

take out
emergency

(a) For PCI cases in which the patient received emergency PCI due to acute coronary syndrome, did the operator appropriately diagnose the patient as suffering from acute coronary syndrome?

(b) What is the estimated numerical percentage of stenosis, based on visual assessment of the patient's angiogram?

(c) Was treatment of the lesion appropriate based on current ACCF/AHA Guidelines or ACCF/AHA/SCAI Guidelines?

(d) Is the patient's clinical situation one that is not addressed by the current ACCF/AHA Guidelines or ACCF/AHA/SCAI Guidelines?

(e) Was it appropriate to treat the lesion, in the reviewer's judgment and understanding of good clinical care?

(f) Was PCI successful, partially successful, or unsuccessful?

(i) A partially successful PCI procedure is defined as achievement of twenty percent to less than or equal to fifty percent residual stenosis and TIMI 3 flow.

(ii) An unsuccessful PCI procedure is defined as greater than twenty percent residual stenosis with a stent, or greater than fifty percent residual stenosis with plain balloon angioplasty or less than TIMI 2 flow.

(g) Was there any complication during the procedure or resulting from the procedure, based on the reviewer's evaluation of the angiogram, cardiac catheterization laboratory report, and the patient discharge summary?

(h) Is there documentation in the patient record that treatment other than PCI, such as cardiac surgery, was considered in cases where it would have been appropriate to consider alternative treatment, based on current ACCF/AHA Guidelines?

Summary of Comments on Draft_Amended_COMAR10 24 17_withtrackchangescomments.pdf

Page: 60

Number: 1 Author: jbrinke1 Subject: Text Box Date: 5/8/2015 1:57:43 PM
take out emergency

Number: 2 Author: jbrinke1 Subject: Sticky Note Date: 5/8/2015 2:34:31 PM
Add to this whether it is angiographically appropriate to perform the procedure.

Also, if there were any intracoronary diagnostics performed (ultrasound, OCT, or FFR).

E. Qualifications of External Reviewer. In order to conduct an external review of an attempted or completed PCI under these regulations, a reviewer must have the minimum following qualifications:

(1) Be board certified in interventional cardiology, except for an interventional cardiologist who performed interventional procedures before 1998 or completed training before 1998 and did not seek board certification before 2003;

(2) Shall have practiced interventional cardiology, as evidenced by maintenance of hospital privileges and the provision of PCI services to patients, within the five-year period immediately prior to conducting the external peer review under this regulation; and

(3) Shall have a lifetime PCI case volume over 750  cases.

F. Review Schedule for External Review. A hospital shall maintain a consistent case review schedule.

(1) Quarterly review. The case review periods for quarterly reviews are January 1 to March 31; April 1 to June 30; July 1 to September 30; and October 1 to December 31.

(2) Semi-annual review. The case review periods for semi-annual reviews are either January 1 to June 30 and July 1 to December 31; or April 1 to September 30 and October 1 to March 31.

(3) A hospital shall timely submit its cases for external review and shall obtain a report on the results of the external review within three months of the closing date of the case review period for quarterly external reviews, and within four months of the closing date of the case review period for semi-annual external reviews.

(4) The dates for inclusion in the quarterly and semi-annual review schedules may be altered by the MHCC through publication of a dated posting on the Commission's website and

Number: 1 Author: jbrinke1 Subject: Sticky Note Date: 5/8/2015 2:18:21 PM
Should cases from training count toward this case number? Clarify.

in the Maryland Register, and direct notification to the director of the cardiac catheterization laboratory or another appropriate contact designated by each hospital.

G. Data Sources Used for External Review. For each PCI case submitted for external review, a hospital shall provide the external review organization or its agent that will conduct blinding for the external peer review organization with the following patient information:

- _____ (1) Medical history;
- _____ (2) Physical exam;
- _____ (3) Laboratory studies;
- _____ (4) Angiogram; 
- _____ (5) Cardiac catheterization laboratory report;
- _____ (6) Cardiac catheterization laboratory log sheet; and
- _____ (7) Discharge summary. 

H. Blinding of Cases for External Review. All PCI cases submitted for external review under these regulations shall be appropriately blinded in such a way that each medical record does not disclose, the following, by timing of submission, blinded information size, location, or otherwise:

- _____ (1) The identity of the hospital where the PCI procedure under review was performed; and
- _____ (2) The identity of the physician who performed the PCI.

