

Fall, 2007

# Society for Clinical Vascular Surgery

## NEWSLETTER

### 2007 - 2008 COUNCIL

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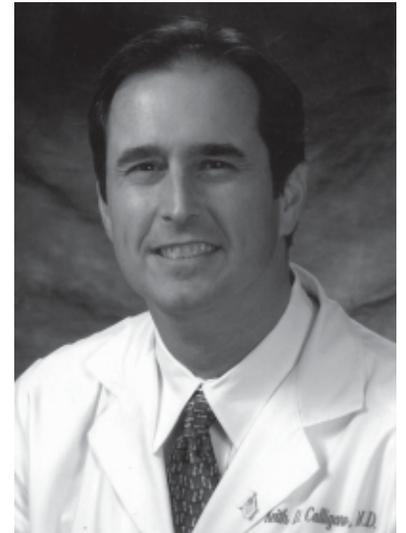
### President's Message

Keith D. Calligaro, M.D.

Planning is well underway for the SCVS 2008 Annual Symposium in Las Vegas, Nevada.

The educational objective of the SCVS is to address the needs of all vascular surgeons who practice clinical medicine, be they members of a university faculty or practicing within a community setting. In addition to a continuation of popular topics that were well-received last year, I am pleased to report that new sessions addressing current key issues are also being offered including one on Management of Certification and another that addresses Primary Certificates and how to set up a fellowship with new training paradigms.

Here are additional details on several of the 2008 Annual Symposium components.



### Enrichment Programs for Targeted Groups

With the help of its commercial partners, the SCVS is offering the following special programs designed for specific audiences:

#### Gore Fellows Program

Building on its continuing success in partnering with the SCVS, **W.L. Gore & Associates** is again offering this program on the first day of the SCVS Annual Symposium and will host the participation of 2<sup>nd</sup> year vascular fellows at the SCVS Annual Symposium.

#### SCVS Fellows Program

Made possible through support from **Boston Scientific**, this dinner symposium provides topics of interest to those surgeons who are transitioning from training to career positions and includes the very popular *Top Gun Challenge* (simulator training).

#### SCVS Young Vascular Surgeons Program

Supported by **Medtronic**, this dinner symposium provides valuable content on practice building techniques for vascular surgeons who have completed fellowships and have been working for 5 years or less.

#### NEW for 2008

With support from **Cook Inc.**, a program designed for late Residents/early Fellows is under development and will be introduced at the Las Vegas meeting.

(continued on page 3)

Society for Clinical Vascular Surgery  
*36th Annual Symposium*

*March 5-8, 2008*

CAESARS PALACE, LAS VEGAS, NEVADA

**PRELIMINARY HIGHLIGHTS OF THE SCIENTIFIC PROGRAM.....**

**POSTGRADUATE COURSE**

**How to Develop Your Own  
Dialysis Access Center**

**POSTGRADUATE COURSE**

**Debranching Techniques  
for Aortic Endografts**

**DEDICATED HANDS-ON SESSIONS**

**SCIENTIFIC SESSIONS *topics to include:***

- ◆ Venous
- ◆ LE
- ◆ Aortic
- ◆ Carotid
- ◆ Dialysis
- ◆ Various

**LUNCHEON SYMPOSIA**

**ALLASTAIR KARMODY  
POSTER COMPETITION**

**INTERNATIONAL PANEL**

**PRIMARY CERTIFICATE SESSION:  
HOW TO SET UP A FELLOWSHIP**

**MANAGEMENT OF  
CERTIFICATION SESSION**

Registration for the Annual Symposium and Hotel Reservations are now available on the SCVS website at [www.scvs.vascularweb.org](http://www.scvs.vascularweb.org). Don't delay. Book your room today! Las Vegas is a mecca for shopping, entertainment, and dining. Visit the SCVS website for "What to Do" in the Las Vegas area.

**DISTINGUISHED VISITING PROFESSOR**

**G. Patrick Clagett, M.D., Dallas, TX  
"EVAR, TEVAR, FEVAR, TOO FAR?"**

**SPECIAL INTEREST GROUP  
BREAKFAST SESSIONS**

**Workstyles, Generational Differences, and  
Young Vascular Surgeons Issues**

*JoAnn M. Lohr, M.D.  
Audra A. Duncan, M.D.*

**Wound Care Management**

*Paula Muto, M.D.*

**Special Issues for Community  
Vascular Surgeons**

*Alan M. Dietzek, M.D.*

**Aortic Endograft Case Reports**

*O. William Brown, M.D.*

**Challenging Cases with Audience  
Participation**

*Alan M. Dietzek, M.D.*

**PROGRAM COMMITTEE**

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Michel S. Makaroun, MD  
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Matthew Dougherty, MD  
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## ABOUT CAESAR'S PALACE

