



Physician Group Incentive Program (PGIP)

Coronary CT Angiography CQI

Clinical Program Development
March 2008

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**BCBSM PGIP
March 2008**

Coronary CT Angiography CQI

Executive Summary

Coronary computed tomographic angiography (CCTA) is a noninvasive imaging test that requires the use of intravenously administered contrast material and high-resolution CT machinery to obtain detailed volumetric images of blood vessels. It is a promising technology and may offer a noninvasive replacement for conventional angiography.

Until recently, CCTA was deemed investigational by Blue Cross Blue Shield of MI as its effectiveness has not been proven. Medicare has issued standardized codes for paying these procedures effective 1/1/07. BCBSM and Blue Care Network are using a "coverage with evidence development" approach to providing coverage for CCTA as an emerging technology. Using a collaborative model, BCBSM/BCN will partner with qualified providers who will contribute data to a data registry. Privileging for inclusion in the consortium will be dependent on meeting objective standards pertaining to equipment, training, staff qualifications and technical and quality improvement infrastructure. The consortium is led by a cardiologist with extensive experience and training in cardiac imaging in general and emerging cardiac imaging technologies in particular. Participating centers work with the Coordinating Center to use the registry to generate practice pattern analyses which will be used to support providers' efforts to develop, apply, assess and improve standards for judicious use of the technology. Providers participating in the consortium will be eligible to perform and bill for CCTA. Providers outside of this collaborative will not be reimbursed for this procedure. The project will enable BCBSM and BCN to pay for coronary artery CT Angiography while ensuring the appropriate use of this new technology.

By joining forces in this way, providers with relevant technical expertise will be able to establish clinical algorithms for judicious use of this and related technologies in common clinical scenarios and examine how the scans are used in practice, what variation exists in such use, what the potential impact of their use are, and use this learning to guide efforts to assure judicious use of the technology.

Introduction

A. Problem Statement

Coronary computed tomographic angiography (CCTA) is a noninvasive imaging test that requires the use of intravenously administered contrast material and high-resolution CT machinery to obtain detailed volumetric images of blood vessels. It is a promising technology and may offer a noninvasive replacement for conventional angiography.

Until recently, CCTA was deemed investigational by BCBSM as its effectiveness has not been proven. Since Medicare has issued standardized codes for paying these procedures effective 1/1/07, there was increasing pressure from the provider community for reimbursement of the procedure.

As with other new technology, BCBSM is concerned that once we make CCTA payable, many providers may purchase CT scanners and begin using them without the appropriate training and experience that is needed to provide our members with high quality care.

B. Background

Coronary artery disease (CAD) is on the rise due to the aging of baby boomers, increasing prevalence of obesity and adult onset diabetes. Since preventive medical therapy can reduce death and disability from CAD, detection and treatment of pre-clinical CAD could have a major impact on public health and healthcare expenditure, with a major impact on healthcare costs.

Recently, CT machines have become available that are highly sensitive and accurate for the detection of CAD. Coronary artery CT angiography represents both a challenge and an opportunity in the context of rising CAD and healthcare costs.

CCTA, using high-resolution (64-slice and greater) CT scanners, is promising because it is highly sensitive and accurate for the detection of CAD. In addition, it is rapid, non-invasive, widely available and easily tolerated. It also may dramatically shorten length of stay in the emergency department evaluation of acute chest pain. CCTA is relatively cheap compared to invasive angiography (\$728 compared to \$1,042). Thus, it is a promising technology and may offer a noninvasive replacement for conventional angiography.

A study on patients who had this imaging service showed that 75% of patients in the CTA group had immediate disposition based on the test. The length of stay for

the CTA group was reduced by 77%, leading to a 15% reduction in the cost of care for these patients.¹

An IMPACCT Treadmill study of 200 patients with chest pain in the outpatient setting also demonstrates apparent cost savings from patients not getting conventional cardiac catheterization after CTA. Before CTA, physicians planned to catheterize 65% of patients. Following CTAs, the actual catheterization rate was only 18%, reducing catheterizations by 72%.²

With Medicare issuing standardized codes for paying CCTA and covering CCTA on a region-by-region basis, BCBSM was faced with increasing pressure from the provider community to make CCTA a payable benefit. However, as effectiveness of this new technology has not been proven, BCBSM wishes to study the appropriate uses of the technologies such as the CCTA while offering the new technologies as a benefit. Using the Value Partnership model, BCBSM uses a "coverage with evidence development" approach to providing coverage for CCTA as an emerging technology.

It should be noted that Medicare is now considering implementation of a coverage with evidence development policy of its own for CCTA.

Environmental Survey

A. What have others done to solve this problem?

The Centers for Medicare and Medicaid Services (CMS) are concerned with how rapidly this technology has been adopted by the clinical community without substantial scientific evidence demonstrating its ability to improve patient outcomes. They conducted an analysis in June, 2007 to determine if a national coverage decision is warranted.³ The analysis sought to evaluate available evidence for the use of CTA when used to diagnose coronary artery disease. In this analysis, CMS also considers the potential of Coverage with Evidence Development as an appropriate national coverage decision. To date, CMS still do not have a national coverage determination.

The Technology Evaluation Center, an office of the BCBS Association charged with development of scientific criteria for assessing medical technologies through comprehensive reviews of clinical evidence, has determined that the use of CCTA for screening or diagnostic evaluation of the coronary arteries does not meet the TEC criteria of clinical effectiveness and appropriateness.⁴

Other Blue plans – Iowa, Idaho, Massachusetts and others have expressed interest in using the BCBSM "coverage with evidence development" approach to pay only limited groups of providers for the service.

B. Constraints/Considerations

(1) Legal/regulatory

- There is a chance providers not included in the consortium will challenge their exclusion under the choice of provider clause in PPO Laws.
- PA 350 precludes paying only a select group of Traditional providers for health care services that are within their scopes of practice.
- Subscriber Certificate language needs to be revised to clarify that BCBSM has the discretion to determine which providers are qualified to perform certain services and cover these services only when qualified providers perform them.

(2) Impact on provider contracts, credentialing, professional societies and organizations

- Provider contract – scope of practice precludes limiting payment to certain physician groups. The new TRUST physician participation agreement, effective 3/1/08, includes a provision that allows precluding non qualified providers from performing and billing for emerging technologies.
- Provider relations – there is additional concern regarding how providers who are excluded from payment will react.