Number: 1 Author: jbrinke1 Subject: Sticky Note Date: 5/11/2015 9:46:03 AM

add "intracoronary ultrasound images/ OCT" if performed. Also include other intracoronary diagnostics or their results.

Number: 2 Author: jbrinke1 Subject: Sticky Note Date: 5/11/2015 9:45:37 AM

All PCI cases may not have a discharge summary. Many elective cases are extended recovery, without a subsequent discharge summary.



Ms. Eileen Fleck
Chief of Specialized Services
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

May 8, 2015

Dear Ms. Fleck,

Thank you for the opportunity to publicly comment on the proposed draft amendments to COMAR 10.24.17 which specifically address the topics of external peer review, internal review of interventional cardiologists and conduct of annual/semi-annual/quarterly performance reviews. Overall, Frederick Memorial Hospital (FMH) appreciates the Commissions' efforts to ensure rigor and standardization surrounding the peer review process, however finds that some of the draft changes are either confusing, over-reaching or conflict with one another. After a thorough review of the proposed changes we have the following questions, suggestions and comments.

We advocate for a more clearly understood requirement surrounding the percentage and/or number of PCI cases to be reviewed both internally and externally. First and foremost we strongly recommend inclusion of both pPCI and npPCI in the total number of external cases reviewed and that the number of cases be 10% calculated semiannually. For an institution such as FMH, this would be approximately 35 cases annually, a reasonable number that reflects what we've historically sent out for external review as well as a volume that is not onerous to prepare and send to a review organization. The per operator external review volume should be 10% also with the minimum set at all cases if fewer than 10 cases are performed at an institution. An annual internal review of approximately 10 cases per operator is also sufficient. The "quarterly or other review period" is unnecessary and confusing. If an institution or operator is deemed to be below the Commission's standard, the MHCC has the authority to require a focused review.

While the Patient Outcome Measures are not in the draft section of the proposed amendments, please note that the metric "30 day all-cause mortality" for elective or primary PCI cases is not obtainable unless the MHCC has a method to do so. In addition the 95% confidence interval is also not known. The metric that is easily available is the in-house risk adjusted mortality for either pPCI or npPCI. We would look forward to an example of how the 30 day all-cause mortality would be applied to Maryland hospitals.

Under the External Peer Review section, Method for Selecting Cases to be Reviewed is unnecessarily restrictive. If an external peer review organization is approved by the MHCC, a hospital should be able to assume that random selection of cases (both pPCI and npPCI) is done appropriately. As FMH has done with all of its external reviews, we have given the organization a list of all PCI and the organization then randomly selects cases. The methodology described is beyond the authority of a hospital to ensure compliance.

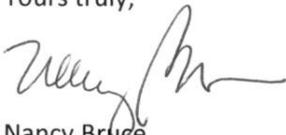
For the Requirements for External Peer Review Required Questions, specifically section 08.C.f for a successful procedure, we disagree with the standards for partially successful and unsuccessful. A residual stenosis of <50% with PTCA and normal TIMI3 flow is successful; a residual stenosis of <30% for stent implant with TIMI3 flow is successful. Unsuccessful for both involves residual stenosis of >50% or <TIMI 2 flow. Partially successful is achievement of TIMI 2 flow or PTCA residual stenosis that is an absolute reduction by 20% in the degree of stenosis with TIMI 3 flow or stent residual stenosis that in the 30-50% range with TIMI 3 flow.

Under the Additional Review proposed requirements, the second and third reviewer should be an option of the facility, not a requirement. While inappropriate procedures are rare, they do (and will) occur and should not in and of themselves trigger a second (or third) review. Trends of inappropriate procedures are a much better indicator of quality than individual cases. Monitoring of appropriateness is done very well on an aggregate basis via the Cath/PCI registry metrics which the Commission receives on a quarterly basis.

Regarding the Requirements for External Peer Review Organizations, the blinding process is challenging and at times nearly impossible. To rid an entire record of hospital identifiers and/or physician identification is very difficult. Records are embedded with identifying information. Abstraction and preparation of medical records to send for external review takes a significant amount of manpower, the additional burden of de-identification and blinding would mean that each page of the medical record would need to be printed, reviewed, and "blacked" out whenever a patient name/or operator/or other facility identifier is mentioned. The records would then need to either be scanned and sent electronically or printed out on paper and sent.

