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Editorial on the Proper Use of Modifier 63 for Congenital Cardiac Catheterization – Educating User and Payer Alike

Sergio Bartakian, MD, FAAP, FACC, FSCAI

In 2016, members from the Society of Cardiovascular Angiography and Interventions (SCAI), recognizing the lack of codes in the existing CPT® coding structure to capture the work for congenital cardiac catheterization procedures, formed the Congenital Interventional Cardiology Coding Workgroup (CICCW). Since that time, the CICCW has been very successful creating numerous new CPT® codes (Table 1) and correcting several long-standing errors in the existing CPT® guidelines, as well.

TABLE 1

Project	CPT Meeting Presented	RUC Survey	RUC Meeting Presented	Status	When Available	New code (wRVU value)
Pulmonary artery angiography with device closure bundles	June 2017	n/a	n/a	Passed	Dec 2017	n/a
new pericardiocentesis codes	Sep 2018	Nov 2018	Dec 2018	Passed	1-Jan-2020	33016 (4.4), 33017 (4.62), 33018 (5.4)
Modifier 63 for infants under 4 kg	Sep 2018	n/a	n/a	Passed	Jun 2019	n/a
Atrial septostomy	Feb 2020	Feb 2020	Apr 2020	Passed	1-Jan-2021	33741 (14.0)
Intracardiac stenting	Feb 2020	Feb 2020	Apr 2020	Passed	1-Jan-2021	33745 (20.0) and 33746 (8.0)
ICE for use with broader range of cardiac cath procedures	May 2020	n/a	n/a	Passed	1-Jan-2022	n/a (existing code)
Congenital diagnostic catheterization base codes	May 2020	Jun 2020	Oct 2020	Passed	1-Jan-2022	93X1X - 93X5X
New Thermolodilution code for congenital diagnostic catheterization	May 2020	Jun 2020	Oct 2020	Passed	1-Jan-2022	93X6X
Stent / angioplasty for repair of coarctation of the aorta	Oct 2020	Oct 2020	Jan 2021	Passed	1-Jan-2022	338X0, 338X1, 338X2
Pulmonary artery / ductal stenting	Feb 2021	Feb 2021	Oct 2021	Passed CPT	1-Jan-2023	
Pulmonary Angiography	Feb 2021	May 2021	Oct 2021	Passed CPT	1-Jan-2023	
Completed	In process / scheduled					

Among the many improvements, a correction was made to add the extensive list of congenital cardiac catheterization codes to the 90000 Code Series of the Medicine / Cardiovascular Section, to be included for use with modifier 63. Despite this change, the specialty continues to meet significant resistance from the payer community with regards to inappropriate denials. The denials stem from incorrect internal guidance on the part of most health insurance companies.

Some payers have incorrectly instructed their staff that the 63 modifier is not to be used to report procedures performed to treat congenital defects. This is entirely false as the modifier is precisely intended for this reason. The entire list of the 90000 congenital cardiac catheterization codes is for exactly that purpose, congenital cardiac defects. The AMA CPT® guidelines do not instruct any limitation for the use of modifier 63 due to the presence of a congenital defect. In fact, the only limitation is for the infant to be under 4 kg body weight at time of procedure.

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Career Opportunities Throughout



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Other payers provide incorrect guidance to deny claims which include the term “infant or neonate” in the procedure code. This is also a grossly misstated fallacy. Although all patients under 4 kg are infants and/or neonates, not all infants and/or neonates weigh less than 4 kg.

The official definition of the term infant is for any child under one year of age; and clearly, the far majority of children under one year of age will not be less than 4 kg. CPT® guidance is very clear about which codes specifically include this increased complexity as “the typical patient” for the given CPT® code. These are found in Appendix F and are the only procedures which inherently include the additional complexity for which modifier 63 is intended.

Finally, here is a sample from one payer which states a necessity to have additional documentation, not unlike guidance for modifier 22.

“Documentation from the patient's record must indicate the significantly greater effort required and the reason for the additional work which may include, but not be limited to, increased intensity or time, technical difficulty of procedure that is not described by a more comprehensive procedure code, severity of the patient's condition, or increased physical and mental effort.” In fact, there is no other requirement for properly appending modifier 63, aside from the patient weight at time of procedure being under 4 kg, and the specific code be in the approved sections of CPT®. It goes without saying, but modifier 63 is not modifier 22. The documentation regarding the reason for increased intensity, greater effort, technical skill, etc. lies solely on the fact that the child is less than 4 kg. Nothing else is needed to justify this work. To further suggest that “a more comprehensive procedure code” could be used is simply demonstrating the total lack of understanding of coding for congenital cardiac catheterization that is so widespread in the healthcare industry.

The members at SCAI and ACC have spent a great deal of time and effort in creating a comprehensive coding framework to capture the extremely complex nature of coding for this specialty. A great deal of collaboration has taken place with CPT® staff, advisors, and panel members to devise a structure which captures the work performed accurately. It is irresponsible for payers to disregard this effort by creating additional internal guidance which results in inappropriate denials for this very complex work.

For any questions regarding the proper use of CPT® codes for congenital cardiac catheterization, it is strongly advised to reach out to SCAI and/or ACC staff for clarification and guidance. Deb Mariani, SCAI staff, dmariani@scai.org or James Vavricek, ACC staff, jvavricek@ACC.org.

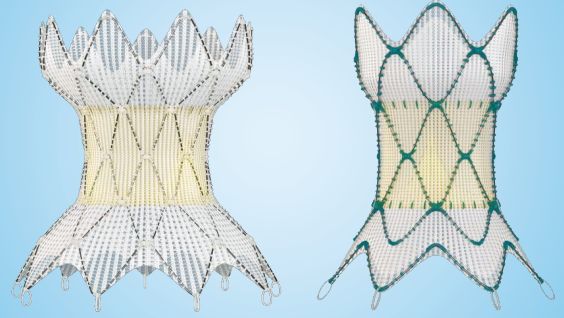
Dr. Bartakian is a board-certified pediatrician and pediatric cardiologist who practices full time in the specialty of congenital cardiac catheterization. He is a former CPT® Alternate Advisor for SCAI and a current AMA RUC Panel member.



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Hospital Directory 2021-2022 Coming Mid-August

- Currently updating listings
- Hospitals that offer Open Heart Surgery for Children in North America
- Contact information at each hospital for Chief of Pediatric Cardiology & Fellowship Director
- Lists each hospital's Pediatric Cardiologists & Cardiothoracic Surgeons
- Distributed to Division Chiefs by mail
- Hard copies will be available at CCT's booth at PICS 2021
- Electronic version available on CCT's website:
www.congenitalcardiologytoday.com



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Indications

The Harmony™ transcatheter pulmonary valve (TPV) system is indicated for use in the management of pediatric and adult patients with severe pulmonary regurgitation (i.e., severe pulmonary regurgitation as determined by echocardiography and/or pulmonary regurgitant fraction $\geq 30\%$ as determined by cardiac magnetic resonance imaging) who have a native or surgically-repaired right ventricular outflow tract and are clinically indicated for surgical pulmonary valve replacement.

