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**Media advisory:** Authors of an article in the Oct. 15 *Journal of the American Medical Association* are available to provide details on “evidence-based reimbursement” as a way to reduce health care costs without diminishing quality.

**TO REDUCE COSTS OF MEDICAL CARE, PAY FOR PROCEDURES THAT ARE KNOWN TO WORK, SAY  
AUTHORS OF EDITORIAL IN *JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION***

**WHAT:** If research finds that a simpler, cheaper treatment is just as effective as a more costly procedure, which one should doctors and hospitals choose? And which one should insurers and Medicare pay for?

Patients suffering from chest pain related to coronary artery disease often undergo percutaneous coronary intervention (PCI), or balloon angioplasty. A major, multicenter study (the COURAGE trial) reported last year that in most cases, intensive medical management can be just as effective, but physicians still have a tendency to reach for the higher-cost option first.

In an editorial in the Oct. 15, 2008 issue of the *Journal of the American Medical Association*, two Cedars-Sinai Medical Center cardiologists describe a disconnect between practice guidelines and clinical practice. The editorial comments on a study published in the same issue that says noninvasive tests that should help guide treatment decisions are not routinely used prior to elective percutaneous interventions.

**WHO:** George A. Diamond, M.D., is a senior research scientist, emeritus, at Cedars-Sinai. Sanjay Kaul, M.D., serves as director of the Cardiology Fellowship Training Program and director of the Vascular Physiology and Thrombosis Research Laboratory in the Division of Cardiology at the Cedars-Sinai Heart Institute.

**RAMIFICATIONS:** Proposals to rein in health care costs without diminishing quality were playing a major role in the upcoming election even before the recent crisis shook the economy. Diamond and Kaul suggest the use of “evidence-based reimbursement incentives” rather than “pay-for-performance.”

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"The Centers for Medicare and Medicaid Services, for example, might set reimbursement for evidence-based care at a higher level than for non-evidence-based care. Thus, a cardiologist performing PCI for a patient with objective evidence of ischemia despite an appropriate intensity of medical therapy would be paid more than for the same patient without such evidence. ... If evidence-based reimbursement policies such as this were adopted, dramatic changes in utilization could be realized virtually overnight (as happened in the 1980s with the advent of Diagnosis Related Groups). The COURAGE trial shows that these changes would place the patient at no additional clinical risk, and the data ... suggest a substantial economic savings," the authors say.

Diamond and Kaul wrote a related article, "Pay for Proof," that is currently appearing at *Forbes.com*. They also wrote a commentary about the COURAGE trial in the *Journal of the American College of Cardiology*, Oct. 16, 2007.

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