Again, on behalf of FMH and our Interventional Cardiology Program, I would like to thank the Commission for the opportunity to comment on these draft regulations. Please let me know if you have any questions or further comments,

Yours truly,



Nancy Bruce
Director Cardiac and Vascular Services
Frederick Memorial Hospital



Eileen Fleck -DHMH- <eileen.fleck@maryland.gov>

Re: Draft Amendments to COMAR 10.24.17 & next CSAC meeting

1 message

Steven Hearne <sthearne1@gmail.com>

Thu, May 7, 2015 at 11:18 AM

To: Eileen Fleck -DHMH- <eileen.fleck@maryland.gov>

Cc: Ben Steffen -DHMH- <ben.steffen@maryland.gov>, Blair Eig <eigb@holycrosshealth.org>, "Chris Haas, M.D." <chaas@wmhs.com>, "David Zimrin, M.D." <dzimrin@medicine.umaryland.edu>, "Jaime Brown, M.D." <jbrown@smail.umaryland.edu>, "James Gammie, M.D." <JSGAMMIEMD@gmail.com>, "Jery Segal, M.D." <jsegal@aahs.org>, Jesus Cepero <jesus.cepero@meritushealth.com>, "John Conte, M.D." <jconte@jhmi.edu>, Josemartin Ilao <ilaoforscience@gmail.com>, Juan Sanchez <Juan.sanchez@stagnes.org>, "Keith Horvath, M.D." <khovath@nih.gov>, Lisa Myers <lmyers@miemss.org>, "Mauro M. Moscucci, M.D." <mmoscucc@lifebridgehealth.org>, "Nancy L. Bruce" <NBRUCE@fmh.org>, "Paul Massimiano, M.D." <pmassimiano@cvtsa.com>, Sharon Sanders <sharong@carrollhospitalcenter.org>, "Stafford Warren, M.D." <staffwarren@yahoo.com>, "Stuart Seides, M.D." <Stuart.F.Seides@medstar.net>, "Thomas Aversano, M.D." <taversan@jhmi.edu>, "William Thomas, M.D." <William.thomas634@gmail.com>, Cheryl Ebaugh <ChEbaugh@carrollhospitalcenter.org>, Donna Deluca <Ddeluca@lifebridgehealth.org>, Hayley Wilmouth <hwilmouth@cvtsa.com>, Heather Farrell <Heather-E.Farrell@dimensionshealth.org>, Janet Kelly <kellyja@holycrosshealth.org>, Kathleen Rubin -DHMH- <kathleen.ruben@maryland.gov>, Megan Song <Megan.Song@medstar.net>, Paul Parker <paul.parker@maryland.gov>, Rachel Sommers <rsommer7@jhmi.edu>, Rebecca Grager <RGrager2@smail.umaryland.edu>, Suellen Wideman -DHMH- <suellen.wideman@maryland.gov>

Eileen,

I also think that it would be appropriate to exempt hospitals from this review process if they are actively under a CIA agreement and are already doing this as PRMC is currently. This probably should be added to the amendment.

Thanks.

Steve Hearne, MD



MedStar Health

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May 8, 2015

Eileen Fleck
Chief, Acute Care Policy & Planning
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

RE: Draft Amendments to State Health Plan for Facilities and Services:
Specialized Health Care Services – Cardiac Surgery and
Percutaneous Coronary Intervention Services; COMAR 10.24.17

Dear Ms. Fleck:

On behalf of MedStar Health, I am writing to respond to your request for comments on the draft amendments to the State Health Plan for cardiac surgery services dated April 17, 2015.

Achieving Quality Objectives

Both Policy 2 and Policy 5 of the Plan, page 6, address the Commission's policies regarding quality for cardiac services.

Policy 2 states that quality will be promoted through the adoption of performance measures to evaluate programs *and through requirements for internal and external peer review of service delivery and outcomes.*

Policy 5 states that a hospital with cardiac surgery and/or PCI services will continuously and systematically work to improve the quality and safety of patient care. This includes planning, implementing and optimizing the use of electronic health record systems and electronic health information exchange that contributes to infection control, care coordination, patient safety and quality improvement.

While we absolutely endorse these policies, we also believe the regulations are more prescriptive and detailed than necessary to meet these objectives. The Commission is proposing standards for qualified external review organizations. These organizations have the expertise to conduct appropriate reviews, and will be able to meet the intent of the statute. A more simplistic, clear approach that does not add unnecessary regulatory hurdles would achieve the Commission's goals. The Commission's Cardiac Services Advisory Committee can provide expertise on any details for an appropriate framework.