Contraindications

The following are contraindications for the use of this device: active bacterial endocarditis or other active infections, known intolerance to Nitinol (titanium or nickel), or an anticoagulation/antiplatelet regimen.

Warnings

General: Implantation of the Harmony TPV system should be performed only by physicians who have received Harmony TPV system training. The transcatheter pulmonary valve (TPV) is to be used only in conjunction with the Harmony delivery catheter system (DCS). This procedure should only be performed where emergency pulmonary valve surgery can be performed promptly. Do not use any of the Harmony TPV system components if any of the following has occurred: it has been dropped, damaged, or mishandled in any way, or if the use-by date has elapsed.

Transcatheter pulmonary valve (TPV): This device was designed for single use only.

Do not reuse, reprocess, or resterilize the TPV. Reuse, reprocessing, or resterilization may compromise the structural integrity of the device and/or create a risk of contamination of the device, which could result in patient injury, illness, or death. Do not resterilize the TPV by any method. Exposure of the device and container to irradiation, steam, ethylene oxide, or other chemical sterilants renders the device unfit for use. The device is packaged with a temperature sensor. Do not freeze the device. Do not expose the device to extreme temperatures. Do not use the device if the arrow on the sensor points to the symbol that indicates that the temperature limit has been exceeded. Do not use the device if any of the following have occurred: the tamper-evident seal is broken, the serial number tag does not match the container label, the arrow on the sensor points to the symbol that indicates that the temperature limit has been exceeded, or the device is not completely covered by the storage solution. Do not contact any of the Harmony TPV system components with cotton or cotton swabs. Do not expose any of the Harmony TPV system components to organic solvents, such as alcohol. Do not introduce air into the catheter. Do not expose the device to solutions other than the storage and rinse solutions. Do not add or apply antibiotics to the device, the storage solution, or the rinse solution. Do not allow the device to dry. Maintain tissue moisture with irrigation or immersion. Do not attempt to repair a damaged device. Do not handle the valve leaflet tissue or use forceps to manipulate the valve leaflet tissue. Do not attempt to recapture the device once deployment has begun. Do not attempt to retrieve the TPV if any one of the outflow TPV struts is protruding from the capsule. If any one of the outflow TPV struts has deployed from the capsule, the TPV must be released from the catheter before the catheter can be withdrawn. Do not attempt post-implant balloon dilatation (PID) of the TPV during the procedure, which may cause damage to or failure of the TPV leading to injury to the patient resulting in reintervention.

Delivery catheter system (DCS): This device was designed for single use only.

Do not reuse, reprocess, or resterilize the DCS. Reuse, reprocessing, or resterilization may compromise the structural integrity of the device and/or create a risk of contamination of the device, which could result in patient injury, illness, or death. Do not reuse or resterilize the DCS. If resistance is met, do not advance the guidewire, DCS, or any other component without first determining the cause and taking remedial action. Do not remove the guidewire from the DCS at any time during the procedure.

Precautions

General: Clinical long-term durability has not been established for the Harmony TPV. Evaluate the TPV performance as needed during patient follow-up. The safety and effectiveness of Harmony TPV implantation in patients with pre-existing prosthetic heart valve or prosthetic ring in any position has not been demonstrated. The Harmony TPV system has not been studied in female patients of child-bearing potential with positive pregnancy.

Before use: Exposure to glutaraldehyde may cause irritation of the skin, eyes, nose, and throat. Avoid prolonged or repeated exposure to the chemical vapor. Use only with adequate ventilation. If skin contact occurs, immediately flush the affected area with water (for a minimum of 15 minutes) and seek medical attention immediately. The TPV and the glutaraldehyde storage solution are sterile. The outside of the TPV container is nonsterile and must not be placed in the sterile field. The TPV and DCS should be used only in a sterile catheterization laboratory (cath lab) environment. Ensure that sterile technique is used at all times. Strictly follow the TPV rinsing procedure. For TPV 25: Ensure that all green sutures have been removed from the attachment suture loops on the TPV before loading onto the DCS. Prevent contamination of the TPV, its storage solution, and the DCS with glove

powder. Verify the orientation of the TPV before loading it onto the DCS. The inflow end of the TPV with attachment suture loops must be loaded first. Do not place excessive pressure on the TPV during loading. Inspect the sealed DCS packaging before opening. If the seal is broken or the packaging has been damaged, sterility cannot be assured. Proper functioning of the DCS depends on its integrity. Use caution when handling the DCS. Damage may result from kinking, stretching, or forceful wiping of the DCS. This DCS is not recommended to be used for pressure measurement or delivery of fluids. Carefully flush the DCS and maintain tight DCS connections to avoid the introduction of air bubbles.

During use: The TPV segment is rigid and may make navigation through vessels difficult. Do not advance any portion of the DCS under resistance. Identify the cause of resistance using fluoroscopy and take appropriate action to remedy the problem before continuing to advance the DCS. Careful management of the guidewire is recommended to avoid dislodgement of the TPV during DCS removal. Once deployment is initiated, retrieval of the TPV from the patient is not recommended. Retrieval of a partially deployed valve may cause mechanical failure of the delivery catheter system or may cause injury to the patient. Refer to the section below for a list of potential adverse events associated with Harmony TPV implantation. During deployment, the DCS can be advanced or withdrawn prior to the outflow struts protruding from the capsule. Once the TPV struts contact the anatomy during deployment, it is not recommended to reposition the device. Advancing the catheter forward once the TPV struts make contact with the anatomy may lead to an undesired deployment or may cause damage to or failure of the TPV and injury to the patient. Refer to the section below for a list of potential adverse events associated with the Harmony TPV implantation. Physicians should use judgment when considering repositioning of the TPV (for example, using a snare or forceps) once deployment is complete. Repositioning the bioprosthesis is not recommended, except in cases where imminent serious harm or death is possible (for example, occlusion of the main, left, or right pulmonary artery). Repositioning of a deployed valve may cause damage to or failure of the TPV and injury to the patient. Refer to the section below for a list of potential adverse events associated with the Harmony TPV implantation. Ensure the capsule is closed before DCS removal. If increased resistance is encountered when removing the DCS through the introducer sheath, do not force passage. Increased resistance may indicate a problem and forced passage may result in damage to the device and harm to the patient. If the cause of resistance cannot be determined or corrected, remove the DCS and introducer sheath as a single unit over the guidewire, and inspect the DCS and confirm that it is complete. If there is a risk of coronary artery compression, assess the risk and take the necessary precautions. Endocarditis is a potential adverse event associated with all bioprosthetic valves. Patients should make their healthcare providers aware that they have a bioprosthetic valve before any procedure. Post-procedure, administer appropriate antibiotic prophylaxis as needed for patients at risk for prosthetic valve infection and endocarditis. Prophylactic antibiotic therapy is recommended for patients receiving a TPV before undergoing dental procedures. Post-procedure, administer anticoagulation and/or antiplatelet therapy per physician/clinical judgment and/or institutional protocol. Excessive contrast media may cause renal failure. Preprocedure, measure the patient's creatinine level. During the procedure, monitor contrast media usage. Conduct the procedure under fluoroscopy. Fluoroscopic procedures are associated with the risk of radiation damage to the skin, which may be painful, disfiguring, and long term.

