

CMS Proposes Greater Carotid Stenting Coverage

BY MARY ELLEN SCHNEIDER
New York Bureau

Officials at the Centers for Medicare and Medicaid Services are proposing to expand coverage for carotid artery stenting to patients younger than 80 years old who are at high risk for carotid endarterectomy and have asymptomatic carotid artery stenosis of 80% or greater.

Under the proposed national coverage determination, a surgeon would perform a consultation to ascertain a patient's high-risk status.

The proposal also spells out coverage for patients 80 years of age and older with either symptomatic stenosis of 70% or greater or asymptomatic stenosis of 80% or greater. Because of safety concerns in that age group, carotid artery stenting would be allowed in this group only when it is performed in a Food and Drug Administration Category B Investigational Device Exemption trial, an FDA-approved postapproval study, or under Medicare clinical trial policy.

If finalized the proposal would replace the current CMS coverage policy under which patients at high risk for carotid en-

arterectomy (CEA) with asymptomatic carotid artery stenosis of greater than 80% can be covered only when carotid artery stenting procedures are performed in an FDA Category B Investigational Device Exemption trial, an FDA-approved postapproval study, or in accordance with Medicare clinical trial policy.

Over the last 6 years, CMS officials have expanded coverage of percutaneous transluminal angioplasty and carotid artery stenting in three separate national coverage decisions. Most recently, in November 2006, CMS established Medicare coverage for percutaneous transluminal angioplasty and stenting of intracranial vessels for the treatment of cerebral artery stenosis of 50% or greater in patients with intracranial atherosclerotic disease as part of an FDA-approved Category B clinical trial.

In proposing the expansion of coverage for patients with asymptomatic carotid artery stenosis, CMS relied on evidence

from external and internal technology assessments, clinical reviews, and postapproval studies.

Two postapproval studies (CAPTURE and CASES-PMS) showed that carotid artery stenting outcomes were similar by provider experience and in settings outside clinical trials.

The trials also did not raise safety concerns about carotid artery stenting in asymptomatic patients with stenosis of 80% or greater, according to CMS.

In patients over 80 years, stenting would be allowed only in FDA exemption trials and postapproval studies, or under certain Medicare clinical trial policies.

CMS officials concluded that the evidence is "sufficient" to find that percutaneous transluminal angioplasty with carotid artery stenting improves health outcomes for patients who are at high risk for CEA surgery and have asymptomatic carotid artery stenosis of 80% or greater. However, carotid artery stenting is not covered in the absence of distal embolic protection, even when technical difficulties prevent it from being deployed, according to CMS.

Although at press time, the Society for Cardiovascular Angiography and Interventions (SCAI) was still reviewing the CMS coverage proposal, Dr. Michael J. Cowley, cochair of the carotid and neurovascular interventions committee for SCAI, said he sees the expansion of coverage as a step in the right direction. However, he expects that the SCAI committee may have concerns about some aspects of the proposal. For example, the requirement to obtain a surgical consult to determine that a patient is high risk is unnecessary and could mean additional costs, he said.

The American Association of Neurological Surgeons was still reviewing the proposed coverage decision at press time. However, in comments to CMS in 2004, the group raised concerns about expanding Medicare coverage for carotid stenting to asymptomatic patients. At that time, the group said that the available data suggested that carotid angioplasty and stenting may be inferior to medical treatment for the prevention of stroke in asymptomatic patients.

CMS is expected to issue a final decision sometime in May. ■

Geriatric Hopes Rest on Improved Medicare Reimbursement

BY BRUCE K. DIXON
Chicago Bureau

Improved reimbursement remains the focus of efforts to shore up the nation's supply of geriatricians.

Medicare's physician fee schedule for nursing home care urgently needs to be adjusted to reflect the real costs of diagnosis and treatment, according to Dr. Steven A. Levenson, president of the American Medical Directors Association (AMDA).

Without such a change, the number of physicians with geriatric competence will continue to decline, and elderly patients will be subjected to increasingly substandard care, Dr. Levenson predicted.

In early February, AMDA went before the American Medical Association's Resource-Based Relative Value Scale Update Committee (RUC) meeting in San Diego with suggested adjustments to nursing home CPT codes (99304-99310 and 99318) that would increase Medicare reimbursement for new admissions, subsequent visits, and annual visits by physicians.

A 5-year fee-schedule review, which began in 2003, was largely completed last year. But certain code families, including nursing home codes, were not submitted for review until the February RUC meeting.