Caesar's Palace is one of the world's best known resort-casinos, celebrating the glory that was Greece and the grandeur that was Rome, in an 85-acre destination location that sets the standard for excitement and luxury. Reigning at the heart of the Las Vegas Strip, Caesar's Palace ranks among the world's top luxury resorts known for their originality and beauty and features more than 3,300 hotel guest rooms and suites, 26 diverse restaurants and cafes, 4.5-acre Garden of the Gods pools and gardens, world-class health spa and salon services and 240,000 square feet of premium meeting and convention space. Its 4,100-seat Colosseum spotlights world-class entertainers such as Celine Dion, Elton John and Jerry Seinfeld, and sits just steps away from celebrity chef restaurants and The Forum Shops. Meeting attendees will not only enjoy Caesar's Palace, but all that Las Vegas offers and it's not just casinos! Las Vegas offers:

- ♦ 340 days of sunshine per year and an average daily temperature of 83 degrees.
- ♦ Nearby natural wonders like Red Rock Canyon, Death Valley, Zion National Park, Lake Mead, the Colorado River, Mt. Charleston and the Valley of Fire.
- ♦ Limitless entertainment with more than 100 daily shows including dinner theater, magic, comedy, music and spectacular, full-scale stage productions.
- ♦ World-class dining and culinary talent from some of the best chefs.
- ♦ Endless shopping options to suit any style or budget, including designer stores, upscale shops and an assortment of boutiques.

### Highlights of the SCVS Council Meeting June 7, 2007 Baltimore, Maryland

- ♦ The SCVS Council submitted the names of 3 candidates to replace Dr. Dennis Baker upon completion of his term on the ICAVL Board. The ICAVL is currently in the process of selecting one of these individuals as the next representative.
- ♦ Dr. Calligaro reported that, upon request, an Annual Report of the activities of the SCVS with respect to the Annual Symposium in Orlando had been submitted to the SVS.
- ♦ The Council voted to allocate the SCVS investment portfolio at Vanguard based upon recommendations made by the SCVS Finance Committee.
- ♦ The Council voted to accept the Vascular Disease Coalition Rules of Governance as the SCVS is one of the founding organizations of the VDC.
- ♦ The Council voted to establish a Members Only Area on the SCVS website.
- ♦ The Council reviewed properties in Florida as potential sites for the 2009 Annual Symposium. The Council voted to reserve the Harbor Beach Marriott Resort & Spa in Fort Lauderdale for the 2009 Annual Symposium.

## RHODES RANCH GOLF CLUB OUTING

Located about 15 minutes SW of the Vegas Strip, Rhodes Ranch Golf Club is the centerpiece of a master-planned development. Born out of the desert at the base of the Spring Mountains and located just minutes from the famous Las Vegas strip, this fabulous facility has quickly become a leader in golf in the Vegas area.

Designed by renowned architect Ted Robinson, the layout provides a unique blend of challenge and playability to golfers of all skill levels. Highlighted by a group of par threes, which Robinson calls the best that he has ever designed, this 6,909 yard course will envelop you in its lush tropical surroundings while providing you with a world-class golf experience.

- ♦ Transfers, greens/cart fees, practice balls, boxed lunch, tax and gratuities included in the fee of \$125.00 per person.
- ♦ Clubs should be at the Caesar's Palace bellstand no later than 10AM Thursday morning if you plan to use group transportation.
- ♦ Sign-up for your specific tee-time upon your arrival at the SCVS Registration Desk.
- ♦ Coach will depart Caesar's Palace Augustus entrance at 12:00 PM, Thursday, March 6<sup>th</sup>. Staggered tee-times begin at 12:30PM, with foursomes going out every 8 minutes.
- ♦ Return transfer will depart Rhodes Ranch at 6PM.

## President's Message *(continued from page one)*

### Special Interest Group (SIG) Breakfast Sessions

The 2008 SIGs will build upon the success of those presented last year and have expanded to include the following topics:

- Workstyles, Generational Differences, and Young Vascular Surgeons Issues
- Aortic Endograft Case Reports
- Special Issues for Community Vascular Surgeons
- Challenging Cases with Audience Participation
- Wound Care Management

### Postgraduate Courses

The SCVS Vice President, Dr. George Meier, is working hard along with the 2008 Program Chair, Dr. Richard Neville, in providing the 2008 attendees with the latest information on specific problems facing vascular surgeons. Remember that the SCVS postgraduate courses are included in the registration fee for all physicians and I encourage all attendees to take advantage of these educational sessions.

Mark the date of the 2008 Annual Symposium in your calendar – March 5-8, 2008 – as a time to learn what's new in vascular surgery while enjoying an exciting venue. I look forward to seeing you in Las Vegas this March.