Potential Adverse Events

Potential risks associated with the implantation of the Harmony TPV may include, but are not limited to, the following: ■ death ■ valve dysfunction ■ tissue deterioration ■ hematoma ■ heart failure ■ cerebrovascular incident ■ perforation ■ rupture of the right ventricular outflow tract (RVOT) ■ compression of the aortic root ■ compression of the coronary arteries ■ sepsis ■ pseudoaneurysm ■ erosion ■ stent fracture ■ arrhythmias ■ device embolization or migration ■ pulmonary embolism ■ occlusion of a pulmonary artery ■ laceration or rupture of blood vessels ■ device misorientation or displacement ■ valve deterioration ■ regurgitation through an incompetent valve ■ physical or chemical implant deterioration ■ paravalvular leak ■ valve dysfunction leading to hemodynamic compromise ■ residual or increasing transvalvular gradients ■ progressive stenosis and obstruction of the implant ■ hemorrhage ■ endocarditis ■ thromboembolism ■ thrombosis ■ thrombus ■ intrinsic and extrinsic calcification ■ bleeding ■ bleeding diathesis due to anticoagulant use ■ fever ■ pain at the catheterization site ■ allergic reaction to contrast agents ■ infection ■ progressive pulmonary hypertension ■ progressive neointimal thickening and peeling ■ leaflet thickening ■ hemolysis. General surgical risks applicable to transcatheter pulmonary valve implantation: ■ abnormal lab values (including electrolyte imbalance and elevated creatinine) ■ allergic reaction to antiplatelet agents, contrast medium, or anesthesia ■ exposure to radiation through fluoroscopy and angiography ■ permanent disability.

Please reference the Harmony TPV system instructions for use for more information regarding indications, warnings, precautions, and potential adverse events.

Caution: Federal law (USA) restricts these devices to the sale by or on the order of a physician.

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Director, Pediatric Cardiac Catheterization Cohen Children's Medical Center – NYC Suburbs

The Department of Pediatrics at the Steven and Alexandra Cohen Children's Medical Center of New York is seeking a BC/BE Fellowship trained Pediatric Cardiologist with additional training or experience in Pediatric Cardiac Catheterization to join our award-winning team of physicians in our New Hyde Park/Queens location. Our division is currently performing about 160 catheterizations per year that include the breath of cardiac interventions and has one of the largest experiences with the Piccolo device in the region, as well as transcatheter valve replacements, device closures etc. The ideal candidate will have at least 5-8 years of clinical experience and have a vision to help assist in the further growth of our rapidly growing division. Our current Cath Lab director is committed to ongoing clinical care and excellence, and to working with the incoming director to support their leadership. Consideration of a more junior person is possible with the potential for transitioning to the director role in the future. Active interest and a track record of research and investigation is highly desirable.

The Pediatric Heart Center at Cohen Children's Medical Center is an integrated program, with specialists in cardiac surgery, cardiology, and critical care. Programs of excellence include interventional catheterization, advanced CT and MR imaging, COVID/MIS-C follow up, Advanced Fetal Center, genetic aortopathies, electrophysiology and device implantation, comprehensive echocardiography, as well as the inception of our heart failure program.

The Steven and Alexandra Cohen Children's Medical Center is rated by US News as the best children's hospital in New York State and one of the five best in the mid-Atlantic region. It is the largest pediatric teaching hospital in the New York metropolitan region, with more than 13,000 admissions per year. It is the tertiary pediatric medical center of Northwell Health, formally the North Shore-Long Island Jewish Health System, and is the only Level-1 Pediatric Trauma Center and ECMO Center on Long Island.

Cohen Children's is the only children's hospital on Long Island that offers comprehensive pediatric/congenital cardiology and cardiac surgery care from pregnancy through infancy, childhood, adolescence and adulthood for congenital heart disease. The Cohen Children's Heart Center provides more than 14,000 inpatient and outpatient visits annually. With one of the highest volume programs in New York State, the Division of Pediatric Cardiology has a long reputation of providing exceptional cardiovascular care throughout the region.

We offer a competitive salary and benefits package. In addition, an academic appointment with The Donald and Barbara Zucker School of Medicine at Hofstra/Northwell is commensurate with credentials and experience. Physicians will be employed as members of Northwell Physician Partners, the seventh largest medical group in the country.

For further details and opportunities, please contact:

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EOE M/F/D/V



The PICS Society Advocacy Program: Power in Numbers! Part 1

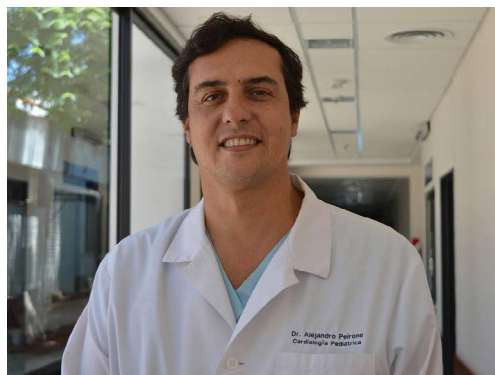
Kamel Shibbani, MD; Natalie Poli, Ed.S; Norm Linsky, MPA, MA

Let's start a conversation about **ADVOCACY**—how our community can advocate for lasting changes to laws, regulations, R&D investment, funding, compensation and related issues that impact us all daily. Are there fundamental advocacy goals we all share? Do we, as a professional society, have the obligation to use our collective voice to affect change? Are there opportunities for doctors and patients to advocate as a team? Do we have “power in numbers” by speaking with one voice?

Based on what several of you have told us, the answers are a resounding yes, yes, yes and yes. That's the focus of this month's column and others in the coming months.