(3) System limitation in paying providers differentially

- BCBSM's claims system does not allow for paying providers differentially. Once fee levels were established for the CCTA procedures, any provider may bill for the procedure and be reimbursed. Medical Affairs is exploring a utility offered by McKesson which would allow limiting payment to selected providers within a particular specialty. In the future, this ability will be embedded in the BCBSM claims payment system.

(4) Member relations – although members will be held harmless, paying for the cardiac scans to only certain providers may be confusing for them. In addition, it is unclear what will happen when a panel provider performs the scan for Traditional members.

Opportunity Assessment

CCTA is an accurate and cost effective technology when used appropriately. Results from a study of CCTA patients show that 75% of patients had immediate disposition based on the test. The length of stay for the CCTA group was reduced by 77% and the cost of care reduced by 15%.⁵

An IMPACCT Treadmill study of 200 patients with chest pain in outpatient setting also demonstrates apparent cost savings from patients not getting conventional cardiac catheterization after CCTA. Before CTA, physicians planned to

catheterize 65% of patients. Following CTAs, the actual catheterization rate was only 18%, reducing catheterizations by 72%.⁷

As with other new technology, BCBSM is concerned that once we make CCTA payable, providers will rush to purchase CT scanners and begin using them without the proper training and experience that is needed to provide our members with high quality care.

To protect BCBSM from such potential overuse, the following approach was discussed:

- (1) Create a sub-panel of TRUST hospitals and/or physician groups that will be allowed to bill and be paid for the scans
- (2) Revise certificate language to clarify that BCBSM has the discretion to determine which providers are qualified to perform certain services and cover these services only when qualified providers perform them.

However, upon further discussion, senior management decided to adopt a “coverage with evidence development” approach to broaden benefit coverage for experimental procedures to selected, qualified providers. By initiating coverage of CCTA with a collaborative quality initiative, BCBSM can partner with providers in examining how the scans are used and understand the impacts of their use. Further, providers in the consortium will be charged with the responsibility to define optimal, judicious use of these services and implement this knowledge in practice in the communities of caregivers referring patients for such procedures. Once more is known about such optimal use, BCBSM may allow other providers to be paid for the scans, or expand inclusion in the consortium.

PGIP CCTA CQI Goals

In the Advanced Cardiovascular Imaging Consortium CCTA Collaborative Quality Initiative, BCBSM partners with interested groups of providers who will contribute data to a procedure registry that will assist BCBSM by having collaborating physicians and facilities develop, apply, assess and improve standards for judicious use. Payment for CCTA will be limited to providers that:

- (1) Meet defined technical and quality standards and
- (2) Agree to participate in the collaborative and submit data to a procedure registry.

Providers outside of this collaborative will not be reimbursed for this procedure. By working with a limited number of providers, BCBSM will be better able to learn how the scans are used, understand what the impacts of their use are, and charge providers with the responsibility to assure judicious use.

Using a CQI approach to “privilege” a limited number of providers deemed eligible to perform and bill for CCTA, the project will enable us to pay for coronary artery CT Angiography while ensuring the appropriate use of this new technology.

Specific objectives of the project are:

- (1) To catalyze providers to take responsibility for studying and defining the appropriate uses of CCTA through:
 - Developing a database and registry to document the utilization patterns of coronary artery CT angiography,
 - Creating clinical practice algorithms designed to guide best practice use of CCTA, and
 - Implementing a continuous quality improvement program in cardiovascular imaging.
- (2) To limit the number of providers that would be paid for these scans to those most qualified to provide the services and who agree to actively participate in the consortium, with a commitment to the goals outlined in (1), above.

Proposed Solution: The Coronary CT Angiography Collaborative Quality Initiative (CQI)

The CCTA CQI is a partnership between the Advanced Cardiovascular Imaging Consortium (ACIC) of Michigan at Beaumont Hospital and BCBSM/BCN. With this CQI, BCBSM/BCN will reimburse CCTAs performed at facilities participating in the collaborative.

The medical policy statement pertaining to CCTA was revised to include the following reference:

“This procedure is no longer considered investigational/experimental. It should be considered a useful diagnostic procedure when indicated. Within the State of Michigan, these services are established **only** if delivered in a facility that is participating in the BCBSM/BCN Collaborative Quality Initiative for Emerging Non-Invasive Cardiovascular Imaging.”⁶

Participants of the ACIC consortium will submit data on use of CCTA to the data registry to support the creation of clinical practice algorithms to guide appropriate use of the technology. Each provider and its operators will have access to their own data, in comparison to the range and average performance in the consortium. All data will be kept in strict confidence, and no provider or operator will have access to identified data from others. The ACIC Coordinating Center for the project will be, under the direction of Gil Raff, MD. Dr. Ella Kazerooni, Director of Thoracic Radiology, University of Michigan is on the ACIC Executive Committee.

The ACIC Coordinating Center will provide administrative, logistic, statistical and analytic support for the consortium. Reports will be generated to guide continuous quality improvement (CQI) efforts at each participant.

1) Participation criteria and expectations

- See attached program standards (Appendix 1).

2) Administration

- Staffing required – the CQI is coordinated by the ACIC at Beaumont Hospital under principal investigator Gil Raff, MD. Clinical Program Development staff will coordinate the recruitment and contracting with participant providers.
- Funding methodology – BCBSM /BCN will provide funding for some of the costs associated with data collection and will fund the registry and report generation and coordination of the CQI efforts through adjusting fee-for-service reimbursement rates for the procedures.

Evaluation of Effectiveness

The Coronary CT Angiography CQI uses a consortium approach to “privilege” a limited number of providers deemed eligible to perform and bill for CCTA. The project will enable us to pay for coronary artery CT Angiography while ensuring the appropriate use of this new technology.

The effectiveness of this CQI has to be evaluated against two specific objectives of the project:

- (1) To pay only providers deemed eligible to perform and bill for CCTA, and
- (2) To develop a database and registry to document the utilization patterns of coronary artery CT angiography. This data registry will be used to create clinical practice algorithms designed to guide best practice use of CCTA.