Knowledge and Compassion
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Clarifications – §.07C(4) and §.07D(5)

MedStar Health supports the staff's efforts to add clarifying language to the sections concerning the requirements of hospitals for certificates of ongoing performance and conducting performance reviews of individual interventionalists. We suggest that the regulations be organized and simplified to clarify what requirements apply to which entities and under what circumstances, who decides whether the interventionalists review are internal or external, annual, semi-annual or quarterly, and when the reports are due to the MHCC. More details about these and other concerns are described below.

Section .07C(4) – in the section referring to elective PCI programs, the existing Plan states that as part of the new certificate of ongoing performance process, a hospital's elective PCI program must annually submit a report to the Commission describing quality assurance activities. The clarifications add a requirement for hospitals to conduct staff meetings every other month for case review [paragraph (a)], and monthly for *primary* PCI system reviews [paragraph (b)], as well as specifying who must attend those staff meetings. It also adds a requirement for "at least semi-annual" external case review [paragraph (c)], and interventionalist reviews that are internal or external, annual, semi-annual or quarterly [paragraph (d)].

Section .07D(5) – The existing plan includes a requirement for hospitals with primary PCI programs to conduct at least semi-annual external case review and annual internal interventionalist review. The draft new language changes the interventionalists performance review to internal or external, annual, semi-annual or quarterly [paragraph (c)], and includes very prescriptive requirements for monthly and bi-monthly staff meetings.

Similar language is found in section .06A(5), certificate of conformance for primary PCI programs; however, this section, which apparently applies to proposals for new PCI programs (although not specifically stated at the beginning of the section) requires external *and* internal case review at least semi-annually, and annual internal review of interventionalists.

These sections all include requirements for monthly and semi-monthly staff meetings, dictating the frequency, composition and subject the for these meetings. It is not at all clear why the Commission would dictate how hospitals hold certain staff meetings. Internal processes, including internal peer review policies, are thoroughly detailed by The Joint Commission and internal bylaws, and thus do not require another layoff of regulatory requirements. These requirements should be deleted.

These sections [and others, such as §.07B(4)] also require an annual report, or upon request, to the Commission detailing quality assurance activities [paragraph (f)]. This appears to be intended as part of the certificate of ongoing performance process, to be conducted generally every five years. And, it is not at all clear what these annual reports are to include, other than documentation of the details of the hospital's quality assurance activities.

It is also not clear why these reports must be submitted every year, rather than only when the certificate of ongoing performance is renewed. Nor is it clear whether separate reports are to be submitted for the cardiac surgery program, the elective PCI program and the primary PCI program, since the requirement is repeated in three different places. These provisions should be simplified.

New Section §.08 – External Peer Review

By setting standards for peer review organizations, as outlined in these draft amendments, the Commission will ensure that external peer review is done properly. As described above, these regulations could meet the intent of the legislation and be much improved if certain sections were less prescriptive. MedStar recommends that the Cardiac Services Advisory Committee, or a selected subcommittee, be consulted to create the necessary language for this section.

This section requires hospitals to review certain PCI cases either semi-annually or quarterly. It carries the ambiguity described above regarding the previous section .07 as to when, or under what circumstances, annual or semi-annual review is required.

Section D(1)(a)(v), requirements for external peer review organizations, states that a Commission approved peer review organization, if the organization includes a reviewer that that is part of a Maryland hospital system, must include at least four hospitals from at least two health care systems. MedStar recommends this be changed to require representation from at least three health care systems in order to assure a more equitable representation. MedStar's Heart and Vascular Institute is the biggest provider of cardiac surgery and PCI services in the Baltimore-Washington area, with four facilities in the Baltimore Upper Shore and Metropolitan Washington regions. The depth and breadth of the services we provide suggests that MedStar could play a critical role in a Maryland-based external peer review organization as envisioned by this section.

Section D(1) has a part (a), but no part (b).

Internal Review of Interventionalists - §.09

Requirements for internal performance review of interventionalists (§.09) also state that the reviews are to be done annually or semi-annually. Again, it is unclear when annual or semi-annual review is required, or under what circumstances. This requirement should be clarified.

Definitions

MedStar has concerns about the definition of cardiac surgery and several other definitions.