We recently posed three questions to colleagues around the world:

- What is the most pressing advocacy challenge in your country?
- What is the most important advocacy challenge globally?
- What should the PICS Society do moving forward?



Let's start the conversation by spotlighting a recent interview we had with Alejandro Peiróne, MD, FPICS, Children's Hospital of Córdoba, Argentina.

Comments lightly edited for brevity.

I ask myself every day how we can help improve the quality of life for patients in my country. Several vital areas come to mind.

Economic challenges in my country: Starting about ten years ago, my country had problems getting access to international credit and loans. This complex area affected everyone, including those of us who care for children and adults with CHD. Our country's infant mortality rate was about 14 per 1,000 newborns. This, much like our government's ability to qualify for better access to international credit, needed to improve. The government worked with us to create a national plan for improved access and quality of care for those with CHD. We worked hard with the government to implement this plan, making important progress in the past decade. Although progress is slow, we are moving in the right direction.

Migration: Another growing challenge relates to migration from neighboring countries. We care for all patients who come to us, but too often migrants do not have ready access to timely care, so we have much work to do—and I believe other countries face similar situations.

Professional education: We urgently need to improve medical education and advocate

Sharing lessons learned: We need to share ideas about how patients with no insurance or ability to pay can get the care they need. I believe this is a universal problem. I have participated in medical missions in Panama, Peru and elsewhere. Our team will be on site for one or two weeks. However, once we leave the overall situation stays the same. Such missions need to provide more education and involve a broader range of medical professionals. We must promote teamwork and constantly improve, educate and network. Everyone has an important role to play.

Quality improvement: The PICS Society can partner with national societies, doctors, hospitals and governments to develop quality improvement plans where you don't have everything. I am in Córdoba, a major city, and have extensive resources available to me. One hundred kilometers away, the situation is totally different: resources are very limited. We all need to work with our respective governments to change this through funding and training. In Argentina our government is eager to partner with us—which is very encouraging!

“When I first came home to Argentina, I thought I could be like Superman and I could change everything quickly. In reality, change takes time. When I go home each day I feel optimistic that we are making progress! We have much work and opportunity ahead.” – Dr. Alejandro Peiróne

for national training and quality standards. In Argentina, we have few pediatric cardiology specialists. Typically, those with CHD are treated by adult cardiologists; this is the only option. In the largest cities, the quality of prenatal diagnosis for CHD is high, but much less so in the countryside. The PICS Society can partner with national societies to develop national training standards and professional education programs—and advocate for their funding.

Global networking: The importance of networking, connecting and sharing ideas globally cannot be overstated. Whether we are discussing quality, education, funding, regulations or other issues, our opportunity to network to achieve common goals is what encourages me.

Optimistic attitudes, realistic expectations: I have been in Argentina since I completed training 20 years ago. When I first came



home to Argentina, I wanted to change everything! I thought I could be like Superman and I could change everything quickly. In reality of course, change is difficult and takes time. I go home every day and I feel optimistic to see how younger physicians and their teams are getting better training, getting published and trying hard – every day – to offer high quality health care to patients.

Working with the national government: If our government is to help, it needs access to data showing CHD treatment and outcomes over time: this is essential to encourage the government to continue investment in CHD care in Argentina and I am sure elsewhere. Our PICS Society has an important information sharing role in that regard.

Final thoughts: We very much need global cooperation. The PICS Society can partner with societies in Argentina, South America and worldwide. I am glad the Society is a global organization dedicated to international cooperation. This is a decathlon—not a hundred-meter dash!

What are your thoughts about advocacy? Want to get involved? Email nlinsky@CHDinterventions.org. Thank you Dr. Peiróne and the PICS Society Advocacy Committee (John Cheatham, MD, Chair; Clifford Kavinsky, MD, PhD, Co-Chair; Hideshi Tomita, Co-Chair). More interviews to come next month!



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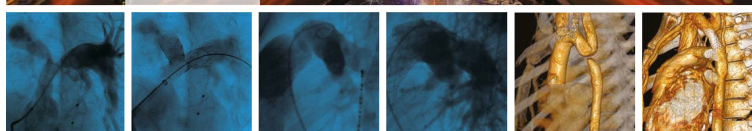


PICS Society

Pediatric and Congenital Interventional Cardiovascular Society



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Pediatric Heart Failure / Transplant Cardiologist

Overview

Children's Minnesota is seeking a dynamic, fellowship-trained pediatric heart transplant cardiologist to lead the Heart Failure Heart transplant (HFHT) program. This physician would have the benefit of collaborating with a comprehensive multidisciplinary team that includes: surgeons, cardiologists, transplant coordinators, dietitians, pharmacists, therapists and social workers. The HFHT program also offers a growing Ventricular Assist Device program as well as a well-established ECMO program.

Our Transplant program partners closely with The Children's Heart Clinic (CHC). Annually, the CHC cardiologists see more than 16,000 patients and surgeons perform over 400 surgical interventions. The CHC's state-of-the-art facilities include a dedicated pediatric cardiovascular intensive care unit, one of 30 approved pediatric cardiac catheterization laboratories in North America for transcatheter pulmonary valve placement, a complete pediatric arrhythmia service including the latest technology for ablation and devices, a collaborative fetal program for diagnosing and managing congenital heart disease in-utero, a collaborative adult congenital cardiology program, an ICAEL-accredited echocardiography lab and a rapidly growing congenital cardiac MRI/CT program.

Program Description

Children's Minnesota's cardiovascular program provides comprehensive pediatric cardiovascular services and on average, we annually perform:

- 425+ cardiac surgeries
- 400+ cath procedures
- 12,000 + echos (1,200+ fetal)
- 370+ cardiac CT/MRIs

Children's Minnesota and Mayo Clinic Children's Center collaborate in the care of children with congenital heart disease and build on each organization's passion for children as well as the complementary strengths of both programs. The Mayo Clinic – Children's Minnesota Cardiovascular Collaborative is one of the largest and strongest pediatric cardiovascular collaborations in the country.

This exciting opportunity is open for a pediatric cardiologist with heart failure heart transplant experience to lead our recognized program. Candidates should have a strong commitment to patient care, teaching and clinical research.