Evaluation methodology

Data for evaluation will come from two sources:

- BCBSM claims data
- Detailed, de-identified, patient specific information and process of care and outcome data collected through the CQI program

The program will enable the analysis of practice patterns with regard to service use for patients with coronary artery disease. More specifically, the analysis can help us in understanding:

- The general impact of the program;

- Whether there is variation in efficiency of use of cardiac diagnostic and intervention services across groups of providers affiliated with imaging centers (meaning those who care for cardiac patients and refer to these imaging centers);
 - Whether there is variation in how cardiac diagnostic and intervention services are used by our members if they are seen by physicians who use advanced imaging as opposed to usual care;
 - Whether CCTA has had an impact on patient care and outcomes; and
 - How well are physicians following protocols for the use of CCTA.
1. To assess the general impact of the program in paying only providers that participate in the consortium, monthly review of claims for CCTA will be conducted to identify providers who are billing and to ensure that providers submitting claims for these services are in the ACIC CCTA CQI. Providers who billed for CCTAs and are not in the consortium will be sent a “warning” letter to “cease and desist”. If they continue to bill for CCTA, Provider audit will conduct a special audit for recovery.
 2. The Coordinating Center, with input from the participating sites, is responsible for aggregate analysis of patterns of practice for the consortium as a whole and on a de-identified basis examining variation in practice patterns across participating centers. The Coordinating Center will share summary reports from such analyses on a periodic basis, BCBSM will not have direct access to the data registry or to any identified data.

Both the Coordinating Center and BCBSM’s analyses will include examination of variation across Centers and over time in patterns of use of multiple imaging modalities (invasive and non-invasive) as well as their correlation to patterns of use of revascularization services. These analyses will help in understanding whether CCTA services supplement or supplant the use of other diagnostic services, and whether patterns of use reflect redundant testing with multiple, over-lapping imaging services (functional testing, i.e., stress testing and pure imaging), or more parsimonious use. Also, the analyses will help clarify what impact these new, high technology imaging services have on patterns of use of diagnostic catheterization and re-vascularization services.

3. BCBSM claims data can further supplement the evaluation strategy as follows:
 - With BCBSM claims data, the evaluation can examine in depth follow-up services that extend beyond the time period that the data registry can sample for the non-BCBSM patients.
 - An analysis of care patterns for patients with ischemic heart disease and separately for those who have interventions for coronary artery disease (PCI, CABG) will help assess whether the volume of cardiac services and costs are increasing at an accelerated rate with the introduction of CCTA use.

The results of this analysis can be used to improve the efficiency of the care our members receive and for physician self-assessment.

Focus of Analysis

The coordinating center's analysis of data from the registry will focus on these broad categories:

1. Appropriateness

The American Colleges of Cardiology and Radiology as well as several imaging societies released a consensus statement of Guidelines for the use of cardiac CT. These will form the initial basis for evaluation of whether physicians are ordering the test appropriately and what percent of studies at the sites are a) Highly appropriate, b) Possibly appropriate, or c) Inappropriate.

2. Safety

Radiation safety is the greatest variable since cardiac CT will have the same risk profile as any CT with contrast. Cardiac CT delivers a lot of radiation due to its high resolution, so meticulous attention to detail is important, particularly as newer methods can drop radiation exposure by 40%.

3. Contribution to Effectiveness

MD reports will be compiled in a database and cross-referenced against catheterization, stress tests and MACE events to demonstrate effectiveness of diagnosis.

4. Cost effectiveness

An appropriately ordered, properly acquired and accurately interpreted CTA should be highly cost effective when used by a properly educated physician community. That is, for example, a large proportion of primary chest pain patients (without known CAD) have non-cardiac causes for their pain. For that reason, a majority of cardiac CT scans are normal, both from outpatients and emergency room patients. Ideally, there would be no further cardiac workup, unless there is a tumor, pericardial effusion or some non-coronary issue. This can be achieved through auditing the number of subsequent tests done after a normal CTA. Conversely, a patient with malignant CAD findings should have a further WU.

Implementation Plan

- Timeframe:

(1) Recruitment of consortium participants

There are two phases in recruitment consortium participants. The first phase recruits hospital participants, with schedule as follows:

- 4/10/07 – 5/1/07: Invitation to apply
- 5/1/07 – 5/31/07: Evaluate applications to select hospital participants
- 6/1/07 – 6/30/07: Contract with participants of CQI
- 7/1/07: Launch program

The second phase expands the program to include physician groups who own/lease 64-slice CT scanners and have qualified personnel who perform the imaging services and interpret CCTA images:

- 9/1/07 – 11/1/07: Invitation to apply
- 11/1/07 – 12/31/07: Evaluate applications to select physician group participants
- 1/1/08 – 1/31/08: Notify applicants of results
- 2/1/08: Launch program for physician groups

(2) Reimbursement system

- 4/10 – 5/1: BCR to make CCTA codes (0145T – 0149T) payable in Location 2 (hospital outpatient)
- 5/1 – 5/31: BCR review and system changes, revisit proposed fees to finalize reimbursement amount
- 6/1 – 6/30: Loading of codes and fees
- 7/1/07: CCTA codes and fees effective
- 11/1/07 – 12/31/07: BCR to expand payable location to Location 3 (physician offices)
- 1/1/08: CCTA codes and fees effective for Location 3

- Communication

- (1) Multiple *Record* articles to notify providers of policy to reimbursed only a limited network of providers
- (2) Policy clarification statements have been circulated to ensure all impacted areas understand the program (see Appendix 2)
- (3) A Q & A was developed to address commonly asked questions (see Appendix 3).
- (4) Communication to CQI participants of CCTA codes and fees

Outstanding Business Risks

(1) Customer/provider

- ASC customer buy-in – Many self funded customers have yet to decide if they will adopt BCBSM's approach of coverage with evidence development

to pay for CCTA. The auto customers, for example, are still reviewing the opportunity to participate in the program.

- Provider relations – providers are confused as to when the procedure will be payable. Despite multiple training sessions with provider consultants, there are numerous queries from providers.
- Access to care – limited choice, payable at location 3 will broaden access to physician groups, specifically cardiologist and radiologist groups who own/lease a scanner and have qualified personnel who provide the imaging services as well as reading and interpretation of the images.

(2) Operational systems

- Our Claims system cannot differentiate providers who are in the consortium. Anyone who bills will be paid, and will be paid at the fee levels (fee for the CT service plus add on for data collection), until such time as an external utility is applied to the claims system, such as the one offered by McKesson, under consideration by Medical Affairs, or the claims system is modified to accept privileging information about providers.

