were mailed to more than 13,000 California physicians on July 24, 2009. The deadline to request a physician's patient list was September 9, 2009. The corrections provided by September 18 were applied to correct the quality results before the information was provided to the health plans. According to Ted von Glahn, the director of Performance Information and Consumer Engagement for the Pacific Business Group on Health (PBGH), who provided guidance for the CPPI project, approximately 1200 physicians provided corrections. The correction process was laborious, but provided some further process refinement. For example, if a patient refused a medication that was deemed necessary, the physician could state that the patient refused. However, starting next year, this option will no longer be available. Mr. von Glahn said that there has been a "spirited" discussion with regard to the patient adherence issue.

Mr. von Glahn also states that the CCHRI executive committee is providing guidance to health plans on how to use these data. He believes that in 2010 these plans will use the data to recognize top performers.

Many physicians were surprised by the CPPI report. The California Chapter of the American College of Cardiology (CA ACC) received many phone calls with questions, concerns, and pleas to help navigate this process. The purpose of this article was to describe the process. CPPI will be an ongoing process; after my discussions with Mr. von Glahn, the CA ACC has been invited to be on the advisory group to help refine the process.

I would like to hear from you about your experiences: Did you submit the corrections? What were the barriers you faced? Your feedback will help us better represent you in this process. This initiative, along with others looking toward collecting individual physician data, is here to stay. We need to become active participants. I look forward to hearing from you. Please feel free to contact me at drdipti@yahoo.com or Lianna Collinge, CEO, at Lianna@caacc.org. ■

Echocardiography Preauthorization Mandates From Private Insurers

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Increasing use of advanced imaging modalities has led to widespread concern about burgeoning expenditures for these procedures. Although recent growth has been most robust for CT, PET, and MRI modalities, echocardiography remains the most utilized cardiovascular imaging test. This has led payors to institute measures that address the appropriateness and utilization of echo services.

One company, Wellpoint, Inc. (Indianapolis, IN), has already unilaterally instituted a program of pre- and postnotification for echocardiography. This program is applicable to all Anthem Blue Cross providers of outpatient echocardiography examinations, whether in a hospital, office, or free-standing facility. Notification of such requirements was mailed to 20,175 physician offices in May 2009. At present the prenotification process is voluntary and not required for payment, but Anthem has expressly stated that prior authorization will become mandated sometime in 2010. At that time, any echocardiographic service performed without an authorization number will be denied even if the service was medically necessary. The program is being administered by American Imaging Management (AIM), a wholly owned radiology benefit management subsidiary of Wellpoint. AIM's proprietary utilization guidelines cover indications and frequency of use for transthoracic, stress, and transesophageal echocardiography services and are available for review on its Web site (http://www.americanimaging.net).

Anthem's prenotification process includes "pre-exam questions" for all echo services, even pediatric cases, no matter the indication for the test. These questions include each patient's current blood pressure, cholesterol values, smoking status, symptoms, "other cardiac risk factors," and the principal diagnosis for the requested service. All of these questions will be asked for every requested echocardiographic service. At present, responses to these questions are not mandatory except for stress echocardiography. These data will be entered into the patient's demographic information by AIM and will be in place for future requested services. AIM's rationale for collection of such data for transthoracic and transesophageal echocardiography is to "allow documentation of patient acuity in relation to coronary artery disease." After provision of an echo service, Anthem requires that notification be then given as to whether the result was abnormal, and as to whether the test result led to alteration of the patient's treatment.

The American College of Cardiology and the American Society of Echocardiography have raised concerns with Anthem regarding the burden such notifications will place on providers of echocardiographic services, and whether such an onerous process helps achieve the laudable goals of high-quality imaging, appropriate resource utilization, and cost containment. We have also expressed our opinion that collection of the aforementioned pretest data is irrelevant in patients undergoing non–stress echocardiograms. Nevertheless, Anthem is moving forward with the program.

We need to develop alternative methods of assuring delivery of quality, appropriate echo services. I invite you to contact me if you have ideas regarding this important issue. ■

Health Care Reform: The Implications for Cardiology

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It cannot have escaped the notice of any US cardiologist that the changes being implemented in the health care reform package currently passing through Congress and, separately, through the Centers for Medicare & Medicaid Services (CMS) will cause major upheavals in our ability to offer the kind of patient care that each of us would wish for ourselves and our loved ones. Although discussing moving targets such as these is fraught with uncertainty, I would like to attempt to outline the major issues and the California Chapter of the American College of Cardiology (CA ACC) response to these issues.

The first issue: the sustainable growth rate (SGR) formula. The problem arose because actual expenses for Medicare (ie, utilization, because Medicare payments are fixed and nonnegotiable) exceeded by a significant amount that which was predicted. Planners built into the legislation formulas that would increase payments if increases in spending fell below estimates, and decrease payments if they exceeded estimates. The increases have exceeded estimates each year, and the cumulative decrease in payments currently mandated by the legislation is 21.5% for every Medicare payment to every specialty.

Adjustments have not occurred because every year Congress has passed a 1-year fix, delaying implementation. CA ACC efforts have been directed toward the permanent repeal of this formula. The current House bill repeals the formula, but the Senate bill again contains a 1-year fix. This is now a $250 billion dollar