Best regards,  
**Keith D. Calligaro, MD, President**  
Philadelphia, Pennsylvania

## Who and What Determines “Standard of Care”

O. William Brown, M.D., J.D.

One of the four basic components of any medical malpractice suit is establishing that the physician has breached his duty to the patient, that is, that the physician has breached the standard of care. If the plaintiff cannot establish this component, then by law, the suit must fail. A physician may not be held liable, per se, for a mere error in judgment, mistake in diagnosis, or the occurrence of an undesirable outcome. Unfortunately, the term “standard of care” has been subjected to many different definitions by both the legal and medical professions. The legal definition is “what the ordinary physician would do in like or similar circumstances”. It should be stressed that the definition states the “ordinary physician”, and not the average physician. Clearly if it said “average physician”, then by definition, 50% of physicians would be committing malpractice. Similarly, it does not state that the standard of care is synonymous with the best medical care.

The standard of care may be established in one of five ways; expert witness, defendant’s admission, plaintiff’s testimony if he/she is an expert, common knowledge, and res ipsa loquitur. An example of “common knowledge” would be that even a lay person knows to avoid large doses of radiation during the first few weeks of pregnancy. Res ipsa loquitur or “it speaks for itself” refers to such situations as a retained sponge in the abdomen. The standard of care may not be established by simply reading an article or reading from a textbook in open court. The material read must be authenticated by an appropriate expert. Treatises, however, may be utilized to impeach the testimony of an expert witness without independent authentication.

In the past, the admissibility of medical procedures as standard treatment was based upon the Frye test which was established in Frye vs. United States. In this case, the court determined that in order for procedures or tests to be admissible, they had to be “generally accepted” by the medical community. This standard was subsequently replaced by the Daubert test (Daubert vs. Merrell Dow Pharmaceuticals) which states that admissible procedures and tests must be based upon “scientifically valid principles”. Interestingly, it is left to the judge to determine whether or not the scientific principles are valid.

Standard of care may include several different approaches to the same problem. However, as technology progresses, physicians must ask themselves, when does the “older procedure” become obsolete? Specifically, is AAA stent grafting the standard of care for the treatment of all patients with infrarenal AAA, or is it simply an option that falls within the standard of care? Does the performance of an open AAA repair in a patient who is a candidate for an endograft constitute medical malpractice? Unfortunately, all too often, this type of determination is left to the jury in a medical malpractice case. In their defense, in many cases, it is the biased testimony of an expert witness that significantly impacts the jury’s answer to these types of questions.

Standard of care for physicians is not determined by the geographic location of the physician’s practice. The standard of care is based upon a national standard and applies equally to all vascular surgeons across the country. The locality rule, which states that location must be considered, applies only to hospital facilities. It has been stated, “Allowance must be made for the type of community in which the actor carries on his practice”. A physician in

Gaylord, Michigan cannot be held liable for not ordering a 128 slice CT scan on a patient if this type of technology is not available in his/her hospital. A physician may not be held liable for using a portable fluoroscopy machine to perform a carotid stent if fixed imaging is not available. However, the more interesting question is whether a hospital can be held liable if fixed imaging is available, and the hospital does not provide equal access to this technology to all credentialed members of the hospital staff?

While it is impossible to protect oneself from less than fully truthful testimony by an opposing party, it is important for vascular surgeons to carefully outline in their preoperative notes all of the treatment modalities available, and, why the surgeon believes that the modality chosen is the most appropriate. This not only goes to providing adequate informed consent, but also stresses the fact that there are multiple treatments which all fall within the standard of care. Providing this type of information has a much greater impact upon a jury if it is contained in a preoperative note as opposed to a pretrial deposition.

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[www.scvs.vascularweb.org](http://www.scvs.vascularweb.org)

**SOCIETY FOR CLINICAL VASCULAR SURGERY**

**You can view the SCVS Newsletter, gather up-to-date annual meeting information, download membership information and applications, read about Society activities, and pay your membership dues on-line.**

# Physician Quality Reporting Initiative (PQRI): What Is It and How Does the Vascular Surgeon Comply With It

Anton N. Sidawy, M.D., M.P.H.  
Past-President, SCVS

*Based in large part on a publication in the Journal of Vascular Surgery entitled: "Pay for Performance: the Process and its Evolution"*

The Tax Relief and Health Care Act (TRHCA) was signed into law on December 20, 2006; Section 101 under Title I authorized a voluntary physician pay for reporting system, which was called by CMS (Centers for Medicare and Medicaid Services) the "Physician Quality Reporting Initiative" (PQRI).