Requirements of the position include:

- Board Certified in Pediatric Cardiology from the American Board of Pediatrics
- Advanced Heart Failure/Transplant fellowship training in a program certified by the American Board of Pediatrics.
- Physicians should have clinical competency and expertise in caring for patients who are candidates for or are recipients of advanced heart failure therapies including mechanical circulatory devices.
- Must have an M.D., D.O. or equivalent degree from another country with a current Minnesota Medical License or the ability to obtain one.
- Ability to be successfully credentialed by both Hospital and 3rd Party Payers

Children's Minnesota

Children's Minnesota is the seventh largest pediatric health system in the United States and the only health system in Minnesota to provide care exclusively to children, from before birth through young adulthood. An independent and not-for-profit system since 1924, Children's Minnesota serves kids throughout the Upper Midwest at two free-standing hospitals, 12 primary and specialty care clinics and six rehabilitation sites. Additionally, Children's Minnesota is Minnesota's only Level I pediatric trauma center inside a hospital dedicated solely to children. Children's Minnesota maintains its longstanding commitment to the community to improve children's health by providing high-quality, family-centered pediatric services and advancing those efforts through research and education

Minneapolis - St. Paul (Twin Cities)

The Twin Cities has an estimated population of 3.5 million making it the 13th most populous metropolitan area in the US. The Twin Cities are known for their extraordinary quality of life, thriving economy, outstanding educational system and vibrant cultural amenities. The large numbers of colleges and universities, as well as the strong economy account for the high per-capita attendance at theatrical, musical and comedy events making the Twin Cities the capitol for arts in the upper Midwest. There are numerous lakes in the region and cities in the area have expansive park systems for recreation. Major sports teams include the Minnesota Twins (MLB), Vikings (NFL), Timberwolves (NBA), Wild (NHL) and the University of Minnesota (Big 10).

For inquires please contact:

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Delayed Aortic Coarctation Balloon Dilatation After Duct Coil Occlusion

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Key Words: Patent ductus arteriosus, Coarctation of the aorta, Transcatheter treatment.

Summary

There are different approaches to the treatment of the combination of Patent Ductus Arteriosus and Coarctation of the Aorta in children using cardiac catheterization. We report, after eight years of follow up, an unusual staged closure of Patent Ductus Arteriosus and aortic ballooning in two separate procedures with several years in between. This child underwent coil patent ductus arteriosus occlusion at nine months of age and later only aortic balloon dilatation performed at the age of six-years-old, with good outcome of the coarctoplasty and no mislay of the right positioning of the coil.

Introduction

Small children with Coarctation of the Aorta (CoA) and Patent Ductus Arteriosus (PDA) usually undergo surgical correction, but transcatheter closure of moderate to large ductus arteriosus with occluder devices and coarctoplasty is now practiced more frequently using different techniques, devices and timing, depending on the patient.¹

We report an aortic balloon dilatation and PDA closure in sequential approach, with some years in between, in a small child who first underwent coil PDA occlusion and later only aortic balloon dilatation with both balloon and coil in a very close spatial relationship.

Clinical Case

Fifteen-year-old female adolescent with diagnosis at the age of seven months of: aortic coarctation, patency of the arterial duct, small-subaortic Ventricular Septal Defect and bicuspid aortic valve.

At the age of eight months, this patient underwent only balloon dilatation of the coarctation because, at that time, it was identified as the target lesion. Additionally, there was not consensus about the presence, or not, of an adequate diameter of the aorta to deploy a device without worsening the lumen of the aorta due to a possible bulging of the aortic retention skirt of the device, which has been reported.^{2,3,4}

One month later the patient underwent ligation of a 4 mm PDA, but a mild to moderate residual leak was evident at the level of the PDA by echo the day after the surgery.

At the age of two years, the patient underwent transcatheter closure of the residual PDA leakage using a detachable coil with

no residual shunt. At that time there was no significant gradient at the level of the former coarctation site. However, four years later, a new coarctoplasty was indicated because after echo followup a gradient of 52 mmHg was identified at the level of the coarctation. At that time an angiotomography was also performed showing the narrowing of the aortic coarctation at the ductal level (**Figure 1**).

Before the procedure, the Telecardiogram showed a 0.59 Cardiac-Torax Index with normal pulmonary flow. The EKG showed sinus rhythm, incomplete right-bundle branch block, QRS axis 60

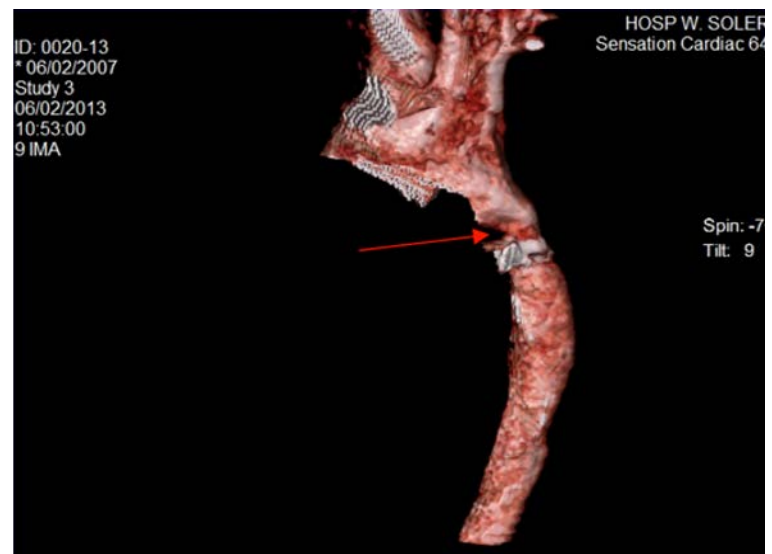


FIGURE 1 Narrowing of the aortic coarctation (arrow) at the ductal ligament level.

degrees and a Sokolow index of 14 mm. The angiography prior to the interventional procedure showed a diameter of 6.8 mm at the coarctation level and the diameter of the abdominal aorta at the diaphragm level was 12mm.

Once the coarctation balloon dilatation procedure was initiated, the arch of the aorta was crossed with a 0.021 × 260 cm Terumo wire using a 6 Fr multipurpose catheter from the right femoral artery access. Conventional angioplasty was performed with a 12 X 4 mm Tyshak balloon (**Figure 2 A-C**). The ballooning was repeated twice using the hand pressure. With the procedure, the peak pressure gradient across the coarctation was reduced to 0 mmHg. During the procedure heparin was administered at 100 mg/kg. It was indicated immediately after the sheath of the femoral artery was put in place.

Post-procedure period was uneventful. Patient was discharged from the hospital five days after the intervention. At the two week follow-up, the patient was stable and remained asymptomatic. Follow-up echocardiography after eight years revealed in-situ

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Nicklaus Children's Hospital is an affiliate of the Florida International University Herbert Wertheim College of Medicine. Our state-of-the-art Advanced Care Pavilion houses a 34-bed cardiac in-patient unit with an adjustable acuity model that allows all rooms to accommodate critically ill patients with heart disease. The Heart Institute offers a full range of services, including the management of patients following congenital heart surgery, interventional catheterization and invasive electrophysiology. Our cardiac surgical program, led by Dr. Redmond Burke, is one of the most transparent in the world. It remains the only cardiovascular surgical program to offer real-time outcomes reporting (<https://rto.nicklauschildrens.org>).