Regarding the definition of "cardiac surgery", the ICD-9-CM procedure codes 35.05, 35.06, 35.07, 35.08 and 35.09 were added to the SHP in 2014. These procedures, which are an endovascular approach to a heart valve repair, were approved by the FDA in 2011 at specific

hospital sites in the US for those patients that were otherwise non-operable. The procedures are now approved for high risk patients. Union Memorial performed approximately 100 of these cases last year, and trials are will soon be underway using these same procedures on moderate risk patients. Two other new procedure codes were also added to the definition of cardiac surgery in the 2014 Plan update: 35.97, percutaneous mitral valve repair and 37.37, excision/destruction of other lesion or tissue of heart, thoracoscopic approach.

These procedures are sometimes performed by the cardiac surgeon or the interventional cardiologist, or both, in the room at the same time, usually in the cardiac cath lab or in a hybrid room. further, reimbursement policies do not consider them cardiac surgery. Because the approach for all these procedures is percutaneously, they are found in the APR-DRGs as PCI procedures. For these reasons, these seven codes should not have been included in the definition of cardiac surgery. The Cardiac Services Advisory Committee should determine whether the Commission’s definitions are up to date.

MedStar Health recommends that these definitions be deleted from the definition of cardiac surgery unless and until either reimbursement policies change to consider them cardiac surgery, and/or the Commission’s own advisory committee provides advice on which current ICD-9¹ codes are cardiac surgery, and which are PCI.

The definition of “percutaneous coronary intervention” continues to include five ICD-9 codes. However, three of those codes do not exist on the CMS list of ICD-9 codes and have not existed since 2005, when they became casualties of bundling. Codes 36.06 and 36.07 are correct codes for PCI procedures.

Other definitions also need revision. The definition of “emergency PCI” incorrectly directly equates emergency with primary PCI. While all primary PCIs are emergencies, not all emergency PCIs are primary PCI. We suggest you refer to the ACC definitions for revisions.

The new definition of “plain balloon angioplasty” should be revised. When no stent is placed, the procedure is a balloon angioplasty as reflected in this definition in the draft amendments. There is no recognized category for a “plain” balloon angioplasty, thus the word “plain” should be deleted.

Finally, the definition of “primary PCI operator” needs to be revised. The primary PCI operator is a case-specific term. The primary operator is generally recognized as the physician that performed that specific case. In addition to this discrepancy, there are complexities in how this term is used. In a case where two physicians were involved, the second physician, often a fellow doing certain parts of the procedure, is not necessarily the primary operator. If improperly used, the term could result in case count errors. Therefore MedStar recommends that the cardiac services advisory committee be consulted to provide guidance to the MHCC on the definition and its uses throughout the Plan chapter.

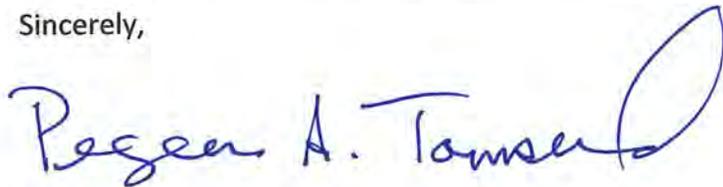
¹ Or ICD-10 codes

This all suggests that all definitions, ICD-9 based or otherwise, should be re-examined for consistency with current practice as defined by professional organizations such as the American College of Cardiology. Again, we believe that using the cardiac services advisory committee, or a subcommittee, would be the best way to address this issue.

Summary

MedStar greatly appreciates the Commission staff's continued work to clarify and strengthen this Plan chapter. We look forward to continued dialogue and discussion, and would be happy to discuss these comments with you in more detail. Please feel free to call.

Sincerely,

A handwritten signature in blue ink that reads "Pegeen A. Townsend". The signature is fluid and cursive, with a large loop at the end of the last name.

Pegeen A. Townsend
Vice President, Government Affairs
MedStar Health



Eileen Fleck -DHMH- <eileen.fleck@maryland.gov>

Please see MMC comments - thank you.

1 message

Jesus Cepero <Jesus.Cepero@meritushealth.com>

Fri, May 8, 2015 at 10:30 AM

To: "eileen.fleck@maryland.gov" <eileen.fleck@maryland.gov>

Cc: "Dr. Robert Marshall" <Robert.Marshall@meritushealth.com>, James Recabo

<James.Recabo@meritushealth.com>, Brett Kane <Brett.Kane@meritushealth.com>

As requested.