"The challenge was to get physicians representing certain other specialties who don't work

in this environment to understand that the geriatric population has changed, and that these patients pose a real diagnostic and management challenge," said Dr. Levenson, a consulting geriatrician in Towson, Md., who is a medical director of five Maryland facilities owned by Genesis Health Care, which operates more than 200 nursing centers and assisted-living communities in 13 eastern states.

The AMA formed the RUC in 1992 to act as an expert panel in developing relative-value recommendations to the Centers for Medicare and Medicaid Services (CMS). The RUC represents the entire medical profession, with 23 of its 29 members appointed by major national medical specialty societies, from anesthesiology to urology.

Although the RUC makes recommendations only for Medicare fees, it influences nearly all health insurers because most base their fees and reimbursement rates on the Medicare fee schedule, said Dr. Len Lichtenfeld, the American College of Physicians' representative on the committee.

A final decision about the reimbursement proposal won't be made before midsummer, pending review by CMS and a public comment period, he said. In the meantime, the RUC discussions remain confidential.

Reimbursement rates lie at the heart of the much-discussed shortage of physicians trained in geri-

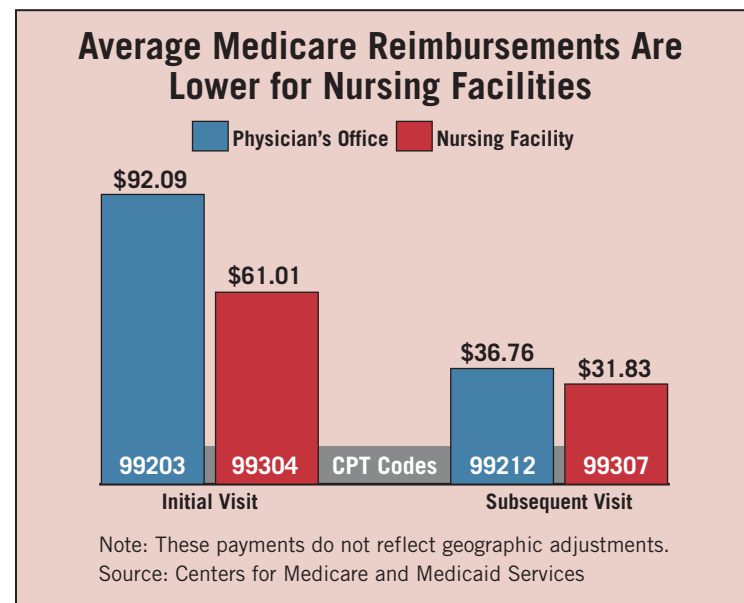
atricians, said Dr. Lichtenfeld, who is a medical oncologist in Atlanta.

"There's no doubt that primary care interests—family physicians and geriatricians in particular—are sorely lagging other specialties when it comes to [Medicare] reimbursement income. Taking care of nursing home patients is a labor of love," he said.

"It's not that the relative value system is screwed up or that CMS is made up of bad people," Dr. Lichtenfeld added. "The problem is there's not enough money being appropriated by Congress, and primary care gets beat up pretty badly as a result of that."

Dr. Sharon Brangman, a member of the board of directors of the American Geriatrics Society (AGS), noted that physicians often shy away from geriatric patients because of the complex nature of their illnesses and medications. "These patients often have complicated social and psychiatric issues and doctors have a limited amount of time they can spend on a given person," said Dr. Brangman, who is professor of geriatric medicine at the State University of New York, Syracuse.

Dr. Arthur Altbuch, a geriatrician in Janesville, Wis., sees nursing home patients, mostly on his own time. "Let's look at the reimbursement rate for a routine visit to a stable nursing home resident, and you are reviewing his weight, vital signs, medica-



tions, and basically everything is okay. In Wisconsin, that pays \$30.76 under code 99307, and that doesn't include driving back and forth to the nursing facility."

Increasingly, physicians won't provide care at nursing homes unless they have enough resident patients to make their time there worthwhile, said Dr. Altbuch, director of the family medicine residency program for Mercy Health System, which spans much of Southern Wisconsin and Northern Illinois.

The relatively small number of geriatricians in the United States—7,000 out of a total physician population of 650,000—is primarily the result of reimbursement issues and the increasing complexity of man-

aging the health of aging patients, but the shortage is aggravated by the junior position of geriatrics in most medical schools, said Dr. Robert Butler, president and CEO of the International Longevity Center in New York City.

About 45 U.S. medical schools offer significant geriatrics curricula, he added, but "just because they have a program doesn't mean they require students to go through it."

Dr. Levenson sees that as a growing problem, because thousands of physicians providing care to geriatric patients "really don't know what they're doing ... and create problems that have to be cleaned up by someone else." ■