References:

1. Presentation to ACIC kick off meeting, Gil Raff, MD, July, 2007
2. Presentation to ACIC kick off meeting, Gil Raff, MD, July, 2007.
3. CMS Opens a National Coverage Analysis on Computed Tomographic Angiography, e-mail from AHIP, June 15, 2007.
4. Contrast Enhanced Cardiac Computed Tomographic Angiography for Coronary Artery Evaluation, Assessment Program, Volume 20, No. 4, Nov. 2005.
5. Presentation to ACIC kick off meeting, Gil Raff, MD, July, 2007
6. BCBSM Medical Policy Statement, July, 2007.

Appendix 1

BLUE CROSS BLUE SHIELD OF MICHIGAN ADVANCED CARDIOVASCULAR IMAGING CONSORTIUM CORONARY CT ANGIOGRAPHY COLLABORATIVE QUALITY INITIATIVE

To be a provider in the BCBSM Advanced Cardiovascular Imaging Consortium (ACIC) Coronary CT Angiography Collaborative Quality Initiative (CQI), the hospital or physician group must be in the TRUST and Traditional networks and also comply with the additional standards listed below.

Program applicants and current network providers will be required to meet and continue to comply with the following standards. BCBSM has sole discretion to determine whether a hospital or physician group meets the following criteria.

Note: Headings in this document are for illustrative purposes only. Standards are not limited to the heading under which they appear. Most standards are applicable to multiple headings.

I. Standards for Maintaining Quality Health Care

A) Hospital must at the time of application and thereafter:

1. Own or lease a 64-slice (or greater) CT machine.
2. Use post-processing software capable of providing cardiac reconstructions and high quality images of coronary anatomy and left ventricular function.
3. Demonstrate to BCBSM's satisfaction that it has an organized, active and supervised continuous quality assurance program pertaining to coronary CTA services with active participation in direction and management of a qualified medical physicist and a level 2 trained cardiologist or radiologist with training as recommended in the *ACR Practice Guideline for the Performance and Interpretation of Cardiac Computed Tomography (CT)*, 2006 or the *ACCF/AHA Clinical Competence Statement on Cardiac Imaging with Computed Tomography and Magnetic Resonance*, 2006 (Attachment 1).

B) Hospital must agree to allow BCBSM to audit compliance with the ACIC Coronary CT Angiography CQI Standards at BCBSM's discretion.

C) Hospital must have the following personnel with appropriate certification to perform and interpret coronary CT scans as recommended in the "Qualifications and Responsibilities of Personnel section" of the *ACR Practice Guideline for the Performance and Interpretation of Cardiac Computed Tomography (CT)*, 2006 (Attachment 1) and the *ACCF/AHA Clinical*

Competence Statement on Cardiac Imaging with Computed Tomography and Magnetic Resonance, 2005 (Attachment 2):

1. At least two physicians on staff who are involved in the CCTA program, interpret the images, and have training consistent with current ACC or ACR standards specific to coronary CTA services:
 - If both physicians are cardiologists – both must have a minimum of level 2 clinical competence training and ongoing CME completion, with both having clinical competence training in contrast and non-contrast studies in accordance with the attached ACC standards.
 - If both physicians are radiologists – each must have prior qualifications in general and/or thoracic CT interpretation or have had extensive training and experience in CT scanning with an emphasis on the thorax and specific experience in cardiac CT scanning, and have supervised experience interpreting cardiac CT studies at the volume recommended in the current, relevant ACR standards.
 - If one physician is a cardiologist and one is a radiologist—the cardiologist must have a minimum of level 2 competence as described in the attached ACC standards and the radiologist must be fully trained in accordance with the attached ACR standards.
 - All studies must be interpreted by physicians with the training referenced above.
 2. Technicians providing imaging services are graduates of an American Medical Association accredited program in radiology technology with a minimum of an Associates degree and have current American Registry of Radiologic Technologists (AART) and/or Certified Radiologic Technician registration/license.
 3. Clinical staff on site is ACLS certified and available for drug administration and resuscitation services.
- D) Hospital must commit to active participation in the ACIC coronary CT Angiography CQI, including development and implementation of consortium-determined clinical guidelines, systematic approach for provision of consultation on optimal imaging strategy to referring physicians, and systematic approach to assuring complete, accurate and timely data gathering, submission and validation.

II. Standards for Controlling Health Care Costs

- A) Hospital must at the time of application and thereafter:
1. Provide coronary CT angiography services in a cost efficient manner, as defined by BCBSM.

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2. Comply with standards for controlling health care costs as required in the TRUST Hospital Participation Agreement.

III. Standards for Assuring Appropriate Utilization of Cardiac Care Services

A) Hospital must at the time of application and thereafter:

1. Demonstrate to BCBSM's satisfaction that it applies appropriateness criteria to case selection and that a quality/appropriateness review process exists for all cases.
2. Demonstrate to BCBSM's satisfaction that established patient selection criteria, including indications and contraindications for the procedure, are utilized and are consistent with current medical standards, such as guidelines established by the American College of Cardiology or American College of Radiology.

IV. Standards for Assuring Reasonable Levels of Access to Health Care Services

A. Hospital must at the time of application and thereafter:

1. Demonstrate to BCBSM's satisfaction that it has appropriate cardiac care equipment and qualified physicians available for immediate management of unstable patients and a minimum of two advanced cardiac life support certified staff.

V. Other Standards

Hospital must at the time of application and thereafter:

1. Recognize that BCBSM will consider any other matters that materially affect the hospital's performance in the selection process.
2. Recognize that customer preference is considered in the selection process.
3. Recognize that BCBSM has the right to exercise business judgment in the selection process.
4. Demonstrate to BCBSM's satisfaction that it has the ability to cooperate with BCBSM, BCBSM members, customer groups and the provider community.

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5. Agree that BCBSM and its customers have the right to delegate certain administrative duties, e.g., preauthorization, audits, etc., to third parties.
 6. Comply with all applicable laws and with all professional and ethical standards.
 7. Agree that BCBSM retains the right to determine customer groups and members eligible to use this panel.
 8. Be free of conflicts of interest relative to BCBSM, its customer groups and members during the term of the Advanced Cardiovascular Imaging Consortium Coronary Ct Agreement.

