboy in the era of the movie ‘Urban Cowboy.’ I even bought myself a cowboy hat and rode the mechanical bull.” But after enjoying 2 1/2 years of remote living in the northern Texas panhandle, he didn’t see his future in the oil business and turned his attention toward medicine.

Rich attended the University of Texas, Southwestern Medical School in Dallas, where he thought he would become a family practitioner. But bigger goals beckoned and he joined the Navy in hopes that he would become a pilot in the flight surgery program. Instead, after his internship in general surgery in San Diego, the Navy sent him to the Naval Hospital in Guam to work as an Emergency Medical Officer for 2 years. Finding the bright side of this assignment, Rich enjoyed scuba diving and ferrying patients to Hawaii with golf clubs in tow.

Rich turned to radiology when he decided to find a specialty that offered more normal hours than emergency medicine. (Of course, he found real sanity when he entered interventional neuro!) He completed a diagnostic radiology residency at the Naval Medical Center in San Diego followed by a 2-year diagnostic neuroradiology fellowship at the Mayo Clinic. Subsequently, he trained in INR with Chuck Kerber at UCSD and David Levy at Kaiser in San Diego.

After starting a new INR service at Naval Medical Center San Diego, and completing 13 years of active duty, Rich left the Navy in 2000 with an honorable discharge and the rank of Commander. Recruited by an old Navy buddy, Rich moved to Kansas where he is currently Chief of Neurointervention & MRI and a Clinical Assistant Professor of Radiology at the University of Kansas in a private practice in Wichita.

As the first and only neurointerventionist in Wichita for several years, he started another INR practice from scratch at Wesley Medical Center and performed many firsts in the area:



stroke thrombolysis, aneurysm coiling, AVM embolization, carotid stenting, and intracranial PTA. In addition to INR, he has a very busy spine pain intervention and peripheral vascular intervention practice including uterine fibroid embolization. He also spends quite a bit of time reading films and even doing the occasional barium enema!

Despite his love for the easy pace of the plains, Rich puts it "into high gear" every chance he gets on his 1700cc Yamaha Road Warrior. The hobby dates back to his days in San Diego, where Rich found the traffic so bad that he decided to try motorcycles as an alternate mode of transportation. After a few lessons from a Corpsmen, Rich bought his first motorcycle and became addicted to the joy of riding. He got his first (and only) speeding ticket (on a bike!) the week after he bought it. "San Diego was perfect for riding. I even rode in the rain," Rich recalls. Rich considers this the only "life threatening" activity he does and will wait for his daughters to get out to college to take up flying.



Still a lover of wide open spaces (he couldn't bear to live in a city), Rich lives with his wife, Judy, his daughters Nicole, 19 (who is a freshman at KU), Jenny, 15, and twins



Rebecca and Melissa, 9, in "the middle of nowhere" — in the country, 20 miles north of Wichita, 2 1/2 miles down a dirt road where he has a small farm growing wheat, milo, soybeans and hay. Other "residents" include two horses, five dogs and two llamas. When asked, "Why llamas?," he replied that he wanted to introduce the girls to caring for animals. Asked if they wouldn't rather have ponies, he answered, "Oh, we have those too! Skittles and Snickers." The llamas were supposed to be for breeding, but when he found out that they were "Jim" and "Frank," that plan was scuttled.

When he's not in the angio suite or on the open road, Rich has also found time to be a good friend to ASITN. He has lent considerable time and efforts to the redesign of ASITN's web site and is still spending many hours on enhancing the "Members Only" section. We thank him for his tireless work on behalf of ASITN!

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The Member Profile is a new column for The Embolus. If you have an interesting hobby and/or want to share some of your personal life with your fellow members, please send an e-mail to info@asitn.org and you may see yourself in this column next quarter!

Calendar of Events

ASITN Events

American Society of Interventional & Therapeutic Neuroradiology

3rd Annual Practicum

May 20-22, 2005

Toronto, Ontario, Canada

Contact: ASITN, 703-691-2272

American Society of Interventional & Therapeutic Neuroradiology

2nd Annual Course & Workshops

August 1-6, 2005

Oahu, Hawaii

Contact: ASITN, 703-691-2272

Other Events

American Society of Neuroradiology

43rd Annual Meeting

May 21-27, 2005

Toronto, Ontario, Canada

Contact: ASNR, 630-574-0220

World Federation of Interventional & Therapeutic Neuroradiology

8th Congress

October 19-22, 2005

Venice, Italy

Contact: Marco Leonardi, +39 051 06225520

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