The COMAR DRAFT Amendments were reviewed by MMC CCL manager, Research nurses, Medical Director and requests for commentary were solicited from the Interventional Cardiologists who practice here. The following reflects the consolidated commentary and requested clarification:

- Will this level of review (external peer and/or internal peer) be indefinite or limited time period?
- p. 38. 39 section d (i, ii, iii) AND p. 46 section c (i,ii,iii): The wording suggests that the *Internal peer review* of Interventionalists **can be eliminated** if there is *External peer review* performed as described. **Requires clarification**
- P. 38 section 4 (a, b,c,d): Continue with current number of Quality improvement/surveillance committees?
 - Strategy of Care (multi-disciplinary/monthly)
 - Interventional Cardiology (case review/multi-disciplinary/bi-monthly)
 - Internal peer review (case review/doctors only/monthly)
 - External peer reviews (case reviews/MAQPAC/semi-annually)
- Elective PCIs– as described in the ACCF/AHA/SCAI Guidelines for PCI: Cases with MACE, complex decision- making regarding AUC: should these cases be included in internal reviews, + 10% of randomly selected cases for each physician? The number of internal reviews could be greater than 10% required.
- p. 36-Focused Reviews can be requested at any time for purpose of auditing data: Timeframe allowed for preparation?
- p. 47, 52, 53 C (1), 55 D (1) – Requirements for External Peer review: Are the proposed “reviewer standards”, “minimum questions” and “Commission Approval” all consistent with the MAQPAC program discussed at the last meeting?
- p. 38 d (ii) - External Peer Reviews only review non-primary PCIs? There may be some hospitals where some of their on-call interventionalists only perform primary PCIS (we have two for whom this is almost always the case)

Jesus Cepero, Ph.D. RN, NEA-BC

Chief Operating Officer

Chief Nursing Officer

Meritus Medical Center

5/11/2015

Maryland.gov Mail - Please see MMC comments - thank you.

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Eileen Fleck -DHMH- <eileen.fleck@maryland.gov>

RE: follow-up question on presentation to CSAC

1 message

Julie Miller <jmmiller@jhmi.edu>
To: Eileen Fleck -DHMH- <eileen.fleck@maryland.gov>
Cc: Julie Miller <jmmiller@jhmi.edu>

Fri, May 8, 2015 at 3:29 PM

Dear Ms. Fleck-

Thank you for your extensive work on the original and revised document.

Please find attached just a few comments within the External Peer review section that we have made (Dr. Jeff Brinker and myself).

One question: it appears that hospitals that are primary PCI-only hospitals only may not have to participate in the external peer process (since they are supposed to only perform PCI in STEMI situations). I would advocate that an external review process could also benefit these hospitals as well, on many fronts, particularly whether the case was a STEMI, whether the PCI was appropriate—or whether surgery should have been considered (often times the infarct artery will re-perfusion in a STEMI before PCI, and the anatomy is more suitable for surgery). Guidelines for PCI in STEMI also are changing, so it becomes important for review for consistency with these professional guidelines. Moreover, the hospitals without an elective program are smaller and would not necessarily have the depth of resources to be able to discuss these cases during internal review. Finally, the guidelines for STEMI for Maryland have also evolved over the years, so it may be beneficial to help hospitals ensure compliance with these guidelines and have external review of documentation.

In addition to the comments contained within the above document: Under the section that describes the number of external peer reviewers, I would consider changes “one” into “at least one”. We use multiple reviewers of the same case for a multitude of reasons—especially to ensure quality and consistency. If there is disagreement on cases, we send it to an additional reviewer. We have found this a very robust and fair process.

Thank you again. Please feel free to contact me directly if I can answer any other questions regarding the comments in the document.

Have a nice weekend.

Regards-

Julie

Julie M. Miller, M.D., F.A.C.C., F.S.C.A.I., F.A.H.A.

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600K



Eileen Fleck -DHMH- <eileen.fleck@maryland.gov>

Re: Draft Amendments to COMAR 10.24.17 & next CSAC meeting

1 message

David Zimrin <dzimrin@medicine.umaryland.edu>
To: Eileen Fleck -DHMH- <eileen.fleck@maryland.gov>

Thu, May 7, 2015 at 1:49 PM

Eileen—
I plan to attend the meeting in person.

Only one minor comment:

On page 57 Section G7 states that a discharge summary be provided for all PCI cases undergoing external review: Many of the elective PCI patients are categorized as "extended recovery" rather than "inpatient" therefore I don't believe that a discharge summary is required unless local hospital policy dictates that. UM St Joseph Medical Center requires a discharge summary for these patients and UMMC patients almost always have one (unless they go home the same day which is a slowly growing subset of PCIs). I do not know about other hospitals around the state.

—David