Program Standards for Physician Groups:

In addition to meeting the above stated program standards Sections I to IV for hospitals, cardiology or radiology professional provider groups may be privileged to participate in this consortium and provide cardiac CTA services and to be so privileged must meet the following criteria pertaining to quality of and access to health care services:

I. Standards for Maintaining Quality Health Care

- 1) The group must use post-processing software capable of providing cardiac reconstructions and high quality images of coronary anatomy and left ventricular function.
- 2) The group must have at least two physicians on staff who are involved in the CCTA program, interpret the images, and have training consistent with current ACC or ACR standards specific to coronary CTA services:
 - If both physicians are cardiologists – both must have a minimum of level 2 clinical competence training and ongoing CME completion, with both having clinical competence training in contrast and non-contrast studies in accordance with the attached ACC standards.
 - If both physicians are radiologists – each must have prior qualifications in general and/or thoracic CT interpretation or have had extensive training and experience in CT scanning with an emphasis on the thorax and specific experience in cardiac CT scanning, and have supervised experience interpreting cardiac CT studies at the volume recommended in the current, relevant ACR standards.
 - If one physician is a cardiologist and one is a radiologist—the cardiologist must have a minimum of level 2 competence as described in the attached ACC standards and the radiologist must be fully trained in accordance with the attached ACR standards.

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- All studies must be interpreted by physicians with the training referenced above.
- 3) Technicians employed or contracted by the group to provide imaging services are graduates of an AMA accredited program in radiologic technology with a minimum of an Associates degree and current American Registry of Radiologic Technologists (ARRT) and/or Certified Radiologic Technologist registration/license.
 - 4) The group must have ACLS certified staff on site for drug administration and resuscitation services when necessary.
 - 5) The group must commit to active participation in the cardiac CTA consortium, including development and implementation of consortium-determined clinical guidelines, systematic approach for provision of consultation on optimal imaging strategy to referring physicians, and systematic approach to complete, accurate and timely data gathering, submission and validation.
 - 6) If the group is a cardiology group, it must provide a full range of cardiac care services including clinical cardiology, non-invasive imaging, invasive diagnostic imaging, interventional procedures and electrophysiology services.
 - 7) The group must have an explicit agreement with a Physician Organization which is a full, active participant in the BCBSM Physician Group Incentive Program to collaborate on population management of patients with potential cardiac illness and assure judicious use of imaging services, including but not limited to cardiac CT angiography services.
 - 8) The group's practice pattern must reflect judicious and appropriate use of health care resources in comparison to that of its peers.

CARDIAC CT ANGIOGRAPHY

QUALIFICATIONS AND RESPONSIBILITIES OF PERSONNEL

A. Physician

The physician shall have the responsibility for all aspects of the study including, but not limited to, reviewing all indications for the examination, specifying the imaging sequences to be performed, specifying the methods of image reconstruction, specifying the use and dosage of contrast and pharmacologic agents, interpreting images, generating an official interpretation⁶, and assuring the quality of the images and the interpretation.

1. Physician with prior qualifications in general and/or thoracic CT interpretation.

The radiologist or other physician who meets the qualifications of the [ACR Practice Guideline for Performing and Interpreting Diagnostic Computed Tomography \(CT\)](#) has substantial knowledge of radiation biology, the physics of CT scanning, the principles of CT image acquisition and post processing including use of diagnostic workstations, and the design of CT protocols including rate and timing of contrast administration. The physician also will have substantial experience in CT interpretation, including CT of extracardiac thoracic structures that will be included on the cardiac CT examination, and experience with CT angiography of other regions of the body. Some of these physicians will also have substantial experience in other methods of cardiac imaging, assessment of cardiac function, and/or experience specifically in cardiac CT. These physicians are qualified to interpret coronary artery calcium scoring based on their prior experience. However, in order to achieve competency in all aspects of cardiac CT imaging, many physicians will require additional education in cardiac anatomy, physiology, pathology, and/or cardiac CT imaging.

The supervising and interpreting physician with prior qualifications in general and/or thoracic CT interpretation should also meet one of the following requirements:

- a. Training in cardiac CT in an Accreditation Council for Graduate Medical Education (ACGME) or an American Osteopathic Association (AOA) approved training program to include:
 - i. Education in cardiac anatomy, physiology, pathology, and cardiac CT imaging for a time equivalent to at least 30 hours of CME; and

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- ii. The interpretation, reporting, and/or supervised review of at least 50 cardiac CT examinations in the last 36 months. Coronary artery calcium scoring does not qualify as meeting these requirements.

OR

- b. Completion of at least 30 hours of Category I CME in cardiac imaging, including:
 - i. Cardiac CT, anatomy, physiology, and/or pathology, or documented equivalent supervised experience⁶ in a center actively performing cardiac CT; and
 - ii. The interpretation, reporting, and/or supervised review of at least 50 cardiac CT examinations in the last 36 months. Coronary artery calcium scoring does not qualify as meeting these requirements.
- 2. Physician who does not have prior qualifications in general and/or thoracic CT interpretation.

The radiologist or other physician who does not meet the qualifications of the [ACR Practice Guideline for Performing and Interpreting Diagnostic Computed Tomography \(CT\)](#) or who meets these qualifications only for a specific anatomic area outside of the thorax requires more extensive training and experience in CT scanning with an emphasis on the thorax and specific experience in cardiac CT scanning. In addition to specific training in imaging interpretation, this training must include knowledge of the principles of CT image acquisition and post processing including use of diagnostic workstations and the design of CT protocols including rate and timing of contrast administration. The physician must also meet the same requirements, or document equivalent training, as those delineated in the [ACR Practice Guideline for Performing and Interpreting Diagnostic Computed Tomography \(CT\)](#) with regard to knowledge of the physics of CT scanning and radiation biology. Documented equivalent supervised experience is defined as supervision at a center where the proctoring physician meets these criteria to independently interpret cardiac CT. ACR PRACTICE GUIDELINE Cardiac CT / 293 will also require additional education in cardiac anatomy, physiology, and pathology.