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PDA coil device with no residual shunt and no indications of recoarctation with 15 mmHg pressure gradient at the site of coarctation balloon dilatation.

Discussion

The transcatheter treatment for Coarctation of the Aorta associated with Patent Ductus Arteriosus in children and adults has been frequently reported in the past, performing the procedure either at the same time or sequentially.⁵ Reports include the use of balloon, stent and even covered stent.^{6,7,8,9,10} Due to the circumstances surrounding our patient without ample duct ampulla to have a previous sternotomy, the presence of residual shunt, and re-coarctation after surgery for PDA, we decided on re-coarctoplasty even though the patient had a previous device at the PDA site. There are previous reports in older patients with the use of Amplatzer devices at PDA level deploying a stent which included both the PDA device and the coarctation leading to better stabilization of the PDA device¹¹ but, to the best of our knowledge, this is the first report about performing a successful aortic coarctation ballooning over a detachable coil in PDA position in such a young patient with a long follow-up period.

Conclusion

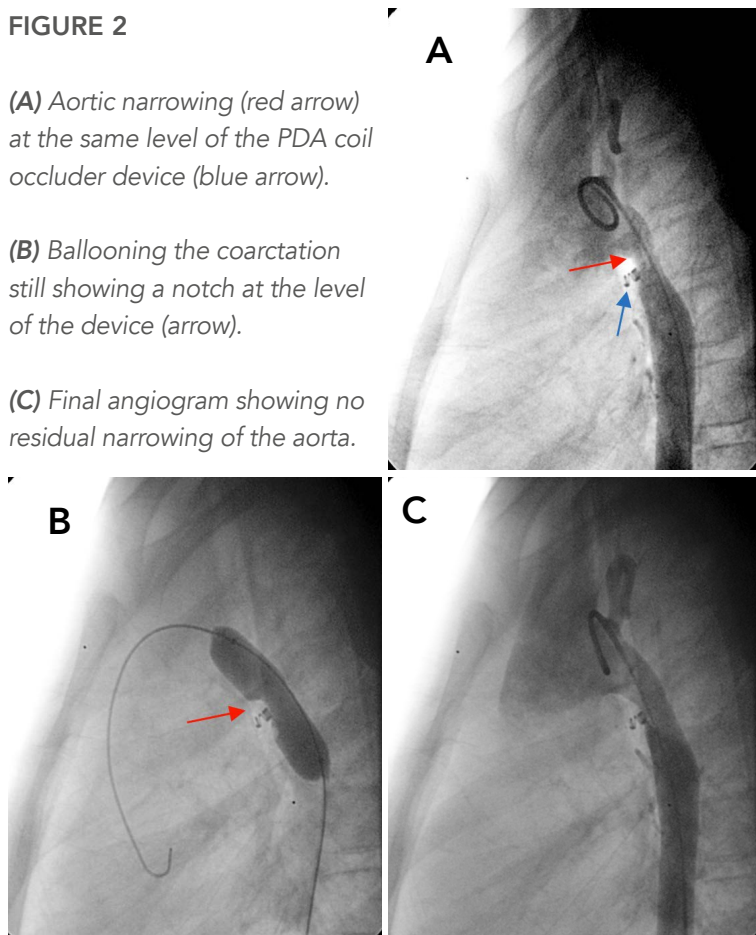
Transcatheter treatment of CoA and PDA in small children is safe. In the presence of previous PDA closure with detachable coil devices, it is possible, after some years, to perform balloon aortic dilatation with a by hand insufflation of the balloon.

FIGURE 2

(A) Aortic narrowing (red arrow) at the same level of the PDA coil occluder device (blue arrow).

(B) Ballooning the coarctation still showing a notch at the level of the device (arrow).

(C) Final angiogram showing no residual narrowing of the aorta.



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The Nicklaus Children's Hospital Heart Institute is a world leader in cardiology and cardiovascular surgery for the care of patients with congenital heart disease. Nicklaus Children's Hospital is expanding its services to the growing number of adult congenital heart disease patients in partnership with top-ranked adult specialists in the region. Interested candidates for the ACHD directorship should have completed a residency in either pediatrics, internal medicine or a combined med/peds program, followed by a three-year fellowship in either pediatric or adult cardiology. Either completion of a two-year ACGME accredited ACHD fellowship or a career demonstrating clinical and academic leadership in the field of ACHD is required. The candidate should be board certified in ACHD.

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Nationwide Children's Hospital Once Again Named on U.S. News & World Report's 2021-22 Best Children's Hospitals Honor Roll

Eighth Consecutive Year for "Best of the Best" Recognition

Nationwide Children's Hospital has been named once again to *U.S. News & World Report's Best Children's Hospitals Honor Roll*. The Honor Roll is a distinction awarded to only 10 children's medical centers nationwide recognized by *U.S. News* as the "Best of the Best." Nationwide Children's was once again recognized at number 8 on the Honor Roll list.

The 2021-22 Honor Roll designation marks the eighth consecutive year Nationwide Children's has received this distinction. The Honor Roll list is based on a hospital's cumulative ranking in 10 specialties evaluated by *U.S. News*.

"Despite the uncertainty posed by the COVID-19 pandemic, our team's commitment to the children in our community and globally has never wavered," said Tim Robinson, Nationwide Children's CEO. "These rankings highlight the high-quality care Nationwide Children's provides and are a testament to our incredible team."

"When choosing a hospital for a sick child, many parents want specialized expertise, convenience and caring medical professionals," said Ben Harder, chief of health analysis and managing editor at *U.S. News*. "The *Best Children's Hospitals* rankings have always highlighted hospitals that excel in specialized care. As the pandemic continues to affect travel, finding high-quality care close to home has never been more important."

The annual *Best Children's Hospitals* rankings, now in their 15th year, are designed to assist patients, their families and their physicians in making informed decisions about where to receive care for challenging health conditions.

The *U.S. News & World Report Best Children's Hospitals* ranking is one means of being recognized for continued progress and improvements in pursuing best outcomes, integrated care and research. For more information, visit *Best Children's Hospitals* and use #BestHospitals on Facebook and Twitter.

