

Re: Patient Thelma Parker  
Sequence of Events

This patient underwent multiple procedures dating 4/7-4/21/2000.

This patient was found to have ischemia based on her non-invasive studies and underwent cardiac catheterization on 4/7/00.

On 4/07/00 cardiac catheterization demonstrated severe coronary artery disease in the right coronary and left circumflex territories.

On 4/10/00, after decision was made for the patient to undergo percutaneous intervention as opposed to coronary artery surgery, complex intervention to the left circumflex territory was performed with great results.

On 4/12/00, the second part of the intervention for this multi-vessel intervention was undertaken to treat the severe disease in multiple areas in the right coronary artery. This was also accomplished without any complication.

On 4/13/00, patient developed high grade heart block, which may be associated with ischemia in the right coronary artery territory. Appropriately, patient was taken to the cardiac catheterization laboratory and a temporary pacemaker was placed to avert potential complications and allow the patient to recover from this episode.

On 4/17/00, patient developed sub-acute thrombosis of the right coronary artery stents which is an expected outcome in 0.5-1.0% of total stent placements. This required taking the patient back to the cardiac cath laboratory for treatment as this is equivalent to an acute myocardial infarction and associated with very high mortality.

Based on persistent bradycardia, on 4/21/00 a permanent pacemaker was placed successfully that allowed for the patient to be discharged in time.

In summary, every aspect of patient Thelma Parker's care was performed appropriately according to the severity of her coronary artery disease, with great outcome, and acceptable complications that were addressed appropriately. There were no indications of prolongation of treatment or multiplication of treatment in order to increase revenue; rather, clear clinical judgment in order to achieve the best clinical outcome was demonstrated, as evidenced by the long term outcome for this patient.

I declare under penalty of perjury that the foregoing is true and correct.

Date:

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Mehrdad Rezaee, MD, PhD

Declaration

1. My name is Mehrdad Rezaee. I am a physician who is board certified in Medicine, Cardiology and Interventional Cardiology. I graduated from the Medical College of Wisconsin in 1994 and completed an internship and residency in Internal Medicine at the Harvard Medical School between 1994 and 1997. I was a Fellow in Cardiology and Interventional Cardiology at the Stanford University School of Medicine between 1997 and 2001. Currently, I am a Staff Cardiologist at four California hospitals and an Assistant Professor of Medicine in Cardiology at the Stanford University School of Medicine. A copy of my CV is attached.

**Paragraphs not germane  
to analysis omitted**

7. I reviewed the portion of the Affidavit that concerns right heart catheterizations and billing issues related to the use of CPT code 93526. The

Affidavit creates a misleading impression about both these subjects. I have practiced interventional cardiology at a variety of hospitals in California and other parts of the country. I also teach interventional cardiology at the Stanford University School of Medicine. First, Dr. Rawling's assertions about how infrequently right heart caths were done in 2001 is misleading. Performing combined right heart and left heart caths was the norm in the profession until the late 90ies and into 2000 and 2001 in some hospitals. Gradually, the perceived need for right heart caths diminished. The focus was more on coronary arteries but in my experience many practitioners continue to this day to perform right heart caths whenever they perform a left heart cath. This is a matter of operator's preference rather than an inappropriate practice. Further, in my experience it has never been done to increase reimbursement. I have practiced at a Veterans Administration hospital where reimbursement is not an issue and yet right heart caths were always performed in conjunction with left heart caths.

8. It is my understanding that Dr. Srivastava observed the practice trend and ceased monitoring hemodynamic pressures in the right heart, but, like many other practitioners, he did continue to run a catheter line into the venous system or to the entrance of the right heart. This is an appropriate procedure because it may become necessary to use that line to inject life saving medicines or to insert a pacemaker during the performance of a left heart catheterization. My residents often do this for me when I intend to perform a left heart catheterization but Dr.

Srivastava does not enjoy the resources available to me at a teaching institution and must perform this procedure himself. It is entirely appropriate that he be paid for performing this procedure. The difficulty for Dr. Srivastava and other practitioners is that there is really no CPT code that adequately describes what they do when they open a line into the venous system. In my view, it was not inappropriate for Dr. Srivastava's office biller to use CPT code 93526 to bill for that procedure along with the performance of a left heart catheterization. It comes close to describing what Dr. Srivastava did and no other CPT code is well suited to the procedure. The alternative would be to simply not bill at all for it but this ignores the sophisticated skill and expertise that Dr. Srivastava used to perform the procedure. Further, Dr. Srivastava's medical records were transparent with regard to what he did. He never claimed to measure or record hemodynamic pressures in the right heart. He correctly indicated that he inserted a catheter to the right heart. If he wanted to misrepresent what he was doing, he could have easily listed right heart pressures in the record and nobody would have been the wiser. Instead, his medical records expressly reveal what he actually was doing and he was entitled to be paid for it.

I declare under penalty of perjury that the foregoing is true and correct.

Date:

  
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Mehrdad Rezaee, MD, PhD