The supervising and interpreting physician without prior qualifications in general and/or thoracic CT interpretation should meet the following requirements:

- a. Completion of sufficient training and experience to meet the qualifications of the [ACR Practice Guideline for Performing and Interpreting Diagnostic Computed Tomography \(CT\)](#). For a physician who assumes responsibilities for CT imaging exclusively in a specific anatomical area such as cardiac CT, this includes:

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- i. Completion of an ACGME approved training program in the specialty practiced plus 200 hours of Category I CME in the performance and interpretation of CT in the subspecialty where CT reading occurs; and
 - ii. Supervision, interpretation, and reporting of 500 cases, at least 100 of which must be a combination of thoracic CT or thoracic CT angiography during the past 36 months in a supervised situation. Coronary artery calcium scoring does not qualify as meeting these requirements.

AND

- b. Included in the above, completion of at least 30 hours of Category I CME in cardiac imaging, including
 - i. Cardiac CT, anatomy, physiology, and/or pathology, or documented equivalent supervised experience⁶ in a center actively performing cardiac CT; and
 - ii. The interpretation, reporting, and/or supervised review of at least 50 cardiac CT examinations in the last 36 months. Coronary artery calcium scoring does not qualify as meeting these requirements.

3. Administration of pharmacologic agents

Physicians administering pharmacologic agents as part of cardiac CT imaging should be knowledgeable about the administration, risks, and contraindications of the pharmacologic agents used and should be capable of monitoring the patient throughout the procedure.

4. Maintenance of competence

All physicians performing cardiac CT examinations should demonstrate evidence of continuing competence in the interpretation and reporting of those examinations. If competence is assured primarily on the basis of continuing experience, performance and interpretation of a minimum of 75 examinations every 3 years is recommended in order to maintain the physician's skills.

5. Continuing medical education

The physician's continuing medical education should be in accordance with the [ACR Practice Guideline for Continuing Medical Education \(CME\)](#) of 150 hours of approved education every 3 years, and should include CME in cardiac CT as is appropriate to the physician's practice needs.

B. Qualified Medical Physicist

A Qualified Medical Physicist is an individual who is competent to practice independently one or more of the subfields in medical physics. The ACR considers that certification and continuing education in the appropriate subfield(s) demonstrate that an individual is competent to practice one or more of the subfields in medical physics, and to be a Qualified Medical Physicist. The ACR recommends that the individual be certified in the appropriate subfield(s) by the American Board of Radiology (ABR) or for MRI, by the American Board of Medical Physics (ABMP) in magnetic resonance imaging physics.

The appropriate subfields of medical physics for this guideline are Therapeutic Radiological Physics, Diagnostic Radiological Physics, Medical Nuclear Physics, and Radiological Physics. The continuing education of a Qualified Medical Physicist should be in accordance with the [ACR Practice Guideline for Continuing Medical Education \(CME\)](#).2006 (Res. 16g).

C. Radiologist Assistant

A radiologist assistant is an advanced level radiographer who is certified and registered as a radiologist assistant by the American Registry of Radiologic Technologists (ARRT) after having successfully completed an advanced academic program encompassing an ACR/ASRT (American Society of Radiologic Technologists) radiologist assistant curriculum and a radiologist-directed clinical preceptorship. Under radiologist supervision, the radiologist assistant may perform patient assessment, patient management and selected examinations as delineated in the Joint Policy Statement of the ACR and the ASRT titled “Radiologist Assistant: Roles and Responsibilities” and as allowed by state law. The radiologist assistant transmits to the supervising radiologists those observations that have a bearing on diagnosis. Performance of diagnostic interpretations remains outside the scope of practice of the radiologist assistant. 2006 (Res. 34)

D. Radiologic Technologist

The technologist should participate in assuring patient comfort and safety, in preparing and positioning the patient for the CT examination including proper positioning of the ECG leads, and in obtaining the CT data in a manner suitable for interpretation by the physician. The technologist’s continuing education credits should include continuing education in cardiac CT performance as is appropriate to the technologist’s practice needs. Basic life support (BLS) and automatic defibrillator (AED) training is recommended.

CARDIAC IMAGING WITH COMPUTED TOMOGRAPHY CLINICAL COMPETENCE AND TRAINING

Cognitive skills required to demonstrate competence in CCT are summarized in [Table 1](#). Candidates for competence in CCT shall have completed a formal residency in general radiology or nuclear medicine or will have completed an Accreditation Council for Graduate Medical Education (ACGME)-approved cardiovascular fellowship. A thorough knowledge and understanding of cardiac and vascular anatomy is required. Because cardiology, nuclear medicine, and radiology training is very much involved with anatomic definition, this requirement should be met or would have been met by individuals completing an ACGME-approved cardiovascular fellowship, nuclear medicine residency, or general radiology residency. Likewise, characteristics of the heart in health and disease by traditional cardiac imaging methods (echocardiography, nuclear medicine, and angiography) will provide a significant background for application to CCT. These dynamic tomographic or projection imaging techniques of the heart are commonplace in formal cardiology training, so little additional instruction is required when interpreting dynamic CCT sequences of the heart for cardiologists (e.g., evaluating ventricular function by watching the wall motion throughout a cardiac cycle). Cardiac physiology is also vital for CCT and CMR, and basic training should be part of both formal cardiology fellowship and radiology residency.

Table 1. Cognitive Skills Required for Competence in CCT

General:

- Knowledge of the physics of CT and radiation generation and exposure
- Knowledge of scanning principles and scanning modes for non-contrast and contrast-enhanced cardiac imaging using multi-detector and/or electron beam methods
- Knowledge of the principles of intravenous iodinated contrast administration for safe and optimal cardiac imaging
- Knowledge of recognition and treatment of adverse reactions to iodinated contrast
- Knowledge of the principles of image post-processing and appropriate applications

Cardiac:

- Clinical knowledge of coronary heart disease and other cardiovascular diseases
- Knowledge of normal cardiac, coronary artery, and coronary venous anatomy, including associated pulmonary arterial and venous structures
- Knowledge of pathologic changes in cardiac and coronary artery anatomy due to acquired and congenital heart disease
- Basic knowledge in ECG to recognize artifacts and arrhythmias

Aorta:

- Knowledge of normal thoracic arterial anatomy
- Knowledge of pathologic changes in central arterial anatomy due to acquired and congenital

Training to achieve clinical competence in CCT (Table2)

The recommendations for all levels of training in the following text represent a cumulative experience, and it is expected that for many practicing clinicians the training will not be continuous. A summary of the training requirements is given in Table 2. Time spent at didactic continuing medical education courses specifically targeting CCT can contribute to the total time. Due to the advancement in the sophistication and widespread availability of electronic training medias, the committee felt that some training can now be obtained outside the laboratory setting. However, for all Level 2 and 3 requirements, minimum time in a CCT laboratory is half of the time listed, with the other half garnered by supervised time, CT exposure and other courses, case studies, CD/DVD training, time at major medical meetings devoted to performance of CCT, or other relevant educational training activities, as a few examples. Several aspects of CCT can be learned from the general CT expert, including use of the workstation, tomographic imaging, and radiation physics, among others. The caseload recommendations may include studies from an established teaching file, previous CCT cases, and electronic/on-line experience or courses.