U.S. News & World Report's 2021-2022 Best Children's Hospitals rankings of Nationwide Children's individual medical specialties include:

- Cancer - #8
- Cardiology and Heart Surgery - #34
- Endocrinology - #11
- Gastroenterology and GI Surgery - #11
- Neonatology - #43
- Nephrology - #9
- Neurology and Neurosurgery - #6
- Orthopedics - #9
- Pulmonary Medicine - #7
- Urology - #11



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About Nationwide Children's Hospital

Named to the Top 10 Honor Roll on *U.S. News & World Report's 2020-21* list of "Best Children's Hospitals," Nationwide Children's Hospital is one of America's largest not-for-profit free-standing pediatric health care systems providing wellness, preventive, diagnostic, treatment and rehabilitative care for infants, children and adolescents, as well as adult patients with congenital disease. Nationwide Children's has a staff of more than 13,000 providing state-of-the-art pediatric care during more than 1.6 million patient visits annually. As home to the Department of Pediatrics of The Ohio State University College of Medicine, Nationwide Children's physicians train the next generation of pediatricians and pediatric specialists. The Abigail Wexner Research Institute at Nationwide Children's Hospital is one of the Top 10 National Institutes of Health-funded free-standing pediatric research facilities.

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To comply with Federal laws, the clinic is obliged to gather statistical information about how many applicants for each job vacancy are Canadian citizens/permanent residents of Canada. Applicants need not identify their country of origin; however, all applications must include one of the following statements: "I am a Canadian citizen/permanent resident of Canada"; OR, "I am not a Canadian citizen/permanent resident of Canada." Applications that do not include this information will be deemed incomplete. The Congenital Cardiology Clinic will support the Canadian work permit and CPSO license application process of the successful candidate.

To find out more information about the Congenital Cardiology Clinic, please visit: <https://drsingla.ca/>

Interested candidates may contact: singla@drsingla.ca



Phoenix Children’s Ranked in all 10 Specialties by U.S. News & World Report’s Best Children’s Hospitals

The Health System is Arizona’s Only Children’s Hospital Ever to be Named to the List

For the fifth time, **Phoenix Children’s Hospital** has earned national rankings from *U.S. News & World Report’s Best Children’s Hospitals* in 10 out of 10 ranked specialties. The health system is the only children’s hospital in Arizona ever to have been recognized by *U.S. News & World Report* and one of only 22 children’s hospitals in the United States to rank in **every surveyed specialty** for 2021-2022.



“We are incredibly proud of our clinicians, administrators and staff who overcame immense challenges last year and redoubled their efforts to provide hope and healing to Arizona families,” said Robert L. Meyer, President and CEO of Phoenix Children’s. “We’ve set our sights on becoming the top destination for pediatric health care in the region. Key to this goal is our ever-expanding footprint as Phoenix Children’s brings high-quality services closer to home for families in the West Valley, the East Valley and throughout Arizona.”

Every year, *U.S. News & World Report* ranks children’s hospitals in 10 clinical specialties using a variety of measures including clinical

expertise, patient outcomes and national reputation. The 2021-22 rankings mark the 11th consecutive year Phoenix Children’s has been named among the nation’s “**Best Children’s Hospitals**” and the fifth time the health system has received high marks in all 10 areas:

- Neonatology - #20
- Cardiology & Heart Surgery - #28, represented by Phoenix Children’s Heart Center
- Neurology & Neurosurgery - #30, represented by Barrow Neurological Institute at Phoenix Children’s
- Orthopedics - #33, represented by the Herbert J. Louis Center for Pediatric Orthopedics and Sports Medicine
- Nephrology - #35
- Cancer - #36, represented by Phoenix Children’s Center for Cancer and Blood Disorders
- Gastroenterology & Gastroenterology Surgery - #36
- Diabetes & Endocrinology - #37
- Pulmonology & Lung Surgery - #40
- Urology - #48

“Achieving top rankings in all 10 specialties reflects the strength of our reputation for clinical excellence among

physicians nationwide and as a pediatric health system offering world-class care,” said Michael Ritchey, MD, Senior Vice President and Chief Medical Officer at Phoenix Children’s. “This recognition validates our hard work over the past year, but we are not content to rest on our laurels and will continue to push for the best clinical outcomes for our patient families.”

Scoring for *Best Children’s Hospitals* includes objective measures such as patient outcomes as well as a hospital’s available clinical resources and compliance with best practices. Rankings also reflect survey results from thousands of pediatric specialists who rate children’s health systems based on where they would send their sickest patients, without respect to proximity or cost.

Phoenix Children’s *Best Children’s Hospital* recognition is one of many clinical distinctions the health system achieved recently. In the past year, Phoenix Children’s was verified a Level 1 Children’s Surgery Center from the American College of Surgeons, earned accreditation from the Adult Congenital Heart Association as an Adult Congenital Heart Disease Comprehensive Care Center, was verified a Tourette Association of America Center



of Excellence in partnership with Banner Sun Health Research Center, and was named Hospital of the Month by Children’s Hospitals’ Solutions for Patient Safety.

About Phoenix Children’s

Phoenix Children’s is one of the nation’s largest pediatric health systems. It comprises: Phoenix Children’s Hospital–Main Campus, Phoenix Children’s Hospital–East Valley at Dignity Health Mercy Gilbert Medical Center, four pediatric specialty and urgent care centers, 11 community pediatric practices, 20 outpatient clinics, two ambulatory surgery centers and six community-service-related outpatient clinics throughout the state of Arizona. The system has provided world-class inpatient, outpatient, trauma, emergency and urgent care to children and families for more than 35 years. Phoenix Children’s Care Network includes more than 850 pediatric primary care providers and specialists who deliver care across more than 75 subspecialties. For more information, visit us at <http://phoenixchildrens.org/>.



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- **Electrophysiology candidates** will have completed an ACGME accredited fellowships in pediatric cardiology and pediatric electrophysiology and should be BC/BE by the American Board of Pediatrics and will be expected to accomplish pediatric electrophysiology certification by the International Board of Heart Rhythm Examiners. Candidate should be skilled in outpatient and inpatient congenital electrophysiology with experience and interest in transcatheter ablations and device implantation/management. Days will be split between the EP lab and clinic. Responsibilities will include attending on-site/satellite EP outpatient clinics including pacemaker/ICD clinics, providing inpatient/consult service coverage, remote device management and cardiology/EP call/weekend coverage on a rotating basis. The Pediatric/Adult Congenital Electrophysiology program has grown in procedural volume over 40% in each of the last two years, and is currently staffed by a single electrophysiologist and dedicated EP APP.
- ACHD board certification will be welcomed for either position but not essential.
- Team includes: 12 cardiologists, 3 congenital heart surgeons, 5 cardiac intensivists, 4 pediatric cardiac anesthesiologists, 2 pediatric cardiac radiologists, 19 ACPs (includes 2 surgical ACPs), 13 sonographers, 3 nurse navigators and 4 dedicated RNs

The **Atrium Health Levine Children's Congenital Heart Center**, established in 2010, has been ranked as one of the top-50 pediatric heart centers in the country by U.S. News and World Report for the last nine years. Our comprehensive services include cardiac imaging, diagnostic and interventional catheterization, electrophysiology, dedicated cardiovascular intensive care staff, and regional referral programs in heart failure / transplantation, adult congenital heart disease, and fetal echocardiography. Surgical and cardiac catheterization volume have been growing at a rate of 10-15% per year. Our state of the art two lab cardiac catheterization and electrophysiology suite opened in February of 2017, with dedicated staffing and anesthesia teams. Our new outpatient office complex opened in December 2020 and is designed to treat all from fetal cardiology to ACHD. We have one of the most comprehensive Cardiac Neurodevelopment programs in the region, providing a multitude of specialty services to our congenital heart population in the same office suite. Participation in investigator initiated and multi-center industry sponsored studies is ongoing within the Heart Center, with the support of an active clinical research department.