For 2007, this law allowed PQRI measures to be reported voluntarily for the period between July 1 and December 31, 2007. Congress allocated funds to pay physicians 1.5% bonus on all Medicare reimbursement for the same time period for reporting on 80% of cases by three or less quality measures. The amount of the bonus is subject to a cap to provide an incentive against under-reporting or reporting only on low volume services. This cap is calculated using a complex formula established by CMS.

There are two types of codes that can be used to report quality measures. AMA CPT II codes, these are codes put together by the CPT panel of the AMA specifically to report quality information. And the G-codes: Government (CMS)-defined to report quality when a CPT II to report a certain quality measure is not available; G-codes will be phased out as more CPT II codes become available. G-codes have also been used for reimbursement purposes, an example of that in the vascular surgery area is the G-code used for reimbursement of preoperative Duplex Ultrasound evaluation of upper extremity vasculature prior to placement of AV access for dialysis. The quality codes, whether CPT II or G-codes, are reported along with the CPT I code that is used to report services for reimbursement.

CMS published 74 measures to be used for PQRI purposes in 2007. Of these, few are of interest to vascular surgeons:

- ♦ Antibiotic prophylaxis in the surgical patient
- ♦ Antibiotics ordered within one hour of the incision
- ♦ Appropriate Antibiotics ordered
- ♦ Antibiotics ordered to be stopped within 24 hours of end of operation
- ♦ DVT prophylaxis
- ♦ Measurements of distal internal carotid diameter as the denominator for stenosis measurement

These quality measures will continue to be available for reporting in 2008 in addition to new measures that will be developed for that purpose. DHHS Secretary will publish by November 15, 2007 a final list in the Federal Register for new measures to be used for 2008.

So far, developing a quality measure has been a complex process. Quality measures have been developed by many organizations including the AMA/Physician Consortium for Performance Improvement (the Consortium) and others. However, TRHCA allowed specialty societies to develop such measures. For CMS to use the measures for P4P purposes they have to be vetted, adopted, or endorsed by a consensus organization (such as the National Quality Forum or Ambulatory Care Quality Alliance). The National Quality Forum (NQF) was incorporated in 1999 in response to the report of the President's Advisory Commission on Consumer Protection and Quality in Health Care Industry. It promotes valid, comparative data needed to improve health care quality. NQF is now the organization whose stamp of approval is important to legitimize a performance measure. The Ambulatory Care Quality Alliance (AQA) was organized by CMS and was convened in September of 2004 by four organizations; the American Academy of Family Physicians, the American College of Physicians, America's Health Insurance Plans, and the Agency for Healthcare Research and Quality. The AQA functions as a consensus builder to get the buy-in for the CMS performance measures from over 100 organizations that currently belong to it. However, AQA is now involved in approval of quality measures as well. ACS and SVS are examples of the organizations that belong to AQA in addition to other specialty societies, healthcare purchasers, healthcare insurers, government agencies, consumer groups, and other quality care experts.

There is no registration necessary to participate in PQRI; just simple reporting of a quality measure would indicate that the particular physician will be a participant. The reporting of quality measures is claims-based reporting, where CPT Category II codes (or temporary G-codes where CPT Category II codes are not yet available) are reported on paper-based CMS 1500 claims or electronic 837-P claims. Quality codes, which supply the measure's numerator, must be reported on the same claims as the payment codes, which supply the measure's denominator.

There are exclusion modifiers for performance measure; one or more exclusions may be applicable for a given measure. Certain measures

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*(continued on back page)*

## Physician Quality Reporting Initiative (PQRI)

*(continued from page 5)*

have no applicable exclusion modifiers. The main exclusion modifiers are related to medical, patient, or system reasons (1P, 2P, or 3P); also an exclusion modifier for unspecified reasons (8P) is also included.

The 1.5% bonus calculation is based on total allowed charges during the reporting period for professional services billed under the Physician Fee Schedule for a particular practitioner. The bonus is paid lump sum. For those physicians currently participating in PQRI (last six months of 2007), they should submit their claims to the National Claims History (NCH) file by February 29, 2008. The bonus payments will be made in a lump sum in mid-2008.

Obviously, the earlier one starts reporting quality measures in the reporting cycle the higher the chance to comply since it is rather hard to catch up and report on 80% of cases if one does not report for the whole cycle. All physicians are encouraged to participate in PQRI; however, since PQRI is based on voluntary reporting, each and every

physician and surgeon should make his or her own decision whether to participate in this program. This will probably be based on the physician's estimate of the administrative cost needed to run this program and on the potential update that can be earned. In doing so, it is important to remember that the 1.5% update is based on the total reimbursement for all cases that qualify for Medicare payment and not only the cases reported on. Therefore, the actual reimbursement mix for each surgeon would also influence this decision.

Of note, as of now, since the 2008 budget has not been approved yet, it is unknown whether funds will be allocated by Congress for PQRI purposes in 2008.

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