Table 2. Requirements for CCT Study Performance and Interpretation to Achieve Level 1, 2, and 3 Clinical Competence

	Cumulative Duration Of Training	Minimum # of Mentored Examinations Performed	Minimum # of Mentored Examinations Interpreted
Level 1	4 weeks*	—	50†
Level 2—non-contrast	4 weeks*	50	150†
Level 2—contrast	8 weeks*	50	150†
Level 3	6 months*	100	300†

*This represents cumulative time spent interpreting, performing, and learning about CCT, and need not be a consecutive block of time, but at least 50% of the time should represent supervised laboratory experience. In-lab training time is defined as a minimum of 35 h/week.

†The case load recommendations may include studies from an established teaching file, previous CCT cases, journals and/or textbooks, or electronic/on-line courses/CME.

For all levels of competence, it is expected that the candidate will attend lectures on the basic concepts of CCT and include parallel self-study reading material. A basic understanding of CCT should be achieved, including the physics of CCT imaging, the basics of CCT scan performance, safety issues in CCT performance, post-processing methods, and the basics of CCT interpretation as compared with other cardiovascular imaging modalities, which include echocardiography, nuclear medicine, CMR, and invasive cardiac and peripheral X-ray angiography.

Level 1 Training

Level 1 is defined as the minimal introductory training for familiarity with CCT, but is not sufficient for independent interpretation of CCT images. The individual should have intensive exposure to the methods and the multiple applications of CCT for a period of at least four weeks. This should provide a basic background in

CCT for the practice of adult cardiology or for general radiology. During this cumulative four-week experience, individuals should have been actively involved in CCT interpretation under the direction of a qualified (Level 2-or Level 3-trained) physician-mentor. There should be a mentored interpretative experience of at least 50 cases for all studies in which other cardiovascular imaging methods are also available; correlation with CCT findings and interpretation is strongly encouraged and should be included if possible. As much as possible, studies should consist of procedures outlined in [Table 1](#). Independent performance of CCT is not required for Level 1, and the mentored interpretive experience may include studies from an established teaching file or previous CCT cases and also the potential for CD/DVD and on-line training.

Level 2 Training

Level 2 is defined as the minimum recommended training for a physician to independently perform and interpret CCT. This is an extension of Level 1 training and is intended for individuals who wish to practice or be actively involved with CCT performance and interpretation.

A physician with Level 2 training should demonstrate clear understanding of the various types of CT scanners available for cardiovascular imaging (EBT and MDCT) and understand at a minimum the common issues related to imaging, post-processing, and scan interpretation, including:

- Important patient historical factors (indications and risk factors that might increase the likelihood of adverse reactions to contrast media, if applicable)
- Radiation exposure factors
- CT scan collimation (slice thickness)
- CT scan temporal resolution (scan time per slice)
- Table speed (pitch) Field of view
- Window and level view settings
- Algorithms used for reconstruction
- Contrast media
- Post-processing techniques and image manipulation on work stations
- Total radiation dose to the patient

Level 3 Training

Level 3 training represents the highest level of exposure/expertise that would enable an individual to serve as a director of an academic CCT section or director of an independent CCT facility or clinic. This individual would be directly responsible for QC and training of technologists and be a mentor to other physicians seeking such training. The minimum cumulative training period will be six months, to include all of the didactic requirements of Level 2 training as well as participation in CCT study interpretation under the direction of a qualified (Level 3-trained) physician-mentor. In-lab training time is defined as a minimum of 35 h/week. Level 3 candidates should be involved with interpretation of at least 100 non-contrast and 300 contrast CCT examinations. For at least 100 of these cases,

the candidate must be physically present and be involved in the acquisition and interpretation of the case. Cases should reflect a broad range of pathology.

In addition to the recommendations for Level 1 and Level 2 training, Level 3 training should include active and ongoing participation in a basic research laboratory, clinical research, or graduate medical teaching. This level also requires documented and continued clinical and educational experiences. Additionally, Level 3 CCT physicians should have appropriate knowledge of alternative imaging methods, including the use and indications for specialized procedures including echocardiography and vascular ultrasound, CMR, and nuclear medicine/positron emission tomography (PET) studies. A summary of the training requirements is given in [Table 3](#).

Table 3. Requirements for Level 2 and Level 3 Clinical Competence in CCT

	Level2	Level3
Initial Experience	<ul style="list-style-type: none"> ● NON-CONTRAST REQUIREMENTS ● Board certification or eligibility, valid medical license, and completion of 4 weeks of training (to include coursework, scientific meetings, and courses/on-line training) ● AND 150 non-contrast CCT examinations (for at least 50 of these cases, the candidate must be physically present, and be involved in interpretation of the case) ● AND completion of 20 h of courses/lectures related to CT in general and/or CCT in particular 	<ul style="list-style-type: none"> ● FULL CCT REQUIREMENTS ● Board certification or eligibility, valid medical license, and completion of 8 weeks (cumulative) of training in CCT ● AND 150 contrast CCT examinations. For at least 50 of these cases, the candidate must be physically present, and be involved in the acquisition and interpretation of the case ● AND evaluation of 50 non-contrast studies ● AND completion of 20 h/lectures related to CT in general and/or CCT in particular
Continuing Experience	50 non-contrast CCT exams conducted and interpreted per year	100 contrast CCT exams conducted and interpreted per year
Continuing Education	20 h Category I every 36 months of CCT	40 h Category I every 36 months of CCT

Appendix 2

	<p>Medical Affairs Special Information</p>
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- P&A ■ NASCO
- Facility □ Dental ■ Professional □ Vision Care
- Hearing Aid □ Drugs □ Master/Major Medical
- McKesson/ClaimCheck □ Medicare Advantage

The procedure or code change outlined in this PCC has been approved by Medical Affairs. If any changes are needed, they are in queue to be loaded to our processing systems. This change will be loaded to systems as effective date for dates of service on or after 7/1/2007.