Atrium Health Levine Children's Hospital (LCH) has 4 pediatric hospitalist teams, a 20-bed PICU (including cardiac ICU), an 85-bed NICU, and an inpatient pediatric rehabilitation facility. LCH hosts a premier Pediatrics Residency Program, serves as a teaching hospital for students of the UNC Chapel Hill School of Medicine, and offers excellent support for clinical research and quality improvement. Additionally, Atrium Health and Wake Forest Baptist Health, including Wake Forest School of Medicine, officially joined together as a single enterprise, Atrium Health. Wake Forest Baptist Health and Wake Forest School of Medicine will become the academic core of Atrium Health, building a second campus of the school of medicine in Charlotte, which is currently the largest city in the U.S. without a 4-year medical school. The growth of the school of medicine will expand existing academic research capabilities in a way that expands opportunities for clinical trials across a large, diverse market with some of the nation's leading medical experts.

LCH has repeatedly been ranked among the Best Children's Hospitals in the nation by U. S. News & World Report, most recently in eight pediatric specialties for 2021-2022 including Neonatology, Pulmonology, Cancer, Gastroenterology and GI Surgery, Cardiology and Heart Surgery, Nephrology, Neurology and Neurosurgery and Orthopedics.

For more information or to submit a CV for review, please contact:

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<https://www.cme.ucla.edu/courses/fetalecho21>**Unit Leader – Cath Lab
(Sign-on Bonus \$5,000)**

Join Redy Children's Cath Lab team as we prepare to move into our new state-of-the art Dickinson Family Image-Guided Intervention Center in Fall 2021! Redy Children's will be the first to utilize radiation-free MRI cardiac catheterization on the West Coast and will offer children and families the first comprehensive pediatric image guided center in the country. Be a part of our tradition of providing innovative cardiac transcatheter procedures to children.

Position Details

Schedule: Days, 8-hour shifts

FTE: Full-Time, Exempt

Location: Main Campus

Job Summary

The Unit Leader provides supervision for the daily operation of the Cath Lab. Responsibilities include, but are not limited to, ensuring that the lab is equipped and staffed to perform procedures which include all therapeutic, diagnostic, and EP cardiac catheterizations. Responsible for providing documentation and support service for testing and ensuring that all ordered procedures are completed in an efficient and organized manner. Able to cross train to other functions, as necessary and appropriate. Responsible for leading, supervising, and influencing the daily operational activities associated with the team. Supports the overall business plan by monitoring team performance and outcomes relative to established goals/measures.

Minimum Nursing Qualifications

- Bachelor's Degree in Nursing
- 5 years of experience
- California Nursing License (RN)
- BLS/CPR from the American Heart Association

Preferred Nursing Qualifications

- Master's Degree in Nursing
- 5-7 years of pediatric experience in at catheterization lab

OR**Minimum Tech Qualifications**

- Graduate of an approved ARRT program
- Cert Radiologic Technologist
- Rad Tech Fluoroscopy Permit
- BLS/CPR from the American Heart Association

Preferred Tech Qualifications

- Bachelor's Degree
- 5-7 years of pediatric experience in at catheterization lab

Interested candidates should contact:

Juan Cruz

JCruz4@rchsd.org

Brian Allison, FACHE

ballison@rchsd.orgTo learn more visit: www.radychildrens.org



**Nicklaus
Children's
Hospital**

Heart Institute

Outstanding Opportunity for a BC/BE Pediatric Cardiac Intensivist in Miami

The Heart Program at Nicklaus Children's Hospital, a 309-bed freestanding children's hospital, and Nicklaus Children's Pediatric Specialists, the physician multispecialty group practice of Nicklaus Children's Health System, have an exceptional opportunity for a BC/BE pediatric cardiac intensivist.

Our Cardiac Intensive Care Unit (CICU) was the first in the Southeast and provides care for newborns and children receiving treatment for congenital heart defects. With a longstanding tradition of excellence, our cardiac critical care team is currently comprised of six full-time attending physicians and six full-time nurse practitioners. We have an illustrious cardiology fellowship and have offered advanced training in cardiac critical care medicine for more than 20 years. The desired candidates should be board certified or eligible in pediatric critical care medicine or pediatric cardiology. Preference will be given to individuals with dual training in pediatric critical care and cardiology or those board eligible in either cardiology or pediatric critical care who have completed a minimum of one year of advanced training in cardiac intensive care medicine. Applicants should exhibit a strong interest in clinical care, education and academics. Nicklaus Children's Hospital is an affiliate of the Florida International University Herbert Wertheim College of Medicine. Candidates possessing all levels of experience shall be considered.

Our state-of-the-art Advanced Pediatric Care Pavilion houses a 34-bed cardiac in-patient unit with an adjustable acuity model that allows all rooms to accommodate critically ill patients with heart disease. The Heart Program offers a full range of services, including the management of patients following congenital heart surgery, interventional catheterization and invasive electrophysiology. Our cardiac surgical program, led by Dr. Redmond Burke, is one of the most transparent in the world. It remains the only cardiovascular surgical program to offer real-time outcomes reporting (<https://rto.nicklauschildrens.org>).

Founded in 1950, the rebranded Nicklaus Children's Hospital is renowned for excellence in all aspects of pediatric medicine and has numerous subspecialty programs that are ranked among the best in the nation. It is also home to the largest pediatric teaching program in the southeastern U.S. Our organization consistently appears on employer award lists such as Fortune magazine's "Best Workplaces In Health Care," Becker's "150 Great Places to Work in Healthcare" and People magazine's "50 Companies That Care." Join a phenomenal team that brings lifelong health and hope to children and their families through innovative and compassionate care.

The Heart Program at Nicklaus Children's, a world leader in pediatric cardiology and cardiovascular surgery for the care of children with congenital heart disease, serves as a beacon to families confronting the reality of a child or newborn with a heart defect.

Competitive compensation and benefits package.

Qualified candidates please contact:

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