Coronary Computed Tomography Angiography (CCTA) payable to Michigan Hospitals participating in the Collaborative Quality Initiative (CQI) for Emerging Non-Invasive Cardiovascular Imaging

Procedure Code	Description
0144T	Computed tomography, heart, without contrast material, including image post-processing and quantitative evaluation of coronary calcium
0145T	Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image post-processing; cardiac structure and morphology
0146T	Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image post-processing; computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts), without quantitative evaluation of coronary calcium

0147T	Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image post-processing; computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts), with quantitative evaluation of coronary calcium
Procedure Code	Description
0148T	Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image post-processing; cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts), without quantitative evaluation of coronary calcium
0149T	Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image post-processing; cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts), with quantitative evaluation of coronary calcium
0150T	Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image post-processing; cardiac structure and morphology in congenital heart disease
0151T	Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3 D image post-processing, function evaluation (left and right ventricular function, ejection-fraction and segmental wall motion) (List separately in addition to code for primary procedure)

Revenue Code	Description
0359	CT Scan – Other CT Scans

Our Clinical Program Development Department has launched the Collaborative Quality Initiative (CQI) for Emerging Non-Invasive Cardiovascular Imaging program in conjunction with Blue Care Network. As a result, effective with dates of service 7/1/2007 and after, the procedure codes listed in this document became payable when the services are provided by a Michigan Hospital participating in the CCTA CQI. A current list of these participating hospitals is shown below. However, these procedures remain non-payable when they are rendered in a

hospital that is not participating in the CCTA CQI. At this time, these procedures remain non-payable for GM/Delphi, Ford, Chrysler, Siemens and MPERS.

Michigan hospitals participating in the CCTA CQI Initiative for Emerging Non-Invasive Cardiovascular imaging are:

1. Borgess Medical Center, Kalamazoo
2. Bronson Hospital, Kalamazoo
3. Chippewa County War Memorial Hospital, Sault Ste Marie
4. Genesys Regional Medical Center, Grand Blanc
5. Hackley Hospital, Muskegon
6. Henry Ford Hospital, Detroit
7. Hillsdale community Health Center, Hillsdale
8. Lakeland Regional Health System, St. Joseph
9. Marquette General Health System, Marquette
10. Mercy Memorial, Monroe
11. Oakwood Hospital, Dearborn
12. Pontiac Osteopathic Hospital, Pontiac
13. Sparrow Health System, Lansing
14. St. John Hospital & Medical Center, Detroit
15. St. John Macomb Hospital, Warren
16. St. John Providence Hospital, Southfield
17. St. Joseph Mercy Hospital Oakland, Pontiac
18. St. John Oakland, Madison Heights
19. University of Michigan, Ann Arbor
20. William Beaumont Hospital, Royal Oak
21. William Beaumont Hospital, Troy

As participating hospitals are added, the list will be updated. Updates to the CCTA program will be available at bcbsm.com under the *I am a Provider* tab in the *News & Updates* section.

Hospitals in the CCTA CQI will be reimbursed for the technical component of the services. Physicians (cardiologists and/or radiologists) will be reimbursed for the professional component of the services. These procedures are payable in locations 1 (inpatient) and 2 (outpatient). Reimbursement for the technical component of CCTA services rendered in the inpatient setting will be included in the hospitals' DRG payment.

Please share this information with others in your department. This document is for internal use only. Questions should be directed to Clinical Programs email box via Outlook.

References:



CCTA program news
release FINAL.DOC



CCTA program news
backgrounder.doc



CCTA program Q&A
Final.doc



Reimbursement
Policy 070107 PDF.pc

Appendix 3

Blue Cross Blue Shield of Michigan and Blue Care Network Launch Pilot Program with 21 Michigan Hospitals to Study and Improve Use of Non-Invasive Heart Imaging Test

QUESTIONS AND ANSWERS:

1. What type of test is being studied?

Coronary computed tomography angiography (CCTA), a non-invasive technology that could replace conventional cardiac catheterization as the preferred diagnostic test for selected patients with heart problems.

Blue Cross Blue Shield of Michigan is funding the pilot program with participating hospitals to enable clinicians learn when CCTA performs better than alternative diagnostic methods.

2. I'm a Blue Cross Blue Shield of Michigan or Blue Care Network member. How can I get involved in the program and receive the coronary computed tomography angiography (CCTA) test?

The program is not seeking volunteers for the test. Physicians determine if the test is medically necessary for eligible patients. They will order the test for patients after determining that the patient meets the American College of Cardiology and American College of Radiology appropriateness criteria and other program guidelines. The test must be ordered by a member's treating physician and it must be performed at one of the participating hospitals in order to be payable.

3. Are all employer groups with BCBSM or BCN coverage participating in the program and are their members eligible to receive the test as a covered benefit?

No. Some Blue Cross Blue Shield and Blue Care Network employer groups have not added CCTA as a covered benefit under their health plans. Members in these groups would be responsible for payment. If your physician orders a CCTA and you are uncertain of your coverage, please call your group benefit representative to find out if it is payable under your health plan.

4. Is the CCTA test used as a screening test?

No. CCTA is used for people with symptoms and risks for coronary artery disease and some other conditions. It is not a screening test.

5. My doctor is not with a hospital participating in the program. How can I get this test?

This is not a research study seeking volunteers. Only people whose medical condition justifies use of CCTA will receive the test.

-More-

6. Can other hospitals still join?

Yes. Hospitals that meet criteria can be added. This currently includes 21 Michigan hospitals. Hospitals in the program are required to own or lease a 64-slice CT scanner, participate in the Michigan Blues' Traditional and PPO hospital networks and meet rigorous standards for the quality of the procedure and training of the staff involved. The next opportunity for eligible hospital to join the program is Fall of 2007.

7. Are there any risks to this test?

The benefits and risks of CCTA should be discussed with your physician. He or she is always the best resource for this kind of information. Generally speaking, CCTA causes a radiation exposure equivalent to about 100 chest x-rays. And, as with all diagnostic tests, an inaccurate result could lead to misdiagnosis or unnecessary treatment.

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